DriveTalk Road Safety Insight Paper

Supporting Fitness to Drive Decisions in Dementia: A Proposed Role for Specialist ADIs

A practical framework for earlier road based evidence, professional signposting and safer, fairer decision making.

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Purpose: This paper explores whether specially trained ADIs could provide structured on road observations that help families and medical professionals make earlier, safer and fairer decisions when cognitive decline may affect driving. The proposed role would not include decisions about legal fitness to drive. It would provide objective evidence, clear signposting and an earlier link between families, clinicians, licensing processes and specialist assessment services. I am seeking partners to help define safeguards, training standards and an independently evaluated pilot.

The evidence gap facing drivers, families and clinicians

Picture a hypothetical conversation. A family has noticed missed junctions, hesitant decisions, reduced safety margins and one or two worrying moments. The driver insists they are fine. Their clinician understands the diagnosis but has not seen them negotiate a busy roundabout or respond to a developing hazard. Everyone cares deeply, and yet nobody has quite the right evidence.

For many people, driving is far more than transport. It protects independence, identity and connection. That is why decisions about driving and dementia must never be reduced to a blunt choice between “carry on” and “hand over the keys”. They need to be safe, proportionate and humane.

My proposal is that specially trained Approved Driving Instructors could help fill this practical evidence gap. They would not decide legal fitness to drive. Their role would be to provide structured, objective observations of real world driving in the vehicle the driver knows best and, where appropriate, on the familiar roads to which they have already limited themselves.

Why this matters now

A dementia diagnosis does not, by itself, tell us exactly how somebody will drive today. But cognitive decline can affect attention, judgement, visuospatial awareness, planning, reaction time and insight. These are the very abilities used repeatedly on every journey.

Families may spot changes first yet struggle to describe them objectively. Clinicians can assess health and cognition but may have little direct evidence from the road. Formal assessment services remain essential, particularly where medical or licensing decisions are required, but there is often an earlier stage when concerns are real, and the next step is unclear.

The delay itself is a serious safety concern. Under the current system, drivers are required to notify DVLA if they have dementia. Those who do so may be asked to complete DVLA's CG1 form, which requests details of the relevant medical professional.

DVLA may then write to medical professionals for information about fitness to drive. In practice, this process can take many weeks or months, creating a long delay between the point at which a family first notices a safety concern and the point at which a licensing decision is reached.

That may leave a potentially unsafe driver on the road for too long. By acting as an effective link between families and medical professionals, this proposed pathway could provide objective evidence earlier, timely referrals and reduce that period considerably.

Medical professionals also need practical evidence from the road. Without reliable information about how a person is driving, a clinician may be forced to decide on an incomplete picture.

That decision could be unfair to a driver who remains safe or possibly cause a safety issue if the driver is unsafe and significant difficulties are not apparent in a clinical setting. We owe it to medical professionals to support their judgement with clear, objective on road observations, while preserving their clinical independence and responsibility for medical advice.

Useful on road information could include whether the driver chooses an inappropriate speed, drifts from their lane, hesitates or makes unsafe decisions at junctions and roundabouts, fails to notice pedestrians, cyclists or developing hazards, becomes lost on familiar routes resulting in attention problems or anxiety, needs repeated prompts, confuses vehicle controls, reacts slowly, repeats the same error, or shows limited awareness of their own mistakes. The report should also record the route, traffic and weather conditions, any assistance given and whether an incident was isolated or formed part of a consistent pattern.

That is the space in which a properly trained ADI could make a valuable contribution.

ADIs already observe what matters

ADIs do much more than teach vehicle control. They observe how drivers gather information, anticipate risk, choose speed and position, plan, respond to changing situations and recover from mistakes. We know the difference between an isolated error and a repeated pattern.

They also know how anxiety, unfamiliar surroundings and an unfamiliar vehicle can affect performance.

This does make the profession a potentially valuable source of disciplined on road observation.

The ADI's value lies in describing what happened—not in labelling why it happened.

What a specialist ADI review could look like

A standard approach could be used to include the type of road situations assessed, the criteria needed to be reported on and, above all, the structure of the assessment so that the ADI and driver are at low risk of a collision.

A standardised report would then be issued to the relevant medical professional outlining any evidence that was apparent which may be linked to a cognitive problem, such as difficulties with multitasking, task switching, visuospatial skills and decision making.

Not a test, and not a diagnosis

The driver would be told plainly that the review is not a fitness to drive assessment and that the ADI will not decide whether a licence should be retained. Rather, it is to act as supporting information so that a medical professional or DVLA can make that decision.

