Facilitation of Therapeutic Recreation Services

An Evidence-Based and Best Practice Approach to Techniques and Processes

EDITED BY **Norma J. Stumbo and Brad Wardlaw**

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This book has been adventure almost ten years in the making. My strong belief in the power of evidence-based practice started with an interest in systematic program design, outcomes, and field-based research. Many colleagues across the globe have fanned the embers of this passion—so many that it would be impossible to acknowledge them all. I hope that each of you know that our many conversations and interactions as well as your own work have allowed me to learn more quickly and think more deeply. Thanks to each of you for working so hard to create a better future for therapeutic recreation professionals.

Thanks also to my personal cheering section of Randy, Barb, and Nancy. Love you all.

—Norma Stumbo

To my parents and Cortney, thank you for all your support through this process.

—Brad Wardlaw

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» CHAPTER 1 »

The Need for Evidence-Based Practice in Therapeutic Recreation Services

Norma J. Stumbo, Ph.D., CTRS

West, Kinney, and Witman (2008), in the second edition of the *Guidelines for Competency Assessment and Curriculum Planning for Recreation Therapy Practice*, delineated a comprehensive list of modalities and facilitation techniques that can be applied to therapeutic recreation practice. They listed modalities such as anger management, community reintegration, coping skills training, horticulture, journal/writing, meditation, reality orientation, values clarification, and the like. They also listed a number of facilitation techniques such as behavioral theory/therapy/modification, counseling theories, learned optimism/positive psychology, and resiliency/hardiness theories. In general, it is difficult to separate modalities from facilitation techniques. However, by definition, modalities are methods of therapy or treatment and often have "content" associated with them, such as the step-by-step method used in problem-solving therapy; facilitation techniques are the processes used to allow clients to reach their outcomes more efficiently and effectively. For example, knowing the underlying principles of cognitive behavioral therapy (a facilitation technique) is important to helping people make desired changes by focusing on their thoughts and behaviors.

West et al. (2008) made a very strong case for the wise selection and use of therapeutic modalities and techniques:

> Selection of modalities and techniques to be used in treatment should be based on the *evidence that exists specific to their utility to address specific needs to improve patient functioning*. Practitioners need to access available evidence that explains the effectiveness of particular interventions. (emphasis added) (p. 15)

Purpose of This Book

The intent of this book is to improve the systematic application of various techniques and modalities to the practice of therapeutic recreation. Improving and standardizing practice is fundamental to increasing our ability to select interventions based on their potential to impact client outcomes. When we fully realize the potential of specific interventions to help clients arrive at certain outcomes, then we can choose these interventions and techniques with greater skill and confidence.

"Systematic application," however, depends on a number of key factors to succeed. These include: (a) evidence-based and theory-based programming, (b) systematic program design, and (c) well-targeted client outcomes. First, every profession benefits from the application of evidence and theory to their practice. Evidence-based practice (i.e., the application of research evidence to intervention design) and theory-based practice (i.e., the application of relevant theory to intervention design) are both equally important to ensure that programs, interventions, or treatments are built on "best practices." Conversely, programs that are designed haphazardly or lackadaisically, say from tradition, therapist interest, or sheer inertia, are unlikely to help clients achieve their goals and fulfill their full potential. Second, program design and planning need to be done with care and through a systematic process using established procedures. Comprehensive program design, activity analysis, protocol development, and program evaluation are a few of the steps of systematic program design used by therapeutic recreation specialists. Third, targeting important and valued client outcomes is extremely important. Clients and their families need to be assured that professionals are providing the best possible care, in the most efficient and effective manner possible, to arrive at the most vital and significant outcomes.

