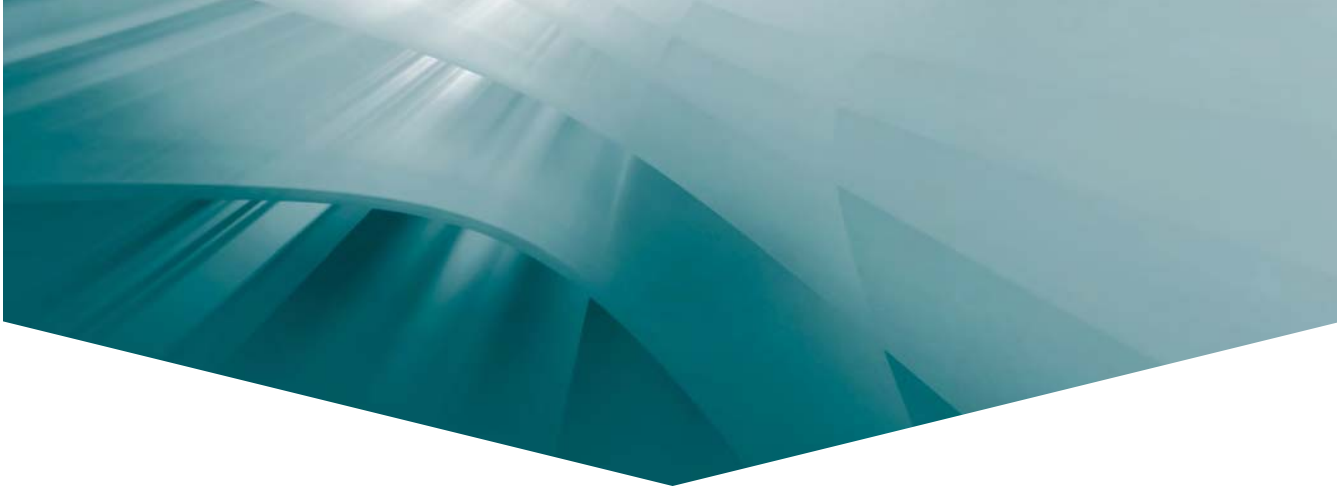
Recreation Therapy With Individuals Living in the Community

An Inclusive Approach

3rd Edition

Marcia Jean Carter and Christen G. Smith

https://www.sagamorepub.com/products/recreation-therapy-individuals-living-community



Recreation Therapy With Individuals Living in the Community

An Inclusive Approach

Third Edition

Marcia Jean Carter
Christen G. Smith

SAGAMORE PUBLISHING

Publishers: Joseph J. Bannon and Peter L. Bannon
Sales and Marketing Managers: Misti Gilles
Director of Development and Production: Susan M. Davis
Production Coordinator: Amy S. Dagit
Graphic Designer: Marissa Willison

Library of Congress Control Number: 2016950518
ISBN print edition: 978-1-57167-811-9
ISBN ebook: 978-1-57167-812-6

Printed in the United States.

SAGAMORE
PUBLISHING

1807 N. Federal Dr.
Urbana, IL 61801
www.sagamorepublishing.com

Contents

Acknowledgments

To those professionals and participants who have and will share in the benefits of inclusion, we extend our gratitude and encouragement.

Professionals and organizations that generously shared materials and expertise for this third edition include the following:

Ashland County Board of Developmental Disabilities, Ashland, OH, Special Olympics, JoAnne Weber, Director of Special Olympics

Cincinnati Recreation Commission, Division of Therapeutic Recreation, Cincinnati, OH, Alayne M. Kazin, CTRS, Therapeutics Coordinator

Fox Valley Special Recreation Association, Aurora, IL, Carolyn Nagle, MPA, CPRP, CTRS, Executive Director; Heather Andersen, CTRS (Formerly Inclusion Manager)

South Suburban Special Recreation Association, Tinley Park, IL, Janet Porter, CTRS, Executive Director; Heather M. Specht, MS, CTRS Inclusion Manager

The King Adult Day Enrichment Program at Rocky Mountain MS Center, Westminster, CO, Michelle King, MS, CTRS, KADEP Director; Donna L.V.Lozano, M.Ed., CTRS, KADEP Internship Coordinator

Turnstone, Fort Wayne, IN, Mike Mushett, CEO; Tina Acosta, CTRS, Director of Adaptive Sports and Recreation; Gail Herendeen, Kevin Hughes, and Ruth Stone photographers

Marcia Jean Carter, ReD, CPRP, CTRS
Christen G. Smith, PhD, CPRP

About the Authors

Marcia Jean Carter 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, Joilet, 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 serves as the editor for the *Therapeutic Recreation Journal.* 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.

