



Professional Issues in Therapeutic Recreation

On Competence and Outcomes

3rd Edition

Norma J. Stumbo

Brent D. Wolfe

Shane Pegg

Editors

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Third Edition

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SAGAMORE  VENTURE

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Acknowledgments

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I'd like to personally thank my sisters, Barbara A. Busch and Nancy L. Lockett, as well as Randy Duncan for being steadfast rocks in a tumultuous couple of years. Their grace and goodness endure.

–Norma J. Stumbo

To Dave and Flo...I will forever be grateful for your support and guidance that provided the foundation for me to discover and pursue my passion.

To Becky...Your patience, support, and faith give me the strength I need each day. You are the strongest woman I know and the best mother and wife on this planet.

To Austyn Grace and Taylor Faith...You are two hearts that beat outside my chest and bring me more happiness that you can imagine; and remember, Wolfes never quit.

–Brent D. Wolfe

To my daughter, Sarah. May you continue to draw upon the collective wisdom of the TR profession to teach some of your allied health peers in Australia a thing or three about delivering good-quality, person-centered, health service offerings.

–Shane Pegg

Preface

The profession of therapeutic recreation has faced many challenges in recent years and we are excited to bring together an incredibly diverse and knowledgeable range of authors to intelligently and articulately present these issues. Change has become such a commonplace element of our modern society that it is now truly a case of adapt, create, and innovate, or ... perish. The new edition draws upon the insight and knowledge of those now leading the TR profession in seeking to better place the profession as a valuable health and human service offering and as a much desired career choice. We, therefore, welcome their valued contributions and especially their enthusiasm for what might yet be.

This latest edition recognizes that the profession must continue to challenge the status quo and one another. Issues and ideas are not stagnant; they are forever changing, and the various sections and chapters of this edition will challenge the reader to conceptualize ideas from new perspectives and in new light. Readers are encouraged to wrestle with the ideas presented. Do not simply read them and file the information away. Interact with the ideas. Discuss the ideas. Argue about the ideas. Whatever you do, do not simply disregard an idea because it represents a viewpoint or perspective that is different from your personal philosophy related to the profession. We challenge all readers to be drawn into the variety of topics, concepts, and perspectives presented in this volume so each can continue to personally grow and enable the profession to continue to grow.

Like the first two editions, this effort has four major sections: Introduction, Education, Practice, and Research. It is clear that these divisions *are largely arbitrary*, as every practice issue affects every research issue, every education issue affects every practice issue, and on and on. However, books require an organizational layout, and these divisions appear to make sense. Each section begins with a Keynote chapter aimed at setting the stage for that particular section. Each section also ends with a Perspective chapter, largely an opinion or viewpoint piece to encourage readers to continue discussion on related issues.

Five revised chapters and three new chapters comprise the Introduction section. The first chapter on competencies and outcomes by Stumbo and Pegg update this information from the second edition. Kensinger provides an updated overview of how the history of the profession affects current issues. The impact of world demographics is outlined by Genoe, Hopper, and Singleton, while Porter, Van Puymbroeck, and McCormick discuss the World Health Organization's International Classification system. Yang and Kim also updated information related to the ways in which therapeutic recreation is evolving worldwide. New to this edition, Mobily voices a unique take on the profession's history, while Beck reviews the definition/philosophical debate that is a long and dominating thread of our history. Lastly,

Widmer and Duerden author a unique perspective of the place of CTRs in corporations.

In the second section on Education issues, McKenney and Van Puymbroeck open with an apt analogy for the dilemma many TR educators face in higher education. Wilder, Carter, Zahl, Greenwood, and Stumbo update statistics on TR programs in North America, while Sklar and Autry refresh the chapter on accreditation. Two new chapters include one on online learning and teaching by Anderson, Heyne, and Thomas, and a second one concerning requiring a master's degree for entry-level practice by Carter, Ashton, Hutchins, and Wolfe. Kinney, Kinney, Witman, and Malcarne round out the Education section with a renewed perspective on curriculum standardization.

Ten chapters make up the Practice section. Wolfe revisits the notion of TR being a process, not a location. Ross and Snethen author a new chapter in this section on current trends in service delivery. Ross and Ashton refreshed their chapter on service models, adding new models to their review. Pegg, Stumbo, and Bennett target the issue of evidence-based practice, while Richeson, Fitzsimmons, and Sardina address the related issue of clinical practice guidelines. Stumbo and Kemeny updated issues surrounding client assessment, and Shank, McGovern, and Nichols take a new approach on professional advocacy via public policy. Hinton and Connolly contemporize the chapter on professional credentialing, while Zahl, Greenwood, Keogh Hoss, Wilder, and Carter refreshed the chapter on comparisons between health care and higher education. Craig brings the Education section to a close with a new perspective chapter on fieldwork experiences.

The fourth and final section on Research has five revamped chapters and one new chapter. Bedini kickstarts this section with a renewed review of the status of TR research. Caldwell and Weybright talk about the continued importance of theory on practice and research. Widmer and Lundberg also expand their chapter on program evaluation and outcome research. Dupuis and Whyte contribute one of the new chapters in this section, addressing the novel idea of research as a participatory process. Stumbo and Zahl also add a new chapter on research ethics. Green, Hopper, and Singleton round out the section and the book with a call for greater cross collaboration in TR research.

Long-time readers may note that several chapters from the second edition are not in this text. For the most part, these former authors chose not to refresh their chapters due to personal reasons, such as retirement or job change, which prevented them from authoring new chapters. When applicable, we encourage readers to refer back to the second edition as needed, as we believe many of these chapters are still relevant.

These 30 chapters represent the prime issues and challenges currently facing the field. We wish to express our deep appreciation to every author who worked tirelessly to research, write, and revise his or her work. We owe them a huge debt, as does the field. We know they do it out of love for the field, and that is greatly appreciated. Thank you all for making this a great edition and addition to our literature.

We hope that readers take the opportunity to read, reflect, question, debate, and take part in moving the profession forward. We close this preface with these words from Eleanor Roosevelt: “The future belongs to those who believe in the beauty of their dreams.” May each reader be inspired and encouraged to get engaged and write a bright and robust future for our field.

About the Authors

Lynn S. Anderson, CTRS, CPRP, is a distinguished service professor in the Recreation, Parks and Leisure Studies Department at State University of New York at Cortland and the director of the Inclusive Recreation Resource Center. Dr. Anderson is the program coordinator for the Therapeutic Recreation Online Graduate Certificate program at SUNY Cortland. The 18-credit certificate of advanced study is designed to provide therapeutic recreation academic coursework needed by practicing professionals to pursue career advancement or national certification. Graduate students in the online program are from every geographic region in the U.S. and Canada. Dr. Anderson received her MS in outdoor recreation and park management from the University of Oregon and her PhD in therapeutic recreation from the University of Minnesota. She serves as associate editor or reviewer for several journals in the field, including the *Therapeutic Recreation Journal*, and has written two textbooks, including the text written with Dr. Linda Heyne titled *Therapeutic Recreation Practice: A Strengths Approach*. Dr. Anderson has worked in outdoor recreation, community recreation, and therapeutic recreation settings, including work for several years as a recreation therapist at a regional health facility and work with Wilderness Inquiry.