The aim of this book is to vastly improve our frameworks for interventions by extracting and synthesizing the best possible evidence and theory, so that therapists can then apply systematic program design and build effective and meaningful programs aimed at specific and known outcomes. To do this, we started with the question: "What interventions and programs are therapeutic recreation specialists, regardless of

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specific settings or client groups or geographic regions, most likely to design, based on our scope of practice?" The answer to that question then became the topical outline for this book. We start out with eight introductory chapters:

1: Need for Evidence-Based Practice
2: Overview of Leisure Education
3: Selecting Programs and Activities Based on Goals and Outcomes
4: Planning and Leading Group Activities/Group Interventions
5: Communication Techniques
6: Instructional Techniques
7: Counseling Techniques
8: Behavior Change Strategies

These chapters are intended to provide the backdrop for selecting, planning, and implementing therapeutic recreation interventions using the most promising and noteworthy practices. Each chapter has considerable research and literature support to ensure readers and therapists that the ideas and guidelines provided therein are grounded in substantial theory, evidence, and, whenever possible, research data.

The remaining chapters address some of the most popular and specific interventions and techniques within therapeutic recreation practice. Topics and evidence were selected by the following criteria:

- Only interventions and practices common to and most often used in therapeutic recreation were included.
- The research and evidence provided was representative of the recent published literature in these areas. The cited studies generally reflect the whole of the available literature, however, only a percentage of all available literature is included.
- Only that research evidence applicable to the provision of therapeutic recreation services was included.
- The sole purpose of inclusion of any data or evidence was the improvement of therapeutic recreation practice and client outcomes.
- When and where possible, information directly applicable to certain client groups was provided.

These criteria resulted in the following 13 chapters on facilitation techniques or modalities.

9: Problem-Solving Therapy
10: Anger Management
11: Social Skills Training
12: Assertiveness Training
13: Physical Activity
14: Pain Management
15: Cognitive Behavioral Approaches
16: Intergenerational Programming
17: Stress Management
18: Sensory Stimulation and Sensory Integration
19: Reality Orientation, Validation, and Reminiscence
20: Community Integration
21: Virtual Reality

In each of these 13 chapters, authors were challenged —and rose to the task with diligence and fortitude!— to present the most recent, compelling, and applicable research concerning their topics. Each chapter contains introductory information, followed by research evidence to support the technique, and related studies in the therapeutic recreation literature. A sampling of resources and illustrative activities are included in most chapters as well.

The intent of this book is to provide students and practitioners with solid information that will improve their practice; that is, improve the likelihood that the interventions they provide are the most powerful and most effective. In order for interventions to be powerful and effective, a number of conditions must be must. Among these are: (a) the use of evidence, (b) the use of theory, (c) systematic program design, and (d) a continuous focus on client outcomes. The remainder of this chapter will review these stipulations.

Intervention as a Means for Creating and Measuring Client Change

A program that is designed and implemented to be *intervention* has, as its outcome, some degree of client behavioral change (that is, behavioral change is the purpose of the program) (Shank & Kinney, 1991; Stumbo, 2000, 2003a, 2003b; Stumbo & Hess, 2001). This may mean an increase in knowledge, an increase in skill, a decrease in some behavior, an increase in functional ability, and so forth.

The targeted outcomes must be applicable to the client upon discharge or exit from the program. It is part of the specialist's responsibility to identify relevant, meaningful, and timely outcomes that will affect the individual's future leisure lifestyle. To be accountable for producing client change, a program has to be

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well-designed and implemented according to a plan that uses best practices to address the desired, specific participant change. On the other hand, programs that are not accountable often lack forethought into the content and process of delivery or the intended outcomes.

Intervention services are those that are: (a) based on client needs or deficits, (b) designed and implemented to improve, reduce, or eliminate those needs or deficits, and (c) targeted toward specific client outcomes as the result of participation in those programs. This implies that functional intervention programs, leisure education programs, and, sometimes, recreation participation programs are "intervention" or "treatment" in that they are goal-oriented and implemented for the specific purpose of producing client outcomes. Each specific program, intervention, or treatment can be evaluated independently from other specific programs, interventions, or treatments. In addition, specific programs or interventions have very distinct characteristics.

