

GROW THROUGH FLOW



NCTRC STUDY GUIDE

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NCTRC Study Guide - Section One: Foundation Knowledge

Part A: Background

Human Growth and Development

Freud's Psychosexual Development Theory:

Age	Name	Pleasure Source	Conflict
0-2 years old	Oral	Mouth: sucking, biting, swallowing	Weaning away from mother's breast
2-4 years old	Anal	Anus: defecating or retaining feces	Toilet training
4-5 years old	Phallic	Genitals	Oedipus (boys), Electra (girls)
6 puberty	Latency	Sexual urges sublimated into sports and hobbies. Same-sex friends also help avoid sexual feelings	
puberty onwards	Genital	Physical sexual changes reawaken repressed needs. Direct sexual feelings towards others lead to sexual gratification.	Social Rules

Erikson's Stages of Psychosocial Development:

Stages	Developmental Task or Conflict to be Resolved
Oral-Sensory (birth to 1 year)	Trust vs. mistrust. Babies learn either to trust or to mistrust that other will care for their basic needs including nourishment, sucking, warmth, cleanliness and physical contact.
Musculo-anal (1-3 years)	Autonomy vs. shame and doubt. Children learn either to be self-sufficient in many activities, including toileting, feeding, walking and talking or to doubt their own abilities.
Locomotor-Genital (3-5 years)	Initiative vs. guilt. Children want to undertake many adult like activities, sometimes overstepping the limits set by parents and feeling guilty.
Latency (6-11 years)	Industry vs. inferiority. Children busily learn to be competent and productive or feel inferior and unable to do anything well.
Adolescence (12-18 years)	Identity vs. role confusion. Adolescents try to figure out "Who Am I?". They establish sexual, ethnic, and career identities, or are confused about what future roles to play.
Young Adulthood (19-35 years)	Intimacy vs. isolation. Young adults seek companionship and love with another person or become isolated from others.
Adulthood (35-50 years)	Generativity vs. stagnation. Middle aged adults are productive, performing meaningful work, and raising a family, or become stagnant and inactive.
Maturity (50+ years)	Integrity vs. despair. Older adults try to make sense out of their lives, either seeing life as a meaningful whole or despairing at goals never reached and questions never answered.

Piaget Theory of Cognitive Development

Stage	Characterised by
Sensory-motor (Birth-2 yrs)	• Differentiates self from objects • Recognises self as agent of action and begins to act intentionally: e.g. pulls a string to set mobile in motion or shakes a rattle to make a noise • Achieves object permanence: realises that things continue to exist even when no longer present to the sense (pace Bishop Berkeley)
Pre-operational (2-7 years)	• Learns to use language and to represent objects by images and words • Thinking is still egocentric: has difficulty taking the viewpoint of others • Classifies objects by a single feature: e.g. groups together all the red blocks regardless of shape or all the square blocks regardless of colour
Concrete operational (7-11 years)	• Can think logically about objects and events • Achieves conservation of number (age 6), mass (age 7), and weight (age 9) • Classifies objects according to several features and can order them in series along a single dimension such as size.
Formal operational (11 years and up)	• Can think logically about abstract propositions and test hypotheses systematically • Becomes concerned with the hypothetical, the future, and ideological problems

Havinghurst Theory of Adult Development:

Early adulthood = finding a mate, having children, managing a home, getting started in a profession

Middle age adulthood = achieving civic and social responsibility, economic standard of living, raising teens, developing leisure activities retirement, reduced income, ties with peers

Theories of Human Behaviour/Behavioural Change

Stress:

- Relationship between person and environment that is appraised by the person as taxing or exceeding his or her resources or endangering his or her well-being.
- A state that results from an actual or perceived imbalance between the demand and the capability of the individual to cope with and/or adapt to that demand that upsets the individual's short-or-long term homeostasis.
- When stress is perceived, people engage in a cognitive appraisal process:
 - o Primary - Appraise the risk or threat
 - o Secondary - Appraise options for responding

Stress - Coping:

- The process of dealing with stress and your response to the stress
- Any effort to master conditions of harm, threat or challenge and bring the person back into equilibrium.
- Four buffers to help manage stress with recreation/leisure:
 1. Sense of competence
 2. Nature and extent of exercise
 3. Sense of purpose
 4. Leisure activity
- Cognitive and behaviour efforts to manage external and/or internal demands (i.e. stress)
- Two types of coping:
 1. Problem-focused
 2. Emotion-focused

Attribution Model:

- The casual analysis of behaviour
- The process by which a person attributes or makes casual inferences “to what I attribute my success and failures”.
- People formulate explanations for their own and others successes and failures.
- Involves two dimensions:
 - 1.) Stability (stable/unstable)
 - 2.) Locus of control (internal/external)
- Involves four determinants of success or failure:
 - o Ability (stable-internal)
 - o Effort (unstable-internal)
 - o Task difficulty (stable-external)
 - o Luck (unstable-external).

Learned Helplessness:

- a perceived lack of control over events
- no matter how much energy is expended, the situation is futile and you are helpless to change things
- people learn to be helpless and become dependant
- behaviours and outcomes are out of one’s control
- occurs when people are exposed to repeatedly to uncontrollable events and being to learn that responding is futile
- When people learn that responding does not work they cease to explore other behavioural options.

Perceived Freedom:

- When a person does not feel forced or constrained to participate and does not feel inhibited or limited by the environment
- Means that the activity or setting is more likely to be viewed as leisure when individuals attribute their reasons for participation to themselves (i.e. actions are freely chosen) rather than determined externally by someone else or by circumstances.
- The freedom to choose your activity; feeling competent; “I can do this”
- LAM relies heavily on concepts of perceived freedom and personal choice.

Intrinsic Motivation:

- To do something for yourself
- Internal desires to do something as a sense of satisfaction
- Is the impetus to do something for internally or personally rewarding reasons
- Individuals often are intrinsically motivated toward behaviour in which they can experience competence and self-determination.

Locus of Control – Internal:

- Believe to largely control outcomes
- Possess the control to change
- Good self-esteem
- Typically, individuals with an internal locus of control take responsibility for their decisions and the consequences of their decisions.
- Obviously, an internal locus of control is important for the individual to feel self-directed or responsible, be motivated to continue to seek challenges, and develop a sense of self-efficacy or self-competence

Locus of Control – External:

- Believe luck, the environment or powerful others are responsible for the outcomes.
- Low self-esteem
- Helpless

- “he made me do it”

Self-Efficacy Theory:

- Is the measure of one's own competence to complete tasks and reach goals
- Generalizes to other areas
- Can be influenced through:
 - o Performance accomplishments
 - o Vicarious experiences
 - o Persuasion
 - o Physiological arousal
- Client's personal evaluations of their abilities directly affect how they cope with their problems.
- Client's expectations of themselves largely determine how willing they will be to deal with their problems, how much effort they will be willing to expend, and whether they will make a perseverant effort.

Performance Accomplishments:

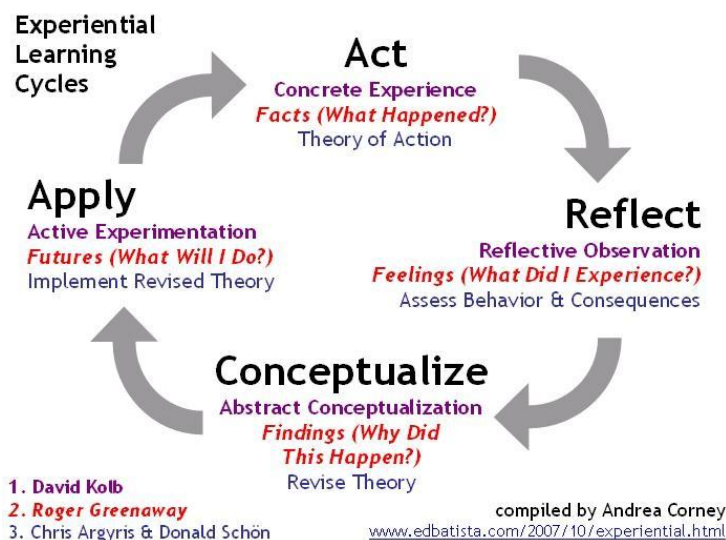
- The client performs the action and derives the desired outcome
- Strongest influence on self-efficacy beliefs
- Repeated success builds a sense of competence
- Practice – with and without support

Leisure Efficacy:

- To meet your own leisure needs, benefits from good circumstances.
- You need a repertoire of skills to be self-capable.
- Meet own needs/goals.

Experiential Learning Model:

- The process of making meaning from direct experience.
- Experiential Learning is learning from experience.
- The experience can be staged or left open.
- Staged experiential learning is often called a Dynamic Learning Experience (DLE)
- *Kolb's model of experiential learning:*



Neulinger's Theory of Leisure:

- A psychological “state of mind” that encompasses freedom of choice and internal motivation
- Individuals can be said to be in a state of leisure if they simply perceive that they have the freedom to choose activities and are motivated by an activity for its own sake, not just for its consequences

- Interactions are between:
 - Perceived freedom
 - Perceived constraints
 - Interactions contribute to outcomes

Attitude Model:

- A learned predisposition to respond in consistently favourable and unfavourable manner:
 - Beliefs
 - Attitudes
 - Intention
 - Behaviour

Theory of Reasoned Action (TRA):

- Derived from the attitude model
- Can predict actions based on personal attitude and perception of how others will view them
- Used as a basis for the practices of health education
- Developed in the 1960's
- Tool for observing behaviour and developing interventions based on those observations
- Person intention is the main factor
- Intention is a function of attitude and subjective norm:
 1. **Attitude:** concerns a person's belief that their behaviour will produce a beneficial outcome
 2. **Subjective norm:** whether key people in the person's life support the behaviour, and whether the subject is inclined to agree with them

Theory of Planned Behaviour (TPB):

- Developed in the 1980's
- A person's intention of doing something is the main factor in determining whether he will actually do it
- Behaviour intention does not necessarily result in action
- Builds on TRA by adding a third indicator of a person's intent:
 3. **Perceived behavioural control:** whether the person believes he can control the conditions necessary for change to occur

Health Belief Model (HBM):

- Health is defined in WHO's constitution as a state of complete physical, mental and social well-being
- Not merely the absence of disease or infirmity
- Recognizes the person with the disability (PWDs) can be healthy
- Used as a basis for the practices of health education
- Developed in the 1950's
- Take health action to avoid consequences
- Four key beliefs that make a person more likely to perform a specific behaviour:
 1. The person believes that the condition which the behaviour will address is a threat
 2. The person is prompted to perform the behaviour, either by people or by messages
 3. The person is confident he is able to carry out the behaviour
 4. The person believes that the benefits of doing the specified behaviour outweigh the negatives.

Transtheoretical Model/Stages of Change:

- Six stages of behaviour change and advocated various interventions to keep clients motivated:
 1. **Pre-contemplation** – client does not feel they have a problem.
 - Interventions would involve making him/her aware of the problems
 2. **Contemplation** – client admits a problem, but is still not sure if he/she wants to change.
 - Interventions would include encouraging the subject to make specific plans to change.
 3. **Preparation/commitment** – client realizes a need to change and gathers information.

- Interventions would include setting goals; awareness of the positives vs. the negatives of change
- 4. **Action** – client follow a plan for change behaviours.
 - Interventions involve providing feedback and support.
- 5. **Maintenance** – client sees the benefits of the new behaviours.
 - Interventions including helping in case of relapse; continues feedback and support
- 6. **Termination** – client can't imagine ever doing the old behaviour.
 - Interventions include proving help when needed and continuing to offer support.

Social Cognitive Theory (SCT):

- Grew out of Social Learning Theory (SLT)
- Introduced in the mid-1980's
- Follows the realization that people learn by watching others
- Behaviour is influenced by three things:
 1. The characteristics of the person
 2. The characteristics of the behaviour
 3. And the environment in which the behaviour would take place
- The relationship among the three characteristics is called - **Reciprocal determinism**
- Changing behaviour is most likely to occur if the person has:
 - **Self-efficacy**: confidence in the ability to do something
 - **Behavioural capability**: the skills and knowledge to do the specified behaviour
 - **Outcome expectance**: a belief that the expected outcome of the new behaviour will be beneficial

Diffusion of Innovation Theory (DIT):

- Explains how new ideas spread and why some ideas never do
- Gained popularity in the 1960's
- Innovation = an idea, practice or object that is perceived as new by a population
- Diffusion = the process by which an innovation spreads through a social system over time
- Five key factors influence whether an innovation will diffuse:
 1. Characteristics of the target population
 2. Environmental context into which the innovation will be introduced
 3. Credibility and likeability of the agent promoting to innovation
 4. Quantity of information communicated to the population about the innovation
 5. Quality of information communicated to the population about the innovation

Stage Theory of Adaptation:

- Based on Kubler-Ross's theories on acceptance of death
- Elements of Stage Theory:
 - Shock
 - Defensive
 - Depression or mourning
 - Personal questioning
 - Adaptation, change and integration

Maslow's Hierarchy of Needs:

- Motivation based theories
 1. Subsistence needs
 2. Safety needs
 3. Need for love and affection
 4. Achievement
 5. Self-actualization

Family Systems:

- Members have different roles, so a change in one's behaviour will affect the others

Diversity Factors

- A person's cultural orientation will impact how he/she will react to the assessment and programming process:
 - o Traditional – original culture has been retained
 - o Marginal – an uneasy mixture of original and other cultures
 - o Bicultural – acceptable comfort with original and newly acquired culture
 - o Assimilation – adopting and internalizing values, beliefs, and behaviours of dominant society
- Stereotyping – making assumptions about an individual based on ideas about a group
- Prejudice – a negative opinion about someone based simply on that person's race, gender, or religion
- Bias – preference for one over another
- Discrimination – unfair treatment of someone based on personal prejudice

Types of Models**Medical Model:**

- Focuses on the individual and pathology and includes identification of underlying disorder, interventions, treatment and cures.
- Assumes that the impairment or condition a person has is the key problem.
- The response is to "cure" or "care"
- Health is the opposite end of the continuum from disease, illness and or disability and focuses on functional ability, morbidity and mortality.
- Believes that the individual has a disability, he/she is not capable of being healthy.
- The medical model promotes the view of a disabled person as dependent and needing to be cured or cared for, and it justifies the way in which disabled people have been systematically excluded from society. The disabled person is the problem, not society.
- Poor health □ optimal health
- Dr. prescribes TR treatment
- Recreation is treatment – as a means to an end, is more clinical

The Public Health Model:

- Focuses on achieving good health and a sense of well-being
- Basic human rights
- Proposes that opportunities (diagnosis/treatment) to achieve health and well-being should be available to all groups

Activity Therapy Model:

- TR is prescribed, similar to medical model
- "blurring" of different departments including music therapy, art therapy, occupational therapy, dance therapy)

Ecological Model:

- Addresses the environment, what has to change in the environment
- Looks at the individual needs and environment needs
- The people around you: community and family
- Changes can occur encompassing both the promotion of abilities and the elimination and individual barriers.

