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CHAPTER 1

ON COMPETENCIES AND OUTCOMES IN THERAPEUTIC RECREATION

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Introduction

Ensuring that healthcare professionals attain and maintain competence is a complex task that is clearly related to their ability to design and deliver quality services that produce wanted client outcomes (Swankin, LeBuhn, & Morrison, 2006). Professional competence is tightly interwoven with service quality. This applies to all healthcare professions, including therapeutic recreation.

One purpose of this text is to help therapeutic recreation professionals and students explore some of the issues related to professional competence and quality service delivery. This implies two broad sets of inquiry. First, how do we ensure our worth—that is, how do we provide proof of professional competence? And second, how do we prove our value—that is, how do we provide proof of our service outcomes? While the aim of this text is not to provide definitive answers to these questions, we hope at least to surface the right questions that spark further debate and inquiry. This chapter embarks on that task by reviewing recent literature on professional competence and service outcomes in order to set the stage for the remaining chapters. This chapter first explores the notion of professional competence before examining concepts related to service outcomes.

How Do We Define the Profession?

Dower, O’Neil, and Hough (2001) authored an interesting treatise on questions to be asked of “emerging” healthcare professions. Among their lengthy list, are these questions that have great relevance to the profession of therapeutic recreation:

• What does the profession do, and how does it provide care? Is there a professional consensus document describing the profession?
• Is the profession best described as a complete system that includes a range of modalities and therapies? If not, would it be better described as a modality that could be provided by members of different professions? If it is a system, what characterizes it as a system?
If it is a modality, what systems and professions employ it?

- How is the profession different from/similar to other healthcare professions, systems, and modalities? What is the value that this profession adds to healthcare? How does the profession promote good health?
- How does the profession fit into the larger health picture? For what range of conditions and health concerns do members of the profession treat/provide care for/advise? For what range of conditions and health concerns do members of the profession decline to offer care/refer to other providers?
- How does the profession fare when held up to a progressive, normative set of goals for health professional such as that developed by the Pew Health Professions Commission? How does the profession measure up to other external norms regarding such issues as risk management or disease prevention?

It is clear that the collective answers to these questions become important for defining the scope of the profession and its future directions. How does therapeutic recreation define and measure professional competence? How do these definitions and measurements impact how we determine and defend service outcomes? Is there consensus on these answers? If not, is it possible to arrive at consensus or, minimally, some mutual agreements?

**What is Professional Competence?**

Greiner and Knebel (2003), in a publication on behalf of the Institute of Medicine, noted that there are five core competencies that all healthcare professionals should possess, regardless of their discipline, to meet the needs of the 21st-century healthcare system. These include:

- Ability to provide patient-centered care; e.g., providing culturally relevant care; coordinating continuous care; and advocating health, wellness, and quality of life;
- Ability to work in interdisciplinary teams that cooperate, collaborate, and integrate services to ensure care is continuous and reliable;
- Ability to uptake and utilize evidence-based practice through the integration of best practices, clinical expertise, and patient preferences;
- Ability to implement quality assessment and quality improvement; e.g., designing and evaluating whether systems and processes of care are improving quality; and
- Ability to utilize informatics; e.g., using information technology to communicate, manage data, and reduce error.

Epstein and Hundert (2002) defined professional competence as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served” (p. 226). They reviewed 195 studies and noted that professional competence for physicians reflected seven dimensions as noted in Figure 1.1. With the exception of technical skills, it appears that this list also applies to therapeutic recreation specialists.