Christen Smith has more than 30 years of broad-based experience in the parks and recreation profession. Most recently, as a member of the Department of Physical Education and Recreation faculty at Gallaudet University, she taught courses in recreation programming and administration. She has managed municipal park and recreation services in Florida, Michigan, Texas, Utah, and Virginia. As a member of the Recreation Administration Department faculty at Aurora University, she taught undergraduate and gradate-level courses in recreation administration. Smith also developed and managed the Leisure Services Institute, an entrepreneurial center at Aurora University providing leadership training for park recreation professionals in the greater-Chicago area. Her background also includes 9 years as vice-president with the American Alliance for Health, Physical Education, Recreation and Dance. Smith holds a PhD in recreation administration and business administration from Texas Woman's University. She completed a master of arts degree in recreation administration and a second master of arts degree in gerontology, both from the University of Northern Colorado. She completed her bachelor of science degree in physical education at North Dakota State University. She is a Certified Parks and Recreation Professional (CPRP).

Preface

The third edition of *Recreation Therapy With Individuals Living in the Community: An Inclusive Approach* reflects the changing nature of health care, health and human services, and our professional focus. A number of trends, legislative directives, technological advancements, and evolving professional practices are creating paradigm shifts that result in individuals with diverse needs and aspirations receiving recreation therapy in their communities. Due in part to the need to manage health-care costs, legislation that promotes access and improved quality, professional practices that emphasize person-centered care, and building upon individuals' strengths while remaining accountable, and a national and international perspective that promotes health-related quality of life, professionals are designing recreation therapy and recreation services within health and human agencies to fully embrace individuals with illnesses and disabilities. Our intent is to provide an overview of the process, referred to as APIED (assessment, plan, implement, evaluate, document), used to design, deliver, and evaluate services that fully incorporate all participants. This third edition of *Recreation Therapy With Individuals Living in the Community: An Inclusive Approach* is designed for recreation therapy, recreation, and health and human service professionals who provide services to all community residents. The text is useful to students enrolled in introductory and programming coursework in recreation therapy, recreation, and courses that address inclusion.

Features that make this text useful to professionals and students include (1) format of the text as modules allows for selective use of specific modules to support training and coursework on particular topics; (2) sequence of the content represents the steps and respective tasks to design, implement, and evaluate an agency's services; (3) illustrations and resources are presented by agencies acknowledged as representing best and evidence-based professional practices and therefore may be used as benchmarks to assess quality and plan for agency improvements; (4) leadership and management practices that are recognized as facilitators of inclusion support; (5) review of participant qualities and implications for addressing these characteristics during APIED; and (6) content is organized to allow professionals and students to efficiently engage with the text in meaningful time increments. The text is organized by 10 modules: Following the introduction (Module 1) are two modules outlining community and agency assessments undertaken prior to and as services are initiated or updated; Modules 4, 5, 6, 7, and 8, respectively, outline the tasks during each phase of APIED; Module 9 reiterates the best practices introduced in Module 1, and for many of these practices presents illustrations from Special Recreation Associations, Public Park and Recreation Agency, and Private Nonprofit agencies; Module 10 reviews participant characteristics and application of APIED with individuals who are organized into five convenience categories representing persons residing in our communities.