Person-Centered Model:

- Believes that people have the capacity to be rational thinkers who can assume responsibility for themselves and whose behaviour will be constructive when given freedom to set directions in life.

- People are seen as motivated by a basic tendency to seek growth and self-enhancement.
- The role of the helping professional in person-centered therapy is to display unconditional positive regard.
- The helper never tells the client what to do, is non-judgemental and nondirective.
- The therapeutic relationship is key.

Human Service Models:

- 1.) Long-term Care model:
 - To maintain one's functioning, to be divisional
 - To enable individuals whose functional capabilities are chronically impaired to be maintained at the maximum level of health & well-being.
- 2.) Therapeutic Milieu Model:
 - Where every person & interaction can be therapeutic.
 - Everyone has equal impact.
 - Emotional problems are often the product of unhealthy interactions with one's environment
 - Staff are organized as a caring community
 - Primary therapist = most effective relationship

Educational Training Model:

- Gain vocational skills
- Focuses on the acquisition of knowledge and skills that are required to become a contributing member of society
- Used in sheltered workshops, vocational rehab centers, day-care centers, school
- Heavy emphasis on classroom-like framework

Community Model:

- Focuses on steps that communities can take to develop preventative programs to effect change
- Special Recreation:
 - o the provision of recreation programs and services that are provided for people who require special accommodations because of unique needs they have owing to some physical, cognitive, or psychological disability
- Social Recreation:
 - o Non-clinical approach for disabled in the community
 - o Recreation as an end to itself.

Social Model:

- Impairment is seen as not vitally important
- The environment attitudes of others, and institutional structures are the problems
- Prejudice, discrimination, inaccessible building
- This model was enthusiastically received by the disability movement

Rehabilitative Model:

- Activities of Daily Living: Activities related to personal care
- These Include: bathing, showering, dressing, getting in and out of bed or a chair, using the toilet, and eating
- A plan of care must be developed that allows for meeting both the physical and psychosocial needs of the client/patient
- Two types of goals:
 1. Rehabilitative – the goal of restoring independence
 2. Habilitative – helping the person function at their highest level

The Psychosocial Rehabilitation Model:

- Focuses on restoring those with mental disorders to the community as functioning society members with a sense of well-being

Part B - Diagnostic Groupings:

(SEE ICF Notes for more detail)

Disability Categories:

- *Cognitive disabilities* – i.e. Traumatic Brain Injury, learning disabilities
- *Physical disabilities* – i.e. Visual Impairment, Hearing Impairment, Cerebral Palsy
 - Least amount of prejudice
 - Longer history of self-identification
 - Stronger advocacy groups
- *Intellectual disabilities* – i.e. Cognitive Impairment (Mental Retardation), Autism
- *Psychiatric disabilities* – Mental Illness, Substance abuse
 - Last to receive government services or benefits

Cognitive Impairments: Result of impaired mental perception

- 1.) Mental Retardation/Developmental Disability:
 - Sub-average intellectual functioning
 - IQ<70, is displayed during the developmental period.
 - Symptoms: low frustration level, short attention span, social immaturity, unable to function independently, poor judgement.
 - Significant impairments in adaptive functioning.
 - Delays in motor, language, self-care.
 - Onset prior to age 18.
 - **TR:** Offers choice, inclusion, mainstreaming. Age appropriate (chronologically not mental age), specially valued integration activities, promote high success activities for low self-esteem.
 - Simplify/Adapt/Repetitive Movements: give choice, structure age appropriate activities.
 - 2.) Prader-Willi syndrome:
 - Is a congenital (present from birth) disease.
 - It affects many parts of the body.
 - People with this condition are obese, have reduced muscle tone and mental ability, and have sex glands that produce little or no hormones
 - 3.) Head Injury:
 - traumatic injury from a head wound
 - Impaired attention span, concentration, memory, lower tolerance for noise, low frustration tolerance.
 - TBI of the Frontal lobe = change in personality, impulsive risk behaviour, little facial emotion. Frontal lobe controls personality and emotions
 - Right FL = pseudo psychopathic behaviours – emotional/social instability
 - Left FL = pseudo depression, Broca's Aphasia (expressive)
 - **TR:** Utilize social skills; need for socialization, community reintegration, build independence, physical development, reading/writing/computer games
- Traumatic Brain Injury (TBI):
- an injury to the brain caused by an external force
 - often leads to coma; confusion, disorientation, mood swings, aphasia,
 - *Cognitive Impairment* □ attention deficit, inability to plan
 - *Physical Impairments* □ aphasia, apraxia, ataxia, perceptual deficits
 - *Social-Emotional Impairments* □ impulsivity, depression, lowered inhibition
 - **TR:** help to reintegrate into the community, become aware of resources, and develop physical well-being, develop support systems, ameliorate depression and loss of independence through creative arts & social events; computer games, physical games reading.
- 4.) Learning Disabilities:
 - i.e. - Dyslexia
 - Deficits in language development

- Hyper activity: ADHA and ADD
- Thought process difficulty, low attention span, distractible, behavior problems in school, low self-esteem.
- **TR:** Provide choice, challenge, & age appropriate activities which are structured for success.

Physical Impairments:

Musculoskeletal System

5.) Spina Bifida:

- Defective closure of spinal canal causing protrusion of spinal cord.
- Can cause paralysis & can have an emotional impact.
- Four major types:
 - o **Myelomeningocele:** an out pouching of the spinal cord through the back of the bony vertebral column that has failed to form.
 - o **Meningocele:** an out pouching consisting of only the coverings of the spinal cord and not the cord itself
 - o **Spina Bifida Occulta:** the failure of the back arch formation.
- **TR:** Wheelchair activities: utilize skills to promote independence, leisure education, community re-integration & exercises to strengthen muscles.

6.) Muscular Dystrophy:

- Progressive, inherited disease, gradual wasting of muscle tissue.
- Can lead to wheelchair use, & cause socially impaired interactions.
 - o **Pseudohypertrophic (Duchane) MD** = enlargement of fatty infiltration – causes contractures and deformities of joints. In w/c by 12 years of age
 - o **Facioscapulohumeral MD** = weakness in upper arms, shoulders, angled forward and lack of facial ability
 - o **Limb girdle MD** = late childhood to middle age – weakness of proximal muscles of the pelvic and shoulder girdles.
 - o **Oculopharyngeal** = 40 to 70 – weakness of eye and throat muscles
- **TR:** Maintain muscle tone, promote movement, accomplishment, exercise, aquatics, assistive devices, and promote creativity through crafts.

7.) Spinal Cord Injuries:

- The higher up the injury occurs, the greater damage.
- Includes loss of sensation below injury.
- *** Types of damage?? Three terms?

Cervical:

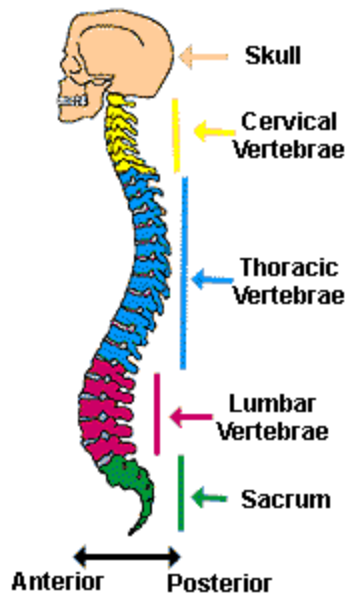
- When spinal cord injuries occur in the neck area, symptoms can affect the arms, legs, and middle of the body.
- The symptoms may occur on one or both sides of the body.
- Symptoms can also include breathing difficulties from paralysis of the breathing muscles, if the injury is high up in the neck.

Thoracic

- When spinal injuries occur at chest level, symptoms can affect the legs.
- Injuries to the cervical or high thoracic spinal cord may also result in blood pressure problems, abnormal sweating, and trouble maintaining normal body temperature.
- *Autonomic Dysreflexia* – at or above T6,
 - o Sweating, flushing above the injury, severe headache, nasal congestion, and nausea
 - o medical emergency

Lumbar/Sacral:

- When spinal injuries occur at the lower back level, symptoms can affect one or both legs, as well as the muscles that control the bowels and bladder.



Nervous System

8.) Multiple Sclerosis:

- 20-40 years of age for onset
- Symptoms: muscle spasms, loss of sensation, bladder control.
- Physical & emotional changes.
- **TR:** Social activities, success-oriented, Range of Motion.

9.) Cerebral Palsy:

- Brain paralysis
- Neuromuscular disorder
- Several types due to location of brain damage:
 - o *Spasticity*: Feature of altered [skeletal muscle](#) performance in [muscle tone](#) involving [hypertonia](#); it is also referred to as an unusual "tightness", stiffness, and/or "pull" of muscles.
 - o *Athetosis*: involuntary motor movement
 - o *Ridgity*
 - o *Ataxia*: poor balance
 - o *tremor*
- speech disturbance and stiffness
- non-progressive: is not degenerative
- **TR:** relaxation, water aerobics, social activities, Increases self confidence

10.) Epilepsy (seizures):

- *Grand mal*: A grand mal seizure (also known as a tonic-clonic seizure) features a loss of consciousness and violent muscle contractions.
- *Petit mal*: A petit mal seizure is the term commonly given to a staring spell, most commonly called an "absence seizure." It is a brief (usually less than 15 seconds) disturbance of brain function due to abnormal electrical activity in the brain.
- **TR:** encourage normalization, reduce stress, fears & stigma; relaxation, community activities, increase locus of control.

11.) Huntington's Chorea:

- A [neurodegenerative genetic disorder](#) that affects muscle coordination and leads to [cognitive](#) decline and [psychiatric problems](#).
- It typically becomes noticeable in mid-adult life.
- The most common genetic cause of abnormal involuntary writhing movements called [chorea](#).

which is why the disease used to be called **Huntington's chorea**.

12.) Parkinson's Disease:

- affect the neuromuscular systems resulting in cerebral tissue degeneration, severe disability, and death
- a disorder of the brain that leads to shaking ([tremors](#)) and [difficulty with walking](#), movement, and coordination

13.) Guillain-Barre syndrome:

- a serious disorder that occurs when the body's defense (immune) system mistakenly attacks part of the nervous system.
- This leads to nerve inflammation that causes [muscle weakness](#) and other symptoms.

Communication Disorders

1.) Visual:

- legally blind 20-200; the majority of legally blind people are over the age of 55
- 2-5% read Braille
- 5% completely blind
- others see shadows/movement
- **TR:** talking books, encourage other senses, orientation, environmental cues, movement, aquatics, dance, large print books, bright colors.

2.) Hearing Loss:

- have minimal noise, lighting is important, have them face you, close-up interactions
- **TR:** use of other senses, emphasize lip movements & hand gestures; adaptive activities encourage sign language.

3.) Aphasia:

- Is an impairment of language ability
- Having difficulty remembering words to being completely unable to speak, read, or write.
- *Expressive aphasia:* loss of the ability to produce language (spoken or written)
- *Receptive aphasia:* can speak with normal grammar, syntax, rate, intonation, and stress, but they are unable to understand language in its written or spoken form.
- *Global aphasia:* cannot speak or understand.

4.) Stroke:

- The initial interventions TRSs prescribe focus on improving strength, endurance and ROM; adjusting to visual neglect; and preventing contractures and spasticity
- **Left CVA**
 - o Right hemi: affects the right side; affects speech, may cause aphasia
 - o Impaired emotions, social interactions, poor memory, difficulty with spoken language & written communication
 - o **TR:** use demonstration, modeling, reality orientation
- **Right CVA**
 - o Left hemi: loss of perceptual/intellectual functioning, logic, visual and spatial depth, difficulty in perceiving around them.
 - o **TR:** use words rather than gestures, keep environment clear of distractions, leisure education.

5.) Autism:

- Onset in childhood
- Primarily exhibiting the following qualities:
 - o inability to develop normal social relationships
 - o delay in speech development
 - o non-communicative use of speech (echolalia)
 - o insistence on sameness
 - o stereotypical play
 - o lack of imagination

- *Echolalia*: the automatic [repetition of vocalizations](#) made by another person
- *Echopraxia*: the automatic repetition of movements made by another person.
- 1/3 have epilepsy
- 75% Mental Retardation.
- **TR**: need structure; may need to address family needs - respite.