Of course, the “content” of therapeutic recreation competencies is missing from these lists, but is delineated in documents such as the National Council for Therapeutic Recreation Certification’s 2007 Job Analysis. Both the content and dimensions of competence are...
Figure 1.1 Dimensions of Professional Competence
(Epstein & Hundert, 2002, p. 227)

- Cognitive
  - Core knowledge
  - Basic communication skills
  - Information management
  - Applying knowledge to real-world situations
  - Using tacit knowledge and personal experience
  - Abstract problem-solving
  - Self-directed acquisition of new knowledge
  - Recognizing gaps in knowledge
  - Generating questions
  - Using resources (e.g., published evidence, colleagues)
  - Learning from experience
- Technical
  - Physical examination skills
  - Surgical/procedural skills
- Integrative
  - Incorporating scientific, clinical, and humanistic judgment
  - Using clinical reasoning strategies appropriately (hypothetico-deductive, pattern-recognition, elaborated knowledge)
  - Linking basic and clinical knowledge across disciplines
  - Managing uncertainty
- Context
  - Clinical setting
  - Use of time
- Relationship
  - Communication skills
  - Handling conflict
  - Teamwork
  - Teaching others (e.g., patients, students, colleagues)
- Affective/Moral
  - Tolerance of ambiguity and anxiety
  - Emotional intelligence
  - Respect for patients
  - Responsiveness to patients and society
  - Caring
- Habits of Mind
  - Observations of one’s own thinking, emotions, and techniques
  - Attentiveness
  - Critical curiosity
  - Recognition of and response to cognitive and emotional biases
  - Willingness to acknowledge and correct errors
important factors in determining a professional’s ability to adequately design and deliver services to constituents. That is, a professional’s competence is closely related to his or her ability to provide high-quality services that help the client achieve desired and meaningful outcomes.

A notable assertion made by Swankin et al. (2006) is that too often in healthcare a profession is too narrowly focused on the initial assignation of competence and fails to periodically assess the professional’s updated knowledge, skills, and clinical performance; his or her need for a methodical improvement plan based on that assessment; and his or her continued demonstration of continued competence. They believe that continuing education requirements be abandoned in favor of stringent professional development plans that require routine periodic assessments, personal improvement plans, extensive record-keeping, and continual monitoring and evaluation of professional competence.

To what degree are professional competence and quality service provision related? Buettner and Fitzsimmons (2007) noted “The individual recreation therapist has a considerable impact on outcomes, both in research and in practice settings. Being the best clinician possible is, therefore, important in advancing evidence based practice” (p. 16). Do you agree that ensuring our worth as healthcare professionals through evidence of continued competence is closely related to proving our value as a profession in delivering sought-after client outcomes? If a professional’s competence is not adequately and continually monitored, are clients put at risk? How does therapeutic recreation fare in establishing and continually measuring professionals’ competence with relation to high-quality practice? The next section will explore the definitions and parameters of client outcomes and their relationship to evidence-based practice.

What are Client Outcomes?

The ability of the professional to designate and deliver services that produce predictable, meaningful, and important client outcomes is of paramount importance to administrators, clinicians, and healthcare consumers alike (McGrath & Tempier, 2003). Conceptualizing and managing service quality is important to all healthcare stakeholders. “It is important that the primary focus of any quality-management system be improved quality of care and treatment effectiveness, with cost-effectiveness a welcome and likely companion” (McGrath & Tempier, p. 469). Central to quality healthcare is the concept of client outcomes.

A number of authors have emphasized that outcomes are the documentable changes in client behavior, skills, and/or attitudes that can be attributed to active participation in the therapeutic recreation intervention program (Dunn, Sneegas, & Carruthers, 1991; Stumbo & Peterson, 2009; Shank & Kinney, 1991; Stumbo, 1996). The following represent definitions of client outcomes located in the healthcare literature:

- The (change in a) state or situation that arises as a result of some process of intervention (Wade, 1999, p. 93)
- Refers to change in a client’s status over time (McCormick & Funderburk, 2000, p. 10)
- Outcomes are reported as changes in the score between two points of time on individual level standardized instruments (Blankertz & Cook, 1998, p. 170)
- The results of performance (or non-performance) of a function or process(es) (Joint
• Outcomes are the observed changes in a client’s status as a result of our interventions and interactions, whether intended or not. Outcomes are the complications, adverse events, or short- or long-term changes experienced by our clients, and represent the efforts of our care. Outcomes can be attributed to the process of providing care, and this should enable us to determine if we are doing for our clients that which we purport to do (Shank & Kinney, 1991, p. 76)

• Client outcomes are the results or changes in the client that result from participation and involvement in services, and, therefore, need to be clarified and targeted before any intervention or service is conceptualized or designed (Stumbo & Peterson, 2009, p. 469).

