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Driving and older adults: Towards a national occupational therapy strategy for screening

Nicol Korner-Bitensky, Darene Toal-Sullivan and Claudia von Zweck

Increasingly, occupational therapists are being asked to participate in screening and assessing individuals who are potentially unsafe drivers. In this series on driving we will first focus on the issues surrounding screening of older drivers in Canada and the role of occupational therapists. We also present three Canadian Association of Occupational Therapists (CAOT) recommendations prepared in response to an inquiry from the Office of the Chief Coroner of Ontario. In December 2005, the coroner requested that the CAOT respond to recommendations emerging from an inquest into the death of a pedestrian hit by a driver who had a progressive neurological disease. A national panel including CAOT members and other experts created the recommendations based on a systematic review of the scientific evidence, provincial legislation and jurisprudence.

Why the increased focus on older drivers?

As the number of elderly individuals increases, so will the number holding licences. In Canada, 71% of those aged 65 to 69 hold a driver's licence as do 23% of those 85 years and older (Transport Canada, 2004).

Why the need for a national occupational therapist strategy?

When miles driven areconsidered, older drivers' risk of motor vehicle crashes resulting in serious morbidity and mortality equals that of the highest risk group, young drivers. These rates begin to rise after age 70, and escalate after age 80 (National Highway Traffic Safety Administration, 2004). Indeed, driving related accidents are the leading cause of accidental deaths in the 65-to-74 year-old age group. Thus, we anticipate a dramatic increase in crashes if nation-wide actions are not taken to improve older driver safety. Occupational therapists, because of their training and professional competencies, are well placed to help reverse this dangerous trend.

Screening -Screening attempts to distinguish between those who require further assessment of their driving safety and those who are most likely safe drivers.

Assessment – Assessment is a more detailed evaluation of driving abilities and safety. It is generally agreed that it should be performed by a health professional with expertise in driving evaluation, most often an occupational therapist.

Why do older adults have high crash rates?

Age-related changes in sensory, cognitive, and physical abilities, in addition to medical conditions, can affect driving safety. Indeed, we have a great deal of evidence suggesting that changes in cognition and perception increase accident risk.

Are all elderly at high risk for accidents or is it health related?

This question has brought about strong debate. Most seniors' groups argue that it is discriminatory to focus on age alone. In partial support of this argument, state-wide screening by age alone using vision tests, road tests, more frequent licence renewal and in-person renewal, has not had much impact on the frequency and severity of crashes (Grabowski, Campbell, & Morrisey, 2004).

So, we pose these questions to occupational therapists – is it that widespread screening is ineffective or is the current screening process using the wrong process or tools? Are the right health professionals conducting the screening?

Current provincial guidelines and legislation

Currently, seven provinces have mandatory physician reporting of medically unfit drivers to the corresponding ministries of transportation and three have discretionary reporting. Some, such as Quebec, have extended the onus of reporting to include other health professionals.

CAOT recommendation #1

We propose that it is important to increase the onus on health professionals other than physicians to assist in identifying potentially unsafe drivers who may need assessment. Therefore CAOT has made the following recommendation:

A medical practitioner or registered health

care provider who is concerned regarding substantial medical or functional impairments of a non-temporary nature that may impact on safe driving, must report their concerns to the Ministry of Transportation by completing a Driver Safety Concern Form.

- Where the term "registered health care provider" indicates a member of a regulated health profession.
- Where the term "functional impairment" refers to reduced functioning in one or more of the following domains known to be important to safe driving: cognition, vision, visual-perception, physical (including motor and sensory), and, behavior.
- Where "must report" indicates a mandatory responsibility.

Why are we proposing this change?

1. Regarding the reasons for expanding to registered health care provider:

- This recommendation is in keeping with the trend towards increased reliance on interdisciplinary teams to provide health care to Canadians.
- Strong evidence from two recent Canadian surveys indicates that family physicians (Jang et al., 2007) and psychiatrists (Menard et al., 2006) support mandatory reporting, but do not feel adequately prepared to take on the role. While it is unlikely that other health professionals will feel more prepared, the goal is to widen the opportunity to identify those at risk of unsafe driving.
- Many Canadians have medical/functional impairments that may impact on driving but may not see a physician for extended periods of time. We have recurring evidence in the news of individuals with severe functional decline who continue to drive with catastrophic outcomes. It is necessary to increase the potential for detection of these individuals before the catastrophic event occurs, through the inclusion of health professionals who are known to have a high prevalence of contact with elderly or disabled individuals.
- It is also important to point out that screening may result in a referral for a driving evaluation with positive interventions by an occupational therapist that may enhance ability to drive, through adaptive equipment or suggestions regarding safe driving in the face of specific impairments. Unfortunately, most individuals currently view reporting as a punitive action.
- Regarding legal concerns about reporting and professional responsibilities for patient confidentiality, it is important that all Canadian health professionals participating in mandatory reporting have legal protection.

2. Regarding the reasons for the use of the term functional impairment:

We undertook extensive efforts to come up with a list of health conditions that would result in mandatory reporting. However, the term functional impairment was deemed more appropriate because:

- The reporting of a specific medical condition by name (for example, dementia) may result in an individual avoiding health care for symptoms, or underreporting symptoms.
- Unsafe driving behaviors are often due to a combination of behavioral, physical, visual-perceptual and cognitive impairments. The extent of these and how they combine to effect driving are complex. For example, an individual with a spinal cord lesion resulting in no use of the lower limbs and limited use of the upper limbs was, in past decades, considered medically unfit to drive. However, these physical impairments, while severe, will not impede driving if the person has the cognitive, visual-perception and behavioral demeanor to use technological devices that enable driving with minimal physical movements.
- The 7th edition of the Canadian Medical Association's Determining Medical Fitness to Operate Motor Vehicles (www.cma.ca) recognizes "that medical standards for drivers often cannot be applied without considering the functional impact of the medical condition on the individual".
- There is increased concern in medical and legal spheres that a focus on diagnosis alone leads to potential human rights discrimination. The bias here relates to using a diagnosis rather than an individual's functional ability to identify safety.

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- Regarding age requirements, there is insufficient support to suggest that screening based on age alone reduces accidents. Again the focus should be on assessing functional abilities. And again, there is a potential for human rights violations when screening by age alone.

CAOT recommendation #2 – Cross Canada use of a Driver Safety Concern Form

In Canada there is no standard format for reporting a concern regarding driver safety. And, because the onus has been largely on the physician to report concerns, there is no general form available for use by other health professionals.

CAOT is thus proposing the national use of a Driver Safety Concern Form (see CAOT website) to report a potential concern regarding an individual's driving safety to the provincial Registrar of Motor Vehicles. The form does not require the reporting of the results of a medical examination or a medical diagnosis, but rather the health professional's statement of a functional concern regarding safe driving. It would not, of course, replace medical, ophthalmology or optometrist forms used for reporting specific medical conditions.

CAOT recommendation #3 – The occupational therapists' role in driver screening and assessment: Building occupational therapist capacity using a three-tiered expertise

Driver screening, assessment and intervention are complex matters. Occupational therapists are ideally suited to provide expertise in each. However, CAOT recognizes that advanced training is required. Thus, it is recommended that three tiers of expertise training become available nationally.

1. **Generalist health professional training** – This health professional would have expertise in screening to detect those at risk of unsafe driving and to assist older individuals to access information on healthy aging and maintaining mobility.
2. **Advanced occupational therapist training** – This occupational therapist would have expertise in assessing physical, cognitive, visual-perception, and behavioral aspects of safe driving using standardized pre-road and on-road assessments.
3. **Advanced-specialized occupational therapist training** – This occupational therapist would have highly specialized expertise in assessment, training/retraining of driving skills, vehicle modifications, use of assistive technology for driving, etc.

It will be important to identify gaps in professional capacity in each of these three tiers as well as the facilitators that will help meet the professional needs in each. CAOT is currently undertaking activities directed towards these goals.

Watch for the continuation of this article in the September issue of *Occupational Therapy Now*.

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For further information on driving rehabilitation visit the CAOT website at http://www.caot.ca/default.asp?pageid=2129.