Every individual, like every community, is unique with resources and supports for applying APIED to promote participants' health-related quality of life. Application of this approach by qualified professionals is recognized as a best practice. While this text was guided by evidence found with literature, research, and expertise, the application of APIED with individuals is influenced by relevant contextual factors that are constantly changing within each community: Consequently, services evolve and vary yet with use of APIED, professionals are accountable and participants and stakeholders are aware of expected outcomes that contribute to their well-being.

https://www.sagamorepub.com/products/recreation-therapy-individuals-living-community

https://www.sagamorepub.com/products/recreation-therapy-individuals-living-community

MODULE I

Introduction: Paradigm Shifts and Practice Influences

Introduction

A primary intent of this publication is to aid in the planning of therapeutic recreation (TR) experiences with individuals living in the community with illnesses, disabilities, or differences. Students and professionals are introduced to application of the APIED (assessment, planning, implementation, evaluation, documentation) or TR process as it might be used in education, health, human service, or recreation agencies. A second intent is to share resources useful to professional development and training focused on the provision of TR services with individuals with permanent or temporary illnesses, disabilities, or differences residing in the community.

Since publication of earlier editions of this text, social, economic, technologic, and demographic trends have and continue to impact service delivery. As the care continuum shifts from the doctor's office and hospitals to community-based services, a broader array of agencies and professionals are becoming members of health and human service teams.

Holistic, participant-centered care is now the focus of services. A shift from the medical approach or deficits model of care to a biopsychosocial approach is grounded on an ecological or systems approach. This approach to care and support acknowledges program delivery is influenced by interrelationships among participants and their communities. Program planners consider each person's capacities and resources as programs are designed. Program outcomes address all factors that support participants' quality of life, health, and functioning in their communities. This shift refocuses professionals from a concern on removing deficiencies to enhancement of individual assets that contribute to quality of life.

Professionals in recreation therapy (RT) rely on theory, scientific evidence, and best practices to define a scope of service. Research has documented the use of a number of administrative, programmatic, and community practices that promote physical, programmatic, and attitudinal inclusion of individuals with illnesses and disabilities in programs and services. Theories and concepts such as self-determination, self-efficacy, and an ecological perspective provide the foundation for an inclusion philosophy. More recently, positive psychology, the WHO-ICF model, and objectives of Healthy People 2020 provide the rationale to expand the scope and intent of inclusive practices.

Health-related quality of life (HRQOL) concepts describe the evolving nature of inclusive philosophy and practice. Professionals design experiences to promote health and well-being that affect overall quality of life. Initially, inclusion referred to supporting persons in appropriate programs. Presently, inclusive concepts encompass individuals with disabilities, illnesses, and differences, their communities, and those experiences related to health, functional status, and ability to perform in life situations. This paradigm shift expands the individuals served, the program opportunities provided, and the outcomes to be achieved as a result of participation.

The trends, foundational concepts, and evidence-based practices influencing the extension and expansion of inclusive philosophy and practices are summarized in this introduction. While TR/RT experiences are the focus of APIED, the TR process is applicable in newly evolving community-based agencies and with health-related experiences. Professionals in health and human service agencies serving a broad array of clientele with varying needs and assets apply APIED to design services that enhance health and well-being. Ultimately the quality of life, interrelationships, and connections among individuals and their communities strengthen and flourish as a result of this holistic approach.

Trends

"Today's health care system is continuing to undergo significant changes" (Sullivan & Decker, 2009, p. 3). Change is the norm. Change in health and human service organizations is constant and is affecting the organization and delivery of health and human service programs; yet change is necessary for growth and viability of participants, professionals, and organizations.

Technology

Technology is a primary contributor to the rapid rate of change. Health information technology, electronic medical records, tele-a-medicine, and robotics, for example, are changing professional responsibilities, facility operations, and care approaches (Hoss, Powell, & Sable, 2006). Advances in technology and treatment are reducing the length of hospital stays and the time professionals have to interact with clients. Consequently, individuals are living with their disabilities and illnesses in the community, relying on local health and human service agencies to support their health and well-being.

Cost Containment

Health care is a business (Stumbo & Hoss, 2009; Sullivan & Decker, 2009), and as such, the focus is on containing costs even with increasingly limited resources to sustain

services in a competitive environment. The growth rate of health care spending continues to advance in developed countries, and paying for services is challenging for North American governments and individual consumers. Accountability demands, benchmarking, and need to reduce medical errors require professionals to improve quality and outcomes and focus on safety in health and human service agencies. A third issue worldwide is access to care among various cultures, generations, and socioeconomic populations. The financially poor experience health disparities: Healthy People 2020 identifies one of four foundational health measures as disparities; the intent of this national agenda is to monitor progress in attaining the highest level of health in all people in the United States (U.S. Department of Health and Human Services, 2010).