• The direct effects of service upon the well-being of both the individual and specified populations; the end result of medical care; what happened to the patient in terms of palliation, control of illness, cure, or rehabilitation (Riley, 1991, p. 58)

• Clinical results (Scalenghe, 1991, p. 30)

The majority of these definitions concur that outcomes represent the differences in the client from the beginning compared to end of treatment (and perhaps beyond). Of course most clinicians are hopeful that client changes or outcomes are positive (in the desired direction of treatment) and result directly from active participation within treatment services. In all cases, outcomes must be targeted prior to the intervention and must be measurable.

Because client outcomes are so complex and multi-faceted, many authors have attempted to classify them into broader health and functional outcome categories. These categories help professionals communicate client needs across disciplines and help individual professionals make sure their services contribute to the overall health and functioning of the clients served. In general, healthcare outcomes can be divided into five overall categories: (a) clinical status, (b) functional status, (c) well-being or quality of life, (d) satisfaction, and (e) cost/resource consumption (Hendryx, Dyck, & Srebnick, 1995; Johnson, 1993; McGlynn, 1995; McGrath & Tempier, 2003).

Clinical status may include measurements of psychopathology, symptomatology, short-term changes in symptoms or severity of problems or syndromes targeted by services (Hendryx et al., 1995; McGlynn, 1995). McCormick and Funderburk (2000) cited Granger (1984) and Ware (1997) to describe clinical status as changes that are measured at the organ level, such as blood pressure, temperature, white blood cell count, respiration, and fitness.

Functional status includes the ability to fulfill social and role functions that reflect broad long-term effects after services have ended and which tend to reflect a person or family’s ability to lead a successful, productive, satisfying life. Examples include ADLs; leisure lifestyle, life and self-care skills; safety; stability of living environment; relationship abilities such as marriage, parenting, and sibling interactions; school or employment status; and engagement in at-risk behaviors (Granger, 1984; Hendryx et al., 1999; Mason, 2000; McCormick & Funderburk, 2000; Tully & Cantrill, 1999; Ware, 1997).

Well-being or Quality of Life includes the personal or subjective definition of well-being for the individual. It may involve relative assessment of satisfaction with living conditions, work or school, leisure, finances, and whether basic and fundamental needs are met (Hendryx et al., 1999; Mason, 2000; McCormick & Funderburk, 2000; Russo, Roy-Brune, Jaffe, &
Satisfaction measures usually target satisfaction with services received. These assessments may help to determine the patients' opinions whether care is accessible, affordable, effective, and professional (Hendryx et al., 1999; Mason, 2000; McCormick & Funderburk, 2000; Mordock, 2000).

Costs and resource consumption balance the need to reduce costs with unfavorable impacts on the quality of care (Johnson, 1993).

Healthcare in general and each profession specifically work in tandem to identify overall trends in outcomes. In the last twenty years or so, healthcare has moved from solely measuring improvement in functional abilities, to health, then to quality of life. As each wave sends ripples throughout the system, professions must respond by honing their ability to identify and measure appropriate and corresponding outcomes.

Of course, outcomes are only as good as the systems put in place to measure and document them. This effort is called outcome measurement. Outcome measurement reflects efforts to document changes in the clients' clinical status, functional status, well-being or quality of life, satisfaction, and cost or resource consumption that result from a particular set of services. As mentioned previously, healthcare is currently moving toward an emphasis on quality of life.

Two parallel decisions must be weighed: what outcomes to measure and how to measure them. Measurement simply refers to the quantification of data in some way, either in absolute terms or in relative terms. “Thus, in order to evaluate the outcome of a process one has to decide and specify what the rehabilitation process is trying to achieve. It is only sensible to measure those factors that the process will or might affect. The measure chosen should focus on the intended area(s) of concern and, as far as possible, should not cover any other extraneous areas” (Wade, 1999, p. 93). Outcome measurement is the “how” after the “what” of outcomes has been determined (Granello, Granello, & Lee, 1999).