Reflections on preparing for life as a graduate student

Jennifer Klein, Alison Douglas, Noemi Cantin and Zofia Kumas-Tan

How you prepare for your graduate career can greatly affect your enjoyment and success as a graduate student. In reflecting upon how little the four of us knew when we started our graduate studies, we felt it was important to share our experiences as new graduate students to help others have a favourable graduate school experience. This publication evolved from a paper we presented at the 2006 CAOT conference. We formed a working group to gather our individual experiences and to disseminate common themes and suggestions to current and future graduate students and their advisors. The first article in this series, "Reflections on applying to graduate school" was published in the May issue of OT Now.

Full-time versus part-time

Now that you have been accepted into graduate school, you must decide whether you will attend as a full-time student or part-time student. Contrary to popular perception, the number of students attending graduate school part-time is about the same as those attending full time (Baird, 1990).

For some of the authors, the opportunity to immerse oneself in full-time schooling and research was the ideal way to obtain a graduate education. Although other commitments may make this impossible for some occupational therapists, if you can arrange for full-time studies, we encourage you to do it! While studying full-time may enable you to focus all your energies on your research, there are drawbacks. When one has five to seven days a week to work on research, procrastination can arise. Remember the axiom, "work expands to fill the time you give it." In addition, as a full-time student, you live and breathe your studies. This is your primary role in life. So if you have a bad day (e.g., realizing that you need to rewrite your proposal or doing poorly on an exam) this can be all consuming.

The part-time degree remains an attractive choice under alternative assumptions for an individual to consider when making educational decisions. Many occupational therapists have other roles including clinician, partner and parent. If you attend graduate school part-time, it is important to set aside specific study blocks (even days) in which you can focus on your school work.

Regardless of whether you are going part-time or full-time, it is important to keep your studies in perspective, set boundaries that permit you to give appropriate attention to your academic work. Set time limits for a task (e.g. "I will compile that annotated bibliography by 4 p.m. today."). Take the first minutes of a work session to identify clearly what you are trying to accomplish so that you don't fritter time away. Set up a work schedule (e.g., work 9 to 5 and stop for evenings).

Choosing an advisor

The quality of the relationship between student and advisor strongly relates to successfully completing the graduate degree (Bair & Haworth, 2004). Do not assume that all faculty members have equal abilities as advisors. Some qualities to look for in an effective advisor include: expertise in the subject; organizational skills; respect for deadlines (including reviewing your work); enthusiasm; empathy; flexibility; and clarity around expectations. An effective advisor also makes time for students, provides constructive and positive feedback, and gives guidance while allowing for autonomy. Similarly, effective students have particular qualities. These include a strong desire to learn, good work ethic, positive attitude and the ability to self-evaluate. An effective student seeks his/her mentor for direction, has self-assurance, and asks questions or challenges his/her mentor.

We encourage you to meet with several potential advisors before deciding upon one. Trust your gut instinct. Several factors can diminish a student-advisor relationship. Avoid anyone who: is controlling, didactic or makes you feel small; appears unavailable; has hidden agendas; or wants to

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impose ideas to the exclusion of the student's own thinking. Some red flags to look for early on include: responding to your calls in an untimely manner, frequently interrupting when you are meeting with them, frequently talking about their own needs, and appearing to be absorbed in their own research area.

Applying for funding

Money is often a primary concern for occupational therapists returning to graduate school. Although nobody ever gets rich being a graduate student, most graduate students obtain financial support that pays their tuition and a small living stipend.

There are numerous funding options; however, they are competitive. As a student you can work as a teaching assistant. This position can include such roles as marker-grader, course coordinator, or lab demonstrator. Details of the assignment will be specified by the department or faculty to which the assistant is assigned. Another option is to work as a research assistant, contributing a specified number of hours to the research of a faculty member. There are also student/research awards that enable students to conduct scholarly activities directly related to their own coursework or to the development of their theses or major projects.

We recommend that you also seek out bursaries and scholarships from external sources such as provincial and federal governments and the private sector. Here are some tips that we learned along the way to assist with your application for external funding programs.

1) Applying for scholarships is time-consuming, when completed correctly. To make it more bearable, view it as a part-time job.

2) Seek multiple sources. Go through your university graduate awards list and write down all of the awards you are potentially eligible for and their due dates. Ask your supervisor and other graduate students in your research area for other suggestions on scholarships, grants and bursaries. Check websites of related fields, for example: Canadian Occupational Therapy Foundation, Canadian Institute of Health Research, Ontario Graduate Scholarship (for graduate students in Ontario), Alberta Heritage Foundation for Medical Research (for graduate students in Alberta). Talk to previous professors from your undergraduate school to see if they have other suggestions.

3) Show how you are gearing your studies to do research in your specific areas (e.g. what electives are you taking to strengthen your knowledge base).

4) Be honest. There are many ways to find out if someone is lying on their application.

5) Having good grades is important.

6) Providing updated transcripts is necessary.

7) Be well-rounded: teach and volunteer.

8) Present at professional meetings and conferences and publish in journals. If you have not published or presented, look at collaborating with others. You can do this by acting as a research assistant in a study and participating in writing the findings. Even when working as a clinician, consider approaching colleagues doing research in a clinical setting to gain experience in writing scientific reports and collaborate on publications. Having publications as you enter graduate school may act as a catalyst to further publications and also facilitate the process of obtaining scholarships.

9) Sell! Sell! Sell! Show the funders why they should invest in you. Tell them how this scholarship is going to help, how you can contribute to the future of your profession (i.e., point out the practical application). Show commitment to your profession e.g. that you will disseminate results of your research through journals, conferences. Express what you hope to do in the future (e.g., teach, perform research). Reviewers want to know that you will incorporate your new knowledge into the profession.

10) Make sure you have a close relationship with your references. Give them an updated copy of your letter of intent and updated resume. Seek their feedback on these two items. Highlight some achievements that would be of interest to them and ask them to incorporate these into their reference letters. Thank them after they have written each reference letter, and let them know the outcome. A little thank you note in the mail is always appreciated.

Conclusion

Attending graduate school is extremely rewarding, giving us a unique opportunity to explore a broad scope of knowledge in our field. Many obstacles can be avoided by doing some advanced planning. We hope that in sharing our experiences with you, you are better able to prepare for your first year as a graduate student.

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Watch for the third article on this series on attending graduate school in the November issue of OT Now.

National Occupational Therapy Month: Yes I can!

Erica Lyle, CAOT Communications Coordinator

October 2007 will mark the fourth annual National Occupational Therapy Month to celebrate occupational therapy's contributions to help people live healthier, more satisfying lives. Continuing with the theme "Yes I Can!" endorses the message of occupational therapy's important role in promoting participation of all people. Incorporating the theme into each year's activities sets the tone for the campaign, creates a sense of brand recognition and supports awareness of occupational therapy.

A special edition of the September/October *OT Now* will complement the "Yes I Can" theme. This special issue will focus on how occupational therapists provide a crucial role in developing strategies for seniors to participate in valued occupations. With this segment of the population rapidly growing, occupational therapists will increasingly be making a difference and the emphasis on providing supports for seniors a vital and essential service.

The national inter-organizational OT Month Committee meets each month to share ideas, strategies and plans for the national campaign. We work collaboratively to create materials that promote awareness of occupational therapy in the community and support our theme. Products and information will be posted on the CAOT website for quick and easy access.

We encourage all occupational therapists to become involved in OT Month. This month is your opportunity to help raise awareness and advocate for your profession. To get involved or for more information on your province or territory's activities, contact a committee member listed below.

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Home-based occupational therapy improved functioning of community dwelling people with dementia and their caregivers' sense of competence

Column Editor: Lori Letts

Summary of Graff, M. J., Vernooij-Dassen, M. J. M, Thijssen, M., Dekker, J., Hoefnagels, W. H. L., & Olde Rikkert, M. G. M. (2006). Community based occupational therapy for patients with dementia and their caregivers: Randomized control trial. *British Medical Journal,* 333(7580), 1196-1201.