Globalization

Healthcare is a global public concern. Globalization yields common threats such as natural disasters, terrorism, and pandemics, and solutions such as telemedicine and alternative delivery models to manage escalating health spending and financing. Demographics worldwide such as aging, income levels, immigration, and violence are adding to the diversity of needs to be met by an already overburdened system. The World Health Organization's International Classification of Functioning, Disability, and Health (ICF) (2002) provides a universal language and framework to describe health and disability. This biopsychosocial model integrates the medical, social, and human aspects of health. Disability and illnesses are universal human experiences and, as therapists, embracing this model suggests we capitalize on participant strengths and include the interrelationships of our communities and human functioning as we assess and deliver services (Anderson & Heyne, 2012; Sylvester, 2011). An ecological approach recognizes the interaction between the environment and individual capacities and together with inclusive practices enables individuals to meet their health needs while living in the community.

From the Hospital to the Community

As the care continuum moves beyond the doctor's office and hospital, the future will see a shift from a profession practiced primarily in hospitals to a profession that is also practiced in the community with TR/RT professionals employed in a variety of settings such as community centers, day rehab, supportive living, home health care, and wellness centers; a broader array of professionals will be providing holistic patient-centered care (Hoss, Powell, & Sable, 2006; Sullivan & Decker, 2009). Informed citizens are participating in health care decisions. Integrated care networks rely on technology to share and organize intervention plans among professionals through community-based rehabilitation models (Anderson & Heyne, 2012). This encourages fiscal prudence by focusing on the performance of an interdisciplinary team to produce outcomes in a timely manner. Concern for access to experiences among persons with and without disabilities and those with temporary impairments is creating a shift from accessibility to universal design and access. Similarly, while there remains a concern for management of chronic diseases such as cardiovascular issues, there is an increasing acknowledgement of lifestyle behaviors that contribute to issues such as diabetes and obesity: This shift encourages a focus on health-related quality of life and well-being or preventative and health promotion practices and measuring outcomes relevant to individual aspirations.

Evidence- and theory-based practice grew out of a desire to use scientific evidence and theory to make informed clinical decisions (Sullivan & Decker, 2009). This effort complements challenges to improve safety, reduce costs, and validate the appropriateness of specific interventions to produce consistent outcomes. While efficacy research may be a challenge in day-to-day practice, program evaluation helps justify effectiveness and viability of therapeutic recreation in holistic health.

The goal of the health care industry is changing from keeping the beds in hospitals filled to keeping people out of the hospital (Sullivan & Decker, 2009). As health and human service professions transition from a medical to a social model of care (Sylvester, 2011), interventions that address deficits will be refocused on assets and capacities, and professional responsibilities will diversify and expand to attend to health of individuals within the context of their communities (Carruthers & Hood, 2007; Witman & Rakos, 2008).

Theoretical Foundations

Theories guide professionals "in determining what may be occurring in particular situations and what may occur in the future" (Devine & Wilhite, 1999, p. 30). Theories provide the conceptual basis to explain and predict experiences and, therefore, are critical to planning effective interventions (Shank & Coyle, 2002). A number of theories explain the shift from an illness approach to holistic health. Evidence-based practices evolve from these theories and help professionals develop new knowledge and strategies to broaden inclusive approaches to promote health in the community. This approach recognizes all people may at some point in their life experience temporary or permanent challenges to a healthy lifestyle.

Self-Determination

Self-determination and choice in decision making have been fundamental to community-based interventions (Bullock, Mahon, & Killingsworth, 2010; Dattilo, 2012). Experiences that promote competence, relatedness, and autonomy come from supportive community engagements and positively impact motivation and the intrinsic ability to take responsibility for our actions and effectively meet our goals (Anderson & Heyne, 2012). Decision making is one element of leisure education programs professionals use to promote self-determination.

Self-Efficacy

Self-efficacy beliefs are foundational to achieving our goals. Those who believe their choices and actions will affect the outcomes of a situation have higher degrees of self-efficacy than those who see little relationship between their actions and outcomes (Stumbo & Peterson, 2009). Individuals acquire effective beliefs through observing others, experiencing success, receiving positive feedback and physical and emotional readiness to perform. The use of mentors and buddies represent strategies to foster participant self-efficacy.