More recently, McGrath and Tempier (2003) concurred with the five categories of client outcomes (clinical status, functional status, quality of life, satisfaction, and cost) suggested by Hendryx et al. (1995), Johnson (1993), and McGlynn (1995). In addition, McGrath and Tempier suggested a number of criteria for outcome measuring assessing these five areas: (a) be widely accepted, (b) be comprehensive, (c) be suitable or meaningful, (d) be sensitive to change, (e) be psychometrically sound, (f) be statistically amenable, (g) and be practical or actionable.

Knowledge of the five client outcome categories (the “what”) and outcome measurement (the “how”) is an important stepping-stone in providing quality care. “In a climate of fiscal restraint and healthcare cutbacks, patient needs may not be met, or they may be met inadequately. Without evaluation, one cannot determine whether or to what extent patient needs are met, what patients’ changing needs are over time, and how best to respond to these needs” (McGrath & Tempier, 2003, p. 471). A tandem effort to improve healthcare quality is evidence-based practice.

Why are Outcomes Important?

Quite simply, specifying outcomes is a minimal expectation of human services. “Healthcare professionals and agencies are expected to demonstrate that the care they
provide does make a difference for the population receiving care” (Ray, 1999, p. 1017). Ray suggested that healthcare professionals be asked about the evidence that they can provide that their service improves, maintains, or promotes the health and/or quality of life of clients. She further suggested that answering this question well depends on the degree to which professionals use evidence (that is, research) to support their service design and delivery.

Interestingly, Kelly (2003) suggested that specifying outcomes might be important because “that which is measured tends to get better” (p. 254). When clinicians pay close attention to the designation of outcomes, they might also be more careful in their design and delivery of programs to clients. By focusing on and measuring the degree of treatment effectiveness, the professional is likely to improve service delivery to clients.

Outcome research or outcome measurement concerns the generation and use of data to evaluate care provided to clients, while evidence-based practice then utilizes this research evidence to make decisions about how services are designed and delivered. Professionals should be able to provide substantiated proof (or evidence) that services are effective, efficient, and lead to valued outcomes. When research results are used as the foundation of practice, services provided to clients are more likely to be of higher quality.

What is the Relationship between Outcomes and EBP?

Evidence-based medicine or practice means that the services delivered to clients should be based on the best available scientific evidence of treatment efficacy or effectiveness (Adams & Titler, 2007; Buettner & Fitzsimmons, 2003; 2007; Linde, 1999; Margison et al., 2000). This means that interventions should be designed and delivered using research evidence to implement “best practices.” Evidence-based interventions are created and delivered based on the best available information on moving clients toward desired outcomes in the most effective and efficient way possible.

The evidence-based concept is highly favored by power holders in government and healthcare organizations because of its capability to 1) advance quality of care and services recreation therapists provide, 2) have fewer variations in recreation therapy practice, 3) provide cost savings that flow from appropriate and timely recreation therapy intervention use, and 4) improve health outcomes in general. (Buettner & Fitzsimmons, 2003, p. ii)

While we may think that therapeutic recreation has little quality research concerning most interventions, Petticrew (2003) and Regan (1998) reminded all healthcare professionals that “best available” is an important clause in that few, if any, professions have enough clear cut research evidence to provide the singular source of decision making. Clinical judgment, expertise, and prior experience all become additional sources to research results (Wittink, Nicholas, Kralik, & Verbunt, 2008).

Effectiveness characterizes how an intervention works under everyday circumstances in routine clinical practice (Aral & Peterman, 1998, Powe, 1996). “The effectiveness of an intervention is the impact an intervention achieves in the real world, under resource constraints, in entire populations, or in specified subgroups of a population. It is the improvement in a health outcome achieved in a typical community setting” (Aral & Peterman, 1998, p. 3). Effectiveness studies attempt to address the degree to which clients improve under treatment as it is actually practiced in the field (i.e., with fewer controls and
manipulations than in efficacy research designs) (Granello et al., 1999).