Psychological Problems

1.) Anxiety Disorders:

- Fear or panic with no apparent reason.
- Approx. twice as many females have panic disorders, posttraumatic stress disorder, generalized anxiety disorder, agoraphobia and other specific phobias
- *Obsessive/compulsive behaviors*: obsessive thoughts and/or compulsive behaviors/rituals
- *Phobias*: unrealistic fears of: flying, heights panic; all affect functioning.
- *Post-traumatic Stress Disorder (PTSD)*: headaches, loss of memory,
- **TR**: stress management, expressive activities, exercise

2.) Personality Disorder:

- Chronic & longstanding & environmental distorted view of relating to others & ourselves.
- **Cluster A** (Odd, bizarre, eccentric)
 - Paranoid PD, [Schizoid](#) PD, [Schizotypal](#) PD
- **Cluster B** (Dramatic, erratic)
 - Antisocial PD, Borderline PD, Histrionic PD, Narcissistic PD
- **Cluster C** (Anxious, [fearful](#))
 - Avoidant PD, Dependent PD, Obsessive-compulsive PD
- Types:
 - Paranoid: characterized by [paranoia](#) and a pervasive, long-standing suspiciousness and generalized [mistrust](#) of others.
 - Anti-social: a long-term pattern of manipulating, exploiting, or violating the rights of others. This behavior is often criminal.
 - Borderline: instability of mood, interpersonal relationships, & self-image. Mood change during the day/several times a day. Feelings of emptiness/boredom. Will try suicide for attention.
- **TR**: help make decisions, challenging activities, modeling, contracts

3.) Mood Disorders:

- *Depression*: loss of appetite, sleep disturbance, lack of motivation, low self-esteem
- **TR**: short term activities, success oriented
- *Manic*: Endless energy, expertise in area, know famous figure.
- **TR**: set limits, provide structure
- *Bi-polar*: (manic-depressive): fluctuating moods,
- lithium to control; from manic>to>depressed
- *Schizophrenia*: A break from reality, disorder in thinking/reality
 - Delusional, bizarre behaviors & hallucinations. (thorazine & stalizine)
 - Hallucinations may occur in any sensory modality (e.g., auditory, visual, olfactory, gustatory, and tactile), but auditory hallucinations are by far the most common and characteristic of Schizophrenia.
 - Auditory hallucinations are usually experienced as voices, whether familiar or unfamiliar, that are perceived as distinct from the person's own thoughts
 - Auditory hallucinations, talking to self, "I'm Jesus", feel others are out to get them, lack of social skills.
- **TR**: social skills training, stress management, coping skills

4.) Eating Disorders:

- *Anorexia*: Thin - force self to vomit up meals to stay thin, organ damage
- *Bulimia*: gorge & purge, onset to young women, poor self-image

- **TR:** Leisure Education, social skills, express feelings, values clarification, family groups, meal planning, No physical work.
- 5.) Chemical Dependency:
- Drug/Alcohol
 - The leisure education component of TR programming is extremely important for individuals with substance-related disorders. Given the fact that most drug users have passive and sedentary lifestyles
 - **TR:** Leisure Education, fitness, social skills, provide choice, set limits, have rules, values clarification.
- 6.) Prison:
- Sex offenders, murderers etc.
 - **TR:** health, fitness, social skills, choice, limits.
- 7.) Organic Brain Syndrome:
- Acute & chronic; physical changes to brain, memory loss, emotional instability, mood changes, poor judgement, confusion, & disorientation.
 - TR Sensory stimulation, positive reinforcement, reminiscence, pet therapy, cognitive games, walking/exercise, nutrition.

Other Diseases

1. Amyotrophic Lateral Sclerosis (ALS) or *Lou Gherig Disease*:
 - Progressive muscular disease in adults that leads to death.
 - A completely physical disease
 - **TR:** Exercise
2. Congestive Heart Failure (CHF):
 - Unable to obtain adequate level of output.
 - RT side, legs swelling,
 - Left side fluid in lungs.
 - Hypertension> leads to heart attack
 - Cardiac - Four functional levels:
 - 1) experience no limits; generally exhibit no symptoms with ordinary activity 7.5+ cal
 - 2) Experience slight limitations; comfortable at rest, some symptoms with ordinary activities. up to 7.5 cal.
 - 3) Experience marked limitations, comfortable at rest, ordinary symptoms with less the activity up to 5.0 cal.
 - 4) Experience discomfort with almost any activity, may perform sedentary activities; 2.5 cal.
 - **TR:** Stress management, relaxation, exercise, awareness of environmental factors.
3. Burns:
 - **TR:** divert person away from pain.
4. HIV/AIDS
 - Human = because the virus can only infect humans
 - Immunodeficiency = because the effect of the virus is to create a deficiency, a failure to work properly with the body's immune system
 - Virus = because this organism is a virus which means one of its characteristics is that it is incapable of reproducing by itself
 - **TR:** stress reduction, socialization, creative arts activities, volunteer opportunities, educational programs and leisure education and counseling.

Part C - Theories and Concepts

Normalization:

- Making available to all persons patterns of life and conditions of everyday life that are as close as possible to the routine circumstances and ways of life.

Inclusion:

- Inclusion is the acceptance of all people regardless of their differences.

- It is about appreciating people for who they are because even though we are all different, we are one.
- Inclusion allows people to value differences in each other by recognizing that each person has an important contribution to make to our society
- Inclusion in recreation is more than allowing children with and without disabilities to participate in the same activity.
- In order for inclusive services to be successful, inclusion must be a value that is shared by all parties involved including: agencies, staff, families, participants, and the greater community.

Least Restrictive Equipment:

- The objective is to use equipment that restricts functional movement the least amount, while offering the maximum safety.

Legislation and Guidelines (Federal, State and Regulatory agencies)

1.) Americans with Disability Act:

- 1990
- Goes beyond agencies that receive federal funds
- Relied heavily of Rehabilitation Act of 1973
- "An Act to establish a clear and comprehensive prohibition of discrimination on the basis of disability."
- Can be enforced with lawsuits.
- George Bush was president
- a) *Title IIA. State and Local Government :*
 - o all activities, services and programs may not charge extra for accommodations
- b) *Title I. Employment:*
 - o Title I of the Americans with Disabilities Act requires employers with 15 or more employees to provide qualified individuals with disabilities an equal opportunity to benefit from the full range of employment-related opportunities available to others.
 - o Covers all aspects from hiring to promoting
 - o Qualified individuals with disabilities
- c) *Title III: Public Accommodations:*
 - o Covers the private sector.
 - o It requires that a wide range of public accommodations in the private sector remove physical, communications and procedural barriers to access by people with disabilities.
 - o Covers sales, rental and service establishments, as well as educational institutions, recreation facilities and service centers.
 - o Covers public accommodations, commercial facilities and private entities that offer examinations or courses related to licensing or certification, and transportation provided to the public by private agencies became effective January 26, 1992 and is enforced by the United States Department of Justice.

2.) The Rehabilitation Act, Section 504:

- 1973
- Section 504 is widely recognized as the first civil-rights statute for persons with disabilities.
- It took effect in May 1977
- No otherwise qualified individual with a disability in the United States, as defined in section 705(20) of this title, shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the [United States Postal Service](#)
- Its broad anti-discrimination policies ensure that individuals with disabilities receive equal opportunities in programs receiving federal funds

- Formed architectural and transportation barriers
- Compliance for PL 90-480
- First civil rights law for people with disabilities
- "Persons with a physical or mental impairment which substantially limits one or more major life activities." Where "Major life activities include caring for one's self, walking, seeing, hearing, speaking, breathing, working, performing manual tasks, and learning."
- Program Accessibility Act:
 - i. Ramps 8.333% maximum grade
 - ii. Parking space 12.5 x 20.5
 - iii. Hand rails 32" high
 - iv. Toilet 20" from floor, stall at least 36' wide

3.) PL 94-142, Education for all Handicapped Children Act:

- 1975
- Free and appropriate public education in a least restrictive environment
- IEP – Individual Education Plan mandates
- Education can include recreation

4.) PL 90 – 480 Architectural Barriers Act

- 1968
- Any building built after 1968 with federal funds must be accessible for the physical handicapped.

5.) Individuals with Disabilities Education Act (IDEA)

- IDEA 2004 – most recent
- The Individuals with Disabilities Education Act (IDEA) is a [United States federal law](#) that governs how states and public agencies provide early intervention, [special education](#), and related services to children with disabilities. It addresses the educational needs of children with disabilities from birth to age 18 or 21
- Students must be provided a [Free Appropriate Public Education](#) (FAPE) that prepares them for further education, employment and independent living
- free/appropriate public education, IEP and least restrictive environments

6.) Older Americans Act

- 1965
- To provide assistance in the development of new or improved programs to help older persons through grants to the States for community planning and services and for training, through research, development, or training project grants, and to establish within the Department of Health, Education, and Welfare an operating agency to be designated as the "Administration on Aging".
- Improved access services
- The Older Americans Act of 1965 was the first federal level initiative aimed at providing comprehensive services for older adults.

7.) Health Insurance Portability and Accountability Act (HIPPA)

- 1996
- Right to privacy of health information
- Developed by health and human services (HHS) to protect privacy of personal health information and took effect April 14th, 2003).

8.) 1996 Welfare Reform

- Transferred welfare programs from federal to states
- No money provided for job training, job development or childcare
- 13 million people affected
- Can only be on welfare for 5 years

-

9.) **Omnibus Budget Reconciliation Act:**

- 1987
- Requires clients in a nursing home be engaged in programs

Theories of Play

Play: Spontaneous, joyful, suspenseful and reality

Psycho-Analytic Theory:

- Engaging in play to reduce anxiety
- I.e. play therapy – abused child uses doll to master situation.
- Therapeutic recreation activities provided approved outlets for aggression and other emotions by facilitating sublimation and permitting unconscious conflicts to be expressed.

Catharsis Theory:

- Use of play to release repressed thoughts, feelings, and emotions.
- An outlet for aggression

Diversion Theory: To amuse ourselves

Compensation Theory: To play/recreate to fulfill needs not met at work.

Surplus Energy: To get rid of excess energy

Types of Play Therapy:

Perspective Play: used to treat specific symptoms or behavioural problems

Filial Therapy: child-centered, includes training parents and then observing and providing feedback

Theraplay: aim to improve attachment – increase child's trust and self-esteem

Cognitive Behavioural Play Therapy: make behavioural changes by learning new strategies and receiving support

Play in a Hospitalized Child's Life:

- Play is the primary means through which the child communicates, copes with stress, learns about the environment and masters new situations.
 - Provides normalcy
 - Emotional adjustment and support
 - Socialization
 - Independence
 - Creative expression
 - Learning and mastery
 - Diversion

Type of Play Activities:

- Dramatic Play
- Story-telling
- Sensory stimulation
- Music activities
- Expressive arts
- Craft activities
- Medical or preoperative teaching
- Creative media play
- Gross motor play

- Fine motor play
- Games and activities
- Creative cooking
- Community out-trips
- Play skills education

Leisure throughout the Lifespan/Development:

Expanders: altered their leisure patterns by the addition of new activities throughout the life course

Contractors: learned and became committed to most of their outdoor recreation activities before 21

Activity Theory:

- asserts that people will be happiest and most fulfilled in direct proportion to how much activity they are able to maintain

Disengagement Theory:

- As the end of life draws near, people will voluntarily disengage from others and from their former activity pattern and society's withdrawal from them will in turn leave them in peace and happiness.

Continuity Theory:

- Those activities and relationships that have been cultivated and maintained over a long period in people's lives are most likely to contribute to well-being and a sense of integrity.

Leisure lifestyle:

- Is the day-to-day behavioural expression of one's leisure related attitudes, awareness and activities revealed within the context and composite of the total life experience
- Leisure lifestyles implies that an individual has sufficient skills, knowledge, attitudes, and abilities to participate successfully in and be satisfied with leisure and recreation experiences that are incorporated into his or her individual life pattern.
- *NTRS Philosophy statement:* Day to day behavioural expression of one's leisure values, attitudes, awareness and skills in their life experiences

Leisure:

- The main variables of perceived autonomy or freedom of choice and intrinsic motivation that reflects behaviours that are enjoyable
- Money, education, age, ethnicity, etc.
- Leisure seen as:
 - **Time:** a block of time
 - **Activity:** social-economic factors -education/money/income/age/ethnicity
 - determines activity/interests
 - **Holistic:** in all aspects of your life
- Self-determined; can be seen as social instrument
- Seen as a means to an end
 - 1.) Freedom of choice
 - 2.) Intrinsic motivation
 - 3.) Sense of satisfactions

State of Flow:

- Csikszentmihalyi
- State of optimal, psychological arousal-when the challenge matches your skill.
- When the skill level is low and the activity challenge is high, the individual is most likely to be anxious. When the skill level and activity challenge are identical or nearly identical (both low and both high), the individual is most able to achieve a state of concentration and energy expenditure.
- The matching of skills and challenges is necessary for satisfying experience.

Self-Actualization:

- Also called self-determination
 - Maslow's hierarchy of needs, to reach your potential
 - A peak experience.
 - physiological needs □ safety/security □ belonging □ self-esteem □ self-actualization
 - the central pervasive personal belief that an individual can exercise some control over his or her own functioning and over environmental events to reach some desired end;
 - Foundational to the individual's sense of competence and control.
 - Individuals with higher self-actualization believe their choices and actions will affect the outcome of a situation
 - Those with lower self-efficacy believe their choices and actions have little relationship to the outcome.
-

NCTRC Study Guide - Section Two: Practice of Therapeutic Recreation**Part A: Strategies and Guidelines****Concepts of TR****Holistic Approach:**

- Looks at the whole person & their needs.
- Recognizes & integrates multiple factors.
- Developed from a broad base of information.
- Integrated from an interdisciplinary frame of reference.

Recreational Experience:

- Everyone has a Right to recreate.
- Recreation as an end to itself.

Treatment Concept:

- Used as a treatment tool to cure
- To use Recreation to meet other needs/goals.

Special/Adaptive Recreation:

- In some cases, activities will need to be adapted or modified to accommodate clients with limitations
- Adaptive equipment may be utilized
 - o i.e. - Bradshaw bowl buggy – w/c designed for bowling
 - o <http://www.recreativeresources.com/linkadaptiveequipment.htm>
- Games may be modified by reducing the dimensions of the playing areas, simplifying the rules, etc.
- The best modification is the least modification.