Positive Psychology

Positive psychology is a primary impetus behind the shift from focusing on deficits and problems to cultivating the strengths and capacities of individuals and society to allow individuals to thrive (Carruthers & Hood, 2007). Recent TR/RT models, The Leisure and Well-Being and the Flourishing through Leisure Models, introduce theoretical support for the important role therapeutic recreation assumes in building capacity and strengths enabling individuals to experience well-being in their environments (Anderson & Heyne, 2012; Carruthers & Hood, 2007). The theories of learned optimism and flow also support positive well-being, control, and happiness as foundational to health and well-being.

"The World Health Organization (WHO) has defined health as a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (Carter & Van Andel, 2011, p. 7). In 2001, the WHO released a model that recognizes the interrelatedness among health factors, environmental influences, and personal factors. The intent of the International Classification of Functioning, Disability and Health (ICF) is to present a common framework worldwide to define and measure health and disability. Disability results from losses of bodily function, activity limitations, and participation restrictions (Shank & Coyle, 2002). The subsequent release of the ICF Checklist (2003) encourages professionals to move away from diagnostic labels to focus on the dynamics among the individual, environment, and society by documenting behaviors influencing health. A coding scheme describes environmental barriers and facilitators to a person's capacities and performance in life experiences, including recreation and leisure. The tool is a way to assess individual functioning and the impact of activity limitations and restrictions in life activities on one's quality of life (Sylvester, 2011). The WHO's definition and model encourage a holistic view of individuals capitalizing on their personal assets while promoting a common language and evidence-based practices. This global interpretation of health aligns with the strength-based approach to practice in TR/RT as presented by the The Leisure and Well-Being and the Flourishing through Leisure Models.

Healthy People 2020 is the most recent comprehensive set of 10-year national health objectives published by the United States Department of Health and Human Services (2010). The focus of this document is on society's influence on health (Yang & An, 2011). The document identifies objectives related to health promotion and disease prevention. Two new focus areas introduced are health-related quality of life and well-being and social determinants of health; both foci embrace concepts important to the delivery and outcomes of services. The document's primary goals promote healthy behaviors across all life stages and intend to prevent diseases and eliminate disparities created by social factors and physical conditions in the environment such as socioeconomic statuses that cause health inequities. Recreation therapists play a vital role in delivering social and leisure activities such as social skills training or education on community leisure resources that promote health-related quality of life and address inequities attributed to individual's social participation (e.g., presence of discrimination, bullying, stereotypes) (Yang & An, 2011).

Ecological Perspectives

Ecological perspective describes the interrelationships among growing and developing individuals and all the systems in their changing environments (Howe-Murphy & Charboneau, 1987). These authors suggested the goal of selecting any intervention is threefold: improving the adaptive capacities of individuals, the supportive qualities of the environment, and interactions between individuals and their environments (p. 19). The systems approach suggests professionals consider the total person and the interconnectedness among all systems within which they live. This theory extends our professional scope of practice to the family, community, and all other social components present in the delivery system such as culture and socioeconomic conditions. This approach suggests people are in a constant process of growth to gain competence and autonomy, indicators of health (Shank & Coyle, 2002). Thus, for example, professionals assess the level of family support and participation restrictions as these variables influence well-being. Successful interventions and inclusion best practices are grounded on this perspective.

The therapeutic recreation process (TR process) of assessment, planning, implementation, evaluation, and documentation (APIED) is a systematic method of planning and delivering services. This accountability model is based on systems theory as APIED takes into consideration the relationships and connections among all the factors affecting targeted participant outcomes (Stumbo & Peterson, 2009). The programs that best realize each participant's intended goals are implemented, and the results of the experience inform future participant goals. This approach takes into consideration the changing nature of clientele, agency, and society. Professional roles are adjusted to support the expectations of various constituencies. The professional uses systems theory to guide practice by determining what interventions and services best contribute to participant health and well-being.

Conceptual Basis of Therapeutic Recreation

The basis for services is found in the terms used to define our professional practice. A definition helps professionals outline a scope of practice and constituents understand the intent of our services.