Efficacy characterizes how an intervention performs under ideal or more controlled circumstances (Aral & Peterman, 1998; Powe, 1996). “Efficacy is the improvement in health outcome achieved in a research setting, in expert hands, under ideal circumstances” (Aral & Peterman, 1998, p. 3). It usually requires randomization to treatment and control groups, and a specific intervention for the treatment group – that usually has met criteria for a single diagnosis (Granello et al., 1999).

The purpose of evidence-based practices is to reduce wide and unintended—fluctuations in practice using the best, cumulated evidence possible to inform and enlighten service delivery. Evidence-based practice improves the predictability and causality of service outcomes and provides regulators, payers, and consumers increased assurance of quality care.

Evidence-based practice, in the largest sense, involves four distinct actions of the part of the healthcare professional:
1. Production of evidence through research and scientific review
2. Production and dissemination of evidence-based clinical guidelines
3. Implementation of evidence-based, cost-effective practice through education and management of change, and
4. Evaluation of compliance with agreed practice guidance and patient outcomes – this process is called clinical audit (Belsey & Snell, 2001).

That is, through evidence-based service delivery, each practitioner should feel confident that she or he is providing the best possible care that is known to produce the most desirable, intended, and meaningful outcomes. Evidence must be gathered through well-designed and meaningful research efforts with client groups and be applicable to daily practice. In the literature, evidence-based practice also is termed empirically validated treatment, empirically supported treatment, empirically evaluated treatment, empirical practice, research-based practice, research utilization, evidence-based treatment, and evidence-based healthcare) (Chambless & Ollendick, 2001; Denton, Walsh, & Daniel, 2002; Evidence-Based Medicine Working Group, 1992; Kendall, 1998; Lee & McCormick, 2002). Below is a collection of definitions of evidence-based practice found in the healthcare literature.

• The aim of evidence-based healthcare is to provide the means by which current best evidence from research can be judiciously and conscientiously applied to the prevention, detection, and care of health disorders (Haynes & Haines, 1998, p. 273)
• Process of systematically reviewing, appraising and using clinical research findings to aid in the delivery of optimum clinical care of patients (Belsey & Snell, 2001)
• Evidence-based healthcare extends the application of the principles of evidence-based medicine (see below) to all professions associated with healthcare, including purchasing and management (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996)
• Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise and our patients' own values and expectations with the best available external clinical
Evidence from systematic research (Sackett et al., 1996)

- Evidence-based healthcare is, at its simplest, the idea that care that health professionals provide should be based as closely as possible on evidence from well-conducted research into the effectiveness of healthcare interventions, thereby minimizing the problems of underuse, overuse, and misuse (Walshe & Rundall, 2001, p. 431)

- The ability to track down, critically appraise (for its validity and usefulness), and incorporate this rapidly growing body of evidence into one’s clinical practice has been named ‘evidence-based medicine’ (Sackett et al., 1996)

- Placing the client’s benefits first, evidence-based practitioners adopt a process of lifelong learning that involves continually posing specific questions of direct practical importance to clients, searching objectively and efficiently for the current best evidence related to each question and taking appropriate action guided by evidence (Gibbs, 2003, p. 6)

- The collection, interpretation, and integration of valid, important, and applicable patient-reported, clinician-observed, and research-driven evidence. The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical judgments and facilitate cost-effective healthcare (Tanner, 1999, p. 99)

- Reliance on current scientific evidence to reach medical decisions (Timmermans & Angell, 2001).