Inclusive Recreation:

- Inclusive services enable people of varying abilities to participate and interact in life's activities together with dignity.
- Services include the concepts of:
 - o right to leisure
 - o quality of life
 - o support
 - o assistance
 - o accommodations
 - o barrier removal

- In some instances participation in community-based programs is initiated through specific inclusion practices or programs.
- Successful and full inclusion is dependent on two factors
 - 1.) The individual with the disability must have the activity skills as well as the interaction skills.
 - 2.) The service provider of recreation programs must view the involvement of individuals with limitations as part of their basic service responsibility

Inclusion Steps:

1. Address individual needs
2. Identify a source of funds
3. Identify support staff – close to same age
4. Provide training – method of adapting and dealing with behaviours

Models of TR Service Delivery

TR Service Delivery Model:

- Nature of service
- Planned interventions as well as leisure experience dimension
- Key element of determining whether an activity is an intervention or a leisure experience is not the nature of the activity, but the clients perception of the experience

1.) Leisure Ability Model (Gunn/Peterson):

- Client-oriented approach to TR
- The needs of the client determine the nature of programs provided
- Maximum control by specialist □ minimum control by specialist
- Four Steps:
 1. Assessment:
 - ID Problem, gather data
 2. **Functional Intervention/Treatment:**
 - Address functional abilities that are prerequisite to leisure involvement and lifestyle.
 - *Domains:* physical, mental/cognitive, emotional/affective and social functioning
 3. **Leisure Education:**
 - Focus on the development and acquisition of various leisure-related skills, attitudes, and knowledge.
 - An appropriate leisure lifestyle appears to be dependent on the acquisition of diverse knowledge and skills.
 - Utilizes an education model as opposed to a medical model
 - Four components (see part D – Leisure education)
 - 1) Leisure awareness
 - 2) Social interaction skills
 - 3) Leisure resources
 - 4) Leisure activity skills
 4. Recreation Participation/Leisure Lifestyle:
 - Part of the expression of leisure lifestyle
 - Examples of recreation participation are activities that:
 - 1) Require many participants and on administrative structure – leagues and tournaments
 - 2) Enjoyed in groups and are facilitated – dramatics, arts and crafts, music
 - 3) Require a specific facility or equipment – fitness and exercise, ceramics
 - 4) Self-initiated and self-directed – park, playground, swimming pool, drop-in center

2.) Health Improvement/Health Promotion Model (Austin):

- Purpose of TR is to enable the client to recover following a *threat to health* (health protection) and to *achieve optimal health* (health promotion)
- Use activity, recreation and leisure to help people deal with problems that serve as barriers to health and to assist them grow toward their highest levels of health and wellness.
- Stability tendency lessons as a client gains optimal health and moves towards actualization.
- Based on the humanistic assumption that human beings have an overriding drive for health and wellness
- Three Steps:
 - o **Prescribed Activity** - CTRS directed:
 - Health protection is prescriptive and exemplified by the stabilizing tendency that pushes clients to achieve health.
 - May be necessary in order to engage them so that they are not passive victims of their circumstances but begin to take action to restore their health.
 - o **Recreation** - Equal participation between client and CTRS:
 - Through recreation, client begins to regain their equilibrium so they may once again resume their quest for actualization.
 - In recreation, clients afford opportunities to experience control over their environments within a supportive, non-threatening atmosphere.
 - Moves away from stability tendencies □ towards actualization.
 - o **Leisure** - Client directed :
 - Leisure is self-directed by client
 - Intrinsically motivated, self-determined
 - Match between abilities and challenges
 - Can play a critical role in helping clients to actualize and move toward optimal health
 - Reaches actualization

3.) The Optimizing Lifelong Health through Therapeutic Recreation model

- Therapeutic recreation specialists work with individuals who have illness, disease, and/or lifelong disability to achieve and maintain leisure lifestyles that will enhance their health and well-being across the life course.
- Through the elements of
 - o selecting
 - o optimizing
 - o compensating
 - o evaluating

4.) Self-Determination and Enjoyment Enhancement:

- It is proposed that teaching participants in TR programs to experience enjoyment and to create environments conducive to enjoyment are important goals for TR service which also contribute to participants' functional improvements

4.) Aristotelian Good Life Model:

- Four major elements
 1. Afflictions and oppression
 2. Aristotelian goods
 3. Freedom
 4. Role of CTRS
- Easy to follow and accommodates a variety of clients and settings
- Using the Aristotelian Model
 - o What is the end goal/purpose?
 - o Underlying assumptions
 - o Theoretical bases

- o Direction for research and practice
- o Could you explain TR with this model
- o Could you design programs?

4.) Benefits Drive Model:

- Focuses on what participants will get out of a program
- Three approaches:
 - a) Quality of life
 - b) Human services
 - c) Marketing
- Four step process:
 1. Identify the problem issue and target goals (assessment)
 2. Determine activity components (plan and implement program)
 3. Document the benefit outcomes (evaluate)
 4. Spread the word about the positive results of the program

Mobily's Summary of Models:

Models are useful for:

- Detection of errors
- As mechanisms to accommodate new developments
- As means for improving the profession
- All seek to reconcile the strict therapeutic outcomes of the clinical setting with the unique modality of recreation activity
- Theoretical based.

Practice Settings

Different Therapeutic Recreation Practice Settings:

1. Hospitals
2. Long-term care/extended care
3. Centers – private/public for people with development disabilities
4. Correctional facilities – adult and youth detention centers
5. Mental health facilities – outpatient day care, community mental health centers, and public/private psychiatric facilities or units
6. Addiction treatment centers
7. Residential settings – group homes, half-way houses, assisted living and shelters
8. Physical rehab units
9. Hospice – end of life facilities
10. Public, not-for-profit recreation
11. Private, for-profit rehab and vocational centers
12. Schools – inclusionary services
13. Special residential schools – visual impairments, hearing impairments, emotional and behaviours disorders, etc.
14. Community based recreation/special education
15. Year round residential camps – individuals with emotional disturbances

Standards of Practice

National Therapeutic Recreation Society (NTRS) Standards of Practice:

- 1.) Scope of Practice
 - Development and implementation
 - Content
 - a) Treatment Services
 - b) Leisure Education Services

c) Recreation Services

- 2.) Mission and Purpose, Goals and Objectives
- 3.) Individual Treatment/Program Plan
- 4.) Documentation
- 5.) Plan of Operation
- 6.) Personnel Qualifications
- 7.) Ethical Responsibilities
- 8.) Evaluations and Research

Code of Ethics

National Therapeutic Recreation Society (NTRS) Code of Ethics:

1.) The Obligation of Professional Virtue:

Professionals possess and practice the virtues of integrity, honesty, fairness, competence, diligence, and self-awareness.

- **Integrity:** Professionals act in ways that protect, preserve and promote the soundness and completeness of their commitment to service. Professionals do not forsake nor arbitrarily compromise their principles. They strive for unity, firmness, and consistency of character. Professionals exhibit personal and professional qualities conducive to the highest ideals of human service.
- **Honest:** Professionals are truthful. They do not misrepresent themselves, their knowledge, their abilities, or their profession. Their communications are sufficiently complete, accurate, and clear in order for individuals to understand the intent and implications of services.
- **Fairness:** Professionals are just. They do not place individuals at unwarranted advantage or disadvantage. They distribute resources and services according to principles of equity.
- **Competence:** Professionals function to the best of their knowledge and skill. They only render services and employ techniques of which they are qualified by training and experience. They recognize their limitations, and seek to reduce them by expanding their expertise. Professionals continuously enhance their knowledge and skills through education and by remaining informed of professional and social trends, issues and developments.
- **Diligence:** Professionals are earnest and conscientious. Their time, energy, and professional resources are efficiently used to meet the needs of the persons they serve.
- **Awareness:** Professionals are aware of how their personal needs, desires, values, and interests may influence their professional actions. They are especially cognizant of where their personal needs may interfere with the needs of the persons they serve.

2.) The Obligation of the Professional to the Individual:

- **Well-Being:** Professionals' foremost concern is the well-being of the people they serve. They do everything reasonable in their power and within the scope of professional practice to benefit them. Above all, professionals cause no harm.
- **Loyalty:** Professionals' first loyalty is to the well-being of the individual they serve. In instances of multiple loyalties, professionals make the nature and the priority of their loyalties explicit to everyone concerned, especially where they may be in question or in conflict.
- **Respect:** Professionals respect the people they serve. They show regard for their intrinsic worth and for their potential to grow and change. The following areas of respect merit special attention:
 1. **Freedom, Autonomy, and Self-Determination:** Professionals respect the ability of people to make, execute, and take responsibility for their own choices. Individuals are given adequate opportunity for self-determination in the least restrictive environment possible. Individuals have the right of informed consent. They may refuse participation in any program except where their welfare is clearly and immediately threatened and where they are unable to make rational decisions on their own due to temporary or permanent incapacity. Professionals promote independence and avoid fostering dependence. In particular, sexual relations and other manipulative behaviors intended to control individuals for the personal needs of the professional are expressly unethical.

2. *Privacy*: Professionals respect the privacy of individuals. Communications are kept confidential except with the explicit consent of the individual or where the welfare of the individual or others is clearly imperiled. Individuals are informed of the nature and the scope of confidentiality.
 - **Professional Practices**: Professionals provide quality services based on the highest professional standards. Professionals abide by standards set by the profession, deviating only when justified by the needs of the individual. Care is used in administering tests and other measurement instruments. They are used only for their express purposes. Instruments should conform to accepted psychometric standards. The nature of all practices, including tests and measurements, are explained to individuals. Individuals are also debriefed on the results and the implications of professional practices. All professional practices are conducted with the safety and well-being of the individual in mind.
- 3.) **The Obligation of the Professional to Other Individuals and to Society:**
- **General Welfare**: Professionals make certain that their actions do not harm others. They also seek to promote the general welfare of society by advocating the importance of leisure, recreation, and play.
 - **Fairness**: Professionals are fair to other individuals and to the general public. They seek to balance the needs of the individuals they serve with the needs of other persons according to principles of equity.
- 4.) **The Obligation of the Profession to Colleagues:**
- **Respect**: Professionals show respect for colleagues and their respective professions. They take no action that undermines the integrity of their colleagues.
 - **Cooperation and Support**: Professionals cooperate with and support their colleagues for the benefit of the persons they serve. Professionals demand the highest professional and moral conduct of each other. They approach and offer help to colleagues who require assistance with an ethical problem. Professionals take appropriate action toward colleagues who behave unethically.
- 5.) **The Obligation of the Professional to the Profession:**
- **Knowledge**: Professionals work to increase and improve the profession's body of knowledge by supporting and/or by conducting research. Research is practiced according to accepted canons and ethics of scientific inquiry. Where subjects are involved, their welfare is paramount. Prior permission is gained from subjects to participate in research. They are informed of the general nature of the research and any specific risks that may be involved. Subjects are debriefed at the conclusion of the research, and are provided with results of the study on request.
 - **Respect**: Professionals treat the profession with critical respect. They strive to protect, preserve, and promote the integrity of the profession and its commitment to public service.
 - **Reform**: Professionals are committed to regular and continuous evaluation of the profession. Changes are implemented that improve the profession's ability to serve society.
- 6.) **The Obligation of the Profession to Society:**
- **Service**: The profession exists to serve society. All of its activities and resource are devoted to the principle of service.
 - **Equality**: The profession is committed to equality of opportunity. No person shall be refused service because of race, gender, religion, social status, ethnic background, sexual orientation, or inability to pay. The profession neither conducts nor condones discriminatory practices. It actively seeks to correct inequities that unjustly discriminate.
 - **Advocacy**: The profession advocates for the people it is entrusted to serve. It protects and promotes their health and well-being and their inalienable right to leisure, recreation, and play in clinical and community settings.

ATRA Code of Ethics:

- 1.) **Beneficence/No Maleficence:**

- Therapeutic Recreation personnel shall treat persons in an **ethical manner** not only by respecting their decisions and protecting them from harm but also by actively making efforts to secure their well-being.
 - Personnel strive to maximize possible benefits, and minimize possible harms.
 - This serves as the guiding principle for the profession.
 - The term “persons” includes not only persons served but colleagues, agencies and the profession.
- 2.) **Autonomy:**
- Respect for the individual’s **right to choice**
 - Therapeutic Recreation personnel have a duty to preserve and protect the right of each individual to make his/her own choices.
 - Each individual is to be given the opportunity to determine his/her own course of action in accordance with a plan freely chosen.
- 3.) **Justice:**
- Access to services must be available to all.
 - There must be fairness in distribution of service based on individual need
 - Therapeutic Recreation personnel are responsible for ensuring that individuals are **served fairly** and that there is equity in the distribution of services. Individuals receive service without regard to race, color, creed, sex, age, and disability/disease, social and financial status.
- 4.) **Fidelity:**
- Tell the truth, the whole truth and nothing but the truth
 - Therapeutic Recreation personnel have an **obligation to be truthful**, faithful and meet commitments made to persons receiving services, colleagues, agencies and the profession.
- 5.) **Veracity/Informed Consent:**
- Therapeutic Recreation personnel are responsible for providing each individual receiving service with **information regarding the service** and the professional's training and credentials; benefits, outcomes, length of treatment, expected activities, risks, limitations.
 - Each individual receiving service has the right to know what is likely to take place during and as a result of professional intervention.
 - Informed consent is obtained when information is provided by the professional.
- 6.) **Confidentiality and Privacy:**
- Always respect people’s privacy and always be confidential with regards to patient care
 - Therapeutic Recreation personnel are **responsible for safeguarding information** about individuals served.
 - Individuals served have the right to control information about themselves.
 - When a situation arises that requires disclosure of confidential information about an individual to protect the individual's welfare or the interest of others, the Therapeutic Recreation professional has the responsibility/obligation to inform the individual served of the circumstances in which confidentiality was broken.
- 7.) **Competence:**
- Continually take steps to attain, maintain and expand your competence in therapeutic recreation practice
 - Therapeutic Recreation personnel have the **responsibility to continually seek to expand one's knowledge base** related to Therapeutic Recreation practice. The professional is responsible for keeping a record of participation in training activities.
 - The professional has the responsibility for contributing to changes in the profession through activities such as research, dissemination of information through publications and professional presentations, and through active involvement in professional organizations.
- 8.) **Compliance with Laws and Regulations:**
- Therapeutic Recreation personnel are responsible for complying with **local, state and federal laws and ATRA policies** governing the profession of Therapeutic Recreation.

Part B: Assessment

Assessment:

- Identifying and obtaining data from many sources, data collection and analysis in order to determine problems &/or needs.
- First step in the therapeutic recreation process.
- Data collection and analysis in order to determine the status of the client.
- Aid us to determine client strengths, interests, and expectations and to identify the nature and extent of the problems or concerns.
- Primary source of info is the client.
- Secondary sources of info include: medical or education records, results of testing, interviews with family or friends, the social history (social worker), case recordings or progress notes that staff have charted, and conferences and team meetings with other staff.