According to the WHO (2002), *functioning ability* is an umbrella term that encompasses all body functions, activities, and participation in daily living. The WHO also recognizes that contextual factors emanating from within the individual and the environment influence our health and functioning ability by acting as barriers or facilitators to our capacity to perform in life situations including recreation and leisure.

Health is a holistic condition encompassing physical, social, emotional, spiritual, and intellectual components of one's life.

Health-related quality of life (HRQOL) concepts have evolved since 1980 and encompass aspects of overall quality of life that affect health (CDC, 2011). For the individual, this includes physical and mental health perceptions, social support, socioeconomic status, functional status, and health risks and conditions. At the community level, this includes resources, conditions, policies, and practices influencing people's health perceptions and functional status. This interpretation recognizes the paradigm shift from a

medical to a biopsychosocial approach to well-being by acknowledging the interactions among the individual and surrounding environment.

Leisure describes experiences including recreation characterized by freedom of choice, intrinsic motivation, pleasant expectations, and perceived competence and control; leisure experiences contribute to a satisfying life and well-being (Anderson & Heyne, 2012; Hood & Carruthers, 2007; Stumbo & Peterson, 2009).

Patient-centered care is one of the five competencies identified by the Institute of Medicine as essential for 21st century health care professionals (Greiner & Knebel, 2001). Accepting person-first language and acknowledging the shift from deficits to assets, the word *patient* is replaced by *person*. A person-centered approach is a way to provide services designed to focus on each person's unique abilities and to encourage every person to develop (Dattilo, 2012). This approach is foundational to inclusive practices and acknowledges the diversity of individuals and settings where purposeful engagements occur. A person-centered approach describes professional interactions that address individuals in the context of their living environments. A person-centered service is designed to achieve goals through individualizing the experience: The role of the professional is to promote health through the application of the APIED process using carefully selected facilitation techniques and interventions. The professional membership organization's definition of the field provides the foundation for the best practices purported in this text:

> *Recreational therapy,* also known as *therapeutic recreation*, is a systematic process that utilizes recreation and other activity-based interventions to address the assessed needs of individuals with illnesses and/or disabling conditions, as a means to psychological and physical health, recovery and well-being. Further, *recreational therapy* means a treatment service designed to restore, remediate, and rehabilitate a person's level of functioning and independence in life activities, to promote health and wellness as well as reduce or eliminate the activity limitations and restrictions to participation in life situations caused by an illness or disabling condition (American Therapeutic Recreation Association [ATRA], 2016).

Wellness is a dynamic concept that implies people desire to realize or maximize their full potential in the environment in which they live (Carruthers & Hood, 2007; Stumbo & Peterson, 2009). Thus, there are many aspects that contribute to well-being, including those that are external to the individual, such as community resources, and those that are internal, such as interests and skills. The achievement of well-being is an ongoing process.

Evidence-Based Practices

Evidence-based practice is one of the five competencies identified by the Institute of Medicine as essential for 21st century health care professionals (Greiner & Knebel, 2001). The professional integrates the research with clinical expertise and participant values to facilitate optimal care. Professionals identify documentable information that demonstrates therapeutic recreation intervention effectiveness (Stumbo, 2003): This in-

formation is then used to design, implement, and evaluate services with specific, identified, measurable, and valued outcomes (Stumbo & Pegg, 2010). Evidence-based practice is an avenue to improve performance, remain accountable, and assure effectiveness by connecting what professionals do with chosen interventions having identified results.

Research and literature have investigated and reported effective inclusive practices (Bullock, Mahon, & Killingsworth, 2010; Dattilo, 2012; Devine, 2012; Klitzing & Wachter, 2005; Miller, Schleien, & Lausier, 2009; Schleien, Miller, & Shea, 2009) enabling individuals with disabilities to engage in community recreation with individuals without disabilities. This body of information is foundational to best practices and the shift to strength-based planning.

Inclusion practices that have been found to remove participation barriers and constraints (Dattilo, 2012; Devine, 2012; Klitzing & Wachter, 2005; Miller, Schleien, & Lausier, 2009; Schleien, Miller & Shea, 2009) are summarized by convenience categories in Figure 1 as either administrative or programmatic practices. Together with the theories and concepts that explain and predict interactions, professionals use evidence-based practices to purposefully engage participants in those experiences that consistently build on their assets and promote their health and well-being while adapting to their ever-changing communities.