Candace Ashton, PhD, LRT/CTRS, is a professor and the Coordinator of Recreation Therapy in the School of Health and Applied Human Sciences at the University of North Carolina Wilmington. She practiced TR/RT in community and health care settings prior to her current roles in academia. She received her PhD from the University of Illinois, her MS from Florida State University, and her BA from the University in Florida, all in the area of TR. She has served as associate editor for the *Therapeutic Recreation Journal*, *American Journal of Recreation Therapy*, and *Health Care for Women International*. She is a past president of the National Therapeutic Recreation Society and has served on a number of national, state, and local boards. She was awarded the ATRA Scholarly Achievement Award in 2010, and is a fellow of the National Academy of Recreational Therapists.

Cari E. Autry, PhD, CTRS, is a faculty member in the Recreational Therapy Program at Florida International University. She received her doctorate degree in Health and Human Performance with a concentration in Therapeutic Recreation and a minor in Special Education from the University of Florida. She has presented at state, national, and international conferences related to therapeutic recreation education, youth development, homelessness, community development, and social capital. Cari has published in journals such as the *Therapeutic Recreation Journal*, *World Leisure Journal*, *Leisure Sciences*, *Sociology of Sport Journal*, and *Leisure/Loisir*. She has also served as an associate editor of the *Therapeutic Recreation Journal* for the past 10 years.

Teresa M. Beck has a BS in Recreation Administration (emphasis in TR) from Indiana University, a MS in Leisure Services (emphasis in TR) from Florida State University, and a PhD in Higher Education Administration from University of North Texas. She currently holds the position of professor of Therapeutic Recreation and associate dean for the College of Health Professions at Grand Valley State University in Grand Rapids, Michigan. She has served on NCTRC's Exam Management Committee, NCTRC's Board of Directors, including holding the position of board chair. She currently is vice-chair for the Committee on Accreditation of Recreational Therapy Education (CARTE). Dr. Beck has been and continues to be active in the profession at the state and national levels.

Leandra A. Bedini, PhD, LRT/CTRS, is a professor and the Director of Undergraduate Studies in the Department of Community and Therapeutic Recreation at the University of North Carolina at Greensboro where she has worked since 1992. She has practiced TR/RT in community, school, and hospital settings prior to her current roles in academia. She received her PhD from the University of Maryland in 1986, her MA from Michigan State University in 1980, and her BS from East Carolina University in 1975. She has served as associate editor for the *Therapeutic Recreation Journal* and the *American Journal of Recreation Therapy*, as well as been Coordinator of ATRA's Research Institute. Her current research interests include exploring the leisure of family caregivers as well as the leisure of women and girls with disabilities. She was awarded the NTRS Research Award in 1997, the ATRA Scholarly Achievement Award in 2000, and is a fellow of the American Therapeutic Recreation Association, the Academy of Leisure Sciences, and the North Carolina Recreation and Parks Association. Her personal leisure interests include bicycling, hiking, softball, auctions, and reading mysteries.

Jamie Bennett is licensed in the state of Utah and certified nationally as a recreation therapist. She has a bachelor's and a master's degree in Recreation Therapy with a focus on working with children to promote emotional health and overall well-being. Jamie has experience working with individuals of all ages in the following settings; mental health, behavioral health, hospice, ropes course and in elementary classrooms. She has a passion for recreation therapy—especially when it is practiced using evidence-based research as a guide.

Linda L. Caldwell, PhD, is a distinguished professor of Recreation, Park, and Tourism Management and Human Development and Family Studies at The Pennsylvania State University, where she has been since 1995. She received her BS from Penn State, her MS from North Carolina State University, and her PhD from the University of Maryland in 1986. Her research primarily focuses on interventions that develop youth competencies, promote healthy lifestyles, and reduce risky behavior in and through leisure. She is the co-developer of two interventions that focus on preventing adolescent risk behavior through positive use of free time: TimeWise: Taking Charge of Leisure Time and HealthWise South Africa: Life Skills for Young Adults. Linda as served as chair of the Children and Youth Commission of the World Leisure Association, past-president of the Academy of Leisure Sciences, and is an elected member of the American Academy of Park and Recreation Administration. Her personal interests include traveling, gardening, photography, scuba diving, and camping.

Marcia Jean Carter, CPRP, CTRS, served as assistant dean in the College of Education and Human Services and Professor in the Department of Recreation, Park and Tourism Administration, Western Illinois University-Quad Cities, Moline, IL. Dr. Carter is currently an adjunct faculty with the University of St. Francis, Joliet, IL. She earned her doctorate from Indiana University. She has held positions in nonprofit and public agencies in outdoor settings and community therapeutic recreation with individuals of all ages and abilities. Dr. Carter initiated the efforts to create NCTRC and was its first chair. Dr. Carter has coauthored several textbooks, including *Therapeutic Recreation: A Practical Approach*, *Effective Management in Therapeutic Recreation Service*, and *Therapeutic Recreation in the Community: An Inclusive Approach*. She has served as an editor/reviewer for the *Therapeutic Recreation Journal*; *Leisure Today*; *Journal of Health, Physical Education, and Recreation*; *Activities, Adaptation, & Aging*; and the *ATRA Annual in Therapeutic Recreation*. She has been recognized with receipt of the J.B. Nash Scholar Award, American Association for Leisure and Recreation; Distinguished Fellow Award, American Therapeutic Recreation Association; Distinguished Service Award, National Therapeutic Recreation Society; and the Distinguished Service Award, Christian Society for Kinesiology and Leisure Studies. Dr. Carter is a fellow of the American Leisure Academy, National Academy of Recreational Therapists, and the Academy of Leisure Sciences.

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Patti Craig is an associate professor in the Department of Recreation Management and Policy at the University of New Hampshire, a NH licensed CTRS (CTRS/L), a member of the American Therapeutic Recreation Association, and the American Congress of Rehabilitation Medicine. She earned a PhD in Education with a Cognate in College Teaching from the University of New Hampshire, MEd in Sport Management and Leisure Studies with an emphasis in Therapeutic Recreation

from Temple University, and a BS in Health and Human Services from the University of Scranton. Prior to her work at UNH, Patti amassed 13 years of direct care experience as a CTRS in a variety of physical medicine and rehabilitation hospitals and community-based TR settings. Patti's specific expertise in fieldwork management/coordination and curriculum/pedagogy evolved from her role as Internship Coordinator in the RMP Department for 15 years, and through her scholarship activities. Patti's scholarship examines ways in which pedagogy and curriculum influence student learning and development in professional preparation programs. Her fieldwork publications appear in journals in TR, Leisure Studies education, and Education/Ed-Psych. Patti's scholarship additionally examines the impact of TR/RT interventions on health and wellness outcomes for individuals with disabilities living in the community.