As such, evidence-based practice involves the systematic collection of data, over time, through near-patient research studies as well as the clinician’s reflective approach in applying this information in daily work with clients. According to Pruett, Swett, Chan, Rosenthal, and Lee (2008) evidence-based practice can be defined as

A total process beginning with knowing what clinical question task, how to find the best practice, and how to critically appraise the evidence for validity and applicability to the particular care situation. . .The best evidence then must be applied by a clinician with expertise in considering a patient’s unique values and needs. The final aspect of the process is evaluation of the effectiveness of care and the continual improvement of the process. (p. 57)

Timmermans and Angell (2001) noted that evidence-based clinical judgment has five important characteristics. Evidence-based clinical judgment: (a) is neither solely evidence nor judgment, (b) requires understanding of the requirements to make a satisfactory clinical decision, (c) increases with opportunity and practice, (d) reduces but does not eliminate clinical uncertainties, and (e) is currently grounded in a Western, allopathic, and professionalized approach to medicine.

King and Teo (2000), while addressing nurses, stated that evidence-based practice might help close the gap between research and practice. “The foundation of evidence-based practice de-emphasizes decision making based on opinion, custom, or ritual . . . Rather, emphasis is placed on applying the best available research findings to specific clinical situations” (p. 597).

For evidence-based practice to advance, better and high-quality evidence from patient-based research is needed, along with more and better ways to incorporate and use this evidence in every-day practice (Bliss-Holtz, 1999; Deaton, 2001; Richardson, 1997).
Rosenberg and Sackett (1996) and Sackett and Haynes (1995) wrote that evidence-based practice can actually be accomplished in three ways: (a) through learning the five steps of evidence-based practice, (b) seeking evidence collected by others, and (c) adopting protocols written by others who have done evidence-based practice research. The ultimate expectation of evidence-based service delivery is improved, informed, and more standardized healthcare for all clients. “Bridging gaps between evidence and practice is central to ensuring that beneficial interventions are used appropriately and harmful interventions are avoided” (Brockelhurst & McGuire, 2005, p. 38).

Although originating in medicine, evidence-based practice has “permeated” social and behavioral professions as well (Pruett et al., 2008, p. 56). This is certainly the case for therapeutic recreation. Stumbo and Peterson (2009) remarked

It is clear that evidence-based practice, because it improves the likelihood of clients achieving the desired outcomes in the most direct and potent manner, is here to stay. Therapeutic recreation specialists who use evidence-based practice will shorten their overall preparation time and heighten their ability to reach meaningful client outcomes. (p. 83)

Hopefully therapeutic recreation specialist can embrace outcome measurement and evidence-based practice beyond just fiscal or management mandates and agree that delivering the best possible services to clients, based on the best available research evidence is more effective and will lead client to better outcomes. It’s not just the smart thing to do, it’s the right thing to do.

**What are the Benefits to Defining and Measuring Outcomes?**

The benefits of evidence-based and standardized intervention programming are wide ranging. Below are some of the professional benefits of evidence-based and standardized practice as noted by Stumbo (2003):

- Provides reasonable guarantee to client and others that programs are designed and delivered for a specific purpose;
- Helps specialist focus on meeting client needs rather than providing programs without purpose;
- Ensures relative consistency of treatment from client to client, day to day, specialist to specialist;
- Groups clients into programs based on need rather than convenience;
- Helps determine content of client assessments;
- Provides direction for content of client documentation;
- Aids in producing predictable client results from programs;
- Allows better data collection about program efficacy in meeting the needs of clients;
- Increases communication between therapeutic recreation specialists throughout the country, as well as with other disciplines; and
- Provides explanation of therapeutic recreation services to auditing groups such as third party payers, accrediting bodies, and administrative policy makers.

These benefits can be divided into areas regarding the program, the clients, therapeutic recreation specialists, and external (to therapeutic recreation) audiences. Benefits to the overall therapeutic recreation program result as close attention is paid to the planning,
selecting, and designing of programs to meet a specific purpose or area of client need. This requires systematic forethought and diligence on the part of the therapeutic recreation specialist as well as a reasonable knowledge of research evidence and theories related to intervention.

Benefits to clients stem from the systematic and purposeful planning that must take place with evidence-based practice and protocols. Clients can be reasonably assured that there is a specific purpose, implementation plan, and predicted outcomes that remain the focus of the program. Clients are more guaranteed that there is a desirable end result of participation in the program. For many clients this assurance results in increased motivation to participate actively in the programs described in the protocol.