Assessment Purposes:

- 1.) Identify Client Information: Problems
- 2.) Initial Baseline Assessment: Treatment Planning/Program Placement
- 3.) Monitor Progress: Formative Evaluation

Methods of Assessment/Assessment Implementation

Assessment Implementation Process:

- 1.) Review assessment protocol
- 2.) Prepare for assessment
- 3.) Administer assessment to client
- 4.) Interviews, observations, self-administered surveys, record reviews
- 5.) Analyze or score assessment results
- 6.) Interpret results for placement into programs
- 7.) Norm-referenced, criterion-referenced
- 8.) Document results of assessment
- 9.) Reassess clients as necessary/monitor progress

Standardized Assessment/Assessment Procedure:

- The consistent administration and reporting of participant data using formal and informal processes accepted by professionals at the particular agency.
- Including: MDS, LCM, LDM and agency developed instruments use to identify participants behaviours, abilities, strengths, skills and expectations.

Implementation of Assessment:

- 1.) Multi-disciplinary and a gathering of information:
 - Collect information on leisure interests
 - Do clients value leisure & recreation?
 - Do they value and understand it & what it means in their life?
 - Can they identify their own personal resources, talents, skills, interests, equipment & supplies?
 - Money, family, transportation likes & dislikes?
 - Can these skills be transferred to their present lifestyle?
 - Can they identify leisure partners?
 - Can they describe a healthy leisure lifestyle?
 - Do they have knowledge of leisure resources
 - Do they have the ability to make decisions and take responsibility for their leisure involvement?
- 2.) Assess how they function in a "normal" environment:
 - Self-initiating?
 - Needs encouragement to participate?
 - Who does client interact with?
 - How do others react to the client?
 - What is the nature of the verbal/no-verbal communications?

Error and Confidence:

- Reducing error
- All assessments scores have error
- Want to minimise so scores are accurate
- Protocols and periodic staff training/retraining
- Use assessments which produce valid, reliable, and usable results

Current TR/Leisure Assessment Instruments**1.) Measuring Attitude****Cooperation and Trust Scale (CAT):**

- High cognitive functioning clients
- Approx. ten mins to administer
- Usually used in a pretest/posttest protocol
- Used on adolescents in summer adventure program
- Purpose: to measure participants perceived level of trust and cooperation
- Self-report assessment
- Sample questions:
 - o Having a groups support makes many things easier to do.
 - o Cooperation is more enjoyable then competition in sports and games.
 - o Trusting others is often a mistake

Free Time Boredom:

- Reading level at 4th grade, high cognitive functioning
- Purpose: to identify the degree to which the participant is bored in the four components that make up boredom which include:
 - 1.) Meaningfulness: the patient has a focus or purpose during their free time
 - 2.) Mental Involvement: the patient has enough to think about and finds these thoughts emotionally satisfying.
 - 3.) Speed of Time: the patient has enough purposeful and satisfying activity to fill their time
 - 4.) Physical Involvement: the patient has enough movement to satisfy them.
- Sample questions:
 - o During my free time, I do not use a lot of my physical skills
 - o During my free time, it feels that time stands still

Idyll Arbour leisure Battery (IALB)

- Purpose: there are four separate testing tools. Each one measures a specific type of leisure attribute.
- Has an executive summary that shows interventions based on scores of each of the other assessments
- Has a summary of participants affect and mannerism during assessment.
- Includes:
 - 1.) Leisure Interest Measure
 - 2.) Leisure Satisfaction Measure
 - 3.) Leisure Attitude Measurement
 - 4.) Leisure Motivation Scale

Leisure Attitude Measurement (LAM):

- Originally known as Leisure Attitude Scale (LAS)
- Purpose: to identify attitudes towards leisure
- High cognitive functioning clients
- Self-report assessment
- Originally developed for research
- Three areas of leisure attitude:

1. Cognitive: general knowledge about leisure, beliefs about leisure, etc.
 2. Affective: evaluation of leisure experiences, liking of experiences, feelings toward leisure, etc.
 3. Behavioural: Intentions, current and past participation
- Sample questions:
 - Engaging in leisure activities is a wise use of my time.
 - Leisure activities are important.

Leisure Interest Measure (LIM):

- High cognitively functioning clients
- Purpose: to measure interest in the 8 domains of leisure activities
- Measures how much interest the client has in the 8 domains of leisure
- Includes: Physical, Outdoors, Mechanical, Art, Services, Social, Cultural and Reading.
- Sample questions:
 - I like to read in my free time
 - I prefer being outdoors
 - I like to create artistic designs in my leisure time

Leisure Motivation Scale (LMS):

- High cognitive function clients
- Purpose: To measure motivation for engaging in leisure activities:
- Four primary motivators:
 - 1.) Intellectual – extent to which the individuals are motivated to engage in leisure activities.
 - 2.) Social – this component measures the need for relationships and being valued by others.
 - 3.) Competence – assesses the extent to which individuals engage in leisure in order to achieve and competence.
 - 4.) Stimulus Avoidance – assesses the need to seek solitude or individual participation.
- Sample questions:
 - To learn about myself
 - To be with others
 - To expand my leisure interests

Life Satisfaction Measure (LSM):

- Originally known as Leisure Satisfaction Scale (LSS)
- Used for high cognitive functioning clients
- Self-report assessment
- Purpose: to measure degree client perceived general “needs” are being met through leisure
- Six categories of need:
 - 1) Psychological – sense of freedom, enjoyment, etc.
 - 2) Educational – intellectual stimulation, learning about self and surroundings
 - 3) Social – relationships with others
 - 4) Relaxation – relief from stress
 - 5) Physiological – physical fitness, stay healthy, control weight, etc.
 - 6) Aesthetic – view areas in which they engage in leisure as pleasing, interesting, beautiful, etc.
- Sample questions
 - My leisure activities are very interesting to me
 - My leisure activities help me relax

Leisure Diagnostic Battery (LDB):

- Probably most researched TR assessment
- Developed originally for in-school use
- First comprehensive battery of instruments designed to assess an individual’s “leisure functioning”
- Based on attribution theory, the term ‘leisure functioning’ describes how an individual feels about his/her

leisure experiences.

- Measures extent of *perceived freedom* in leisure & current level of leisure functioning; areas in need of improvement and impact of leisure services.
- Self-report assessment
- Long and short forms are available
- Used for people with and without disabilities
- The LDB consists of 8 components:
 - **Section 1: Perception of Freedom in leisure:**
 - 1) Perceived leisure competency scale
 - 2) Perceived leisure control scale
 - 3) Leisure needs scale
 - 4) Depth of involvement in leisure scale
 - 5) Playfulness scale
 - **Section 2: Barriers to Leisure:**
 - 6) Barriers to leisure involvement scale
 - 7) Knowledge of leisure opportunity test
 - 8) Leisure preference inventory

Leisurescope Plus and Teen Leisurescope Plus:

- Purpose:
 - To identify areas of high leisure interest.
 - To identify the emotional motivation for participation,
 - To identify individuals who need higher arousal experiences (risk takers).
- Used for adults and for adolescents
- Preferences are divided into 10 categories (game, music & art, adventure, etc.)
- Clients respond after viewing “collages” (pictures on cards or slides)
- Which do they like better?
- Validity & reliability studies reported

Life Satisfaction Scale (LSS):

- Clients with moderate to no cognitive impairment
- Purpose: to measure perceived satisfaction with life
- Self-report assessment
- Sample questions
 - I feel miserable most of the time
 - I never dreamed that I could be as lonely as I am now
 - I haven't a cent in the world

Measurement of Social Empowerment and Trust (SET):

- Purpose: to measure changes in perception of social attitudes and skills as a result of a treatment program or adventure
- Adolescents and adults with moderate to no cognitive impairment.
- Five subscales:
 - 1.) Bonding/Cohesion – see self as connected to group
 - 2.) Empowerment – able to influence people and events around person
 - 3.) Self-awareness – identify own feelings
 - 4.) Self-affirmations – ability to state beliefs and goals
 - 5.) Awareness to others – awareness of trust in others
- Sample questions:
 - At present I get along with others
 - Feel accepted by others
 - Understand how my actions affect others

2.) Measuring Function Skills:

Bus Utilization Skills Assessment (BUS):

- Clients with cognitive and/or physical impairment
- Purpose: to determine skills client has in relation to using public transportation.
- Determine if clients are cognitively and socially competent to use public transportation independently
- Two Sections:
 - 1.) Evaluations *functional skills* such as: appearance, getting ready, waiting for the bus, interaction with strangers, pedestrian safety, riding conduct and transfers
 - 2.) Evaluates *maladaptive behaviours* such as anxiety, depression, hostility, suspiciousness, unusual thought content, hallucinations, disorientation, etc.
- Uses detailed checklist and observation

Comprehensive Evaluation in Recreational Therapy (CERT – Psych/Behavioural, Revised):

- For psychiatric settings, short term or acute care.
- Also known as CERT- Psych/R
- Checklist based on observation
- Youth and adults with a developmental age of at least ten.
- Purpose: to identify and evaluate behaviours relevant to successfully integrate into society using appropriate social skills.
- Three performance areas:
 1. General:
 - Attendance, appearance, attitude toward recreation therapy, posture.
 2. Individual Performance:
 - decision-making ability, judgement ability, ability to form individual relationships, expression of hostility, performance in organized activities, performance in free activities, attention span, frustration tolerance, strength/endurance, etc.
 3. Group Performance:
 - Memory for group activities, response to group structure, leadership ability in groups, group conversation, etc.

Comprehensive Evaluation in Recreation therapy (CERT – Physical Disabilities)

- Adults in rehab/loss of function
- Purpose to establish baseline for functional skills related to leisure
- Reassessment of the same client helps to establish skill recovery or loss.
- Checklist based on observation
- Eight areas:
 - 1.) Gross motor function:
 - Neck control, weight bearing, right lower extremity movement, etc.
 - 2.) Fine motor function:
 - Right manual movement ability, right manual movement endurance, etc.
 - 3.) Locomotion:
 - Wheelchair maneuverability, transfer ability, ambulatory ability, etc.
 - 4.) Motor Skills:
 - Fine motor coordinator, gross motor coordination, recreation time, etc.
 - 5.) Sensory:
 - Ocular pursuit, depth perception, auditory acuity, etc.
 - 6.) Cognitive:
 - Judgement/decision making ability, attention span, memory, orientation, etc.
 - 7.) Communication:
 - Verbal expressive skills, verbal receptive skills, written receptive skills, written expressive skills, etc.

8.) Behaviour:

- Adjustment to disability, social interaction skills, frustration tolerance level, emotions.

FOX:

- *The Activity Therapy Social Skills Baseline*
- Individuals with a primary or secondary diagnosis of dementia, MR/DD, or brain injury
- Developmental level of approx. 6 months - 4 years.
- Purpose: to evaluate the clients relative level of skill in the social/affective domain
- Most of the skills included in this assessment are important building blocks to development of a mature leisure lifestyle.
- Divided into 12 levels of ability, the lowest being Social Level I.
- Six areas of abilities Include:
 - The clients reaction to others
 - The clients reaction to objects
 - The clients seeking attention from other to manipulate the environment
 - The clients interaction with objects
 - The clients concept of self
 - The clients interaction with others

Functional Assessment of Characteristics for TR (FACTR):

- Original population was adults in VA hospitals (rehab, psych, geriatric, hospitals, etc.)
- Can be used as an initial screening for most populations
- Purpose: to assess basic functional skills, see if client qualifies for services and to identify the area most likely to improve with services.
- Examines functional skills for leisure involvement
- Use of chart review and observations
- Three domains:
 1. Physical:
 - 11 areas including: Sight/vision hearing, ambulation, general coordination, etc.
 2. Social/emotional:
 - 11 areas including: dyad, small group, competition, conflict/argument, etc.
 3. Cognitive:
 - 11 areas including: orientation, receptive language, attending and concentrating, long-term memory, etc.

Functional Fitness Assessment for Adults over 60yrs:

- Seniors with limited disabilities
- Purpose: to determine the functional capacity of older adults in six areas of function relative to established ego and sex-related norms.
- Measures six areas including:
 1. Body Composition
 2. Flexibility
 3. Agility/Dynamic Balance
 4. Coordination
 5. Strength/Endurance
 6. Endurance

Functional Hiking Techniques:

- Appropriate for any client group who is ambulatory and has cognitive disabilities.
- Purpose: to determines ability to demonstrate skills to hike independently.
- Measures ability to:
 - Select appropriate attire
 - Demonstrate pacing patterns
 - Demonstrate uphill/downhill techniques

- o Demonstrate techniques to move under obstacles
- o Demonstrate techniques to move over obstacles

General Recreation Screening Tool (GRST):

- Written for clients with MR/DD
- Purpose: Measures general developmental level of the client in 18 areas related to leisure.
- Takes approx. 15 mins to score after observing the patients in two or more activities.
- Measures 18 areas of leisure including:
 - o gross/fine motor
 - o hand-eye
 - o play behaviour
 - o language use
 - o following directions
 - o problem solving
 - o emotional control
 - o people skills
 - o etc.