Mat Duerden, PhD, is a professor in the Department of Experience Design and Management in the Marriott School of Management at Brigham Young University. He teaches courses on experience design and evaluation. His research focuses on processes and outcomes associated with structured recreation experiences in work and nonwork contexts. He currently is studying the role of recreation in organizations and families. Mat also works as a consultant in designing and evaluating experience for a variety of commercial and non-profit organizations. In a former life, Mat worked for over 10 years as a whitewater rafting guide. He and his wife, Chenae, have four kids, and they love to spend as much time outside in the mountains as possible.

Sherry L. Dupuis is the former director of the Murray Alzheimer Research and Education Program and a professor in Recreation and Leisure Studies at the University of Waterloo. She has a bachelor's degree in Music from Queen's University, a master's degree in Recreation and Leisure Studies and Gerontology from the University of Waterloo, and a doctorate in Family Studies from the University of Guelph. Guided by an authentic partnership approach and a number of years' experience working in long-term care, her research program focuses on ensuring all older adults are supported in living life to the fullest. Leisure is an important means of achieving this. She is committed to critical participatory action research and artsbased approaches as a means of promoting personal and social transformation and social justice. To this end, she is currently the colead of the Partnerships in Dementia Care (PiDC) Alliance, a large culture change initiative focused on creating a new culture of care and support, one that places close relationships at its core; ensures active involvement in decisionmaking by all; provides empowering, lifeaffirming and humanistic care and support; and ensures that processes and strategies are in place so all in the context are well equipped to support and better able to translate research into practice.

Suzanne Fitzsimmons, GNP, ARNP, is a geriatric nurse practitioner, a recreation therapist, a dementia researcher, and an educator. She is the author of the *Dementia Practice Guidelines*, *Brain Fitness*, *Health Promotions*, and several other books and chapters. She has been involved in numerous research studies, created training videos, written over 75 articles, and has presented extensively across the world on the topic of nonpharmacological interventions for dementia behaviors. She has taught online courses for 15 years and currently teaches in the undergraduate and graduate departments of Gerontology and Recreation therapy for the University of North Carolina at Greensboro, Florida International University at Miami, FL, and the University of Southern Maine.

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in community-based recreation programs. His current scholarly interest is related to the use of leisure and leisure education for improving fitness for adults living in community-based supportive living environments, and increasing access to extracurricular activities in schools by students with disabilities.

Janell Greenwood, MBA, CTRS, has been in the Therapeutic Recreation field for over 15 years; she has served in several capacities including practitioner, educator, and administrator. Her experience includes working with individuals with developmental, physical, and mental disabilities; in addition, she has focused on at-risk youth; she has worked in clinical, community and correctional settings. Her research includes therapeutic recreation curriculum, education and evidence-based practice. She currently teaches Brigham Young University-Idaho and oversees the Therapeutic Recreation Program.

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Betsy Kemeny is an assistant professor in Recreational Therapy at Slippery Rock University. She specializes in service-learning programs for older adults, youth with autism, and veterans with disabilities. She most recently conducted a study on the current state of assessment in recreational therapy.

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Jun Kim is currently an assistant professor in the Department of Health Education and Recreation, Southern Illinois University Carbondale. Jun received his master of art in French Literature in France and earned the degree of master of science at the University of Wisconsin-La Crosse majoring in leisure program development. He continued his PhD degree at the University of Utah-Salt Lake City. His research interest has been exploring the relationship between psychological benefits and the beauty of nature. He is interested in creating special programs/activities for people with disabilities to experience the beauty of nature with musical/natural sounds. He teaches courses at the graduate and undergraduate levels in the Department of Health Education and Recreation at SIU.

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Neil R. Lundberg, PhD, CTRS, is an associate professor of Therapeutic Recreation at Brigham Young University in the Marriott School of Management. He is the former program director at the National Ability Center in Park City, UT, where he provided leisure education and therapeutic programming for individuals with disabilities for nearly a decade. He specializes in adaptive sports, including skiing, waterskiing, cycling, and outdoor education and is a fully certified adaptive and alpine ski instructor. His latest work focuses on the impact of adaptive sports and recreation programs for veterans returning from combat with posttraumatic stress and military sexual trauma. Neil enjoys spending time outdoors with his wife, Melanie, and their six children.

Brian K. Malcarne currently teaches at York College of Pennsylvania as an assistant professor of Therapeutic Recreation. He received his therapeutic recreation academic training and MS in Youth and Family Recreation from Brigham Young University. He completed his PhD in Parks, Recreation, and Tourism Management at Clemson University. He is a Certified Therapeutic Recreation Specialist (CTRS) with professional experience specializing in adolescent psychiatric treatment and outdoor behavioral health. Additional areas of professional experience include national park interpretation, youth development programs and camps, adventure recreation, and ropes course facilitation.

Bryan McCormick is a professor of Recreation, Park and Tourism Studies at Indiana University and has served as a member of the Public Health-World Health Organization for ATRA. Bryan's research has focused on the social and community functioning of individuals with severe mental illness cross culturally. He was the U.S. study center lead for the core set for schizophrenia, developed during 2014–2015.

John N. McGovern is president of Recreation Accessibility Consultants, LLC. His firm advises states, counties, cities, park districts, nonprofits, and businesses on compliance with the Americans with Disabilities Act (ADA). He worked in public parks and recreation for more than 30 years, always responsible for providing community-based therapeutic recreation services. While working in Illinois at an intergovernmental partnership that provides TR services, he co-chaired the Illinois parks and recreation legislative committee the year the property tax cap was lifted for local tax levies to support community-based TR programs. Always interested in civil rights, he earned his law degree at Loyola University of Chicago in the evening division, and it complements his MA and BA in Recreation Administration with a TR Option from the University of New Mexico. He writes and speaks frequently about the application of the ADA to public parks and recreation sites, policies, and programs.

Alexis McKenney, EdD, CTRS, is an associate professor of Recreational Therapy (RT) at Florida International University (FIU). Dr. McKenney has published several articles and chapters on topics related to character development and RT, RT internationally, RT as a viable service in educational settings, and RT issues in higher education. Much of Dr. McKenney's research has focused on examining effects of lifeskills and RT interventions designed to assist in the treatment of youth with disruptive behavior disorders and/or who are considered to be at risk for behavior problems. Currently, using the social model of disability, she is researching changes in attitudes and behaviors among students who participate in disability simulation activities while abroad, as well as a developing a model to explain the process of moving from a sympathetic response to one of empathy and advocacy. In addition, Alexis is presently a co-editor for the *American Therapeutic Recreation Association Annual*, and a reviewer for the *American Journal of Recreation Therapy* and the *Therapeutic Recreation Journal*.

Kenneth E. Mobily is a professor in the Therapeutic Recreation Program in the Department of Health and Human Physiology at the University of Iowa. He teaches courses in Therapeutic Recreation, Research, and Human Anatomy. His research pertains to exercise among older adults, ethics, and disability studies.