Prepared by Kim Schryburt-Brown, CAPs Advisory Group Member.

Research question/purpose: Does community-based occupational therapy affect the daily functioning of people with mild and moderate dementia and the sense of competence among their primary caregivers?

Design: The research design was a single-blind randomized control trial (RCT). Participants were randomly assigned by block randomization to an intervention or control group and the groups were stratified by level of dementia (mild or moderate). Participants, caregivers and occupational therapists conducting treatments were not blinded to the treatment group. Outcome assessors were blind; unmasking of the assessors was monitored and occurred with 21 participants (in 82% of cases, blinding was maintained). Participants allocated to the control group received the intervention at the end of the trial and they received usual care (no occupational therapy) during the study period.

Setting: Occupational therapy was delivered in the participants' homes.

Participants: One hundred and thirty five participants were recruited (275 were assessed for eligibility) from a university-based memory or day clinic in a department of geriatrics in the Netherlands. The inclusion criteria included the following:

- 65 years of age or older
- diagnosed with mild to moderate dementia
- living in the community
- having a primary caregiver who provided care for them at least once per week

Severity of dementia was assessed with the Brief Cognitive Rating Scale, with scores of 9-24 indicating mild dementia and scores of 25-40 indicating moderate dementia. Participants were excluded if they had the following:

- Geriatric Depression Scale score above 12
- severe behavioural or psychological symptoms of dementia
- severe illness as diagnosed by a geriatrician
- inability to identify occupational therapy goals
- not on a stable treatment of a dementia-related drug (e.g., cholinesterase inhibitor or memantine)
- caregiver with a severe illness

Baseline data were collected on 132 participants; 114 people were evaluated at six weeks and 105 people were evaluated at the 12 week follow-up.

The average age of participants in the study was 79.1 in the intervention group and 77.1 in the control group. Caregivers' mean ages were 66.0 and 61.3 (intervention and control group, respectively). Seventy-seven participants with dementia were female and 95 caregivers were female. Seventy-nine caregivers were partners, 43 were daughters.

Interventions: The treatment developed by a consensus panel of experienced occupational therapists, consisted of 10 one-hour sessions held over five weeks. Occupational therapists offering the intervention had approximately 80 hours of training and were experienced (at least 240 hours) in providing client-centred intervention to people with dementia. The intervention included individualized goal setting, compensatory and environmental strategies as well as training caregivers with cognitive and behavioural interventions. Assessment and goal setting over the first four sessions used the Occupational Performance History Interview with the participant, an ethnographic interview with the caregiver, and the Canadian Occupational Performance Measure with the participant and the caregiver. Total intervention time (direct and indirect) averaged 18 hours per participant.

Outcome measures: Participants and their primary caregivers were assessed at baseline, six weeks and 12 weeks. The primary outcome measures for participants were the process scale of the Assessment of Motor and Process Skills (AMPS-process) and the performance scale of the Interview of Deterioration in Daily Activities in Dementia (IDDD-performance). The outcome for caregivers was the Sense of Competence Questionnaire (SOC-Q).

Main findings: At baseline, there were no significant differences between intervention and control group participants except for age (intervention group participants and caregivers were slightly older), which was controlled for in the analyses.

At six weeks, AMPS-process scores were 1.2 (SD 0.7) for the intervention group and 0.2 (SD 0.8) for the control group. The difference between groups was 1.5 (95% confidence interval 1.3 to 1.7), with a large effect size of 2.5. IDDD-performance scores were 14.4 (SD 6.1) in the intervention group compared to 25.3 (SD 8.6) in the control group, with a difference of –11.7 (95% CI: -13.6 to -9.7). Effect size was 2.3. Primary caregivers who received the intervention felt significantly more competent than those in the control group, with mean SOC-Q scores of 104.6 (SD 13.4) in the intervention and 88.4 (SD 13.7) in the control group; difference between groups was 11.0, 95% confidence interval 9.2 to 12.8), with an effect size of 1.2. P values for all outcomes were <0.0001

At 12 weeks, mean AMPS-process scores were 1.2 (SD .0.8) in the intervention and 0.02 (SD 0.7) in the control group; the difference was 1.6 (95% CI: 1.3 to 1.8), effect size was 2.7. IDD-performance scores were 13.6 (SD 6.0) for the intervention group and 27.2 (SD 8.9) for the control group, with a difference of -13.6 (95% CI: -15.8 to -11.3) and an effect size of 2.4. Caregivers' sense of competence was also significantly better at 12 weeks, with SOC-Q scores of 107.3 (SD 13.6) in the intervention group compared to 89.4 (SD 14.4) in the control, with a difference of 9.6 (95% CI: 4.7 to 14.5) and an effect size of 0.8. P values for all outcome measures were <0.0001.

Authors' conclusions: Occupational therapy treatment improved participants' daily functioning and reduced the burden of care for the caregiver. The effect sizes of all primary outcomes were higher than those found in pharmacological or other psychosocial interventions. Effects were still present six weeks post-intervention, which justifies implementation of this occupational therapy intervention.

The full version of the paper is available at no charge through the British Medical Journal website.

Commentary on Graff et al. (2006). Community based occupational therapy for patients with dementia and their caregivers: Randomized control trial

The paper by Graff and colleagues is a welcome addition to the research literature as it examines community-based occupational therapy for persons with mild/moderate dementia and their caregivers. Although there are published studies on the efficacy of occupational therapy, few address community-dwelling individuals specifically (Steultjens et al., 2004), and most are descriptive, with few randomized controlled trials (RCT). Rehabilitation RCTs can have methodological limitations, such as small sample size, limited ability to blind patients and therapists, and potential for contamination between groups (Legg & Langhorne 2004). Methodological rigour can be compromised when complex interventions (home occupational therapy) are implemented with a heterogeneous sample (individuals with dementia and their caregivers) by different therapists. However, the authors have tried to overcome these difficulties through careful description of research design, sampling and a range of outcome measures relevant to the sample and interventions used. Overall the quality of this paper is good but a number of issues are worth further exploration.

Method issues

In this study, Graff and colleagues sought to determine the effectiveness of community-based occupational therapy on daily functioning of persons with dementia and sense of competence in their caregivers. The recruitment strategy is well described. Rural clients, those with poor access to transportation, without a family physician to refer them to a specialist, or people with behavioural/social/anxiety issues that prevent them from going to an outpatient clinic may have been excluded from the study. The single, blind randomized study design was appropri-

About the commentators -

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ate and the method well described and executed. Patients were aware of group allocation but not the researchers assessing the outcomes, and patients were asked not to inform assessors of their group. Concealment/masking was maintained 82% of the time. While Graff and colleagues suggest that the results do not appear greatly affected by observer bias, analysis excluding those for whom unmasking occurred may have strengthened the research findings. Intervention strategies and therapist training are clearly described but 'usual care' offered to the control group is not described beyond the fact that no occupational therapy was provided. The study would have been potentially strengthened with an attention control.

An appropriate range of assessments and outcome measures were used. The Geriatric Depression Scale (GDS) with a cut-off of 12 was used to exclude people with untreated depression. It is unclear from the study report whether the 30-point or 15-point scale was used. However, the first author clarified that the 30-point scale was used. This is important information since a score of 12 on the 15-point scale indicates a major depression. It would have been helpful for the authors to clearly state which GDS scale was used. Since depression is related to motivation, initiation etc. (outcomes measured in this study) a confounding variable could be significant numbers of people in one group being treated for depression. Ongoing monitoring of medication management throughout the study would have helped assure readers that group differences were not related to medication changes.

There is no rationale for why the Interview of Deterioration in Daily activities in Dementia (IDDD) was selected over the Assessment of Motor and Process Skills (AMPS) motor scale. The AMPS is appropriate as an outcome, but it is puzzling why only the process scale was reported. Diminished motor skills affect the quality of ADL performance in persons with dementias, even amongst those who are higher functioning. Oakley, Duran, Fisher and Merritt (2003) recommended that motor as well as process skills should be addressed with this client group. The first author clarified that the AMPS motor scale was used as a secondary measure and will be reported on in a future paper. This information would have been useful for readers providing an explanation of why it was not used as a primary outcome measure.