Idyll Arbour Activity Assessment:

- Intake assessment form for long-term care/nursing homes
- Written to meet Omnibus Budget Reconciliation Act (OBRA) regulations
- Helps complete MDS
- Purpose: to obtain information to develop a treatment plan
- Chart review, observation, interview
- Five sections:
 1. Personal and medical history
 2. Leisure interests
 3. Leisure history
 4. Individual performance/social strengths
 5. Maladaptive behaviours

Inpatients Rehabilitation Facility – Patient Assessment instrument (IRF-PAI)

- Completed by numerous members of the interdisciplinary treatment team
- Summary assessment
- Inpatient rehab unit or hospital including: stroke; brain dysfunction; neurologic conditions; spinal cord dysfunction, Non-Traumatic/Traumatic; amputation; arthritis; pain syndromes; orthopedic disorders; cardiac disorders; pulmonary disorders; burns; DD and medically complex conditions.
- Purpose: to gather data to determine the payment of each Medicare Part A fee-for-service patients admitted to an inpatient rehab unit or hospital
- Measures what the client with a disability actually does, not what she ought to be able to do.
- Similar to long-term care
- Uses FIM in clinical section

Leisure and Social/Sexual Assessment (LS/SA)

- Developed for adolescents and young adult clients who are diagnosed as having MR/DD or other disabilities that cause a person to struggle with appropriate social behaviours and appropriate social interactions.
- Purpose: to provide the therapist with a tool to assess the breadth and depth of a participant's understanding of appropriate social and sexual roles
- Three sections:
 1. Basic personal data
 2. Structured interview - Explore understanding of activities/leisure
 3. Structured interview - Explore understanding of dating, marriage and sexuality

Recreation Early Development Screening tool (REDS):

- Individuals with severe/profound MR or severe DD who function less than 1 year of age
- Was designed for adults
- One of the few TR assessment for clients who are extremely disabled
- Purpose: to assess developmental level.
- Tests development levels 0-1 months to 8-12 months
- Observation
- Measures five areas:
 1. Play
 2. Fine motor
 3. Gross motor
 4. Sensory
 5. Social/cognition

School Social Behaviour Scale (SSBS):

- Youth ages 5-18 in school or treatment settings
- Purpose: to measure social competence and antisocial behaviour
- Identify students who are behaviourally at-risk and who could benefit from prevention/intervention
- Measures:
 1. Social Competence:
 - Interpersonal skills, self-management skills and academic skills
 2. Antisocial Behaviours:
 - Hostile-irritable, antisocial-aggression, and disruptive demanding

The Social Attributes Checklist – Assessing Young Children’s Social Competence

- Preschool or elementary school age children, with and without disabilities
- Purpose: to measure social behaviour related to developmentally appropriate social competence
- Research show if children do not have minimal social competence by age six they have a high probability of being at risk
- Observation
- Three areas:
 1. Individual attributes:
 - Usually in positive mood, usually copes with rebuffs adequately, shows capacity to empathize, etc.
 2. Social skills attributes:
 - Approaches others positively, is not easily intimidated by bullies, takes turns fairly easily, etc.
 3. Peer relationship attributes:
 - Usually accepted versus neglected or rejected by other children, is named by other children as someone they are friends with or like to play and work with, etc.

Therapeutic Recreation Activity Assessment (TRAA)

- Clients with TBI, DD, Psychiatric disabilities, or receiving supported care like residents of a nursing home, group home, adult daycare center, or assisted living facility
- Best for people who have severe mental illness
- Purpose: to assess basic functional skills as demonstrated in a group setting
- Also has a protocol for assessing clients with significant impairments
- Uses interviews and a series of activities
- Measures six areas:
 1. Fine motor skill
 2. Gross motor skill
 3. Receptive communication

4. Expressive communication
5. Cognitive skills
6. Social behaviours

Comprehensive Visual Neglect Assessment (CvNA):

- Clients with right CVA with left neglect.
- Purpose: to measure density and scope of visual neglect
- Uses a dart board

3.) Measuring Participation Patterns

Assessment of Leisure and Recreation Involvement (LRI):

- Individuals with moderate or no cognitive impairments
- Purpose: to measure perception of involvement and not just participation
- Self-report assessment
- Six cognitive/emotional elements that influence actual participation in activity:
 - 1.) Importance of activity
 - 2.) Pleasure derived from activity
 - 3.) Interest in activity
 - 4.) Intensity or absorption in activity
 - 5.) Centrality to perception of self
 - 6.) Meaning of activity
- Sample questions
 - My favourite activities give me pleasure
 - My leisure activities give me a sense of value in my life

Leisure Assessment Inventory (LAI):

- Developed for seniors and adults with DD
- Also appropriate for middle-ages and older adults with moderate to no cognitive disability.
- Purpose: to measure the leisure behaviour of adults
- Assess participation
- Four Subscales including:
 - 1.) Leisure Activity Participation Index (LAP) – measure of activity involvement
 - 2.) L-PRED Index – measure of leisure activities in which the individual would like to increase participation.
 - 3.) Leisure Interest (L-INT) Index – measures degree of unmet leisure involvement
 - 4.) Leisure Constraints (L-CON) Index – assesses the degree of internal/external constraints that inhibit leisure participation.

Leisure Step-Up:

- Assessment and leisure education program
- Wide variety of populations
- Most appropriate for psychiatric adults and adolescents in behaviour med. or substance abuse units.
- Can also be used with physical/developmental disabilities and long-term care homes
- Built on Nash's model of hierarchy
- Uses pictures geared for adults 50 and older
- Four subscales:
 1. Leisure activity participation index – reflect leisure repertoire, measures of involvement
 2. Leisure preference index – activities persons would like to [participate in
 3. Leisure interest index - unmet involvement
 4. Leisure constraints – internal and external constraints
- *Leisure level model steps:*
 1. *Assessment*

2. *Identify problem*
3. *Understanding healthy leisure*
4. *Experience healthy leisure participation*
5. *Unresolved issues of past and relationship between leisure and what is going on at the time*
6. *Planning the future*
7. *Opportunities to observe leisure activities*
8. *Arts, crafts, music, drama, dance and home activities*
9. *Exercise, games, sports, physical activities and health*
10. *Education, cultural, volunteering, collecting and service to others*
11. *Therapist offers congratulations and states participant is ready to participate in own activities of their own choice – discharge*

State Technical Institute's leisure Assessment Process (STILAP):

- Adults with physical disabilities
- Measures general scope of leisure activity skills in order to provide a basis for program decision making regarding a more balanced & leisure skill repertoire.
- Fourteen competencies including: physical skill that can be done alone, activity dependent on some aspect of the outdoor environment, etc.

Recreation Participation Data Sheet (RPD):

- Way to monitor the balance of leisure activities offered to clients living in group homes to ensure that staff offer an appropriate mix of activities
- More a method of documenting participation than an assessment
- Purpose: to monitor client's involvement in leisure activities
- Areas: participation, initiation, independence, physical output, satisfaction, average size of groups and average time spent in activities.
- Has a supplemental physical activity sheet to monitor physical activity

4.) Community Integration Program

- Any population that needs to regain the ability to use community resources, including but not limited to patients with physical disabilities, DD, psychiatric disorders, head injuries and youth at risk.
- Purpose: to give the TRS a standardized tool to measure many different aspects of a patient's knowledge and functional skills related to accessing community resources
- The CIP measures the knowledge and skills required for using resources within the community
- Each module measures different aspects of knowledge and skills required for integration.
- The CIP is one of the most powerful tools for the TRS because it provides the therapist with the ability to help the patient and treatment team gauge how well the patient will function after discharge
- Helps measure the patient's ability to implement new skills and knowledge gained during treatment
- Whole manual is 321 pages.
- Three basic steps
 - 1.) Pretest – walk/talk steps before do
 - 2.) Field Trial – demonstrate skills in community
 - 3.) Posttest

5.) Interdisciplinary Assessments

Resident Assessment Instrument (RAI):

- Interdisciplinary assessment and care planning process
- Used in long-term care
- Computerised
- Used to assess, reimburse and quality assurance
- Summary assessment

- Identifies: needs, strengths, preferences, description of functional skills, directs content of care plan
- Identifies need for further assessment
- T1a = Recreation Therapy
- Basic components:
 - 1.) Minimum Data Set (MDS):
 - Mandated by the Omnibus Reconciliation Act (OBRA) of 1987 to ensure that all nursing home residents were assessed, provided with services, and monitored on a regular basis.
 - The MDS has undergone several changes in the past few years, with the last one occurring in the summer of 1998.
 - As of July 1, 1998 the Prospective Payment System began and Section T. was added to the MDS, which requires the reporting of Recreational Therapy treatment services under Section T. 1a.
 - HCFA is currently collecting statistical data on the use of recreation therapy through Section T. 1a. To evaluate for future reimbursement rates.
 - The MDS documents the number of days and total minutes of recreation therapy administered during the past seven days.
 - Recreation Therapy is considered a rehabilitation treatment option, and must be provided by a qualified provider (a certified therapeutic recreation specialist or a certified therapeutic recreation assistant under the supervision of a therapist).
 - The scope of intensity, duration, and service provided must be within the physician or nurse practitioner's prescription. If recreation therapy is ordered, it is considered medically necessary and appropriate, and therefore, the facilities' obligation to provide the service for their residents.
 - If the facility does not employ a certified therapeutic recreation specialist, the facility is required to contract for this service.
 - 2.) Triggers:
 - Scores that indicate the need for further assessment in one of more the 18 areas of more in-depth assessment.
 - 3.) Resident assessment Protocols (RAPs):
 - Assessment protocols that provide guidelines for further assessment by the triggers
 - 4.) Resource Utilization Guidelines
 - 5.) Prospective Payment systems
 - 6.) Quality Indicators

Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI):

- Completed by various members of interdisciplinary team
- Summary assessment
- Professionals first assess functional needs using another assessment and then summarized findings on this document
- Clients in inpatient rehabilitation unit or hospital
- FIM is part of this summary
- Used to determine payment for Medicaid

Functional Independence Measure (FIM):

- Not a standardized testing tool
- Included as part of the in-client rehabilitation facility client assessment instrument
- An 18-item, 7-level ordinal scale.
- 7 level scale ranging from dependence to independence
- 126 indicated independence, while a score of 18 indicated full dependence
- It is the product of an effort to resolve the long-standing problem of lack of uniform measurement and data on disability and rehabilitation outcomes.
- Areas include: eating, grooming, bathing, dressing, problem solving, etc.

- Used in rehabilitation
- Basic indicator of severity of disability
- Can be administered quickly and to groups

Global Assessment of Functioning (GAF):

- Scale in a managed care environment
- Behaviours health (psychiatry/substance abuse)
- Looks at overall functioning
- Continuum from psychiatric illness to health
- Scale 1 (sickest) to 100 (healthiest)
 - o 81-90/91-100 = positive mental health
 - o 31-70 = most outpatients
 - o 1-40 = most inpatients
- Areas include: psychological impairment, social skills, dangerousness, occupational skills, substance abuse

Pain Scale:

- There are a variety of scales
- In 2001 JCAHO required that all professionals working with clients, including TR need to complete a pain assessment.

Other Inventories and Questionnaires

Leisure Activity Blank (LAB):

- Measures past leisure participation & intentionality of future involvement
- Three point rating scale
- Leisure participation categories include:
 - o Mechanics, Sports, etc.
 - o Past involvement = 6 categories
 - o Future = 8 categories

Leisure Barriers Inventories (LBI):

- Examines leisure barriers in eight categories: time, money, transportation, partners, etc.
- Client responds to 48 items on 3 point scale (agree - don't know - disagree)

Recreation Behavior Inventory (RBI):

- To assess clients cognitive, sensory and perceptual motor skills as prerequisite to leisure participation.
- 87 behaviors to be observed during 20 activities, rated on a 3 point scale.
- Intended for children but, reportedly used in psychiatric and long term care settings.

Identify Resource Utilization Guidelines (RUGS III):

- Summary of scores and places in 1 of 7 tx groups or categories
 1. Rehab
 2. Extensive services
 3. Special care
 4. Clinically complex
 5. Impaired cognition
 6. Behaviour problem
 7. Reduced physical function

Mini-Cognitive Test:

- Assess dementia by having patients remember and repeat three common objects and draw a clock face indicating a particular time

Mini-Mental State Examination (MMSE):

- Assesses dementia through a series of tests, including remembering the names of three common objects, counting backwards, naming, providing location, copying shapes and following directions.

Digit Repetition Test:

- Assesses attention by asking the patient to repeat two numbers, then three, then four and so on

The Confusion Assessment Method (CAM):

- Used to assess delirium, not dementia
- Part one is an assessment instrument that screens for overall cognitive impairment.
- Part two includes only those four features that were found to have the greatest ability to distinguish delirium or reversible confusion from other types of cognitive impairment.

Timed Up and Go test (TUG):

- Used to assess a person's mobility and requires both [static and dynamic balance](#).
- Uses the time that a person takes to rise from a chair, walk three metres, turn around, walk back to the chair, and sit down.
- During the test, the person is expected to wear their regular footwear and use any [mobility aids](#) that they would normally require.
- The TUG is used frequently in the elderly population, as it is easy to administer and can generally be completed by older adults.

Functional Vision Assessment (FVA):

- Children who have low vision
- An assessment of how a child uses the vision he or she has in everyday life, so it is usually not done with children who are totally blind or have light perception only.
- Since a child's visual condition and abilities can change over time, the functional vision assessment needs to be repeated periodically.
- A functional vision assessment will investigate how a child uses his/her vision for near tasks:
 - closer than 16 inches intermediate tasks
 - 16 inches to 3 feet distance tasks
 - more than 3 feet away

Pure Tone [Audiometry](#) (PTA):

- Key [hearing test](#) used to identify [hearing](#) threshold levels of an individual, enabling determination of the degree, type and configuration of a [hearing loss](#).
- PTA is a subjective, behavioural measurement of hearing threshold, as it relies on patient response to [pure tone](#) stimuli.
- PTA is used on adults and children old enough to cooperate with the test procedure

Norm-referenced Test:

- samples the client's attitudes or functional ability and then compares the client's scores against the scores received by the general population
- compare a client to a reference group with similar characteristics

Other Sources of Assessment Data

- Medical Records: information on physician's examination reports and the client's medical history.
- Educational Records: academic skill, sensory modes for most effective learning, etc.
- Testing: objective data about client.
- Interviewing family and friends: knowledge about the clients past leisure interests and behaviours
- Social History: normally completed by the social worker
- Progress notes: written by various staff

- Treatment teams: formal and informal sharing or information
- Visiting the client's home/community: what is accessible to the client in their home community?

Criteria for Selection/Development of Assessment

Reliability:

- Used to indicate the probability that, given similar conditions, similar results will be achieved
- If research is reliable it should be able to be applied to similar target populations with similar outcomes
- Scoring consistency with different CTRS's

Types of Reliability:

- 1.) **Test-retest:** measures the same subjects with the same instruments at different times.
- 2.) **Alternative-form Method** (multiple-form): compares results from two forms of the same measuring tool.
- 3.) **Split-half Method:** the measuring tool is divided in half, and the results from each half are compared
- 4.) **Interobserver reliability** (interrater reliability): two observers use the same method of measurement and compare results.
- 5.) **Intraobserver reliability** (intrarater reliability): a single observer compares results gathered at different times.
- 6.) **Internal Consistency:** a measure of how consistently participants respond to items in the testing instrument. Useful when a test measures a single variable.