According to Connolly (1984):

> the bottom line of designing a program is to put together a strategy, intervention, or approach that will aid those who participate in the program to accomplish behavioral change in the form of improved functional abilities and/or acquisition of new knowledge and skills. One measure of the effectiveness of a program, therefore, is documenting the outcomes clients attain as a consequence of participating in the program. (p. 159)

Riley (1991a) draws attention to the concepts of "measurable change" and "relationship" (p. 59). "The causal relationship between the process of care (intervention) and the outcomes of care (change in patient behavior) is critical" (Riley, 1991a, p. 59). Several authors advocate that there must be a direct and proven link between the goals of the program, the type of program being delivered, and the client outcomes expected from participation in the program. It is this link that is central to the concept of intervention and accountability for services (Carruthers, 2003; Ross & Ashton-Shaeffer, 2003).

Intervention- or outcome-oriented programs have unique characteristics that are distinguishable from nonintervention programs. In order for therapeutic recreation programs to be considered intervention, the delivery of the intervention or treatment must be:

- focused on a systematic assessment of client characteristics, needs, and/or deficits
- designed in advance to be efficient and effective in its delivery
- able to produce targeted, meaningful, timely, and desired client outcomes
- able to produce evaluation data indicating achievement (or non-achievement) of client outcomes
- part of a larger systematic, comprehensive set of quality programs (Stumbo & Peterson, 2009)

These characteristics imply that the designer must specify the intended outcomes as well as the process to accomplish the outcomes *prior* to the implementation of the program. Intervention assumes a well-defined, goal-oriented *purpose* to the activity or program being provided. There is a well-thought-out plan for getting the participant from point A to point B, through his or her participation in a program or programs that are specifically designed for that purpose (Carruthers, 2003; Ross & Ashton-Shaeffer, 2003). These well-thought-out plans often require the underpinnings of research evidence and theory in order to best target client outcomes.

Clinical Decisions Using Evidence, Theory, and Systematic Design

Decisions about which interventions are most effective and efficient for a particular client or group of clients are often difficult to make with confidence, for both new and experienced clinicians alike. Most often, these decisions can be improved by searching for related research and theories and by applying them to develop best practice; that is, making sure the interventions we provide are the most likely of all possible options to produce the desired outcomes in the most systematic, efficient, and effective manner (Stumbo & Peterson, 2009).

Research evidence and theories of intervention are important to program development, not only at the comprehensive design level but also at the specific program level (Caldwell, 2001, 2003; Stumbo, 2003c; Widmer, Zabriskie, & Wells, 2003). Using research evidence and theories of intervention can aid the therapeutic recreation specialist in many ways, including:

- reducing the amount of time and effort in creating "from-scratch" program designs by providing an overall framework and implementation strategies

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- improving the connection between clients' needs, program design and implementation, and client outcomes
- improving standardization of and consensus about programs for specific client groups
- improving the ability to evaluate program effectiveness for individual clients, for groups of clients, and for therapeutic recreation as a service

There are many ways in which the therapeutic recreation specialist can improve the likelihood that interventions can address client needs and be delivered efficiently and effectively. Two recent trends in health and human services are affecting therapeutic recreation program design: (a) evidence-based practice and (b) theory-based programming.

Evidence-Based Practice

The first trend is evidence-based practice. The overall aim of evidence-based practice is to reduce wide (and unintended) variations in practice, and instead use the best, accumulated evidence possible to inform, enlighten, and direct practice. "Evidence-based practice can be described as the selection of treatments for which there is some evidence of efficacy" (Denton, Walsh, & Daniel, 2002, p. 40). Evidence-based practice improves the predictability and causality of service outcomes and provides regulators, payers, and consumers increased assurance of quality care. Through the use of evidence-based practice, each professional should increase his/her confidence that the services being provided are the most meaningful, most targeted, and most successful approaches possible (Stumbo, 2003d). Evidence-based practice means conducting or using research results to inform the design and delivery of therapeutic recreation practice (McCormick & Lee, 2001).