Administrative

- An agency-wide mission statement articulates inclusive practices and promotes a welcoming culture.
- Agency-wide goals include inclusive practices.
- Agency employment of qualified and experienced (CTRS credential) professionals to facilitate and coordinate inclusive service delivery: Recommended competencies include the following:
  - Skills to provide on-site technical assistance throughout the agency
  - Knowledge of disabilities, adaptations, applied behavior analysis or behavior modification, and program evaluation
  - Skills in bridge building, communication, and forming partnerships
  - Understanding of the applicable laws
- Staff training on principles and practices of inclusive service delivery is routinely offered agency-wide including all staff levels, volunteers, persons without disabilities, and companions.
- Physical and programmatic accessibility are ensured through ongoing and routine review of plans and agency policies and procedures that are discrimination free.
- Appropriate funding is available for adaptive equipment and other accommodations such as contracted sign language interpreters and staffing to modify participant-to-staff ratios.
- Networking and collaboration among professionals, caregivers, community agencies, and schools through, for example, advisory groups, create greater awareness, information sharing, and service promotion.
- Marketing materials use inclusive language, target persons with disabilities, and include official welcoming statements.
- Direct marketing by partnering with caregivers and consumer groups addresses personal concerns of caregivers and identifies participant outcomes.
- Evaluation measures participant outcomes, success of supports, and training needs.
- Accessible transportation is available.

Figure 1.1. Best Practices

Figure 1.1. **(cont.)**

Programmatic Assessments • Assessment: individual, activity, and environmental identify strengths and supports for successful engagements. • Caregiver support for inclusion is considered with appropriate strategies used to promote caregiver acceptance and alleviate their concerns and fears.
Program planning • Program planning information from assessments and activity analyses are used to prepare accommodation plans outlining supports with behavioral plans when necessary. • Codes of conduct outlining acceptable and unacceptable behavior are designed with each program or intervention. • Leisure education is incorporated and includes leisure awareness, decision-making, resource awareness and use, social skills, and activity skills.
Program implementation • Adaptations occur with equipment/materials, activities, environments, participants, and instruction. • Skill instruction uses task analysis, modeling, demonstration, and physical assistance. • Distractions are removed from the program environment. • Behavior strategies such as reinforcement and reward systems are used when appropriate. • Inclusion support staff are used to modify staff-to-participant ratios when individual assistance is supportive of success. • Cooperative rather than competitive activities or activities that promote equal rather than hierarchical relationships are implemented. • Stimulation-controlled environments or quiet spaces are available to promote individual safety and re-orientation. • Technical support on specific accommodations with individual participants is provided by qualified staff. • Peer-empowerment strategies are used to help participants become more involved with activities.
Program evaluation • Program evaluation measures participant satisfaction and outcomes, the inclusion process, and staff training needs.
Documentation • Documentation records success with various accommodations; and if supportive, behavioral notes with specific participants are retained to assist with planning future experiences. • Documentation includes assessment results, individualized intervention plans, measurable goals with behavioral objectives, participant progress, reevaluation, transition planning, and required facility documentation (NCTRC, 2015).

References

American Therapeutic Recreation Association (ATRA). (2016). What is RT/TR: FAQ about RT/TR. Retrieved from https://www.atra-online.com/what/FAQ

Anderson, L., & Heyne, L. (2012). *Therapeutic recreation practice: A strengths approach.* State College, PA: Venture.

Bullock, C. C., Mahon, M. J., & Killingsworth, C. L. (2010). *Introduction to recreation services for people with disabilities: A person-centered approach* (3rd ed.). Urbana, IL: Sagamore.

Carruthers, C. P., & Hood, C. D. (2007). Building a life of meaning through therapeutic recreation: The Leisure and Well-Being Model, part I. *Therapeutic Recreation Journal, 41*(4), 276–297.

Carter, M. J., & Van Andel, G. E. (2011). *Therapeutic recreation a practical approach* (4th ed.). Long Grove, IL: Waveland Press.

Centers for Disease Control and Prevention (CDC). (2011). HRQOL concepts. Retrieved from http://www.cdc.gov/hrqol/concept.htm

Dattilo, J. (2012). *Inclusive leisure services* (3rd ed.). State College, PA: Venture.

