From the Desk of the Editor

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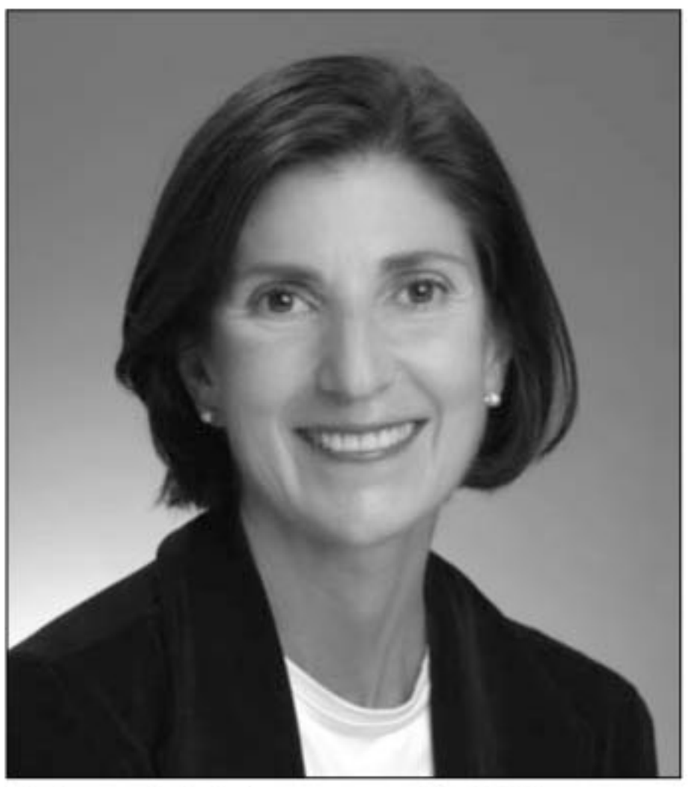

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This issue of the *American Journal of Occupational Therapy* includes the summaries from a systematic evidence-based literature review, funded by the Centers for Disease Control and Prevention, on occupational therapy and driving and community mobility for older adults. Following established procedures and methods to appraise and synthesize research findings from selected studies, each author developed a scholarly summary of the interventions and their implications for occupational therapy practice. Each article addresses a specific aspect of driving and community mobility directed toward improving performance and supporting participation among older adults. The majority of studies reviewed were conducted outside of the occupational therapy discipline—and many took place outside the health care arena entirely—yet, they influence and support practice in occupational therapy. Because the practice area and the supporting research represent a diversity of disciplines, it is important to build and maintain multidisciplinary collaboration when providing occupational therapy services. Although the existing literature is valuable and contributes to occupational therapy practice, it lacks emphasis on occupation and participation outcomes.

Evidence Supporting Driving and Community Mobility Practice

The history of driving rehabilitation as a practice area is filled with legend, anecdotes, and photographs; it grew out of necessity to allow operation of the earliest vehicles. Approximately three decades after Henry Ford revolutionized the assembly line to build automobiles, Franklin Delano Roosevelt had hand controls installed in his 1938 Ford convertible to accommodate his polio-related lower-extremity weakness. Since that time, occupational therapy practitioners, driver educators, and installers of mobility equipment have developed the practice of driving rehabilitation through instinct and application of rehabilitation and driver education theories and principles.

Notable progress has been made toward formalizing driving rehabilitation as a practice area, beginning with the incorporation of the Association for Driver Rehabilitation Specialists in 1977 (ADED, 2007) to bring together practitioners with the common goal of supporting driving among people with disabilities. The establishment of the multidisciplinary Certified Driver Rehabilitation Specialist (CDRS) credential in 1995 (ADED, 2007) furthered efforts by standardizing the knowledge base of the practice. The American Occupational Therapy Association's (AOTA's) implementation of the Specialty Certification in Driving and Community Mobility program in 2006 (AOTA, 2007) established a professional identity and occupation-based focus for this area of practice. Despite these recognized efforts to solidify the practice area, the clinical practice of driving rehabilitation continues to be dictated largely by the application of strategies from other practice areas and principles from other disciplines rather than by evidence.

The evidence-based literature review revealed findings that were specific to and focused on outcomes related to crashes, injuries, and fatalities rather than outcomes targeting occupational performance, engagement, or participation. Most of the studies were outside the occupational therapy and health care literature, forcing practitioners to rely on therapeutic approaches used in other practice areas (e.g., applying new driver education curricula to clients with neurological impairments). The ability of practitioners to incorporate evidence into driving rehabilitation practice is further compromised by the same lack of time, resources, and skills typically experienced by other health care providers (Cameron et al., 2005).