In the situation where significant concerns exist but where there is no declared medical condition, the ADI would signpost the driver and family towards their healthcare professional, the DVLA process or a formal Driving Mobility assessment.

A simple seven stage pathway

1. **Request or referral:** A driver, relative, GP, memory service or road safety professional raises a concern.
2. **Informed consent:** The purpose, limits and intended recipients of the report are agreed.
3. **Structured drive:** A trained ADI observes defined behaviours in suitable conditions.
4. **Objective report:** The ADI records facts and repeated patterns, not diagnoses.
5. **Clear signposting:** Significant concerns trigger referral to the appropriate professional or assessment service.
6. **Better conversation:** The report gives the driver, family and clinician a shared evidence base for next steps.
7. **Follow up agreed:** As dementia is a progressive condition, a follow up assessment would monitor deterioration in skills. This would be annually, but a shorter duration reassessment may be appropriate in some situations.

Specialist training would be non-negotiable

This could not simply be added to an ordinary lesson diary. ADIs undertaking the role would need recognised additional training in recognising typical signs of cognitive impairment, communication, safeguarding, confidentiality, consent, report writing, legal responsibilities, DVLA processes and local referral routes.

There is also a wider occupational road risk issue. An ADI may encounter a driver showing signs of cognitive impairment or undiagnosed dementia during a risk assessment or a standard training course for business or taxi drivers.

Without the knowledge to recognise potential warning signs, and the boundaries of their own role, the ADI may be unable to give an employer appropriate, proportionate advice or recommend further professional assessment. That creates a risk that an emerging condition will go unrecognised and unmonitored as it progresses.

Dementia is not restricted to older people. More than 70,000 people in the UK are estimated to be living with young-onset dementia *(1)*, which develops before the age of 65, and many will still be of working age when symptoms emerge.

Wider dementia prevalence is also projected to rise substantially in the coming years, increasing the importance of timely, proportionate decisions about driving safety. *(1)*

Yet ADIs can be discouraged from learning about dementia and driving because the condition is viewed primarily as a medical matter. It is a medical condition but when changes in attention, judgement, planning, behaviour or insight affect someone behind the wheel, it is plainly a driving issue as well.

ADIs do not need to diagnose a cognitive impairment, they do need enough awareness to recognise concerning patterns, respond within professional boundaries and signpost appropriately.

Training must also cover the emotional impact of driving cessation. A calm, respectful review can protect dignity even when the outcome is difficult. The aim is neither to prolong unsafe driving nor to remove independence prematurely; it is to make the decision better informed.

(1) *Alzheimer's Research UK*

Who would benefit?

- **Drivers** would receive a fair opportunity to demonstrate current ability and hear honest, practical feedback whilst in familiar surroundings and a familiar vehicle.
- **Families** would gain an objective basis for conversations that can otherwise become painful or confrontational.
- **Clinicians** would receive structured observations to complement clinical judgement.
- **Road safety** could benefit from earlier recognition of repeated, concerning patterns.
- **The ADI profession** would gain a meaningful specialist development route and a stronger role in healthy ageing and public safety.

Firm boundaries protect everyone

Any credible scheme would need safeguards from the outset. ADIs must not diagnose cognitive impairment, determine legal fitness to drive or imply that their report replaces medical advice, DVLA decision making or a formal mobility centre assessment.

Reports should not undermine an official fitness to drive decision at Driving Mobility and ADIs should not become involved if their doctor or DVLA has referred them for one of these assessments.

Drivers must understand who will receive the report and how it may be used. There must be clear arrangements for data protection, professional indemnity, quality assurance, complaints and escalation when an immediate and serious risk is observed.

The pilot should also define how participating ADIs would be selected, accredited, audited and removed from the scheme if standards were not met. Payment arrangements must not create pressure to produce a particular outcome, and the driver must have access to an explanation, correction process and independent complaints route.

Context matters too. A person experiencing cognitive decline may perform less well under intense stress. Where appropriate, reviewing everyday driving in a familiar car and environment may give a fairer picture than beginning with unfamiliar roads and controls without lowering the safety standard.

There is already a foundation to build on

The UK already has established Driving Mobility centres offering specialist assessment and advice, and these services must remain central where a medical condition or disability may affect driving.

The proposed ADI pathway would complement them by offering an earlier source of structured observation and appropriate signposting.

There is also practical local experience to learn from. In Hampshire, a road safety driver appraisal service has operated for more than two decades, supporting drivers, families and medical professionals with on road observations. In 2007 the scheme won a Prince Michael of Kent International Road Safety Award for demonstrating a direct link between the provision of this service and casualty reduction.