Equivalency:

- Also known as parallel-form or alternative form reliability
- Include following components:
 - o How closely correlated are two or more forms of the same assessment?
 - o Two forms have been developed and demonstrated to measure the same construct
 - o Forms have similar but not the same items
 - o Short and long forms are not equivalent

Validity:

- describes how well the assessment results match their intended purpose
- Ability to measure as intended
- Are you measuring what you think you are measuring?
- Relationship between programs and assessment content?

Types of Validity:

- 1.) **Construct Validity:** use of an outside, objective opinion to determine whether something is valid.
- 2.) **Internal Validity:** represents a causal relationship which can be tested to determine that the program is responsible for the change that is being measured.
- 3.) **External Validity:** the extent to which the results of a program can be applied to similar groups.

Threats to Validity:

- Assessments should be valid for intended use
- Unclear directions
- Unclear or ambiguous terms
- Too few/many items
- Method of administration
- Testing conditions
- And subjects health, reluctance and attitudes

Criterion-Related Validity:

- +1 or -1 is a perfect relationship
- 0 = no relationship

- $R = -.40$ to $= -.70$ acceptable range
- Two types:
 - 1.) Predictive - the effectiveness of one set of test or research results as a predictor of the outcome of future experiments or tests - (extended period of time)
 - 2.) Concurrent - applies to validation studies in which the two measures are administered at approximately the same time - (Immediate)

Stability (test-retest) Basics:

- How stable is the assessment?
- Was it influenced overly by the passage of time?
- Same group assessed two times with the same instrument and results of the two tests are correlated
- Are the two tests scores alike?
- Time effects (Longer/shorter)

General Assessment Concerns:

- Lack of high quality assessments
- Validation problems
- Use of assessments for purposes not validated
- Lack of assessment resources
- Cost of assessments
- Specialist competence
- Lack of protocols (i.e. developments, conduct, score, interpret)
- GIGO = garbage in, garbage out

Observation and Interview Techniques

Observation:

- Casual:
 - o Type of non-systematic observation in which we engage on a daily basis.
 - o It is responding to our environment in a somewhere random fashion and out of our personal bias and background.
 - o Not skilled, directed or purposeful.
- Skilled:
 - o Carefully completed in an organized manner and are as free as possible from personal bias.
 - o Knowing what to look for & what to expect, learn to disregard irrelevant information.
 - o Unobtrusive so as not to alter or change client's behaviours.
- Naturalistic:
 - o No attempt to manipulate or change natural environment.
 - o Keeping an on-going account of the client's behaviour through written anecdotal notes
 - o What to look for while completing observations:
 - 1) General appearance
 - 2) Motor activity
 - 3) Interpersonal interaction
 - 4) Body language
 - o Areas of observation: Personal appearance, posture & movement, manner, facial expressions, general level of activity, intentional activity, cognitive ability, communication.
- Specific Goal Observation:
 - o Assess a well-defined behavior.
 - o Might include observing an adult playing a card game or observing an adolescent square dancing. These activities make certain cognitive, psychomotor, or social demands on the client.
 - o Role playing – client is told to act as though he/she normally would in the situation
- Standardized Observation:
 - o Two major forms:

- 1.) *Standardized or norm-references instrument* – measure of how an individual performs in relation to others who are from the same classification of persons.
- 2.) *Criterion referenced tests* – measures achievement toward some established standard.

- o Reliability: produces stable results over time
- o Validity: measures what it is designed to measure

- **Duration Recording:**

- o When you are interested in how long a behavior occurs, you record the amount of time that the client displays the behavior.

- **Interval Recording:**

- o Indicates how frequently a behavior is displayed during a specified time interval.

- **Continuous Recording:**

- o When the therapist records both the beginning of the behavior and the end of the behavior, it is called

Anecdotal Records:

- Provide factual description of actual behaviour in natural situations that are significant indicator of total behaviours
- Allows recording in non-standardized form
- *Issues:*
 - o Can be time consuming
 - o Hard to be objective
 - o Difficulty in deciding level of detail to record
- *Techniques:*
 - o Determine in advance what to observe
 - o Develop procedures for coding
 - o Train observers

Interview:

- The interview has three purposes:
 1. Opportunity to gain information from the client and to observe the client
 2. Begin to develop a relationship, or gain rapport with the client
 3. Orientation to the program or programs available to the client
- Areas for information seeking during interviews:
 1. Readiness for treatment
 2. Degree of rationality
 3. Relationship with others
 4. Resources for support
 5. Leisure related problems
 6. Leisure values
 7. Awareness of leisure
 8. Basic skills needed to develop leisure skills
 9. Leisure history
 10. Appearance
 11. Other problem areas

Interview Techniques:

- Need to be consistent
- Conduct interview in a quiet, private and comfortable environment
- Introduce self
- Introduce therapeutic recreation services
- Establish rapport

- Determine strengths and weaknesses
- Close interview
- Specific Techniques include:
 - Open-ended questions
 - Closed ended-questions
 - Reflection
 - Facilitation
 - Silence
 - Confrontation
 - Clarification
 - Interpretation
 - Summation
 - Transition
 - Self-Revelation
 - Positive reinforcement
 - Reassurance
 - Advice

Other Techniques:

- **Probing** is a question that is directed toward yielding information in order to gain empathetic understanding. Probes are open-ended questions requiring more than a yes or no reply. The purpose of the confronting response is to assist the client to achieve congruency in what he or she says and does, to help him or her be fully aware and honest in gaining self-understanding.
- **Confrontation** involves “telling it like it is,” without being accusatory or judgmental.
- **Informing** transpires when objective and factual information is shared with the client.
- **Self-disclosing** allows personal disclosure on the part of the helper with the intent of providing the client with an opportunity to perceive the helper as another human being who has encountered situations, thoughts or feelings similar to those faced by the client.

General Interview Guide:

- Open ended questions
- Singular questions
- Clarity of questions
- Avoid why?
- Neutral vs. biased questions
- Leisure interest instruments – normally checklist format
- Five open ended questions:
 1. What do you enjoy (past/present leisure interests)
 2. What about that do you enjoy (characteristics of pursuits that are enjoyed)
 3. Recently what has brought you enjoyment/happiness to your day? (current leisure status)
 4. What is stopping you from enjoying _____? (or some of those activities/i.e. barriers)
 5. Is there something that you have always wanted to do? (dreams)

Interview Guidelines:

- List of questions/issues to be explored
- Obtain basically the same information in each interview
- Topics are listed, but interviewer can probe
- Useful in group interviews

Subjective Data: what “client” tells you

Objective Data: anything else you or others observe

Part C: Documentation

Impact of Impairment and/or Treatment on the Client

- Side effects of medication
- Medical precautions:
 - Intervention should always include adequate assessment procedures and approval of a physician prior to initiating the program, and the specialist should receive sufficient training to qualify him or her as an exercise leader.
 - When designing an exercise program for people with disabilities, a TR specialist can explore the various considerations involved in making adaptations.
 - four examples of considerations recommended for exploration:
 - (a) Determine resting heart rates
 - (b) Calculate maximal and target heart ranges
 - (c) Complete isolated arthritis stretching exercise
 - (d) Participate in a chair aerobics activity.”
- Mood = emotional state
- Affect = the outward expression of the emotional state

Facial Expressions:

- Flat affect = none
- Broad affect = wide range
- Blunted = little, very slow
- Inappropriate = range, but inconsistent and inappropriate
- Restricted= one type

Interpretation/Documentation of Assessment

Client Documentation:

- A large part of being accountable is documenting what happens to the client as a result of involvement in the program.
- “If it is not written down, then it did not happen.”
- Includes:
 - Assessment summaries
 - Treatment or program plans
 - Progress notes
 - Discharge/referral summaries.
- Document connections between program goals, client goals, and client program involvement and client outcomes.
- In all cases, documentation and written records should focus on client behavior, rather than the specialist’s perceptions or guesses.
- In each case, the specialist is responsible for selecting the most significant aspects of client behavior for documentation

Principles of Quality Client Documentation:

- 1.) Consistency and Accuracy of Information** – must be accurate, objective and consistent
 - *Objectivity*: only info that is factual and objective.
 - *Accuracy*: needed in correct spelling, grammar and punctuation
 - *Behavioural Language*: focus on clients behaviour, descriptive action words and meaningful language
 - *Consistency in Information*: client to client, and between clients and specialists
- 2.) Conciseness in Client Documentation** – short, succinct sentences are recommended, also consistent
- 3.) Clarity in Client Documentation** – using meaningful phrases and making sure it is clear to the reader
 - *Meaningful phrases*: descriptive, behavioural terms
 - *Technical Guidelines*: legible and written with ink, only approved abbreviations

- o *Mistaken entry*: simply cross out the word with a single horizontal line, write “error” and initial/date it.
- o *Signing notes*: every note should be signed with professional credentialing (i.e. CTRS)
- o *Abbreviations*: only ones approved by agency
- *Writing styles*: inappropriate wording (i.e. a lot of = many, several), absolutes (i.e. all the time = frequently), redundant phrases (i.e. necessary requirements = requirements)

Charting Methods - Four Major types:

1.) Narrative Format

Source Oriented Medical Records (SOMR):

- Each professional group or source typically keeps data separate from the other professional groups or sources
- Separates recordings according to discipline
- Sections of the chart are designated for medical notes, nursing notes, TR notes etc.
- + Side = easier for each discipline to record all data in one place
- - Side = places data in too many locations making it fragmented & cumbersome to retrieve data & more difficult for a team approach.
- Unstructured
- The following need to be included:
 - a) Change in patients condition
 - b) Patients response to treatment or medication
 - c) Lack of a change in condition
 - d) Patient or family members response to teaching

2.) Problem Oriented

Problem Oriented Medical Record (POMR):

- Organized around the client’s problems rather than source of data:
- Is a comprehensive evaluation
- Five parts:
 - 1) *Data base*: data collected during assessment
 - 2) *Problem list*: analysis of data base establishes a problem list, in numbered order with date.
 - 3) *Initial plan*: outlines an approach to be used to meet each of the identified problems.
 - 4) *Progress notes*: record the results of interventions/client progress. Using SOAP, SOAPIE or SOAPIER forms
 - 5) *Discharge summary*: noting problems and resolutions

Subjective, Objective, Assessment and Plan (SOAP):

- Daily progress report in the patients chart
- Should express:
 - o Any changes in the patient’s symptoms and complaints?
 - o Current physical findings? Any changes?
 - o New developments
 - o Current formulation and plan for the patient
- Can write a SOAP(IE) progress note:
 - Subjective data**: gathered from client
 - o Example: stated feelings.
 - Objective data**: based on observation & other sources
 - o Example: engaged in activity for 40 minutes.
 - Assessment**: conclusions based on data review
 - o Example: anxiety level is slowly decreasing & there appears to be an inability to express feelings.
 - Plan**: plan believed to resolve the problem

- o Continue plan as outlined in initial plans.
- Interventions: specific intervention implemented
- Evaluation: Patient's response to interventions
- Revision: changes made from the original treatment plan

3.) Focus Charting (DARP):

- Method for organizing information in the narrative portion of the client's record to include data, action and response for each identifies concern.
- Client-centered approach to documentation
- Utilizes a column format
- Advocates state the "Focus" is much more comprehensive then "Problem"
- Focus = current concern or behaviour, or a significant event in client status
- Includes four categories:
 1. Data – subjective and/or objective information supporting the stated focus or describing observations at the time of significant events
 2. Action – a description of the actions taken by the therapist in the form of interventions or programs
 3. Response – a description of the client's response to the interventions, activities, or situation. It can include a statement that treatment plan goals have been attained. Client outcomes are included in this section
 4. Plan – next interventions to be implemented

4.) Charting by Exception (CBE)

- Purpose is to make trends in patient status more obvious, reduce the amount of time spend in documentation, and make current information about the patients status readily available.
- Only findings that are significant, abnormal or that deviate from professional standards or protocols are recorded.
- Contains several components:
 - o Flow sheets
 - o Documentation referencing standards
 - o Protocols and incidental orders
 - o A database
 - o Diagnosis-based care plan
 - o SOAP (IER) progress notes

Other Methods of Charting:

- Problem-Intervention-Evaluation (PIE)
- FACT
- Core
- Outcomes

Discharge/Transition Plan:

- Usually the final component included in the clients record
- Some agencies use SOAP (IER) format while other prefer a more narrative summary or a combined narrative- standardized form.
- "Begin making plans for discharge the day the client is admitted."
- Summary of the client's involvement and progress within the therapeutic recreation programs.
- The following are suggestions of info included in a discharge summary:
 - o Major client problems or goals
 - o Services received by the client
 - o Clients response to functional interventions, leisure education and recreation participation services
 - o Remaining problems or concerns

- o Plan for post-discharge leisure involvement

Methods of Writing Measurable Goals and Behavioural Objectives

- Included in treatment plans - only measureable goals and objectives

Client Goals:

- General objectives
- Broad in nature and may be contrasted with objectives
- Proposed changes in the individual or their environment
- A broad statement of desired behaviour that the participant will demonstrate
- Set in a positive term; sense of direction
- i.e. increase social interaction with others

Client Objectives:

- Specific behavioural objectives
- Describe proposed changes in the individual client or in the client's environment.
- States what the participant will do
- A statement that describes an outcome
- A course of action to meet a goal
- Clear and descriptive of observable behaviour
- Written in terms of participants behaviour
- Narrowly written and deal with very specific, objective and measureable behaviours.
- i.e. initiates conversation with others during social recreation activities without staff prompting
- most common type is behavioural objectives because they translate into client outcomes

Behaviour Objectives:

- Contains three parts:
 1. **Behaviour:** a specific behaviour to be demonstrated by participant - verb
 2. **Condition:** when and where the behaviour will occur - a given or a restriction
 3. **Criteria:** the measureable outcome how well must it be done, correctness, time span, percentage, what is acceptable or successful performance
 - The criterion in the behavioral objective delineates the exact amounts and nature of the behavior that can be taken as evidence that the objective has been met.
 - A criterion is a precise statement or standard that allows individuals to make judgments based on the observable, measurable behavior
- I.e. after ten lessons (condition) the participant will swim (behaviour) one length of the pool (criteria).