Sharon Nichols, CTRS/L, FDRT, is a Constituent Services Representative for U.S. Congresswoman Carol Shea-Porter in her NH 01 District Office. She has over 30 years of experience in therapeutic recreation working as an administrator, director, adjunct faculty member, clinician, and consultant. She has been an active leader in the profession serving on the chair of the NCTRC as a board member, treasurer, and chair from 2012–2015. She also served as chair of the National Association of Recreational Therapist and president of ATRA. She has also presented at over 200 international, regional, state, and local conferences, workshops, and seminars on leadership, advocacy, health care, ethics, and topics related to professional practice.

Shane Pegg, PhD, is a senior lecturer in the Tourism Cluster of the School of Business at The University of Queensland, Australia. He has been involved in a wide array of research and consultancy projects related to leisure and well-being. He has a particular interest in the co-production of accessible tourism and leisure service experiences. Shane received his BA (Rec Mgt.) (Hons) from Griffith University, his MS and Grad Cert in Gerontology from the University of Utah, and his MBA and PhD from Central Queensland University. A passionate advocate for therapeutic recreation in Australia, he has published over 70 refereed journal articles and book chapters, and is a past recipient of the American Therapeutic Recreation Association's Outstanding Professional Award.

Heather R. Porter is an associate professor in the Dept. of Rehabilitation Sciences at Temple University. She's written and edited four RT textbooks based on the ICF and serves as the RT Practice Series Editor for Idyll Arbor. She served as chair of ATRA's ICF and WHO Committee for three years and has been a member of the committee since its inception in 2004. She contributed to the development of the Lower Limb Amputation ICF Core-Set, gave ICF presentations to local and national audiences, and developed a graduate-level ICF academic course. She additionally maintains the RT Wise Owls website to promote RT evidence-based practice, organizes an annual RT evidence-based practice conference, and serves as the lead chair for ATRA's Physical Rehabilitation and Medicine Section.

Nancy E. Richeson, PhD, CTRS, FDRT, joined the faculty at the University of Wisconsin at La Crosse in 2014, after retiring as a professor emerita from the University of Southern Maine. She is currently an associate professor in the College of Science and Health at the University of Wisconsin at La Crosse. She is a recreational therapist and gerontologist. She graduated with her PhD in Gerontology from the University of Nebraska, and is a Certified Therapeutic Recreation Specialist®. Her interests are diverse and include being a Reiki master/teacher, and a registered therapy dog tester and observer. Dr. Richeson has had a productive career conducting research and providing programs and services for older adults, with a focus on those with dementia. She has contributed to an understanding of how psychosocial programs can decrease the use of psychotropic medication and be used to treat the neuropsychiatric behaviors of older adults with dementia. She has also worked to increase physical activity for community-based older adults, and provided evidence to support Reiki and animal-assisted therapy as modalities within Recreational Therapy practice. Her work has resulted in numerous peer-reviewed articles, book chapters, and national reports. She is dedicated to advancing practice by providing research to support interventions. Her work is innovative and creative and can easily be implemented in clinical practice.

Jo-Ellen Ross, PhD, CTRS, is an assistant professor at Temple University in the Department of Rehabilitation Sciences. She has been and continues to be a practitioner in community and hospital settings. Her primary research interests revolve around inclusion and community engagement via play, recreation, and leisure and the meaning of leisure particularly for persons with disabilities. She is very active in the profession including being on the board of directors for ATRA and the NJ licensure committee of NJEPA TRA. Additionally, she is active with the American Camp Association.

Angie Sardina, MS, CTRS, received a bachelor of science degree in Health Sciences with a concentration in Therapeutic Recreation from Florida Gulf Coast University. After completing her undergraduate degree, she accepted a graduate assistantship at The University of North Carolina at Greensboro to obtain a master of science degree in Parks and Recreation Management. Following graduation, Angie was hired at Cypress Cove in Fort Myers, Florida, in 2010 and worked as a Certified Therapeutic Recreation Specialist for four years. She is currently a doctoral candidate at the University of South Florida in the School of Aging Studies. Her research interests include determinants of poor physical function and disability in late life, and health promotion-based interventions to improve health and independence among older adults. Additionally, Angie has previously focused on the development of nonpharmacological interventions for persons with dementia. She is a co-author of the *Dementia Practice Guidelines for Recreational Therapy*, and currently serves on the editorial board of the *American Journal of Recreation Therapy*.

John W. Shank is professor emeritus, Department of Rehabilitation Sciences, College of Public Health at Temple University in Philadelphia PA. He spent most of his academic career at Temple where he served as program director and chair of the Department of Therapeutic Recreation. In addition to teaching undergraduate and graduate students, John conducted funded research related to behavioral health and psychiatric rehabilitation, and the community inclusion of persons with a variety of disabling conditions. He has published widely, and has served his profession in a variety of capacities. He founded and chaired the Legislative Coalition for Therapeutic Recreation which harnessed cooperative advocacy efforts between NTRS and ATRA. He also served on ATRA's Public Policy team. John is a Distinguished Fellow of the American Therapeutic Recreation Association, and a Distinguished Fellow of the National Academy of Recreational Therapy.

Jerome F. Singleton, CTRS, works in the Leisure Studies Division in the School of Health and Human Performance at Dalhousie University. Dr. Singleton is cross-appointed to the School of Nursing, Sociology, Faculty of Management and Anthropology at Dalhousie University, to the école de Kinésiologie et Récréologie, Université de Moncton, and Faculty of Health Science at the University of Leithbridge. Dr. Singleton's research is in the area of leisure and aging.

Sydney L. Sklar, PhD, CTRS, is a professor and chair of Recreation and Sport Management, coordinator of the Recreation Therapy concentration, and director of the Challenge Center at the University of St. Francis. He serves on the Council for Accreditation of Recreation, Sport and Tourism Related Professions and is a member of the editorial board of the *Therapeutic Recreation Journal*. His research interests include therapeutic recreation education, outdoor interventions, and youth and community development. In his free time, Syd enjoys playing guitar and spending time outdoors with his wife, Bev, and his children, Frank and Etta.

Gretchen Snethen, CTRS, is an assistant professor in the Department of Rehabilitation Sciences at Temple University and the assistant director of the Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities, a research and training center funded by the National Institutes on Disability, Independent Living, and Rehabilitation Research. Her research focuses on the development of leisure-based interventions to support individuals with serious mental illness increase independent engagement in the community and improve health and well-being. In addition to intervention research, she is interested in exploring environmental characteristics that either promote independent engagement.

