MENTAL DISORDERS

There is no certain way of predicting which persons with mental disorders (the American Psychiatric Association's preferred term for psychiatric illness) will have accidents, but many high risk drivers are such because of symptoms from psychiatric conditions. In a review of medical literature spanning 1960-2000, the National Highway Traffic Safety Administration noted that people with schizophrenia, personality disorders and chronic alcohol abuse are at highest risk for unsafe driving.[A] (Refer to Substance Use Disorders FAP for guidelines)

Given that many mental disorders wax and wane in severity, this FAP attempts to provide guidelines that protect public safety but allow driving when possible. Recommendations are drawn from a review of medical literature, a review of recommendations from other states, and from the experiences of physicians in Maine.

Diagnosis of a mental disorder is important, but clinicians should also focus on a patient's function, in particular attention and concentration, executive function (or other cognitive changes related to psychiatric diagnosis), psychosis, psychomotor retardation, response disinhibition or impulsivity, intent for dangerousness to self or others, and on whether or not the patient has the insight to recognize limitations or the judgment to stop driving if the limiting symptoms occur.

When assessing safety and stability, clinicians may also consider patient histories and collateral information about motor vehicle crashes, driving citations, relapses in substance use disorder, patient compliance with treatment, and relapses in the mental disorder for which the patient is being treated in order to gain a fuller picture of the patient's ability to drive safely. One episode of poor judgment does not necessarily mean a patient should stop driving. There should be a pattern of concerning behaviors or symptoms.

Many individuals with psychiatric illness are maintained on medications on an outpatient basis. These drugs have varying degrees of sedative side effects and can potentiate other central nervous system depressants. Persons receiving such medications should be screened in terms of severity of side effects incident to medication and the adequacy of the remission of symptoms related to the mental disorder.

Normally, BMV will not require reporting of prescribed medications used as ordered. However, in cases where proper use of prescription medications have resulted in driver impairment, such as OUI, crashes, reports of unsafe driving, or when a clinician is concerned that a patient may be non-compliant with driving recommendations, use of the Opiate Replacement and Prescription Medication FAP is appropriate. Please note that clinicians are responsible to assess their patients for potential risk and advise them whether to drive or not based on their medications and medical conditions.

Medications that are of particular concern for sedation, especially if patients are prescribed more than two or are concurrently prescribed opioids or are abusing drugs or alcohol, include the tricyclic antidepressants, sedative hypnotics, some antipsychotics, and benzodiazepines. Methadone and benzodiazepines are a particularly troubling combination for risk of sedation. (See Substance Use Disorder FAP if that is primary diagnosis).

Special Circumstances

Electroconvulsive Therapy (ECT): A seizure induced by ECT treatment is not considered a Seizure Disorder for purposes of driving a motor vehicle. Transient confusion or cognitive changes would be expected to clear in a day or two after treatment, during which the patient should not drive. However, it is possible for ECT treatments to result in long-lasting cognitive changes that impair the ability to drive safely, usually in the context of evolving dementia. Under these circumstances evaluate according to the Dementia FAP.

Psychogenic Non-epileptic Seizures (PNES): PNES are considered to be a form of Conversion Disorder in DSM-V (the most recent DSM at the time this FAP was written).[BC] Until a formal diagnosis of PNES has been made (consultation with Neurology and EEG Video Monitoring are especially helpful in this regard), clinicians should use the FAP for Seizures even if PNES is suspected. Once PNES is formally diagnosed, the evaluation of driver safety should be individualized but patients with PNES are very likely to fall in to category 3b or 3c on this FAP. There is no clear consensus in the medical literature about driving limitations for PNES , but in a study in the United Kingdom, 50% of neurologists who specialize in diagnosing PNES felt that driving restrictions should be similar to that for epilepsy. There are reports of motor vehicle crashes related to PNES.[D] Prognosis for cessation of psychogenic seizures is better if PNES resolves spontaneously in the first year or two, but poor if the symptoms have gone on for 10 or more years.

Novel treatments or treatment in development: Transcranial Magnetic Stimulation[E] and intravenous ketamine are examples of new or novel treatments at the time of this FAP preparation that have no track record in the medical literature as far as driver safety is concerned (but are not meant to be the only treatments considered here). Practitioners using any new or novel treatments are strongly urged to consider a patient's ability to drive safely as part of their post-treatment assessment protocols.

FOR REFERENCES, SEE BIBLIOGRAPHY AT END OF DOCUMENT.

FUNCTIONAL ABILITY PROFILE
Mental Disorders[1]

Profile Levels	Degree of Impairment[2]/ Potential for At Risk Driving	Condition Definition / Example	Interval for Review and Other Actions
1.	No diagnosed condition	No known disorder	N/A
2.	Condition fully recovered	Past history of a psychiatric disorder in sustained remission 2 years or more. No impairment in driving abilities from medication/treatment side effects, and does not meet listed criteria below.	N/A
3.	Active impairment	Please refer to narrative section "Special Circumstances" regarding PNES & ECT. On-going symptoms that meet current DSM criteria for a mental disorder[3]; and	
	a. Mild	Condition stable but less than 2 years; no cognitive impairment; minimal functional impairment from symptoms or medications or other treatments; or Occasional recurrence of mild to moderate symptoms without suicidal or homicidal intent and with insight and judgment adequate to stop driving if functional limitations or medication side effects occur	1 year
	b. Moderate	History of symptoms such as suicidal or homicidal intent, aggressive or violent behaviors, impulsivity, psychosis, inattentiveness, or cognitive changes; with poor insight into limitations that create a risk for driving that occur only during recurrence of the psychiatric disorder. Symptoms have improved with treatment and have been stable for at least 3 months. Cleared by clinician to drive. Clinician should recommend ROAD TEST if, driver is returning to	6 months ROAD TEST if recommended by clinician

		driving after 6 months or more of no driving; or if they are transitioning from Severe Profile Level 3c to Moderate 3b.	
	c. Severe	Persistent or progressive psychiatric symptoms that are not expected to improve despite adequate treatment or due to chronic patient non-compliance, AND 1 or more of the following: Chronic dangerous behaviors toward self or others; chronic suicidal or homicidal intent; chronic delusions or hallucinations that impair driving ability; severe anger, impulsivity or irritability that create a driving hazard; chronic poor insight and judgment about driving limitations leading to dangerous behaviors; significant executive function or cognitive changes related to psychiatric condition; chronic medication or treatment side effects such as sedation, blurred vision or tardive dyskinesia that impair safe vehicle operation; or New condition or onset of symptoms, under investigation **and** that may pose risk to safe operation of a motor vehicle.	No driving

[1] For further discussion regarding PSYCHIATRIC DISORDERS, please refer to NARRATIVE found at beginning of this section.

[2] For further explanation of degree of impairment, please refer to SECTION 3.

[3] For substance use or withdrawal disorders, please see FAP for Substance Use Disorders.