This research provides a foundation for evidence-based practice of therapeutic recreation services by bringing forth the best possible information that is available on some of our most used techniques and interventions. Evidence-based practice in therapeutic recreation services has been advocated strongly to ensure that clients receive the best treatments possible (Lee & McCormick, 2002; Stumbo, 2003a, 2003b, 2003c; Stumbo & Pegg, 2010; Stumbo & Peterson, 2009; West et al., 2008). Through diligently using the best possible evidence of effectiveness (often through research results), we are more likely to provide those interventions and programs that move clients most steadfastly to the targeted end. In that way, evidence-based practice allows us to be much more confident that our intervention choices are based on a solid foundation, instead of programs being offered because of tradition, ease of implementation, or therapists' interests and skills. "The foundation of evidence-based practice de-emphasizes decision making based on opinion, custom, or ritual. . . . Rather, emphasis is placed on applying the best available research findings to specific clinical situations" (King & Teo, 2000, p. 597).

For example, if research shows that meditation practices are more effective than aerobic exercise at inducing relaxation for older individuals, then therapeutic recreation program designs and their delivery should reflect the evidence from these research studies. In a second example, Stumbo (Chapter 10 of this text) cites a number of research studies that demonstrate that relaxation training, social skills instruction, and cognitive behavioral training are highly effective in significantly improving youths' ability to manage anger. Therapeutic recreation specialists who use this research in their program development will (a) shorten the time it takes to conceptualize, design, deliver, and evaluate their anger management program; (b) be more assured of producing desirable client outcomes; (c) be able to judge whether the same outcomes result from their programs; and (d) show proof that services are up-to-date, accountable, and based both on best practices and evidence.

However, searching for and obtaining such reports—and actually practicing evidence-based health care—is often beyond the capabilities and resources (time, effort, cost, and administrative disincentives) of the professional (Glanville, Haines, & Auston, 1998). One of the possible solutions to this dilemma is for the profession (likely, researchers) to conduct systematic reviews of the research literature and make these syntheses available to working professionals and students. Elsewhere, Stumbo (2003c, 2003d, 2003e) has written on the importance of conducting and understanding systematic reviews for improving therapeutic recreation practice. Each chapter of this book has been written with extreme care and diligence, although not each has used a systematic review protocol per se. Instead of a posing a "clinical question" that would be applicable to one setting or one group of clients (Stumbo, 2003d, 2003e), we posed a much larger set of "professional questions." That is, we first asked, "What interventions and programs are therapeutic recreation specialists, regardless of specific settings or client groups or geographic regions, most likely to design, based on our scope of practice? What are the best available theories and research investigations that support these interventions? What are the implications of these theories and investigations for therapeutic recreation practice?"

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So perhaps instead of applying the term "systematic review" for the process used throughout this book, the better term might be "clinical review," as suggested by Clegg and colleagues (2000) and Siwek and colleagues (2002). According to Bhandari et al. (2002), clinical reviews answer "background questions" such as overall effectiveness of a technique or intervention, while systematic reviews ask "foreground questions" pertaining to a more specific aspect of client care, perhaps about a specific diagnosis.

Regardless, supporting programming decisions with research evidence and applicable theories is appropriate, necessary, and beneficial in both cases. First, the use of research and theory ensures that practitioners are more able to predict a precise estimate of the treatment effect of specific interventions for a specific group of clients (Bhandari et al., 2002). Second, the value or the outcome of the intervention is more easily communicated to treatment team members and clients and their families. And third, when quality systematic reviews are available, the professional can choose from recommendations and tailor them to the clients' needs, spending more time with clients and less time struggling for ideas (Myers, Pritchett, & Johnson, 2001).

It is clear that evidence-based practice, because it improves the likelihood of clients achieving the desired outcomes in the most direct and potent manner, is here to stay. Therapeutic recreation specialists who use evidence-based practice will shorten their overall preparation time and heighten their ability to reach meaningful client outcomes. Evidence-based practice, like theory-based programming, will enhance the effectiveness and efficiency of therapeutic recreation programs.

Theory-Based Programming

Led by several scholars in the field, theory-based programming is an idea whose time has come. Caldwell (2001, 2003) and Widmer, Zabriskie, and Wells (2003) provided numerous examples of theories that might be used in therapeutic recreation programming. Some of these examples are: (a) self-efficacy, (b) perceived freedom, and (c) stress-coping.