Norma J. Stumbo is currently retired after being at Illinois State University and the University of Illinois from 1984 to 2008. She has taught subjects at the University of Queensland (Australia), the University of Western Sydney (Australia), and the Southern Institute of Technology (New Zealand). Her professional work experience includes physical medicine and rehabilitation, long-term care, at-risk youth, independent living, and a women's prison. She has written and edited several books, including *Facilitation of Therapeutic Recreation Services: An Evidence-Based and Best Practice Approach to Processes and Techniques* with Dr. Brad Wardlaw; *Therapeutic Recreation Program Design: Principles and Procedures* (3rd-5th editions) with Dr. Carol A. Peterson; *Client Outcomes in Therapeutic Recreation*; *Client Assessment in Therapeutic Recreation*; *Professional Issues in Therapeutic Recreation* (1st-2nd editions); *Study Guide for the National CTRS Certification Examination* (1st-5th editions) with Dr. Jean Folkert; *Leisure Education I: A Manual of Activities and Resources* (1st-2nd editions); *Leisure Education II: More Activities and Resources* (1st-2nd editions); *Leisure Education III: More Activities and Resources*; *Leisure Education IV: Activities for Individuals with Substance Abuse*, and *Intervention Activities for At-Risk Youth*. She has also published many refereed articles in the *Therapeutic Recreation Journal*, *Annual in Therapeutic Recreation*, and the *American Journal of Recreation Therapy*, as well as other journals. She has presented over 400 research and educational sessions and scores of keynotes at state, national, and international conferences and conventions, and received awards at the international, national, regional, and local levels. Norma received her PhD in Leisure Behavior/Therapeutic Recreation from the University of Illinois at Urbana-Champaign; she received her master's and bachelor's degrees in Recreation and Park Administration/Therapeutic Recreation from the University of Missouri-Columbia.

Patricia K. Thomas, MPA, CTRS, is a clinical associate professor at the University of Wisconsin-Milwaukee. She entered academia in 1999 as the instructor for field-based courses and internship coordinator in the Therapeutic Recreation Degree Program. She brought 18 years of experience in health care to the program as a recreation therapist, supervisory recreation therapist, chief of recreation therapy, and administrative assistant to the chief of staff in the Department of Veterans Affairs. She created the totally online undergraduate Therapeutic Recreation Certificate Program, which has flourished since 2006. Since 2013 she has also administered the Occupational Studies Undergraduate Program. Professor Thomas has a long history of service to the therapeutic recreation profession in the American Therapeutic Recreation Association (ATRA) and the National Council for Therapeutic Recreation Certification (NCTRC). She started as the *ATRA Newsletter* editor. She progressed to serving as the Behavioral Health Representative on the Collation of Rehabilitation Therapy Organizations for the ATRA Joint Commission on Accreditation of Health Care Organizations (JCAHO) Committee to the ATRA JCAHO Committee Chair for several years. From 2011-2014, Thomas served on the NCTRC Board of Directors as member at large, chair elect, and chair during her final year on the board. She has presented at the local, regional, and national levels. Thomas received her B.S. in recreation with a therapeutic recreation concentration from the University of Wisconsin-La-Crosse. She completed her MPA with a health care concentration from the Long Island University.

Marieke Van Puymbroeck is a professor of Parks, Recreation, and Tourism Management and the Recreational Therapy Coordinator at Clemson University. Marieke's professional interests include incorporating the ICF into research and education, and her research focuses on improving the quality of life for informal caregivers and individuals with chronic disease or disability through the use of complementary and alternative medicine interventions. Marieke sits on several national rehabilitation research advisory boards that are working on mobilizing the ICF for more applied use in practice.

Elizabeth H. Weybright, PhD, CTRS, is an assistant professor of Human Development at Washington State University. She received her BS and MS in Therapeutic Recreation from Indiana University and her PhD from The Pennsylvania State University. Drawing from the fields of leisure and prevention science, her research focuses on adolescent development within the leisure context and specifically how leisure may contribute to, or prevent, risk behavior.

Colleen Whyte is a faculty member in the Department of Recreation and Leisure Studies at Brock University. Her research program is focused within the area of leisure and aging. She is particularly interested in understanding the lived experiences of older adults within Canadian society, and the contributions of recreation and leisure to personal quality of living for older adults living in long-term care homes. Colleen has been a Certified Therapeutic Recreation Specialist (CTRS) since 2000, and was previously employed as a recreation therapist working in outpatient rehabilitation, inpatient mental health, and geriatric services within the Ontario healthcare system.

Mark A. Widmer, PhD, TRS, is a professor in the Department of Experience Design and Management in the Marriott School of Management at Brigham Young University. He teaches in the Therapeutic Recreation program and the MBA program. His research focuses on achieving targeted outcomes through theory-based adventure programming in Outdoor Behavioral Healthcare (OBH) and in organizations. He also works as a consultant conducting outcome research, field guide and clinical and clinical training in OBH. Since 2008, he has worked as a consultant with large multinational firms using the TR process to help executives be more effective and build strong corporate culture. Mark enjoys road, mountain and snow biking, alpine and Nordic skiing, ice climbing, canyoneering, backpacking, fly-fishing, whitewater kayaking, small boat sailing, and photography. Mark and his wife, Suzy, have four children and three granddaughters.

Allison Wilder, PhD, CTRS/L, is an associate professor and faculty fellow with the Center on Aging and Community Living at the University of New Hampshire. She has over 20 years of experience as a practitioner of recreation and recreational therapy. Her research is focused on the intersection of disability and aging as they relate to leisure functioning.

Jeffrey P. Witman teaches at York College of PA and is a facilitator for Teambuilders, Inc. in Lebanon, PA. Jeff's graduate work was completed at the University of Oregon and Boston University, and his previous college teaching was at Kent State and Lock Haven Universities. He is a Certified Therapeutic Recreation Specialist. His 25 years in practice included stints as director of Occupational Therapy and Therapeutic Recreation Services at Hampstead Hospital in NH and as director of Recreational Therapy at Philhaven Behavioral Health in PA. He's been an active volunteer with Easter Seals and No Longer Alone Ministries, a frequent presenter at professional meetings, and a consultant to several human service agencies. Jeff served as president of several state and national professional organizations and has chaired state boards for Very Special Arts and for Senior Olympics. He has authored more than 120 publications, including books focused on outdoor education/adventure programming, competencies for therapeutic recreation practice, teambuilding, social skills development, and leisure education/wellness. Jeff has received both the Distinguished Fellow Award and the Scholarly Achievement Award from the American Therapeutic Recreation Association. He has served as editor of the *ATRA Annual* and as guest editor for special issues of the *Therapeutic Recreation Journal*.

Brent D. Wolfe, PhD, CTRS is an associate professor in Recreational Therapy in the College of Health and Human Sciences at Georgia Southern University in Statesboro, GA. and has more than 16 years of experience in the TR profession as a practitioner and educator. He served as president of the National Therapeutic Recreation Society (NTRS) and currently serves on the board of directors for the American Therapeutic Recreation Association (ATRA) as the treasurer. He has focused on a variety of topics related to leadership, disability, and therapeutic recreation and believes that the key to being a successful leader, student, therapist, and person is the same thing—listening. Brent spends his free time with his wife, Becky, their two daughters, Austyn Grace and Taylor Faith, their dog, Bella, and two cats, Sugar and Leyla.

Heewon Yang is originally from South Korea and came to the United States in 1995 to pursue his master's degree at the University of Tennessee, Knoxville (emphasis in therapeutic recreation). He continued his education at Indiana University for his doctoral degree in Leisure Behavior with an emphasis in Therapeutic Recreation. Prior to his academic career, Heewon worked at various settings including mental health hospitals, nursing homes, orphanages, shelters for the homeless, and a global company as a recreation programmer and facilitator. Heewon's primary research interest is in the effects of therapeutic recreation programs for adolescents with behavioral problems (i.e., aggressive behaviors). Heewon is a full professor in the Department of Recreation and Leisure Studies at California State University Long Beach.