Supporting Participation Through Driving and Community Mobility

Community mobility, which includes driving, has been identified as an instrumental activity of daily living (IADL) and has been defined as "moving self in the community and using public or private transportation such as driving, or accessing buses, taxi cabs, or other public transportation systems" (AOTA, 2002, p. 620). Occupational therapists measure occupational performance in community mobility through the ability to access and use transportation, the ability to safely operate a motor vehicle, and other mechanisms to access the community. In addition to addressing occupational performance, practitioners need to consider the entire spectrum of outcomes, including client satisfaction, quality of life, participation, and engagement (AOTA, 2002, p. 628) when establishing goals and designing intervention plans. The pitfall of limiting outcomes to occupational performance is a resulting lack of consideration for the client's well-being. This broad consideration of clients' health and well-being is particularly important in the area of driving and community mobility because research findings suggest decreased social participation (Glass, de Leon, Marottoli, & Berkman, 1999) and increased depressive symptoms (Marottoli et al., 1997) after driving cessation.

The problem is further compounded because the United States is an automobile-dependent country. U.S. society has experienced urban sprawl, has insufficient transit infrastructures, and stigmatizes the use of mass transit, so the need and desire for spontaneous automobile operation remains high. By and large, people need to be able to drive to access their basic needs and desires outside the home. Driving has become a symbol of independence that people with disabilities and nondriving older adults are forced to compromise because of the lack of transportation alternatives.

Driving and community mobility are important activities in their own right. However, the importance of these activities increases when one views the impact of driving and community mobility on the ability of a person to participate in other areas of occupation, including education, work, play, leisure, and social participation. In a recent study addressing subjective experiences of community-dwelling homebound older adults, study participants reported "access to transportation as being a large barrier to their ability to access the community" (Sanders, Polgar, Kloseck, & Crilly, 2005, p. 153). In this context, driving and community mobility become an occupation enabler (Mihailidis & Davis, 2005; Polgar, 2006)—They allow the older adult to engage in other occupations and participate within the community. Although a person may be able to perform the activities needed to purchase food at the grocery store, play cards at the community center, or eat at a restaurant, being able to navigate the bus system or drive one's car provides the valuable link to engagement in other occupations that support participation. As health care providers, occupational therapy practitioners lose sight of client-centered and occupation-based outcomes by focusing on the techniques, intervention approaches, and public health perspective of reducing injuries and fatalities. Occupational therapy practitioners should support participation in a meaningful life, whether by driving or by using transit resources or by virtual participation.

Future of Driving and Community Mobility in Occupational Therapy Practice

Knowledge of the evidence related to driving and community is valuable not only to those working in driving rehabilitation but also for many occupational therapy practitioners working with older adults. Whether the occupational therapist provides services in an outpatient facility, an inpatient rehabilitation hospital, or a community health center, driving and community mobility should be a key component of the evaluation process. Asking questions regarding the client's driving and community mobility needs and priorities should be basic to all occupational therapy evaluations. It is vital that all occupational therapy practitioners consider driving as both an occupation and an occupational enabler for all appropriate clients.

The articles in this issue offer tools for understanding the area of driving and community mobility from the perspective of both occupational therapy and non-occupational therapy researchers. The introductory article, "Background and Methodology of the Older Driver Evidence-Based Literature Review," describes the process for developing the focused questions for the systematic reviews. By adapting methods used in public health to understand a given area of interest, the authors were able to determine an effective structure and process for locating and selecting evidence relevant to occupational therapy. This approach resulted in four focused questions, each describing a specific, targeted aspect of interventions related to driving and community mobility, including interventions with the person, the vehicle, the roadway infrastructure, and policy and community mobility.

Whether one is an occupational therapy practitioner, administrator, educator, researcher, or student, the articles in this issue will challenge the reader to think broadly about the occupation of driving and community mobility for older adults. The following evidence-based review summaries will expand practitioners' and researchers' thinking beyond the immediate scope of medical model practice to appreciate the impact of context and environments and the work of other disciplines on their own practice and inquiry. Depending on one's circumstances, this broadened thinking could result in including questions related to driving and community mobility in an occupational therapy evaluation, speaking to one's hospital administrator about starting a driving or community mobility program, improving an existing driving rehabilitation program, participating in an established driving research initiative, meeting with one's local highway department to advocate for signage changes to facilitate older driver navigation through highways, or being aware of features of a car that help or hinder driving performance. ▲

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