> Becoming skilled in using theories to develop therapeutic recreation (TR) assessments, programs, and evaluations can lead to many important outcomes, such as increased programmatic efficacy and ability to better communicate with colleagues. . . . Theories provide the foundation for understanding TR programming, and as a result, can become one of the most important tools a TRS can use. . . . All competent TRSs provide some reasoning behind what they do. Answers such as "I want to improve self-efficacy" or "The patient needs to increase anger-management skills" explain in general what the TRS's treatment goals might be. A good theory, however, will provide the tool to specify beforehand what might happen, and even more important, why it might happen. (Caldwell, 2001, p. 349)

An example of the extensive use of theory in program development is work done by Hood and Carruthers (Carruthers & Hood, 2002; Hood & Carruthers, 2002). Believing that "[t]heory is an extremely useful tool for understanding, predicting, and/or changing human behavior" (Hood & Carruthers, 2002, p. 138), these researchers studied stress-coping theory and applied it to individuals with alcoholism. Two major intervention strategies emerged: (a) decreasing negative demands and (b) increasing positive resources. Each of these strategies included a number of substrategies, such as using social networks for support.

After this thorough review of the literature, they designed and tested a seven-session coping skills program, with goals, implementation details, and an evaluation strategy (Carruthers & Hood, 2002). After implementing the stress-coping program at three different hospitals, they reported that clients perceived the goals of the coping skills intervention program as very important, clients believed their own improvement on the goals as a result of the program was approximately 75 percent, and clients actually achieved the behavioral goals approximately 80 to 95 percent of the time. The specialists who implemented the program at the three different hospitals felt the intervention was brief but more effective than previous attempts in this area. Compared the effectiveness of most of therapeutic recreation programs, these results are phenomenal, both from a client-change perspective and from a therapist-utility standpoint.

These are but a few examples of the growing base of evidence-based practice and theory-based programming in the therapeutic recreation literature. It is anticipated that this text will be a major step forward in identifying applicable theories that are suitable for therapeutic recreation services.

Why do evidence-based practice and theory-based programming matter to therapeutic recreation? The answers are many. First, they improve the chances of getting to client outcomes more quickly by focusing programming efforts on sound and proven information. Second, they improve the justification or rationale for

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services that are based on specific evidence and theory, rather than on happenstance or whim. Third, both efforts becoming more accepted and universally applied will improve the standardization of practice and create common ground among therapeutic recreation professionals and with their colleagues from other disciplines. Clearly, evidence-based practice and theory-based programming can greatly aid comprehensive and specific program designs' rationale and effectiveness.

Tied in with the notion of evidence-based practice and theory-based programming is a parallel concept of systems design; that is, knowing that the whole of the program is far greater than each of its parts individually. For that to occur, several systems or procedures must be in place before accountable services can be delivered to clients dependably.

Systems Design and Therapeutic Recreation Intervention

The beauty of using a systems approach for designing therapeutic recreation programs is that the designer must specify the intended outcome as well as the process to get there *prior* to the implementation of the program. That is, systems design assumes that there is a well-defined, goal-oriented *purpose* to the activity or program being provided. Objectives, goals, and outcome measures help define where the program is going and how it is going to get there. There is a well-defined plan for getting the participant from point A to point B, through his or her participation in a program that has been specifically designed for that purpose. This is a major factor that helps system-designed programs to become intervention.

The general theory of systems is based on two concepts. The first is the concept of "wholeness." This implies that any entity can be viewed as a system and can be studied for its dynamics as a complete entity. Readers are familiar with the use of "systems"—for example, stereo systems, the solar system, the criminal justice system, the public school system, the welfare system, a weather system, a car's cooling system, a body's circulatory system, the ecosystem, etc. Although the parts can be identified, broken down, analyzed, and studied, the total entity has characteristics and dimensions that are greater than the sum of its parts. Thus, viewing just the parts or components does not give a realistic picture of the total entity.