Casualty numbers for drivers over 60, in three separate areas of Hampshire were recorded over a four year period and showed an average decrease of around 35%. This four year period encompassed the switch from a standard driving appraisal without doctor referrals, to appraising drivers with cognitive impairment that had been referred by medical professionals. *(See appendix A)*

This kind of accessible, locally delivered model illustrates what is possible, provided an appraisal informs rather than determines legal fitness to drive.

What should happen next?

ADI associations, road safety teams, dementia organisations, memory services, medical bodies, mobility centres and licensing authorities should come together to design a limited, independently evaluated pilot.

I invite the DVLA, driver training bodies, road safety organisations, medical representatives, dementia organisations and Driving Mobility services to examine this proposal and help shape a limited pilot.

The immediate aim should be to establish whether a trained ADI pathway is feasible, what governance would be required, and which organisation should coordinate its development.

That pilot should test training standards, consent, safeguarding, consistency between ADIs, the usefulness of reports to clinicians, referral outcomes and the experience of drivers and families. It should ask one central question, does earlier, better evidence lead to safer and fairer decisions?

ADIs should not make the final decision. But with the right training and safeguards, they could help everyone reach it with greater clarity.

Join the conversation

If you are an ADI, road safety professional, clinician or family member with experience of these decisions, your perspective matters. What training and safeguards would give you confidence in such a service? Where should the ADI role begin, and where must it end?

Author biography: Graham Mylward is the founder of DriveTalk Consultancy and an experienced driving and road safety professional. For 16 years, he ran a Hampshire driver appraisal scheme that supported hundreds of medical professionals and families with practical on road evidence. His work focuses on proportionate approaches to driver risk and informed decision making.

(1) Alzheimer's Research UK, Dementia Statistics Hub: https://dementiastatistics.org/about-dementia/

Appendix 1

Hampshire County Council

Prince Michael Road safety Awards 2007

Award Submission: Improved Public Education – Driver Education

Introduction

In the mid 1990's Hampshire's road safety team became aware of the increasing proportion of elderly people making up the population. More importantly to us, was the very significant increase expected in those who would be licence holders. In 2001, around two million people in the UK aged 70+ held a current driving licence – by 2015 this figure is expected to rise to around four and a half million.

Because older people are now healthier, living more active lifestyles than previous generations of retired people, more are driving and will expect to continue driving well into old age. We reasoned that this could result in an increase in the number of casualties, especially serious or fatal, within this road user group. Apart from the obvious distress this would cause, their fragility would create additional problems for healthcare professionals as their injuries tend to be more serious, they take longer to recover and some never fully recover.

Innovation

We had to find a way of managing the potential risks that still allowed them to maintain an active, independent lifestyle. We decided to offer a practical, on-road driving assessment. Older drivers have a wealth of experience but ability changes with age. Long-term illness or medication can also impact on safety.

In its Road Safety Strategy, the Government said of older drivers:
'Our aim is to find ways of helping older people to drive safely for as long as they are fit to do so, rather than taking measures to prevent them from driving at all'.
This perfectly reflected the aims of our Older Driver Assessment.

It is not a test - there is no pass / fail criteria - it is a voluntary, informal and confidential assessment. The aim is to offer help and advice that will enable that person to continue driving - with improved safety. It is delivered by specially selected, Grade 5/6 Approved Driving Instructors (ADI's) who have a good understanding of the needs of older drivers. We provide comprehensive training for the ADI's, which they must successfully complete before we employ them to deliver our assessments..

To meet their declining ability and slower reactions, older people usually modify their driving style. They tend to use local, familiar roads with less traffic so the assessment is delivered from the person's home, using their own car on a route discussed beforehand and planned to reflect this. A current driving licence must be produced and eyesight is checked.

General ability is assessed but the assessment can be adapted to investigate a particular concern, help someone return to driving after an enforced break, or help them get used to a new car.

Following the practical drive each person is given a comprehensive de-brief when any concerns and necessary remedial actions are discussed. At this point a detailed report is

Achievement

As you will see from the table our efforts were rewarded with an average reduction of 38% in the number of driver and passenger casualties aged 60 and over within the targeted districts. The number of assessments delivered throughout the County also increased from under 200 per year to over 300.

Car Occupant Casualties aged 60 & over 2002 to 2005 by Hampshire District					
District	Year	KSI's	Slight	Total	4 year total
New Forest	2002	10	88	98	
	2003	19	93	112	
	2004	9	49	58	335
	2005	8	59	67	
Test Valley	2002	9	51	60	
	2003	8	34	42	
	2004	2	28	30	163
	2005	4	27	31	
Winchester	2002	8	64	72	
	2003	10	38	48	
	2004	3	34	37	203
	2005	4	42	46	

In order to monitor our performance and further improve the service, after an interval of two months each person is asked to complete an evaluation report on their assessment. Almost without exception, the comments are very positive.