Analyses and presentation of results are reasonable, and differences in daily functioning between the intervention and control groups were impressive. Improvements as measured by the AMPS, the IDDD and SCQ (Sense of Competence Questionnaire) were maintained at 12 weeks. As intervention was completed in 5 weeks, sustained improvements at 12 weeks is impressive. Such differences between groups only reinforce the need to know what intervention the control group received.

Application to practice

The results of this study are important for those working with persons with dementia and their caregivers. Improvements are more likely to be sustained when caregivers are fully involved and this is often missing from studies of this kind. Improving a caregiver's sense of competence should decrease the burden of care and result in a reduction in the need for assistance from healthcare resources. This has considerable emotional, social, and economic implications for practice.

It is positive to see a multi-faceted approach, not just focusing on mental health issues but the whole person-environment-occupation interface for client and caregiver. It is a good example of breaking the barrier between physical and mental health. More discussion on strategies that could be used to implement such a program in the long term home care setting would have been useful, for example the benefits of training paid caregivers to maintain levels of functioning in residents. Future research could explore the application of the intervention.

Our main frustration with this paper is that usual treatment and the training program have not been comprehensively described. Eighty hours of training which appears to be required (although this is not explicitly stated), to implement this program is a considerable commitment. We suspect it would be unreasonable to expect most home care therapists to spend this much time, energy, and money learning about something with relatively little return for them (in this study 18 hours per patient and caregiver) and that this would be a major barrier to research utilization and knowledge transfer.

The authors state that guidelines on the training program have been published elsewhere, but these are in Dutch. The authors cite a recent paper (Graff et al., 2006) that presents the intervention in the form of a case study, and a pilot study was published by the authors in 2003. While these sources along with the study protocol published as a supplement on-line by BMJ, provide further information

about the intervention, practitioners or researchers wishing to implement the study in English would find this frustrating and a barrier to implementation. The first author has informed us that translation to English is planned, which will be welcome.

Despite these comments, we found this an exciting study. We fully support therapists receiving rigorous and extensive training before implementing community programs. Further studies of this kind have the potential to increase our knowledge of how best to support caregivers and their family members in the community.

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Discussion Questions for CAP column on Graff, 2006

1. ***Is eighty hours for training realistic for occupational therapists to apply an intervention like this in practice? How might that training be feasibly adopted by occupational therapists and the organizations that provide occupational therapy services to people with dementia?***
2. ***Reporting the amount of unmasking (18% in this study) is not often seen in rehabilitation studies, but may become more common as a result adoption and use of guidelines from the use of the CONSORT statement < http://www.consort-statement.org/>. How can we best evaluate and minimize the rates of unmasking in rehabilitation trials?***
3. ***Can the intervention discussed in this study be integrated into current occupational therapy practice settings in Canada, or would new services need to be initiated?***

This April at the annual AOTA conference held in St.Louis, Missouri, CAOT Executive Director Claudia von Zweck and CAOT President Sue Forwell attended the annual President's Tea. From left to right, the guests included:

Back row (L to R) - Carolyn Baum, outgoing AOTA President; Martha Kirkland, AOTF Executive Director; Fred Sommers, AOTA Executive Director.

Middle row (L to R) - Mary Blake Huer, Dean of Health Sciences, University of Indianapolis; Claudia von Zweck CAOT Executive Director; Ruth Ann Watkin, AOTF President; Linda Florey, NBCOT President; Julia Scott, Chief Executive British College of Occupational Therapists; Mary Evert, AOTA Delegate to WFOT; Karen Jacobs, AOTA Past President; N. Stelman, Netherlands.

Front row (L to R) - Susan Forwell, CAOT President; Penny Moyers, AOTA Incoming President; Dee Christie, Council Chair British College of Occupational Therapists; Cristina Bolanos, Mexican Occupational Therapy Association.

Paths to graduate education: Opportunities for occupational therapists with entry-to-practice credentials

Thelma Sumsion, Margo Paterson, Helene Polatajko, Deb Stewart and Manon Tremblay

For occupational therapists who already hold their professional qualification, this article will inform you about some of the available paths to pursue graduate education focused on occupation or occupational therapy. Currently the available options for pursuing graduate education include the following:

1. Research Master's Degree (e.g. MSc, MA)
   - Degree that normally involves completion of course work and a research project with a thesis
   - Usually takes about two years of full-time study.
   - Your research project can be tailored to focus on an area of interest provided there is a faculty member with the knowledge base to supervise your work.
   - Most of these degrees have a requirement that some time be spent on campus but some are offered either full- or part-time through distance education.

2. Course based Master's Degree (e.g. MBA, MEd, MRSc)
   - All course work.
   - Usually takes three to five years part-time.
   - Available as a course based Master's Degree that can be completed in one year of full-time study.
   - Some may be offered online.

3. Clinical or Professional Master's Degree (e.g. MScOT, MOT)
   - Provides the upgrading you need to have the Professional Master's designation.
   - One-year program providing advanced theory and knowledge.

4. Doctoral Program (e.g. PhD)
   - Programs can be entered from either a Professional or Research Master's Degree.
   - Emerging trend in some universities is to enter these from a baccalaureate degree.
   - May be offered on either a full- or part-time basis.
   - Consists of both course work and a more in-depth thesis than required for masters level work.
   - Frequently a comprehensive exam.
   - Usually takes four to five years of full-time study.

5. Clinical or Professional Doctorate Program (e.g. RehD)
   - Stronger clinical focus rather than an in-depth research focus.
   - Learner may take approximately eight courses and do a thesis project that is smaller than a PhD thesis.
   - Overall program may be about four years of full-time study.

6. Graduate Certificate
   - Alternative to completing a Master's Degree.
   - Good alternative if your preference is to focus on a specific area of study.
   - Can be completed online.

We have not identified any specific programs as these offerings are a moveable feast with frequent changes, revisions and additions. If your goal is to pursue graduate education, we suggest you contact the university of interest to you to obtain further details or directions.

For further information about the Canadian universities which have occupational therapy programs, you can visit the website for the Association of Canadian Occupational Therapy University Programs (ACOTUP) at www.acotup-acpue.ca.

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Column Editors: Helene J. Polatajko and Jane A. Davis

Viewing youth homelessness through an occupational lens

Kitty P. Y. Chan, Kimberley Garland, Karima Ratansi and Batsheva Yeres

Homelessness has become an increasingly heated issue of debate in Canada over the past few decades. Much discussion has focused on how to get individuals off the streets; however, there are too few programs which support and enable an effective and positive transition back into mainstream society. Auerswald and Eyre (2002) suggest that homeless programs are most effective with individuals in the transitional states within a life cycle of homelessness, for example youth with a newly acquired homeless status. As these youth have not firmly established their status and face instability in their prospects in the street, interventions that specifically target this group are more likely to be successful (Auerswald & Eyre, 2002), especially if those interventions are viewed from an occupational perspective.

The adolescent years can be a time of conflict and instability as youth struggle to establish their physical, psychological and emotional selves (Aviles & Helfrich, 2004). Youth typically have not developed the basic skills necessary to be autonomous beings. During these formative years, support and positive role models are crucial for development; specifically to develop occupational repertoires that will help youth sustain their lives, meet their needs, pursue their dreams, and contribute to society. Oftentimes, homeless youth lack the support of their family, peers or school figures, and the positive influence of established and contributing members of society. Thus, for homeless youth living on the streets can be especially stressful, as many do not have the basic skills, personal capacity or social supports to meet the demands of their new harsh environment.

In their work with homeless individuals in Canada, MacKnee and Mervyn (2002) identified specific situations, such as secure housing, educational achievement, participation in legitimate work and supportive relationships, as well as connections with mainstream peers, family members, support counseling or a spiritual community, that facilitate a permanent transition off the streets. Homeless individuals can improve their self-confidence and perception of self-worth by exploring their occupational potential through development of their natural talents (MacKnee & Mervyn, 2002). Herzberg and Finlayson (2001) suggest that a community-based framework emphasizing a collaborative approach between service providers and recipients, helps to highlight client strengths, including their natural talents, and supports client wellness. Also, Nabors, Hines and Monnier (2002) emphasize the constructive effects of introducing rewards or incentives into programs to help define what constitutes positive behaviour. By placing a value on meaningful occupational engagement, a rewards or incentive based collaborative program may enhance compliance of youth participants and enable positive outcomes.