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Keynote: Ensuring Our Worth, Proving Our Value

Norma J. Stumbo

Education Associates

Shane Pegg

University of Queensland

Ensuring that health care professionals attain and maintain competence is a complex task that is clearly related to their ability to design and deliver quality services that produce desired client outcomes (Naccarella, 2015; Swankin, LeBuhn, & Morrison, 2006). Professional preparation and competence are tightly interwoven with service quality (Boswijk, 2013; Fouad et al., 2009; Frenk et al., 2010). This applies to all health care professions, including therapeutic recreation (TR). See Figure 1.1 on some national data about TR in the United States.

One purpose of this text is to help TR 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 and verify our worth (i.e., how do we provide proof of professional competence?). And second, how do we prove our value (i.e., 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 initially reviewing the recent literature on professional competence and service outcomes. This is followed by a brief introduction to some of the critical issues that have emerged in recent years in order to then set the stage for the remaining chapters.

Number of TR Jobs: 18,600

Number of NCTRC Certificants as of March 2016: 15,494¹

Job Outlook, 2014-2024: 12% (faster than average)

Employment Change (2014-2024): 2,200

Employment settings in 2014:

Hospitals (state, local, and private): 35%

Skilled nursing facilities: 20%

Government: 19%

Ambulatory health care services: 8%

Continuing care retirement communities: 6%

2015 Median Pay: \$45, 890 per year; or \$22.06 per hour

Pay by setting:

Government: \$55,500

Hospitals (state, local, and private): \$48,320

Ambulatory health care services: \$46,200

Skilled nursing facilities: \$39,990

Continuing care retirement communities: \$37,250

States with the highest employment rates of TRSs:

New York: 1,720, averaging \$52,760

California: 1,710 averaging \$63,990

Pennsylvania: 1,310, averaging \$43,150

Illinois: 1,060, averaging \$46,440

Massachusetts: 820, averaging \$42,130

Note: Data synthesized from Occupational Employment Statistics, Occupational Employment and Wages, May 2015, 29-1125 Recreational Therapists, Bureau of Labor Statistics, Available from <http://www.bls.gov/oes/current/oes291125.htm> and Recreational Therapists, U.S. Bureau of Labor Statistics, available from <http://www.bls.gov/ooh/health-care/recreational-therapists.htm>

¹Personal correspondence with Anne Richard, May 26, 2016.

Figure 1.1. 2015 United States Data on TR Specialists

How Do We Define the Profession?

Dower, O'Neil, and Hough (2001, p. 5–7) authored an interesting treatise on questions to be asked of “emerging” health care professions. On their lengthy list are these questions that have great relevance to the profession of TR:

- 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 health care professions, systems, and modalities? What is the value that this profession adds to health care? 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 professionals 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. For instance, how does TR 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?

Frenk et al. (2010) noted that health professions, especially medicine, have experienced three generations of educational progress during the past century. The first phase, launched at the beginning of the 20th century, focused on science-based curricula. The second phase highlighted problem-based instruction, and the third phase, which the authors argued is just currently coming to the fore, is systems-based learning, which focuses on “adapting core professional competencies to specific contexts, while drawing on global knowledge” (Frenk et al., 2010, p. 1925). Although TR was not a recognized and formalized profession at the commencement of the 20th century, and therefore missed out on engaging in this initial effort, the latter two phases have been central to our more recent history.

Like all health-related professions, TR is concerned about how to identify and verify professional competence. Fouad et al. (2009) reported that Epstein and Hundert (2002, p. 226) defined 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.” Brody (2014), in talking about Peabody’s (1927) historical address on “The Care of the Patient,” noted that medical competence includes both the art and the

<http://www.sagamorepub.com/products/professional-issues-therapeutic-recreation-3rd-ed>

science of care, synthesizing chemistry, physiology, and psychology to develop accurate diagnoses. Even before the term *biopsychosocial model of care* was introduced, Peabody was a strong advocate of such an approach. In this context, it is worth noting that the integration and blending of science and “art” (Nichols, 2009) has been recognized as an important pillar for TR.

Fouad et al. (2009) remarked that health care competence implied (a) performance at an acceptable level and (b) integration of multiple competencies. Because competence is so complex, professions often talk about competence in terms of competencies to be learned or displayed. “Competencies, then, are conceptualized as elements of components of competence, and consist of discrete knowledge, skills, and attitudes” (Kaslow et al., 2004, as noted in Fouad et al., 2009).

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

- Ability to provide patient-centered care (i.e., 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)
- Ability to utilize informatics (e.g., using information technology to communicate, manage data, and reduce error)

Epstein and Hundert (2002) reviewed 195 published studies and noted that professional competence for physicians reflected the presence of seven dimensions (See Figure 1.2). With the exception of technical skills, these dimensions of competence could also be applied to TR specialists.

Of course, the “content” of TR competencies is missing from this list, but it is delineated nevertheless in TR-specific documents such as the National Council for Therapeutic Recreation Certification’s™ (NCTRC™) *2014 Job Analysis* (NCTRC, 2015) and *Guidelines for Competency Assessment and Curriculum Planning* (West, Kinney, & Witman, 2008) (See Figure 1.3).

Both the content and dimensions of competence are 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. Conversely, Frenk et al. (2010) asserted that health-related professions spend too much time and energy on building walls (delineating professional boundaries) instead of building fences (creating interdisciplinary care competencies).

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 (hypthetico-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

Figure 1.2. Dimensions of Professional Competence (Epstein & Hundert, 2002, p. 227)

Essential Knowledge Areas of Therapeutic Recreation (NCTRC, 2015)

- I. Foundational Knowledge
 - A. Theories and Concepts
 - B. Practice Guidelines
 - C. Diagnostic Groupings
- II. Assessment Process
 - A. Selection and Implementation of Assessment
 - B. Assessment Domains
- III. Documentation
- IV. Implementation
- V. Administration of Therapeutic Recreation Services
- VI. Advancement of the Profession

Content Areas for Curriculum Planning (West, Kinney, & Witman, 2008)

- A. Foundations of Professional Practice
- B. Individualized Patient/Client Assessment
- C. Planning Treatment/Programs
- D. Implementing Treatment/Programs
- E. Evaluating Treatment/Programs
- F. Managing Recreational Therapy Practice
- G. Support Content/Competencies

Figure 1.3. Examples of Competencies Necessary for Therapeutic Recreation Practice

The present division of labor between the various health professions is a social construction resulting from complex historical processes around scientific progress, technological development, economic relations, politic interests, and cultural schemes of values and beliefs. The dynamic nature of professional boundaries is underscored by the continuous struggles between different professional groups to delimit their respective spheres of practice. The division of labor at any specific time and in any specific society is much more the result of these social forces than of any inherent attribute of health-related work (Frenk et al., 2010, p. 1926).