Commitment

As with most voluntary schemes, the very people who most need their driving assessed are those least likely to apply. Therefore, we are re-launching the scheme as 'The Older Driver Skills Scheme' and will call it a 'driving appraisal', rather than a 'driving assessment'. Our research has shown that the word 'assessment' deters older drivers, that it is too closely aligned with 'test'. We believe that by referring to it as an 'appraisal' and by producing an information leaflet (sent under separate cover) drivers will better understand our aim and be more willing to participate. We will then promote it more vigorously throughout Hampshire, knowing that this initiative does achieve the desired casualty reduction.

Well Researched

The casualty rate, all severities, per mile does increase for car drivers aged over about 65 and the fatality rate increases very significantly. Someone in their eighties is around six times more likely to die in a given accident than a person aged around 40.

Source: road safety researcher Dr Kit Mitchell

As a significant proportion of our clients are in their 80's and 90's a 'slight bump' is also far more serious to them, often leading to a loss of confidence that causes them to stop driving.

completed. This is then typed and sent with a covering letter clearly stating the findings of the assessment and what follow-up action should be taken.

If driving was to a safe, satisfactory standard they would be advised to concentrate on the points highlighted to further improve safety. Regular assessment would be recommended to check that a safe, satisfactory standard was being maintained.

If driving was unsatisfactory, with potentially dangerous errors, the assessor would strongly emphasise the need to address all points highlighted so that a safe satisfactory standard was achieved and maintained. The assessor may recommend some retraining with an ADI. Reassessment within a set time frame to establish that all concerns had been addressed would be strongly encouraged.

If driving was unsafe and the assessor was convinced that it would not be possible (often for a medical reason) for that person to raise their driving to a safe, satisfactory standard, they would advise them to stop driving. Reasons for the decision and why compliance was necessary would be discussed. Assessors are experienced in dealing with drivers who have a wide range of medical conditions which could affect their safety and that of other road users. We appreciate that when people need to give up driving they can become depressed and socially excluded so assessors are encouraged to discuss concerns with them (and their family) so that they are aware of alternative means of travel available to them.

Most drivers consider themselves to be good drivers, yet freely admit that they would not now pass the driving test – quite a contradiction. With road and traffic conditions having changed so drastically it makes sense for all drivers to update their skills.

In 2002 car occupant casualties aged 60 and over increased in Hampshire, with a significant increase in three districts – The New Forest, Test Valley and Winchester. In an attempt to reverse this trend we embarked on a series of initiatives for the three districts, with particular emphasis on The New Forest district.

We formed a partnership with healthcare professionals and visited every GP Surgery to provide information about the older driver and our Older Driver Assessment Service. On a number of occasions we were given the opportunity to present to the GPs themselves but at others it was the practice manager who then disseminated the information. Posters and leaflets were placed in waiting rooms. We also delivered presentations at hospitals to Consultants, Doctors and Nurses. These healthcare professionals now use our assessment service on a regular basis to establish, for example, whether a patient has recovered sufficiently from a stroke to return to driving; whether dementia means someone should stop driving or whether they are safe to continue for a time (if they do continue, six monthly reassessment is the norm); whether their medication has a detrimental effect on safe driving.

Other partners such as District Councils, Parish Clerks, Age Concern Hampshire, voluntary and community groups, retirement and leisure clubs, information centres all provided strong support by disseminating information and distributing literature. We received valued assistance from so many people who were only too willing to help this most vulnerable road user group.

The three targeted districts in Hampshire - The New Forest, Test Valley and Winchester are in the top four districts for 'Rural Isolation' in Hampshire. Significantly more of their population is also aged 75 and over – The New Forest has a markedly older profile than any other Hampshire district. Our research found that drivers in the above districts intended to continue driving because of their rural isolation – irrespective of ability. Our initiative does address this.

Replicability

We have provided guidance to other Local Authorities wishing to implement a similar programme. Clearly, if such a programme were adopted nationally, casualties would reduce and many older people would continue to enjoy the benefits that driving can bring.

Sustainability

We have not increased the cost of the assessment since we introduced it in the mid 1990's, we continue to subsidise it and charge just £25. It takes around one and a half hours to deliver. As stated earlier, we are re-branding it as an appraisal to attract drivers at an earlier age, allowing us to prevent rather than react to problems.

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