In addition to services addressing their housing, education and health care needs, homeless youth require life skills guidance, such as time and money management, planning and community skills (Aviles & Helfrich, 2004; DeRosa et al., 1999). However, youth report a conflict between accessing basic survival needs and seeking and maintaining employment, as many food and shelter services were only available during business hours (DeRosa et al, 1999). They also feel that the strict rules and regulations of youth shelters can be barriers to transitioning off the streets (DeRosa et al., 1999). Homeless youth demonstrate difficulties in many aspects of their life; thus, a holistic and global approach is required to reduce environmental barriers, enabling them to re-enter mainstream society. The unique needs of each homeless youth must be taken into account when offering services and formulating a program which will enable their engagement in meaningful occupations.

"... the ultimate goal of a client-centred collaborative occupation-based initiative for youth homelessness ... must enable the youth's development of complete and meaningful occupational repertoires through engagement in diverse occupations."

CSOS Canadian Society of Occupational Scientists

Edited by Polatajko and Davis, on behalf of CSOS.
visit CSOS at www.dal.ca/~csos/index.htm

Characteristics of an occupational perspective

Client-centred collaborative practice is key in enabling occupational engagement, thus homeless youth must be engaged in a collaborative relationship with program professionals, with each providing their expertise. Using the Canadian Model of Occupational Performance (CMOP) (Canadian Association of Occupational Therapists, 2002) and relevant literature as a guide, the characteristics of an effective client-centred, occupation-based program include the following:

- sufficient professional support in addition to tangible emergency supports, such as housing and food;
- identification of barriers to and supports for transition from homelessness which exist in the youth's environment;
- life skills training that enriches the cognitive, affective and physical capacities of the person to enable engagement in various occupations across diverse environments; and
- targeting the specific needs of youth.

"Homelessness is an issue in need of an occupational perspective ... to enable the development of a meaningful and balanced occupational repertoire."

Once enrolled in the program, the participants should follow a flexible path that enables them to pursue their specific realistic hopes and dreams from initiation through development to completion, an outcome that prepares them to commence a meaningful life off the street and contribute to society. Diverse resources and occupational opportunities must be available within different components of any program to enable this disadvantaged group to reframe their lives and construct new identities. Thus, the ultimate goal of a client-centred collaborative occupation-based initiative for youth homelessness must go beyond simply removing homeless youth from the streets. It must enable the youth's development of complete and meaningful occupational repertoires through engagement in diverse occupations, focused on meeting their needs, as well as, contributing to their communities and society. The ideal program must provide youth with the capacity to remain off the streets, but most importantly ways to uncover who they are as occupational beings and citizens.

Eva's Phoenix

Eva's Phoenix is an excellent example of a transition program for homeless youth, having many of the suggested characteristics discussed above. Focused on youth from 16 to 24 years, it is a comprehensive homeless program developed in the Greater Toronto Area, operating under the umbrella organization of Eva's Initiative (2005a; 2005b). Its philosophy is based on the Chinese proverb: "Give a child a fish; he'll eat for a day. Teach a child how to fish and she'll eat forever" (Eva's Initiative, 2005b, Chap. 5, p. 2), with the program's goal focused on guiding each participant through a learning process so that he or she becomes a functional and productive participant in society.

This philosophy is consistent with the values of occupational therapy, focusing on enabling the client as an active participant in developing their own occupational lives. Eva's Phoenix addresses the needs of homeless youth through the use of a comprehensive approach focused on housing, employment and training, social support and life skills. When enrolled at Eva's Phoenix, each youth is provided with a support team, which consists of a primary worker who identifies the youth's housing and personal needs, and an employment counselor who identifies the youth's employment and educational needs. The transitional housing consists of 10 shared townhouse-style units, which house up to 50 youth for up to a year. This supportive living environment offers youth the opportunity to learn a number of occupation-based skills, such as saving money, budgeting, cooking and shopping. The youth learn conflict resolution strategies, tips for managing relationships and how to set appropriate goals for themselves. They can participate in different committees associated with housing, such as the social, maintenance, gardening, governance and food committees.

For the youth to be eligible for the transitional housing, they also must be enrolled in the employment program. The youth work with their support team to identify their interests, abilities and work potential. They complete a four-week career and employment preparation program to develop a career plan and learn basic job readiness skills, and then are placed in a work environment that reflects their interests and

About the authors –
Kitty Chan, Kimberley Garland, Karima Ratansi and **Batsheva Yeres** are currently enrolled in their first year of the MScOT Program in the Department of Occupational Science and Occupational Therapy at the University of Toronto. You can reach the first author, Kitty Chan at kittypy.chan@utoronto.ca

abilities. The placement lasts up to 20 weeks and serves as either a pre-apprenticeship or work experience, which could potentially lead to a full- time job. During the pre-employment phase the youth are paid a $200 stipend/week and during their work experience they are paid minimum wage.

Throughout the youth's time at Eva's Phoenix they must participate in one of four mentorship programs: workplace, one-to-one (with community adults), project-based (with a professional), or peer (with graduates of the program). The youth are required to meet with a mentor once a week for at least six months. Upon graduating from Eva's Phoenix, the youth will have a place to live, employment, work experience, a training plan or an apprenticeship and learned a number of life skills to ensure their success in the community.

Looking through an occupational lens

Eva's Phoenix has been shown to be successful in confronting the homeless issues of youth in the Greater Toronto Area, and it highlights the potential power of occupation and what an occupation-based client-centred approach could resemble. Viewing youth homelessness through an occupational lens provides insight into the current and possible future occupational needs, desires and potential of these youth. Homeless youth require guidance to identify their occupational struggles, and performance and engagement issues. Once their occupational struggles, resources and barriers are adequately identified, appropriate supports and resources can reveal and enable the occupational potential of each homeless youth and guide him or her to engage in meaningful occupations within mainstream society.

The goal of Eva's Phoenix is to help individuals to re-enter functionally into mainstream society. This focus is necessary and appears sufficient for addressing the current needs of homeless youths; however an additional emphasis on establishing structured and unstructured, significant, diverse and valued occupational experiences, in addition to those of basic self-care and paid work, may help to maintain the youth's occupational development following re-integration into mainstream society. This could prevent re-entry into a homeless status in the future and help to establish themselves as contributing, occupational citizens. Occupational therapists are privileged with the responsibility of enabling occupation for all individuals, and homelessness is an issue in need of an occupational perspective; occupational therapists have expertise to offer in this area, to enable the development of a meaningful and balanced occupational repertoire.

Acknowledgements

This article is a reflective piece based on a presentation made by the authors for their first term Occupational Therapy Practice course at the University of Toronto. The authors would like to acknowledge Janice Garton, J. Kyle Leming and Alicia Malachowska for their contributions to the original presentation.

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Write for the Sense of Doing column

As occupational therapists our primary role is to enable people's occupation. To do this well we need to understand occupation to its fullest. This column is an exciting opportunity to exchange perspectives on occupation and its significance to our practice. If you have been involved in a practice situation that reflects an interesting perspective on occupation, we would like to hear from you! Please e-mail an outline or an idea for a possible article to Fern Swedlove (OT Now editor) at fswedlove@shaw.ca or Jane Davis (Sense of Doing co-editor) at ja.davis@utoronto.ca .

Announcing the 2007 CAOT award recipients

Volunteers play an essential role in the work of any organization and the Canadian Association of Occupational Therapists (CAOT) awards celebrate contributions to our Association. Volunteers sit as members of the Board of Directors, chair or member of a committee, represent the Association on national coalitions and task forces and contribute to the development of CAOT products and services such as our journal, practice magazine and website.