Benefits to therapeutic recreation specialists are many. Knowing that programs have a defined purpose and targeted outcomes helps the specialist implement and evaluate them with more confidence and uniformity. Program delivery becomes standardized rather than haphazard, as does professional terminology.

Another benefit then becomes the ability to better communicate and market therapeutic recreation services to outside constituents. This may include other disciplines, health care administrators, external accrediting bodies, insurance companies, and clients themselves. The ability to provide consistent, high-quality, and predictable client care is essential in this era of accountability. Shorter lengths of client stay support more predictable timelines for intervention and both evidence-based practice and use of clinical guidelines allow therapeutic recreation specialists to be more responsive in this area. These efforts form the foundation of common practices that move the profession toward greater accountability.

What are the Barriers to Defining and Measuring Outcomes?

There is no doubt it: Outcome measurement in healthcare is difficult (Greenhalgh, Long, Brettle, & Grant, 1998; Greenhalgh & Meadows, 1999). Beyond problems with the psychometric properties of outcome measures such as lack of validity and reliability [see for example, Bilsker and Goldner (2002), Deaton (2001), Goldsmith, Bankhead, and Austoker (2007). and Greenhalgh et al. (1998) for interesting discussions], social and behavioral science professions have added tribulations.

Wittink et al. (2008) noted that nonpharmacological treatment is usually complex and difficult to standardize, partially because treatment is being adjusted even as it is being carried out. They discussed the field of pain management as an example of a specialty that uses performance-based measures (such as standing or sitting tolerance), external criterion measures (such as return-to-work variables) and various self-reported measures (such as pain quality, mood, degree of disability, and the like), but still often fails at measuring outcomes of treatment due to the lack of normative measures against which each client’s scores can be compared. As such, “effect” of treatment cannot be measured explicitly enough to declare the treatment either a success or a failure.

Likewise, Chronister, Chan, da Silva Cardoso, Lynch, and Rosenthal (2008), Johnson, Dow, Lynch, and Hermann (2006), and Pruett et al. (2008) have noted extensive difficulties in defining and measuring outcomes in rehabilitation counseling. They noted that rehabilitation counseling calls for a diversity of job functions performed over a wide range of settings, with diverse groups of clients, using various intervention approaches, with
sometimes dissimilar philosophies. Zlotnik and Galambos (2004) noted similar problems in social work and called for professionals to concentrate efforts on high-quality program evaluations and intervention studies, using more sophisticated designs with multiple sites and multiple populations.

Clearly, therapeutic recreation is not the only profession that has few, if any, significant outcome studies. It is difficult to get traction on this important effort. But if not now, when? If not you, then who?

**Discussion Questions**

1. In comparison with other professions with which you are familiar, how does therapeutic recreation fare in terms of being well-defined and coherent?
2. What other foundational professional competencies you would add to the lists provided in this chapter? Prior to looking at the newest NCTRC Job Analysis, construct a list of professional competencies for therapeutic recreation. How does your list compare to NCTRC and other students in your class?
3. What is the relationship of professional competence to client outcomes? If a therapeutic recreation specialist is not able to well-define and measure client outcomes prior to designing and delivering the service, what does this say about his or her competence? How does this compare to other health professionals such as surgeons, physical therapists, and acupuncturists?
4. What are typical client outcomes for therapeutic recreation? Which of the five major areas of outcomes listed in this chapter do most therapeutic recreation outcomes fall into? Is there professional consensus on which client outcomes are important? On how to measure them and report their achievement?
5. What is the relationship of client outcomes to evidence-based practice? Why has evidence-based practice become so popular in healthcare? What are the advantages of evidence-based healthcare to clients? How well does therapeutic recreation use available evidence (i.e., research) to develop programs for client involvement? What would be the consequences if therapeutic recreation specialists were more involved in evidence-based practice?
6. How will professional competence, client outcomes, and evidence-based practice impact therapeutic recreation in the near future? What does therapeutic recreation need to do to ensure its future? What role will you play?

**References**


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