The second concept of general systems theory is that of "interrelatedness." This concept attempts to explain that parts or components of a system interrelate with one another. These interrelationships between parts are as important as the individual parts. Systems theory, including the concepts of "wholeness" and "interrelatedness," have brought a new perspective to the study of many entities—natural phenomena, man-made entities, organizations, and human delivery systems, as the examples above illustrate. The systems concept has facilitated the understanding of complex human, social, and natural entities.

Systems theory, however, is more than a method of analysis and description. It has been translated into many practical applications. One of the most common applications is to the process of program planning. Systems planning models provide developed steps or procedures for program design, implementation, and evaluation. The models are not designed for any one discipline but rather are procedures that can be used in any field of service.

The flexibility of the systems approach enables diverse program content and structure to exist. The planning, implementation, and evaluation procedures guide the planner systematically through program development without dictating actual content or implementation strategies. However, the method facilitates logical design in interrelated stages, providing continuity and accountability to the program plan.

Simply stated, a systems approach to program planning focuses on three basic concerns:

1. Determining what the program is to accomplish (where you're going)
2. Designing a set of procedures to get to those goals (how you're going to get there)
3. Developing criteria to determine if the program did what it was designed to do (how do you know if you got there?)

Many systems planning models have been developed and implemented for various planning needs. Some are very complex and rely on computer technology; others are quite simple and basically outline the major stages of program development. Regardless of the level of sophistication, seven basic components are built into any systems planning model:

1. Determining the purpose, goals, and objectives
2. Designing a specific set of procedures and content to accomplish the purpose, goals, and objectives
3. Specifying implementation of delivery strategies
4. Designating an evaluation procedure
5. Implementing the program
6. Evaluating the program
7. Revising the program based on evaluation data

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It is easy to see that these seven steps are clearly related to therapeutic recreation intervention or treatment programming. A program that is designed and implemented to be intervention has as its outcome some degree of client behavioral change (that is, behavioral change is the purpose of the program). This may mean an increase in knowledge, an increase in skill, a decrease in some behavior, and so on. To be considered intervention, a program has to be well-designed and implemented according to a plan—a *system*—that specifically addresses participant change. A systems approach is a useful tool for intervention designers to ensure that clients attain the desired and intended outcomes.

Client Outcomes

Focusing on client outcomes in the development, delivery, and evaluation of therapeutic recreation interventions is more important than ever. A number of authors have emphasized that outcomes are the documentable changes in client behavior, skills, and/or attitudes that can be attributed to active participation in the therapeutic recreation intervention program (Dunn, Sneegas, & Carruthers, 1991; Shank & Kinney, 1991; Stumbo, 1996, 2002; Stumbo & Peterson, 2009). "Outcomes are the observed changes in a client's status as a result of our interventions and interactions. 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). Some of the definitions of outcomes that appear in the literature are listed in Table 1.1.

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.

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. Navar (1991) explained this as "providing the right patient with the right service [at] the right time in the right setting at the right intensity and for the right duration" (p. 5). Client outcomes can be categorized in many ways; a useful schema was suggested by Gorski (1995):

- changes in clinical status (effect of treatment on patient's symptoms)
- changes in functionality (effect of treatment on client's lifestyle)
- change in utilization of medical resources (effect of treatment on using additional health-care services)
- recidivism (examining patterns of relapse or re-entry into the medical system)

Table 1.1. Definitions of Client Outcomes

- The [change in a] state or situation that arises as a result of some process of intervention (Wade, 1999, p. 93)
- Refers to change in a client's status over time (McCormick & Funderburk, 2000, p. 10)
- Outcomes are reported as changes in the score between two points of time on individual level standardized instruments (Blankertz & Cook, 1998, p. 170)
- The results of performance (or non-performance) of a function or process(es) (JCAHO, 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)
- 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, 1991a, p. 58)
- Clinical results (Scalenghe, 1991, p. 30)