CAOT Fellowship Award

This award has been established to recognize and honour outstanding contributions and service made by an occupational therapist over an extended period of time. Fellows of CAOT are eligible to use the credential FCAOT.

Mary Manojlovich

Mary is a consistent and outstanding contributor to the profession of occupational therapy in many, unrecognized ways. Whenever asked by the professional association, Mary is always ready to speak on behalf of occupational therapists and advocate for the profession. Under Mary's strong leadership, she guides occupational therapists to have a voice and advocate for clients who need our services. As a mentor and a role model in occupational therapy, Mary enables occupational therapists who practice in changing environments to move forward with confidence. She is a tireless worker and always seems to have the energy and the motivation to do what needs to get done. This endless source of strength has also been a source of inspiration for others whether they are starting off in their profession or have been in the field for many years. Mary has shown that she is not afraid nor intimidated but more importantly, not complacent when changes occur and which could potentially greatly affect occupational therapists and the practice of occupational in Newfoundland and Labrador and Canada. She has been a strong voice for all of us.

- Adapted from her letter of nomination written by Kim Larouche.

Dr. Helen P. LeVesconte Award for Volunteerism in CAOT

This award is given to an individual or life member of CAOT who has made an exceptional contribution to the profession of occupational therapy through volunteering with CAOT.

E. Sharon Brintnell

Beginning with her appointment as the CAOT Board Director from Alberta in 1974, Sharon Brintnell became the President in 1979. Sharon has served in a number of positions including: Secretary; Chair of the Documents Review Committee and Task Force on Affiliate Status; Chair and Member of the Examination Development Committee and Item Generation Committee; Member of the Education Council Ad Hoc Committee to Revise Educational Standards and Certification Committee and conference abstract reviewer. From 1988 to 1994, Sharon's volunteerism moved to the international stage as the CAOT Alternate Delegate to the World Federation of Occupational Therapists (WFOT). During that time she also served as a member of the WFOT International Committee and the Congress Committee. In 1998, Sharon became a WFOT Executive Committee Member and Treasurer and continues to serve in that capacity. Sharon is also a member of the Canadian Occupational Therapy Foundation. Sharon has received several awards of recognition as commendations from her professional community, including the 1985 Muriel Driver Memorial lectureship Award.

Sharon's influential collaboration includes contributions to the national occupational therapy guide-

lines for client-centered practice. Her expertise in the conceptualization and evaluation of educational programs is sought after. Sharon has been at both the heart and the forefront of the development of occupational therapy. Her footprint has been made by her provocative writings on the essence and evolution of occupational therapy as well as through her dynamic and indestructible commitment to all roles and activities that she undertook with respect to CAOT's direction. On a more personal note, Sharon's leadership and mentoring of all her students and colleagues have strengthened the profession and CAOT directly and indirectly in so many ways.

- Adapted from her letter of nomination written by Annette Rivard, Joyce Magill-Evans and Martha Roxburgh.

Award for Innovative Practice

This award was established to recognize and honour the exceptional contributions of an individual occupational therapist who has shown innovation and leadership in clinical practice.

Pam Andrews

Pam Andrews is an outstanding, innovative occupational therapist who sees through obstacles to the potential beyond. Pam sets her fine mind and innovative approach to resolving barriers in a wide variety of settings. Demonstrating leadership at its very best, she empowers everyone around her to become advocates for universal design.

In her work as Facilities Project Leader for the Regional Facilities Planning and Project Development arm of the Vancouver Coastal Health (VCH), Pam provides consultation regarding accessibility, signage and way finding for renovation and construction projects for the VCH service delivery areas. In this leadership role, Pam has been instrumental to change policy and help design effective, planned environments. These changes have enabled people who come to the buildings that comprise the VCH to participate in valued occupations.

While Pam was studying to be an occupational therapist, she designed an award winning device to help open doors and participated in a committee at the University of British Columbia to improve access on campus. Since graduation, in addition to her work at the VCH, Pam has also been an active community advocate through her participation in a variety of committees and workshops which include the Advisory Committee for Disability Issues for Vancouver (ACDIV). For example, through her involvement on this committee, Pam helped design the new checkout counter at the Vancouver Public Library so that they are fully accessible. Through all of her various work both as a leader and volunteer, Pam has always excelled at engaging others and actively involving them in projects. Through problem solving, laughter, deep commitment, optimism, respect, compassion and a very strong will, Pam arms the community to become advocates for all.

-Adapted from her letter of nomination written by Ginny Fearing and Jo Clark.

Darla King

Darla King is a confident, enthusiastic and innovative occupational therapist who is highly respected by her peers, clients and students. She is skilled in program design, implementation and evaluation, as well as a proven team member with exceptional organizational and communication skills. Leadership and innovation are two themes reflected in Darla's work which include participating as a member in the following projects: Primary Health Care Network for the Bonne Bay Project, Western Newfoundland; Newfoundland and Labrador Association of Occupational Therapists representative on Interprofessional Primary Health Providers Working Group; CAOT Integrating Occupational Therapy in Primary Health Care Advisory Group, Western Injury Coalition and Seniors Wellness Committee. In her work with this committee, Darla has helped to build community capacity to address senior's issues. Darla's sustained contribution to the Seniors Wellness Committee has resulted in great success.

Darla believes that getting on board with the right team leads to opportunities for growth. Building successful relationships is a key to improving occupational therapy services. Darla is no stranger to taking risks in her occupational therapy career and to being innovative; she recognizes opportunities where others might not. Recently, she began the position as the Inclusion Consultant with Child Care Services in the Western Health Region of Newfoundland. This is another new role for Darla and occupational therapy and will focus on promoting inclusion of children with special needs in child care settings through enhancing inclusionary programming and practices. Darla views this opportunity as an excellent opportunity to demonstrate the skills an occupational therapist can bring to this position.

- Adapted from her letter of nomination written by Brenda Head.

Award of Merit

The Award of Merit is given to acknowledge significant cont ributions to the profession of occupational therapy by occupational therapists and non-occupational therapists.

Johanne Desrosiers

Johanne was an associate editor for French papers published in the *Canadian Journal of Occupational Therapy* from 2001 to 2006. During this period, the number of French papers published increased as a result of her work editing, reviewing and mentoring authors to assist with preparing their papers for publication.

Helene Polatajko

Helene is the co-author of "*Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice Through Occupation*". This publication captures the latest developments in occupational therapy practice, research and education through national consultation with occupational therapists across the country.

Elizabeth Townsend

Elizabeth is the co-author of *"Enabling Occupation II: Advancing an Occupational Therapy Vision for Health, Well-being, & Justice Through Occupation"*. This leading publication complements *"Enabling Occupation: An Occupational Therapy Perspective"*. This new book will shape occupational therapy practice in Canada today and into the future.

CAOT Provincial/Territorial Citation Award

These awards acknowledge the contribution to the health and well-being of Canadians of an agency, program and/or individual within each province/territory who is not an occupational therapist.

Saskatchewan Society of Occupational Therapists - Lynnda Berg

Manitoba Society of Occupational Therapists - Manitoba Schizophrenia Society

Ontario Society of Occupational Therapists - The Ontario Brain Injury Association

New Brunswick Association of Occupational Therapists -
River Valley Obedience and Field Trail Club Inc.

Newfoundland and Labrador Association of Occupational Therapists -
Greg Hussey
Janet McGrath Kelly

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Jennifer Jarman
Lyn Jongbloed
Bonnie Kirsh
Terry Krupa
Zofia Kumas-Tan
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CAOT 2006 Student Award Winners

Each year, CAOT provides a student award to a graduating student at each Canadian university who demonstrates consistent and exemplary knowledge of occupational therapy theory throughout the entire occupational therapy program.