Devine, M. A. (2012). A nationwide look at inclusion: Gains and gaps. *Journal of Park and Recreation Administration, 30*(2), 1–18.

Devine, M. A., & Wilhite, B. (1999). Theory application in therapeutic recreation practice and research. *Therapeutic Recreation Journal, 33*(1), 29–45.

Greiner, A. C., & Knebel, E. (Eds.). (2001). *Health professions education: A bridge to quality.* Washington, D.C: Institute of Medicine, National Academies Press.

Hood, C. D., & Carruthers, C. P. (2007). Enhancing leisure experience and developing resources: The leisure and Well-Being model, part II. *Therapeutic Recreation Journal, 41*(4), 298–325.

Hoss, M. A. K., Powell, L., & Sable, J. (2006). Healthcare trends: Implications for Therapeutic Recreation. In M. J. Carter & J. E. Folkerth, (Eds.), *Therapeutic recreation education: Challenges and changes* (pp. 107–122). Ashburn, VA: NTRS/NRPA.

Howe-Murphy, R., & Charboneau, B. G. (1987). *Therapeutic recreation intervention: An ecological perspective.* Englewood Cliffs, NJ: Prentice-Hall.

Klitzing, S. W., & Wachter, C. J. (2005). Benchmarks for the delivery of inclusive community recreation services for people with disabilities. *Therapeutic Recreation Journal, 39*(1), 63–77.

Miller, K. D., Schleien, S. J., & Lausier, J. (2009). Search for best practices in inclusive recreation: Programmatic findings. *Therapeutic Recreation Journal, 43*(1), 27–41.

National Council for Therapeutic Recreation Certification. (2015). *2014 NCTRC Job Analysis Report.* New York, NY: Author.

Schleien, S. J., Miller, K. D., & Shea, M. (2009). Search for best practices in inclusive recreation: Preliminary findings. *Journal of Park and Recreation Administration, 27*(1), 17–34.

Shank, J., & Coyle, C. (2002). *Therapeutic recreation in health promotion and rehabilitation.* State College, PA: Venture.

Stumbo, N. J. (2003). Outcomes, accountability, and therapeutic recreation. In N. J. Stumbo (Ed.), *Client outcomes in therapeutic recreation services* (pp. 1–24). State College, PA: Venture.

Stumbo, N. J., & Keogh Hoss, M. A. (2009). Higher education and healthcare: Parallel issues of quality, cost, and access. In N. J. Stumbo (Ed.), *Professional issues in therapeutic recreation* (2nd ed., p. 367–388). Urbana, IL: Sagamore.

Stumbo, N., & Pegg, S. (2010). Outcomes and evidence-based practice: Moving forward. *Annual in Therapeutic Recreation, 18*, 12–23.

Stumbo, N. J., & Peterson, C. A. (2009). *Therapeutic recreation program design principles and procedures* (5th ed.). San Francisco, CA: Pearson Benjamin Cummings.

Sullivan, E. J., & Decker, P. J. (2009). *Effective leadership and management in nursing* (7th ed.). Upper Saddle River, NJ: Prentice Hall.

Sylvester, C. (2011). Therapeutic recreation, the International Classification of Functioning, Disability, and Health, and the capability approach. *Therapeutic Recreation Journal, 45*(2), 85–104.

U.S. Department of Health and Human Services. (2010). Healthy people 2020. Retrieved from http://www.healthypeople.gov/2020/

Witman, J. P., & Rakos, K. S. (2008). Determining the "other related duties" of therapeutic recreation and activity professionals: A pilot study. *American Journal of Recreation Therapy, 7*(2), 29–33.

World Health Organization (WHO). (2002). Towards a common language for functioning disability and health, ICF. Geneva, Switzerland. Retrieved from http://www.who.int/classifications/icf/en/

World Health Organization (WHO). (2003). ICF checklist. Retrieved from http://www.who.int/classifications/icf/training/icfchecklist.pdf

Yang, H., & An, D. (2011). Healthy people 2020: Implications for recreation therapy. *American Journal of Recreation Therapy, 10*(4), 17–23. doi: 10.5055/ajrt.2011.0007.