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Therapeutic recreation may target and contribute to the achievement of any and all of these broad client outcomes. Because client outcomes represent the differences in the client from the beginning compared to the end of services (and likely beyond), they are crucial to many services and efforts. Being accountable means being able to design and deliver programs that will bring about some predetermined outcome or behavioral change in the client. In essence, targets for behavioral change must be identified *before* programs can be designed and delivered to create that change. This implies that each service, such as nursing, social work, or therapeutic recreation, must be able to target specific behavioral change in the client that will occur as a result of the client's participation in that discipline's service. There must be a direct link between the process or delivery of care, and the outcomes expected from it (Riley, 1987, 1991a).

The ability to produce client outcomes is contingent on well-designed and systematic programs into which clients are placed based on the needs shown from assessment results. The relationship or causal link is a strong one (Riley, 1987, 1991a; Stumbo, 2000, 2003b, 2003c, 2003d; Stumbo & Hess, 2001).

Important Characteristics of Outcomes

Dunn, Sneegas, and Carruthers (1991) noted that within the profession of therapeutic recreation a variety of terms (e.g., "objectives," "behavioral objectives," "performance measures") have been used to define what is currently termed 'outcome measures.' What outcomes are relevant? What outcomes carry the greatest importance to clients, given their demographic, ethnic, and cultural characteristics? What outcomes are attainable during (especially brief) intervention? The answers to these questions may be unique for each individual agency.

Stumbo (2000) documented six characteristics of outcomes that are valued and have utility for measurement purposes. These six characteristics are as follows (see also Table 1.2).

Table 1.2. Characteristics of Client Outcomes

Client outcomes must be:

- Identifiable
- Measurable
- Achievable
- Demonstrable or Documented
- Predictable or Causal
- Meaningful

- Outcomes must be *identifiable*. This task is of primary importance and must be done before other measurement tasks are undertaken (Johnson & Ashton-Shaeffer, 2000; Stumbo, 2000; Stumbo & Hess, 2001). What outcomes from the therapeutic recreation service are important to the clients seen at this facility? What target outcomes fit within the scope of therapeutic recreation practice that will benefit these clients and fall within the intent of this facility and its other health care disciplines?
- Outcomes must be *measurable* (Buettner, 2000; Hodges & Luken, 2000; Stumbo, 2000). While most health-care providers believe their services contribute to the overall, global health and well-being of their clients, these "measures" often are deemed too broad and lack meaning in today's health-care environment. There is greater interest in defining outcomes more specifically and in smaller terms. Therapeutic recreation specialists need to locate and document outcomes in five areas: clinical status, functional status, well-being or quality of life, satisfaction with care, and cost/resource utilization (see Stumbo, 2003c). What categories of outcomes or outcome indicators are produced by therapeutic recreation services? What important outcomes of therapeutic recreation services are measurable, and how and when will they be measured? Will these measurements be sensitive to change within a short time period?
- Outcomes must be *achievable* (Hodges & Luken, 2000; Johnson & Ashton-Shaeffer, 2000). Shortened lengths of stay have complicated the accomplishments of most health-care professionals. With fewer days of inpatient or even outpatient care, it is difficult and sometimes impossible to achieve the outcomes that may have been identified five or ten years ago. What can be accomplished within a patient's two-day or five-day stay? What is important in this person's treatment, and how can it be achieved? It has been a difficult task for most therapeutic recreation professionals to narrow their scope of measurement (and programming) to fit the patient's length of stay.
- Outcomes must be *demonstrable* or *documented* (Buettner, 2000; Stumbo, 2000). For example, if a stress-management program is to produce measurable changes in the clients' behavior, attitude, or level of stress, the therapeutic recreation specialist must be able to document that change.

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Often, this means having valid and reliable instruments or tools that measure the level of behavior, attitude, or knowledge that is targeted, and how that changed as the result of care. It also means having a body of research that supports these outcomes (Seibert, 1991).