Narges Adab, University of British Columbia
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Christine Clement, University of Manitoba
Becky Desjardins, University of Western Ontario
Vanessa Hawes, University of Toronto
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Nicole Moran, University of Alberta
Kerry Oulton, Queen's University (MSc OT program)
Sebastien Pollet, McGill University
Justine Poulin, Université Laval
Catherine Schmidt, Dalhousie University
Astrid Scholte, McMaster University
Heather Wright, Queen's University (BSc OT program)

2007 Muriel Driver Memorial Lectureship Award – Dr. Terry Krupa

Photograph by Asha Lanthier

Dr. Terry Krupa

Dr. Krupa graduated from the University of Toronto occupational therapy program in 1979 and began her career at the Clarke Institute of Psychiatry in Toronto. While working for the next 10 years with clients with severe psychiatric disorders, she returned to school and in 1984 earned her Master's in Education from the Ontario Institute for Studies in Education of the University of Toronto (OISE). In 1989, she began her academic career at Queen's University and continues to work there. While at Queen's, she achieved the rank of associate professor, was chair of the Occupational Therapy Program for four years and received her Doctorate in Education from OISE in 2000. Through her outstanding efforts as an educator, researcher and practitioner, Dr. Krupa has impacted the profession of occupational therapy.

As an educator, she has won multiple awards for her exceptional skills in teaching, guiding and inspiring students. She is a mentor to many students who have chosen to practice in mental health. Dr. Krupa is an inspirational speaker and speaks with great knowledge and respect to local, provincial, national and international audiences. She continually challenges her audience by stretching their ideology in a well-researched and stimulating way. She has spoken extensively on recovery, client-centred care and mental health systems that support the integration of treatment and rehabilitation systems, as well as the occupational lives of individuals with serious mental illness. Dr. Krupa's outstanding facilitation and organizational skills have been evident at numerous conferences and knowledge transfer venues.

As a researcher, Dr. Krupa has demonstrated leadership in all areas of research, including grantsmanship, publication and knowledge translation. Her work has focused primarily on community and work integration for persons with serious mental illness. Dr. Krupa has been a principal investigator and/or co-investigator on grants from the highly competitive Tri Council Agencies such as the Social Sciences and Humanities Council and the Canadian Institute for Health Research. She has also been awarded research funds from the Ontario Mental Health Foundation and the Ontario Federation of Community Mental Health and Addictions Programs. She was the principal investigator for a three-year project on Assertive Community Treatment teams, part of an Integrated Community Mental Health Initiative, the first coordinated, multi-site research initiative in community mental health in Ontario.

Dr. Krupa has been extremely productive in the area of publication and knowledge translation, with many publications in text books and peer-reviewed journals. Through her publications, she has disseminated an occupational view of people with mental illnesses. Her work is highly applicable to practice and has helped to change the face of therapeutic interactions as well as service delivery.

As a practitioner, Dr. Krupa has made groundbreaking contributions to the lives of people living with serious mental illness. She is an exceptional therapist who has worked in clinical occupational therapy roles such as vocational counsellor, case manager, program coordinator and consultant. She has consistently worked to enhance client-centred care within an occupational therapy framework.

Dr. Krupa is a tireless volunteer, providing leadership to develop and support survivor organizations and consumer-run businesses. She was a founding member and board member of the Ontario Chapter of the International Association of Psychosocial Rehabilitation, as well as a founding member, board member and vice-president of Voices, Opportunities and Choices Employment Club. This not-for-profit organization is dedicated to the creation of affirmative businesses run by and for persons living with mental illness. Recently, she contributed to the development of an educational bursary to ensure that the associates of these businesses have access to the resources required to fulfill their educational goals.

Dr. Krupa's involvement in the mental health field focuses on the promotion of client-centred practice, the occupational issues experienced by persons with mental illness and the development of mental health systems that truly integrate rehabilitation and treatment principles and practices. She has served as both an ambassador and advocate for the profession while remaining focussed on her primary passion of full citizenship and community inclusion for people with mental illness.

Her expertise has been sought by numerous international researchers and practitioners and has led to frequent requests to serve on committees and task forces. For example, she represented CAOT on the Canadian Collaborative Mental Health Initiative, Ontario Ministry of Health and Long-Term Care, and Mental Health Human Resources Working Group. During her tenure as associate editor of the Canadian Journal of Community Mental Health, Dr. Krupa ensured that issues related to occupation were addressed and encouraged occupational therapists to publish their work through a national venue. As a founding member of the Ontario Chapter of Psychosocial Rehabilitation Canada she helped create an infrastructure to support the development of occupation-focussed practices in community mental health. As chair of the Steering Committee for the Systems Enhancement Evaluation Initiative, she oversaw the evaluation and knowledge dissemination related to developments in community mental health. She was also an Advisory Committee member for the Ontario Federation of Community Mental Health and Addictions Programs.

A member of CAOT throughout her career, Dr. Krupa has made many contributions to our national association. For the past year, she has been a member of the Advisory Committee of the newest edition of Enabling Occupation. She is a reviewer for the *Canadian Journal of Occupational Therapy* and Canadian Occupational Therapy Foundation grant applications.

In recognition of her exceptional work, Dr. Krupa has received numerous honours and distinctions. In 1999, Dr. Krupa won the Alumni Teaching Award, which is given annually for outstanding teaching. She has also received the Blue Star Award for Excellence in Teaching in the School of Rehabilitation Therapy for a record seven years. She holds cross appointments at Queen's University to the School of Nursing and Department of Psychiatry. She is adjunct senior research fellow at the University of South Australia and is an honorary board member of the Ontario Chapter of Psychosocial Rehabilitation Services.

Her work has been recognized throughout the world and deserves national recognition through this important award.

- Dr. Krupa's colleagues were proud to nominate her for the Muriel Driver Memorial Lectureship Award. This article was adapted from their nomination letter.

COTF Grants and Scholarships

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Is an in-hospital assessment truly reflective of the functional capacity of an older adult living at home?

Véronique Provencher

During my years of clinical work with older adults hospitalized in a rehabilitation unit, a great number of these people would say while doing a meal preparation assessment: "I can do it at home"; "It makes me nervous to do it here". Since then, these questions keep coming back to me: Are older people truly more independent at home? If that is the case, are they sufficiently independent to assume an acceptable degree of risk when they are at home? Honestly would I not underperform in an anxiety producing context? This article is a reflection on the risks of underestimating the functional capacities of some older adults on the basis of an assessment performed in a hospital setting and on the social impacts associated with such a practice.

No time available for a home visit

People aged 65 and over represent an important proportion of the clients admitted to Intensive Functional Rehabilitation Units (IFRU), one of the main rehabilitation programs offered in hospital settings. After a hospital stay in the IFRU, clients may be reintegrated into their homes, oriented towards a residence with support services or admitted to a long-term care centre. One of the main functions of the occupational therapist working in an IFRU is to evaluate the client's capacity to perform their daily activities. After an evaluation, the occupational therapist can recommend the resources that will be required for the client, a determining factor when it comes to choosing a living environment. When an older adult faces some difficulties while doing their daily activities, which can no longer be adapted by changes to their home environment, the rehabilitation team must consider a change of living arrangement.

In the province of Quebec, due to logistical restraints (e.g. shorter hospital stay of clients, frequency of treatments) and policy decisions (in Quebec, the responsibility for home assessments is assumed by occupational therapists working in local community service centres [CLSCs] once the clients have been reintegrated into their home), occupational therapists practising in a IFRU do not generally perform home assessments. When clients are leaving the IFRU, the assessment of the risks associated with living at home is essentially based on a functional profile established in a hospital context, using instruments with a limited ecological validity (McNulty & Fisher, 2001).

According to a widespread clinical assumption, older adults have a tendency to use compensation strategies more often in a familiar setting. This optimization of the residual capacities could lead to a greater level of independence which, even if subtle, could be sufficient to allow the person to remain at home. However, there is little documentation of the fact that clients apparently present a differential sensitivity to the familiarity of the living environment and that the profile of older adults could indicate greater capacities in a home setting. But who are these older people whose real capacities tend not to be reflected by in-hospital assessments? Current knowledge can provide some answers.

Who performs the best at home?

