

Carers supporting mobility transitions for drivers with cognitive decline: Road safety issues

Dr Marilyn Di Stefano¹, Jasmine Roic¹ Tricia Williams²

¹Dept of Occupational Therapy, La Trobe University, Bundoora, ²VicRoads, Kew: Melbourne, Australia

Email for correspondence: m.distefano@latrobe.edu.au

Extended Abstract

Key Words: cognitive impairment; carer role; signs of driving decline; road safety risks

Background: Cognitive impairments can influence an individual's ability to drive safely. If deficits are due to a progressive disease like dementia, driving cessation is inevitable. Carers¹ may express concern about and attempt to modify driving behaviours. There is little in the published literature about the role of carers in identifying driver declines and managing mobility transitions. This phenomenon is important to understand as the demographics of our population changes, we have more people surviving to an older age and the incidence of dementia increases (Australian Bureau of Statistics, 2011; Access Economics, 2009).

Rationale and Aims: Given the ageing population and reliance of older Australians on the private car for transport (Alsnih & Hensher, 2003), licensing authorities, health practitioners and the community in general will encounter increasing numbers of older people for whom community mobility may be associated with mobility challenges and increased road safety risks. Carers of drivers with dementia provide support and make decisions on a regular basis regarding potentially difficult issues including mobility transitions and driving cessation (Perkinson et al., 2005). This study gathered information from carers about their experiences of supporting drivers with chronic health conditions. Details about carer perceptions of events indicative of driving skill decline, and the strategies, and resources they utilised to manage challenges and risks, were collected. This evidence is important to inform policy, programs and interventions to support both drivers and carers.

Method: A cross-sectional design was chosen to give a profile of the experiences of carers within one time span (three years of a driving transition period) (Schofield & Knauss, 2010). Purposive recruitment via Alzheimer's Australia (Victoria), and other agencies, as well as convenience sampling methods were used to recruit participants from within Victoria, Australia. A detailed anonymous, self completion questionnaire consisting of 30 closed and open ended response items was used to collect data. Participants were encouraged to add comments throughout to provide the opportunity to express their experiences in their own words (De Vaus, 2002). Descriptive statistics and content analyses were applied to data collected.

Results: Forty participants (carers) completed questionnaires: participants had a mean age of 55 years and were most often the driver's child (n=23), another family member (n=8) or spouse (n=7). Twenty eight participants provided care on at least a weekly basis. Participants described 40 drivers (23 male and 17 female) whose mean age was 80 years with declines in driving ability associated with diagnosed dementia, mental illness, other neurological conditions and often accompanied by low insight. Most participants rated driver health status as either fair or poor for physical health (n=27), psychosocial health (n=25) and cognitive health (n=29). Twenty five of the drivers held a valid licence and 20 were still active drivers. Only four of the carers for this latter group felt comfortable about driving continuation whilst

¹ Carers will be used to denote family members, neighbours or significant others who support an individual to manage driving transitions.

others had mixed feelings (n=10) or were uncomfortable (n=6), many detailing concerns related to safety, risk of social isolation and inflexibility regarding using alternative forms of transport (n=18).

Events triggering carer concerns frequently included patterns of unsafe driving behaviours including being easily distracted, misjudging distances, driving too fast for conditions and difficulty with lane keeping (n=26). Respondents also reported triggers such as other people expressing concern (n=21), minor crashes (n=14), scrapes (n=14), unsafe vehicle operation (n=13) or inattention to road rules (n=11). Participants reflected on the time they were most concerned about their care recipient. They rated the likelihood of the driver causing harm to themselves or others while performing common activities of daily living as medium-to-high risk for driving (n=32) and cooking (n=22). The majority of participants believed the driver to be at moderate-to-high risk of *minor* incidents or violations (n=36) and more than half felt the driver was at risk of *major* incidents (n=25). Participants reported that most of the drivers denied any driving difficulties when attempts were made to discuss concerns; many became upset, hostile or expressed feeling targeted.

Participants applied practical strategies and sought professional assistance, with varying degrees of success. Many participants talked with family (n=34) and/or doctors (n=23). With regard to the latter, many felt consultations were only useful when health professionals “took the blame” for initiating assessments and recommending driving cessation as this helped to redirect decision making and tension away from the carers. Participants also reporting hiding the car keys (n=11) or selling/removing the car (n=10). The highest effectiveness ratings for strategies were reported for transporting the driver (n=20) and/or offering to visit more frequently (n=15). Recommendations participants offered to other carers were most commonly “be pro-active” and act early (n=23), plan and research the health condition and its’ consequences (n=11), and communicate frequently (n=8).

Significance: Carers play a significant role in identifying at-risk drivers, managing mobility transitions and optimising their road safety. A safe system approach requires (a) working with stakeholders to support both carers and drivers (b) community and health professional education to increase awareness of driving skill changes associated with chronic health conditions, and (c) promotion of assessment and licensing options.

References

Access Economics (2009) Keeping Dementia in Front of Mind: Incidence and Prevalence 2009 – 2050. Downloaded on 9th August, 2011 from <http://www.apo.org.au/research/keeping-dementia-front-mind-incidence-and-prevalence-2009-2050>

Alsnih, R. & Hensher, D.A. (2003) The mobility and accessibility expectations of seniors in an aging population. *Transportation Research Part A: Policy and Practice*, 37(10), 903-916.

Australian Bureau of Statistics (2010) 3201.0 – *Population by Age and Sex, Australian States and Territories, Jun 2010*. Downloaded on 9th August, 2011 from <http://www.abs.gov.au/Ausstats/abs@.nsf/mf/3201.0>

Australian Bureau of Statistics (2011) 3222.0 – *Population Projections, Australia, 2006 to 2101*. Downloaded on 9th August, 2011 from <http://www.abs.gov.au/ausstats/abs@.nsf/PrimaryMainFeatures/3222.0?OpenDocument>

De Vaus, D.A. (2002). *Surveys in Social Research*. (5th ed.). St Leonards, New South Wales: Allen & Unwin.

Perkinson, M.A., Berg-Weger, M.L., Carr, D.B., Meuser, T.M., Palmer, J.L., Buckles, V.D., et al. (2005) Driving and dementia of the Alzheimer type: Beliefs and cessation strategies among stakeholders. *The Gerontologist*, 45(5), 676-685.