- Outcomes must be *predictable* or *causal* (Riley, 1991b). That is, there must be a direct relationship between the intervention and the outcome. Using the example of a stress-management program, it would be unwise to measure differences in leisure attitudes as an outcome, since a change in leisure attitudes is unlikely to be directly attributable to a stress management program.
- Outcomes must be *meaningful* (Buettner, 2000; Devine & Wilhite, 1999; Johnson & Ashton-Shaeffer, 2000; Lee & Yang, 2000; McCormick & Funderburk, 2000; Shank, Coyle, Kinney, & Lay, 1994/1995; Stumbo, 2000). With all the constraints above, client outcomes must still be meaningful to the client and his or her recovery or health status, as well as valuable to third-party payers. What important contribution does therapeutic recreation make to the client's success? What unique contribution does therapeutic recreation make to other services provided by the health-care team? What outcome changes in the client would make the most difference in his or her life?

A great deal of effort on the part of the specialist should be spent considering which client behaviors, skills, or attitudes can be changed, given the goals and design of the program. For example, if clients' average length of stay is seven days, it would seem difficult to change attitudes that took a lifetime to develop. Instead, the specialist might choose to help the client increase his or her knowledge of community leisure resources, an outcome that typically can be expected within seven days of intervention. The outcome has relevance, importance, and is attainable. Smaller, more measurable client outcomes may be preferable to larger, less measurable outcomes.

Several authors have provided guidelines for selecting and developing client outcome statements (Anderson, Ball, Murphy, & associates, 1975, as cited in Dunn, Sneegas, & Carruthers, 1991; Shank & Kinney, 1991). These authors suggested that the specialist create and implement client outcome statements that consider:

- the efficiency and effectiveness of demonstrating client change
- a reasonable relationship between the services provided and the expected outcome
- the connection between occurrence of the outcome and the timing of data collection
- the relevance to the client, his or her culture, and society
- the goals and intent of the program
- an appropriate level of specification, but not reduced to trivial detail
- individual client variation within any given program
- both long-term and short-term goals and objectives
- the social, home, and community environment to which the client will return
- behaviors that are generalizable and transferable to a variety of settings and situations

It is clear that client outcomes and the specific programs or interventions that are designed to attain them are intricately related; interventions must be created and delivered in a way that client outcomes will result.

Benefits of Evidence-Based, Theory-Based, and Systems-Inspired Outcomes

The benefits of evidence-based, theory-based, and systems-inspired intervention programming are wide ranging. Below are some of the professional benefits of these best practices in therapeutic recreation services:

- provides reasonable guarantee to client and others that programs are designed and delivered for a specific purpose
- helps specialist focus on meeting client needs rather than providing programs without purpose
- ensures relative consistency of treatment from client to client, day to day, specialist to specialist
- places clients into programs based on need rather than convenience
- helps determine content of client assessments
- provides direction for content of client documentation
- aids in producing predictable client results from programs
- allows better data collection about program efficacy in meeting the needs of clients
- increases communication between therapeutic recreation specialists throughout the country, as well as with other disciplines

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- provides explanation of therapeutic recreation services to auditing groups such as third-party payers, accrediting bodies, and administrative policy makers (Stumbo & Peterson, 2009)

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

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

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

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

Summary

- The purpose of this book is to improve therapeutic recreation specialists' systematic application of various techniques and modalities.
- Evidence-based practice, theory-based practice, systems-designed practice, and the continual focus of client outcomes are important to the improvement of therapeutic recreation services.
- Interventions are those services which have as their outcome some degree of client behavioral change (behavior, knowledge, attitudes, skills).
- Evidence-based practice uses research and evaluation results as the basis for the design and implementation of services.
- Theory-based practice uses sound theories, such as self-efficacy, perceived freedom, and stress-coping, as the foundation to design and implement services.
- Systems-designed programs are based on three broad questions: Where are you going? How are you going to get there? How do you know if you got there?
- Focusing on client outcomes; that is, the change in clients based on our services helps therapeutic recreation specialists to design streamlined and purposeful programs.
- There are numerous benefits to embracing evidence-based, theory-based, systems-inspired programs within therapeutic recreation services.

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