Normal aging is generally accompanied by declining executive functions (Ska & Joanette, 2006). These functions refer to a series of cognitive processes (planning, inhibition, mental flexibility) that facilitate the adaptation of a person in new situations (Perry & Hodges, 1999). The older person presenting an executive function deficiency may have difficulties solving new problems, eliminating non-relevant information and managing several tasks simultaneously, particularly when performing complex daily living tasks (Collette, Poncelet & Majerus, 2003). Among these tasks, when the executive functions have been affected, meal preparation becomes very vulnerable (Godbout, Doucet & Fiola, 2000), characterized notably by an inefficient management of the ingredients requiring different degrees of cooking.

In addition, meal preparation would be strongly sensitive to a change of setting, since it requires constant interaction with the environment. The difficulties experienced by an older adult in performing this activity may be worsened in a hospital setting. An unfamiliar situation can modify not only the demands of the task, but also the emotional state of the older adult. In fact, the new environment (type and arrangement of the materials to be used) may

generate anxiety, which could put even more demands on the executive functions (Wetherell, Reynolds, Gatz & Pederson, 2002). Consequently, the older adult has very little cognitive resources to prepare complex dishes and eventually will forget to turn off heating elements or eat non-nutritional foods. The fire hazards and malnutrition observed during the in-hospital assessment would ultimately compromise their capacity to remain at home safely.

However, a familiarity with the environment, defined as the individual's knowledge of their home setting and the routines used to perform the activity (Park, Fisher & Velozo, 1994), would help the older adult to compensate for these deficiencies and would require a lesser demand of the executive functions (Juillerat & Van der Linden, 2003). Few studies have been done on the impact of familiarity on the performance of common activities in normal aging. A study by Park et al. (1994) of 20 older adults with some physical incapacities living in the community compared the performance of two activities in a familiar setting (home) and in an unfamiliar setting (clinical), using the Assessment of Motor and Process Skills (AMPS). The analysis revealed that half of participants showed increased process skills at home. The authors suggest that anxiety and limited coping skills could have affected the performance in the hospital setting. The analysis performed did not allow the authors to establish a profile of the participants who benefited from the familiarity of their living environment.

Therefore, it is possible that during the assessment of meal preparation in a hospital setting, some more significant difficulties emerge in people presenting anxiety or an impairment of the executive functions. Moreover, it could be assumed that a familiarity with the environment tends to lessen the functional impact of these deficits, inducing a feeling of security or favoring the use of automatic reactions. Yet, a familiarity with the environment does not appear as helpful to improve the performance of older adults with severe executive deficits associated with a brain injury or dementia (Darragh, Sample & Fisher, 1998; Nygard, Bernspang, Fisher & Winblad, 1994). In summary, it would appear that a familiar environment would not be beneficial to everyone.

Home assessment: A profitable practice for people and society

Considering the social costs associated with the institutionalization and the wish of a majority of older adults to finish their lives living at home, the professional team of IFRU must consider a return to the home environment if that milieu is more suited to the client's needs. However, an in-hospital assessment, which does not reflect the real ability of some older adults to live alone at home, can lead the occupational therapist to underestimate their level of independence and to wrongly justify a change of their living environment. It is therefore important that occupational therapists assure that the functional profile of the client established in a hospital setting is representative of their capacity to perform their activities of daily living. In fact, an adequate estimation of the functional capacities of the client at home favours the recommendation of services better suited to their needs, which ultimately contributes to reduced government spending and optimizes the client's quality of life.

About the author –
Véronique Provencher is presently a PhD student at the Centre de recherche sur le vieillissement, Institut universitaire de gériatrie de Montréal and previously worked in a geriatric rehabilitation unit and day hospital. You can e-mail Véronique at veronique.provencher.1@umontreal.ca

This reflection demonstrates the importance of adequately documenting the client's cognitive profile and emotional state, because of the differential functional impact of the deficiency of the executive functions and the level of anxiety. These observations suggest that occupational therapists collaborate closely with other members of the team, in particular with the neuropsychologists and the social workers, in order to improve the results of our own analysis. Our clinical instincts suggest that with these clients, we use strategies that would increase their familiarity with the assessment setting: e.g., proposing to the client to "explain their recipe to us" and often contributes to increasing their confidence. While the preparation of the morning breakfast, according to their routine and with the materials used at home, should provoke some automatic reactions but, is it enough to recreate the optimal conditions offered in a real living environment?

For change to take place

The tendency of some older people to have a lower functional performance in a hospital setting and the limited predictive value of the instruments we use with this clientele lead me to believe that a home visit could be a prerequisite, before they are discharged from the IFRU. Although the present circumstances are not favorable, this reflection would sug-

gest that government authorities review, in partnership with health institutions, the IFRU mandate and consider the benefits of such a practice with regards to both the efficiency of health care delivery and the clients' quality of life.

Acknowledgements

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Dr. Barbara J. O'Shea honoured by Dalhousie University

Elizabeth Townsend

Dr. Barbara O'Shea

Canadian occupational therapists can be proud of Dr. Barbara O'Shea who was awarded an honorary Doctor of Laws by Dalhousie University on May 24, 2007. The following are excerpts from the citation by Elizabeth Townsend and the University:

"More than 25 years ago, Barbara O'Shea sat alone in an office on the tenth floor of the Tupper Building [at Dalhousie University]. But she wasn't alone for long. She recruited faculty, attracted students and built a world-class curriculum. She realized Dalhousie's long-held dream of establishing a School of Occupational Therapy for Atlantic Canada.

In the early 1980s, there were fewer than 100 qualified occupational therapists in the four Atlantic provinces. Today, as the school celebrates the 25th anniversary of its founding, there are more than 700 occupational therapists doing their vital work throughout the region. Her extraordinary leadership in a resource-challenged context has enabled Atlantic Canada to grow our own professionals. Occupational therapists serve our communities by enabling children with disabilities to develop their talents, adults to realize their potential despite mental, physical and social challenges, and seniors to live quality lives.

Dalhousie's desire to have its own occupational therapy program stretches back much further than a quarter century. In fact, the Dalhousie University Senate first approved the development of a program in 1956. By the late 1970s, pleas to reduce occupational therapy wait lists encouraged Dalhousie and Dr. Robert Tonks, then Dean of the Faculty of Health Professions, to get the job done. And for that, you need a champion. Dr. Tonks recruited Ms. O'Shea.

When she accepted an appointment as associate professor at Dalhousie, Ms. O'Shea was already well known nationally and internationally as a visionary occupational therapy leader. She studied occupational therapy at the University of Toronto and graduated in 1958. She began her career as a progressive cli-

nician, working with children and adults with upper limb amputations, particular those for whom myoelectric prostheses provided the most effective technology. She then went to Queen's University in Kingston to help in developing the baccalaureate program with time out to attend Colorado State University in Fort Collins, where she earned a Masters of Science in Occupational Therapy in 1976.

Ms. O'Shea is the founder of our school and served as its director for 16 years, from 1981 to 1997. She has been Professor Emerita at Dalhousie University since 1999.

Throughout her career, Ms. O'Shea has been an innovator. In the late 1980s and 1990s she developed the first occupational therapy list service. She also encouraged innovation in faculty and students. She championed research and evidence-based practice before it was fashionable. She has been a mentor to many people who are now leaders in the field.

Without Barbara O'Shea's boundless energy, innovation, commitment to excellence and regional awareness, occupational therapy in Atlantic Canada might still be waiting for a champion. For her ability to inspire, for her pioneering spirit and for her incredible legacy at Dalhousie, I ask you, Mr. Chancellor, on behalf of Senate, to bestow on Barbara O'Shea, the degree of Doctor of Laws, honoris causa."

About the author –
Elizabeth Townsend is professor and second director of the School of Occupational Therapy, Dalhousie University, Halifax, Nova Scotia. You can contact Liz at Liz.Townsend@Dal.Ca

Update from the COTF

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The 2007 Art Show will be held on Thursday, November 22 at the Enoch Turner School House in Toronto. If you will be in the Greater Toronto Area at that time, please come to see the art work, meet the artists and support COTF. For more information, please contact skamble@cotfcanada.org.

Your support counts! COTF sincerely thanks the following individuals, companies and organizations for their generous financial support during the period of February 1, 2007 to March 31, 2007. COTF will acknowledge donations received after April 1st, 2007 in a future issue.

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