A notable and related assertion made by Swankin et al. (2006) is that too often in health care, 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 held the view that continuing education requirements should 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. In contrast, TR has historically relied on continuing education (typically in the form of collecting continuing education units (CEUs) at conferences or through written material) in-

stead of professional development plans or peer review of competence, a practice that continues to the present day.

In contrasting the two positions, a number of pertinent questions emerge related to professional competence and the impact of competence on the TR services being delivered. For instance, to what degree are professional competence and quality service provision related? Do you agree that ensuring our worth as health care professionals through evidence of continued competence is closely related to proving our value as a profession in delivering sought-after client outcomes? Are CEUs the best way to ensure our competence? If a professional's competence is not adequately and continually monitored, are clients put at risk? How does TR fare in establishing and continually measuring professionals' competence in relation to ensuring high-quality practice? These are all questions that TR professionals must become very comfortable in answering, both individually and collectively, if the profession is to have any sort of viable future as higher and higher expectations are placed, internally and externally, upon those charged with providing health care services. The next section will explore the definitions and parameters of client outcomes and their relationship to evidence-based practice.

What Are Client Outcomes and Why Are They Important?

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 health care consumers alike (McGrath & Tempier, 2003; Whiteside, Smith, Gazarek, Bridge, & Shields, 2015). Conceptualizing and managing service quality is important to all health care 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 health care 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 a TR intervention program (Dunn, Sneegas, & Carruthers, 1991; Shank & Kinney, 1991; Stumbo, 1996; Stumbo & Peterson, 2009). See Figure 1.4 for some of the current definitions of client outcomes in the TR literature.

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.

- 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 nonperformance) of a function or process(es) (Joint Commission on Accreditation of Healthcare Facilities, 1995; p. 717)
- 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)

Figure 1.4. Definitions of Client Outcomes

Because client outcomes are so complex and multifaceted, 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, health care 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., 1999; 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 that 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 & Cantrell, 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, & Ries, 1997).

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).

Health care in general, and each profession specifically, work together to identify overall trends in outcomes. In the last 20 years or so, health care has moved from solely measuring improvement in functional abilities, to health and increasingly nowadays, to considering 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 that are consistent with both health policy and service expectations.

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, health care 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

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Health care in general, and each profession specifically, work together to identify overall trends in outcomes.

addition, McGrath and Tempier suggested a number of criteria for measuring 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, and (g) 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 health care 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). Moreover, it should be noted that specifying outcomes is a minimal expectation of human services. As such, the clear expectation of all stakeholders involved in the process nowadays is that health care professionals and agencies alike be able demonstrate that the care they provide does make a difference, is the most effective available, and is based on the best evidence at hand (Hoffmann, Bennett, & Del Mar, 2010; Margarita, Dizon, Grimmer-Somers, & Kumar, 2012). Ray (1999) suggested that health care 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 results) 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.

Challenges and Opportunities for the Therapeutic Recreation Profession

To this point, the discussion has centered on a consideration of professional competencies and client outcomes, yet it must be noted that the reform agenda that is driving this industry-wide change is not without some issues and challenges for the TR profession. It is timely, then, to reflect briefly upon some of these before moving on to the chapters that follow in which these issues are each addressed in some greater detail.

Let us start this discussion by reaffirming that the current health care delivery system has been radically reformed over the last two decades or so from one heavily dependent upon historic and experiential evidence to one nowadays where the clear expectation is for decision making and services to be validated in terms of rigorous research evidence (Kumar, Perraton, & Machotka, 2010). Yet, as noted by Whiteside et al. (2015), a lack of evidence in many areas of allied health continues to be a point

of strong contention as more and more within the field are required to embrace service processes and practices essentially embedded within the evidence-based practice approach. Moreover, an overemphasis on what Adams, Burke, and Whitmarsh (2014) referred to as the “next big things” has served, the authors contended, to be dismissive of critically more valued discussions about why the last big thing failed, and what has actually worked in the past and how that knowledge compares to the new evidence that has emerged. In calling for a greater acceptance of the value of “slow research,” the authors have argued that the constant push for innovation by market forces that nowadays drive much of the policy making and decision making in health care has led to a situation where good practice is beginning to be overlooked in favor of quick and tangible outcomes where data is considered the key (Adams, Burke, & Whitmarsh, 2014). So how does TR respond to all of this?

From the outset, it must be asserted that the availability and application of good evidence must be a critical cornerstone of TR practice, so efforts that are based in good quality research and that result in a better quality of care for clients must always be valued by the profession (Klitzing, 2011). While the TR field has always been somewhat eclectic in nature by taking good ideas and evidence from a range of related areas including medicine, nursing, occupational therapy, physical therapy, and mental health services to name but a few, and using these to good effect in delivering TR services, this alone is no longer considered sufficient.

It is argued that greater effort to validate measurement tools and forms of intervention specific to the field has now become critically important for the long-term viability of the profession. One of the immediate challenges is that TR does not have one significant repository of validated instruments and other evidence from which practitioners nationally, and internationally for that matter, might readily draw. In addition, the range of instruments we do have access to are somewhat limited and often validated for use with a particular population or purpose in mind.

There are some TR-focused researchers cognizant of this issue who are working to add to the body of knowledge as best able, given the significant effort, time, and resources that such activity consumes. The recent work of researchers, such as Carruthers and Hood (2007) and Hood and Carruthers (2007), as well as Heyne and Anderson (2012), are good examples of research teams seeking to progressively fill this void by introducing theoretical conceptual frameworks and validating suitable tools that then serve as useful resources for others to utilize. For example, in arguing the case for the greater application of a strengths-based approach to TR practice, both sets of researchers contended that if interventions are properly planned and implemented within a biopsychosocial (or more holistic) model of practice, TR specialists can and will have a significant influence on the production of valued outcomes and on the quality of life of individuals and their communities.

In seeking to validate such outcomes, of course, one would hope that the regular use of standardized measures would be everyday practice for most in the field, but as Witman and Ligon (2011) noted, this is not the case. These authors reported that nearly 96% of those working in TR relied principally upon nonstandardized instruments, focused heavily on the client’s leisure history and personal interests, to

inform practice. Such a widespread approach can be partly explained because of the profession's long-held focus on interventions geared to the particular interests and needs of the client being serviced. On one hand, it makes good sense to collect data about the clients' leisure interests. On the other hand, use of such a limited range and type of data is no longer a good fit if practitioners are to demonstrate the relevance of their efforts in a health system where an evidence-based approach is not just desired but is becoming mandatory.

Clearly then, current strategies to enhance integration between research and clinical practice in TR need to be reconsidered. The process of making research evidence readily available to clinical practitioners, known as knowledge transfer or knowledge translation as it is referred to in some health circles, is a critical step, and yet it remains an undervalued (and applied) element of evidence-based practice (Barac, Stein, Bruce, & Barwick, 2014).

Given this importance, it is perhaps surprising to note that there are only a relatively limited number of studies that have reviewed how knowledge transfer unfolds in practice settings, and even fewer related to health care settings (Ferlie, 2009). Ward, Smith, House, and Hamer (2012) have described knowledge transfer as a dynamic and fluid process that incorporates distinct forms of knowledge from multiple sources. Rather than being linear and deterministic in nature, the researchers found in their review of how three health service delivery teams went about sourcing and utilizing evidence in responding to particular work-based challenges that knowledge transfer, rather than being a behavioral phenomenon, "was largely social and political in nature and involved professional identities and norms, in addition to individual beliefs" (Ward et al., p. 302). The concept of "knowledge brokers" is one of the many strategies currently being trialed to determine if they lead to improved client outcomes through better application of evidence-based practice. Knowledge brokers are intended to act as a bridge to facilitate health care decisions that are based on sound evidence and which facilitate high-quality client care, optimal health outcomes, and adherence to quality and safety standards (Conklin, Lusk, Harris, & Stolee, 2013). Since this is still a new concept, the general effectiveness of such strategies has yet to be determined. The varying complexities to be found across the diverse range of health settings makes such efforts difficult to implement and even more difficult to properly evaluate (Gagliardi et al., 2014).

Many of the above mentioned issues are not owned solely by TR in isolation of other health care and social service professions. In fact, quite the contrary is true. Many professions in the allied health and service fields are also being challenged to provide and effectively utilize a comprehensive range of resources (Manns & Darrah, 2006; Whiteside et al., 2015). Some, of course, are better positioned than TR is at the current time. For example, occupational therapy comes to mind as an exemplar. Due to its long history and strong alignment with the use of standardized instruments to validate services, the occupational therapy field is much better positioned in terms of designing programs based on research evidence and proving client outcomes. So this then begs the question, what are some of the core issues

of concern at hand, and how does the TR profession more favorably position itself alongside some of the more prominent “players” in the allied health field?

In undertaking a trend analysis of TR curricula over the last 40 years or so, Wilder, Zahl, Greenwood, Carter, and Stumbo (2015) identified a range of micro and macro concerns worthy of attention. At the micro level, the authors noted that many of the TR programs accredited throughout North America employed fewer than two full-time academic staff and that the total number of these staff had fallen markedly since the turn of the century. Many factors, often outside the control of the TR faculty, have led to the withdrawal of some programs and the downsizing of others. The authors also noted that many staff now employed to instruct in TR programs were not research trained, with many completing only a master’s degree prior to being employed at the instructor level.

The authors, in citing the recent research of Stumbo, Carter, Wilder, and Greenwood (2013), revealed that three in four academic staff now working as TR educators were female, with only around 11% of this group of educators identifying as being of an ethnic minority. Clearly, diversity is fast becoming an issue of concern for the profession as is the inability of TR programs generally to attract a sufficient level of enrollment in doctoral programs to ensure there is an adequate supply of trained graduates available to replace the significant number of baby boomer faculty now moving through the retirement pipeline.

The very small number of research-trained, doctoral-level graduates now leaving higher education institutions exacerbates this issue further as presumably these same candidates are the ones best positioned to engage purposefully in much needed research to validate new instruments and protocols as well as demonstrate the true value of our collective effort (Wilder et al., 2015). Research is important to any profession if it is to have any chance of remaining informed and compliant with ever higher standards of knowledge and level of competency in today’s health-care setting.

Clearly, there is much work to be done. Yet, when compared to other periods of endeavor, it is in the current climate, and in responding to the challenges now facing the profession, that there exists the greatest opportunities for those wishing to engage purposefully in the reform process and become part of the leadership group that the profession so rightly deserves. Truly, in many respects, it is such an exciting time to be able to embrace the possibilities of what TR might be.

Sylvester’s (2015) reimagining of what the engaged practice of TR might be in the future is both exciting and, it must be said, also a little daunting. His assertion that “change is inevitable; progress or a better state of affairs is not,” is a critical but valued position that is entirely consistent with what many of us working in the field have experienced first hand (Sylvester, p. 168). Sylvester rightly pointed out that challenge for all of us is to “understand more fully what therapeutic recreation is currently before then proceeding to imagine how it might be improved to become

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“...change is inevitable; progress or a better state of affairs is not.”

something even better” (Sylvester, p. 168). As Sylvester challenges us all, “if therapeutic recreation as it presently exists is not the best of all possible worlds that only gets better with time, then the courage and capacity to reimagine and change are crucial” (2015, p. 170).

Clearly, strong leadership within the profession is central to such activity. A point argued by Wilder et al. (2015, p. 144), who noted that both the physical therapy and occupational therapy professions have effectively reinvented themselves in recent years by “carving out new areas of service, creating demand before the consumer was even aware that new forms of service are needed.” Action also advocated for TR by Widmer, Duerden, and Taniguchi (2013), who considered the profession to be at a critical crossroads at a time in which failure to innovate and adapt can lead to obsolescence, with outright failure a distinct possibility. In a business sense, this is often referred to as organizational drift and can be identified in operations that fail to keep pace with changing consumer needs and/or that are slow to respond to new threats or pressures in the business environment. This then quickly leads to a situation in which the operation is fully exposed to the volatility of market forces with a consequential outcome being the loss of any competitive advantage it may have previously held. As pointed out by Dekker (2011, p. xiii),

No organization is exempt from drifting into failure. The reason is that routes to failure trace through the structures, processes, and tasks that are necessary to make an organization successful. Failure does not come from the occasional, abnormal dysfunction or breakdown of these structures, processes, and tasks; but is an inevitable byproduct of their normal functioning. The same characteristics that guarantee the fulfillment of the organization’s mandate will turn out to be responsible for undermining that mandate.

Widmer, Duerden, and Taniguchi (2013, p. 1) have contended that while “a vibrant role may lay in a clinical focus, the value and power of therapeutic recreation services may have a more extensive role to play in today’s changing world.” As the authors rightly point out, the time is right to consider how TR might be diversified to take advantage of the industry-wide reforms occurring and the new movements in the health field being introduced (i.e., positive psychology), in order to capitalize on the opportunities that are now becoming available to us. Thus, as argued by Wilder et al. (2015), it is timely then for TR to identify the proper balance between prescription, standardization, and innovation in order and start to work toward a value proposition that all stakeholders endorse. Critically, what role will you, as an individual and/or as part of a collective, seek to play in this process?

Discussion Questions

1. In comparison with other professions with which you are familiar, how does TR fare in terms of being well-defined and coherent?

2. Create your own lists of foundational and TR-specific competencies. How do they compare with those presented in this chapter? How do you think they will evolve in the future?
3. What is the relationship of professional competence to client outcomes? If a TR 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 TR? Which of the five major areas of outcomes listed in this chapter do most TR outcomes fall into? Is there professional consensus on which client outcomes are important? On how to measure them and report their achievement?
5. What are some of the issues currently challenging TR? How important is knowledge transfer for addressing some of these issues? What strategies do you think should be employed?
6. How will professional competence, client outcomes, and evidence-based practice impact TR in the near future? What does TR need to do to ensure its future? What role will you play?

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