Performance Objectives:

- o Four Behavioral Domains:
 1. Cognitive: intellectual processes of learning or knowing learning capability; decision making; follows directions, short term memory, problem solving, concentration/attention span, attention to details.
 2. Psycho/Social: psychological & social functioning; Independence, ability to form relationships, frustration tolerance, self-concept, evaluate and value oneself.
 - Engagement: 1st phase of social interaction
 - Affect: outward expression of feeling
 - Social appropriateness: manners, etiquette, hygiene, & dress
 - Social anxiety: confidence, competent, appear to be anxious, tense
 - Communication skills, relationship skills and self-presentation skills
 3. Physical: Physical functioning in the environment
 - Overall coordination: functioning of sensory system & body parts
 - Activity level: intensity of sensory system & body parts
 - Strength: capacity for exertion, flexibility, bending/stretching
 - Balance> Endurance> Physical Health:

- Ability to right self->Withstand exertion over time>mobility> & overall state of wellness
4. Affective: facial expression, body gesture, self-esteem

SMART: Important characteristics of Objectives

- Concept has been around since the 1950's
- Peter Drucker – “Management by Objectives” philosophy
 - Specific – exactly what is to be done?
 - Measurable – how will you gauge success?
 - Achievable – can what you want to do actually be done?
 - Realistic – do you have the resources to do it?
 - Time-related – what is the deadline?

Part D: Implementation

Nature and Diversity of Recreation/Leisure Activities

Recreation Activities:

- Form of organized activity that is freely chose and has the potential of many desirable outcomes

Leisure Activities

- Time, activity, state of mind, symbol of social status and holistic effect

Play Activities:

- Activities in which one engages freely and from which satisfaction is derived

Selection of Programs, Activities and Interventions

Comprehensive Program Plan (CPP):

- Benefits of a CPP:
 - Stability
 - Flexibility
 - Accountability
 - Complement other disciplines
- CPP is done prior to any other program development and usually is only done once, periodic updates
- Steps include:
 1. Analysis –to investigate thoroughly the clients and their leisure-related needs
 - Areas include: the community, agency, clients, TR department and TR profession
 2. Conceptualization – the statement of purpose and goals
 3. Investigation – program components □specific program
 4. Determination – selection of program components that will achieve the intent of the statement of purpose and goals
- Policy and procedure manual
- Written plan of operation

Specific Program Plan (SPP):

- the operational units that put the comprehensive goals and purpose into motion
- agency or unit goals □ operational programs
- derived from the operational plan (See section III-B)
- guide the design of individual participant interventions
- written guidelines for the delivery of specific programs and services
 - o including: aquatic therapy, pet therapy, leisure education
- a set of activities and their corresponding interactions that are designed to achieve predetermined goals selected for a giver group of clients

- specific programs are selected and developed that related to different categories of client need
- Program Plan:
 - o Statement of purpose
 - o Terminal performance objectives (TPOs)
 - o Enabling objectives (EOs)
 - o Performance Measures (PMs)
 - o Content and Process Descriptions (CPDs)
- Implementation Plan:
 - o Sequence sheet or session format description
 - o Performance sheet
 - o Implementation description

Individual Intervention Plan:

- Programs that focus on achievement of individualized outcomes and benefits
- Titles found in practice settings much include:
 - o care plans, treatment plans, specific program plans, individual education plans or individual rehabilitation plans

Activity Selection Factors:

- Age/age appropriateness
- Number of clients
- Staff/client ratio
- Budget/facilities available
- Staff skills
- Etc.

Program Design:

- Key client characteristics need to be addressed when designing a program including:
 1. Gender
 2. Age
 3. Ethnicity
 4. Education
 5. Religion
 6. Financial condition

Purpose/Techniques of Activity and Task Analysis

Activity Analysis Principles:

- Analyze - activity as normally or traditionally engaged in
- Rate - activity as compared with other activities
- Analyze – without regard for specific disability group
- Analyze – for minimal level of skills required for basic, successful participation

Activity Analysis:

- Process of systematically appraising what behaviours and skills are required for participation in a given activity
- What will doing the activity do to an individual and does the individual possess the skills needed for the activity?
- Process that involved the systematic application of selected sets of constructs and variables to break down and examine a given activity
- Determine the behavioural requirements inherent for successful participation
- Activity analysis rating form
- Understand an activity and its potential contributions to behavioural outcomes
- Break down an activity into component parts

- Best modification is the least modification
- Behavioural domains:
 1. Physical:
 - Basic body position – determining what body parts are involved.
 - Types of movement – bending, stretching, reaching, etc.
 - Cardio-vascular fitness, endurance level, exertion required
 - Number and nature of movements
 - Different senses utilized: hearing, seeing, fine motor manipulation of an object
 - Coordination of body parts
 - Hand-eye coordination
 2. Cognitive:
 - Number and complexity of rules – appropriate for client?
 - Memory retention - Short/long term memory needed?
 - Concentration needs
 - Verbalization and command of language
 - Strategy
 - Intellectual skills vs. chance
 - Academic skills – reading, writing and math
 - Recognition – forms, shapes, colors, sizes, numbers, etc.
 3. Affective/Emotional:
 - Does the activity release tension: stress?
 - Potential for enhancement of self-esteem?
 - Does the activity cause frustration?
 - To what degree can one express creativity?
 - What emotions are expressed? Six emotions:
 1. Joy – winning/egos/competitive activities
 2. Guilt – can result in counter responses of resentment and hostility
 3. Pain – rejected or eliminated
 4. Anger – physical restraint, being stuck by a person/object
 5. Fear – insecure about the ability to perform , failing
 6. Frustration – when skill does not match requirements of task
 4. Social:
 - Cooperation emphasized or element of competition?
 - How much leadership needs to be provided?
 - Eating skills required?
 - What communication skills: verbal, body language?
 - What type of Interaction Patterns:
 - *Intra-individual*: action taking place within the mind or an action involving the mind and a part of the both, but not requiring contact with another person or external object.
 1. i.e. daydreaming, meditating, etc.
 - *Extra-individual*: action directed by a person toward an object in the environment, requiring no contact with another person.
 1. i.e. reading, watching TV, crafts, computer games, etc.
 - *Aggregate*: an action directed by a person toward an object in the environment while in the company of other people who are also directing action toward objects in the environment. No action between participants in necessary.
 1. i.e. crafts, hobby groups, bingo, etc.
 - *Inter-individual*: action of a competitive nature directed by one person toward another
 1. i.e. Chess, checkers, honeymoon bridge, singles tennis, etc.
 - *Unilateral*: action of a competitive nature among three or more persons, one of whom is an antagonist or “it”.
 1. i.e. tag, hide and go seek, etc.

- *Multilateral*: action of competitive nature among three or more persons with no one person as an antagonist.
 1. i.e. scrabble, poker, monopoly, etc.
- *Intragroup*: action of cooperative nature by two or more persons intent upon reaching a mutual goal. Action requires positive verbal and nonverbal interaction
 1. i.e. musical groups, dramatic plays, service projects, etc.
- *Intergroup*: Action of a competitive nature between two or more intra groups
 - I.e. softball, doubles tennis, bridge, etc
- Other consideration: Number of individuals required for participation, physical proximity, physical contact, degree of communication requires, appropriate clothing, etc.

Activity Analysis Steps:

1. Determine the tasks the client does or need to do as well as when/where/how the activity is carried out
2. Activity is divided into component parts so the client can master a small part of an activity at a time
3. Devise methods to help the client master each step in the activity
4. Identifies the desired outcomes

Benefits of Activity Analysis:

- Better comprehension of the expected outcomes of participation
- Greater understanding of the complexity of activity components
- Info about whether the activity will help the client achieve intended outcomes
- Info for selection a facilitation, instructional, or leadership technique

Task Analysis:

- Breaking down an event or larger behaviour into small, discrete, and specific sub-behaviours that are to be performed in a particular order
- Takes a task and breaks it down step by step into small steps, explaining each single part of the activity.
- i.e. how to - tie a shoe/throw a Frisbee
- Elements include:
 - o Chaining
 - o Shaping
 - o Partial participation

Activity Modifications:

- Two types:
 1. **Modification for Individual Participation:**
 - When certain functional abilities are absent or impaired (disabled individuals):
 - A rule can be eliminated or simplified
 - A procedure changed
 - A change of equipment
 - Keep the activity and action as close to the original or traditional activity as possible
 - Modify only the aspects of the activity that need adapting
 - Individualize the modification
 - The modification should be as temporary as possible
 2. **Modification to Enhance the Therapeutic Benefit:**
 - Analysis is made concerning the group members who will engage in the activity
 - Some individuals may have difficulty with certain aspects of the activity
 - Minor modifications then are made for those individuals or for the group so that the therapeutic benefit can be obtained.
 - i.e. rolling a bowling ball from a sitting position

Other Modifications include:

- Assistive Techniques

- Technology/Adaptive Devices
- <http://www.recreativeresources.com/linkadaptiveequipment.htm>

Types of tournaments:

- Challenge:
 - o Designed to continually test a person's skill
 - o Designed for individuals
 - o Over any length of time
 - o Requires little supervision
 - o No one is eliminated
 - o Utilizes a lot of time and court/field space
- Pyramid:
 - o Shaped like a pyramid
 - o Could be used for 10 or more
 - o Participants on the same level
 - o Creates variety of levels of play
 - o Vertical and horizontal challenges
- Ladder:
 - o Small number, generally under 10
 - o Ranked by skill or random
 - o Time/place agreed upon by players
- Round-robin:
 - o Determine # of games and rounds
 - o Determine facility
 - o Determine which teams will play which teams
- Elimination:
 - o Single
 - o Double
 - o Consolation

Modalities/Interventions

Interventions and Facilitation Techniques:

- Compatible methods of interaction and specific experiences that are selected to achieve preplanned outcomes and predetermined objectives or goals

Interventions:

- Pavlov and Skinner
- Operant conditioning:
 - o eliminate inappropriate responses and substitute appropriate/positive responses

Behaviour Management:

- *Positive reinforcement*: techniques to change behaviour
- *Shaping*: reinforcement only when certain standard is reached, process by which reinforcement is differentially applied to the responses that are made toward approximating a desired behavior.
- *Chaining*: linking one learned response to another
- *Prompting*: leader physically guides
- *Fading*: gradual removal of physical guidance
- *Token Economies*: tokens as rewards for behavioural performance
- *Contracts*: written agreement to perform certain behaviours

Intervention Program:

- Systematically designed prior to implementation, with outcomes in mind
- Designed based on client characteristics and needs
- Identified client outcomes
- Able to produce desired outcomes or results

Facilitation Techniques:**1. Values Clarification:**

- To help individuals explore and make decisions based on their personal values
- Can be used in leisure counseling programs:
 1. Become aware of beliefs and values
 2. Choose among alternatives
 3. Matching stated beliefs with actions
- help clients in making autonomous decisions consistent with their values
- choosing, cherishing, acting
- pie of life

2. Cognitive Retaining:

- Socially oriented training program
- Focuses on: consistency, patterns, caring and rewards for acceptable behaviours
- Uses verbal and non-verbal communication (pictures, instruction cards, etc.)
- To demonstrate the irrationality to the assumptions on which the behaviour is based

3. Bibliotherapy:

- Employs reading materials to help clients become aware of others that share problems similar to theirs and to help bring new insight
- Employs reading materials such as novels, plays, short stories, booklets, and pamphlets to help clients become aware that others share problems similar to theirs and to help bring new insights into being.
- Traditionally has been associated with psychiatric treatment, often as an adjunct to psychotherapy

4. Cinematherapy:

- Having clients watch films that they later discuss with a therapist

5. Horticulture Therapy:

- Uses activity of working with plants to bring about therapeutic outcomes
- Commitment to goal and sense of responsibility

6. Therapeutic Communities:

- Informal and communal atmosphere
- Regular group meetings on issues in daily life
- Clients and staff share the work of maintaining/running community
- Clients influence each other's behaviours
- Organizing is shared by staff and clients
- Shared beliefs within community

7. Humor:

- Laughter and humor have been associated with both being healthy and becoming healthy.

8. Therapeutic Touch:

- A non-touch technique that involves the therapist passing his or her hands two to six inches above the clients body in order to transfer healing energy

9. Stress Management/Relaxation Techniques:

- Mind and body are inter-related
- Used to ease stress of flight or fight responses of the body
- Means to deal with excess tension brought about by stress
- Variety of techniques including:

1. Deep breathing – breathing techniques
2. Progressive relaxation
3. Autogenic training
4. Mental/guided imagery
5. Yoga
6. Biofeedback
7. Massage
8. Stretching

10. Assertiveness Training:

- Help people become more assertive in social relationships, sexual expression, work-related interactions or other social situations
- Enables one to more effectively stand up for one's rights and beliefs
- An off-shoot of behavioural therapy desensitisation
- Develops inter-personal skills
- Neither aggressive or passive
- Utilizes techniques such as:
 - Role playing, rehearsal modeling, reinforcement techniques

11. Social Skills Training:

- Socially acceptable behaviours that enable a person to engage in effective interactions with others and to avoid socially unacceptable responses from others.
- Modeling, role playing, feedback, instructions, social reinforcement, homework

12. Cognitive Rehabilitation:

- Used with ABI and TBI
- Executive functions – attention, memory, ability to initiate, plan, organize and regulate behaviours
- Principle of empowerment
- Interdisciplinary team approach
- Games and activities to improve functioning

13. Reality Orientation:

- Technique to meet the needs of elderly patients possessing moderate to severe degrees of disorientation and confusion
- Daily program using repetition to teach information about name, place and time
- Frequent follow-up during the day
- Used to reduce confusion and increase autonomy and life satisfaction
- Visual aids may be used: clocks, calendars, maps, etc.
- Regular repetition of basic facts and constant orientation to time, place, names, events of the day and things in the environment.

14. Sensory Training/Stimulation:

- Attempts to maintain and improve the functioning of regressed patients through a program of stimulus bombardment directed towards all five senses.
- To improve perceptions, alertness and the opportunity of interaction with the environment by stimulation of the five senses:
 1. *Tactile*: touching, feeling objects of different sizes, textures, softness and hardness.
 2. *Olfactory*: smelling to strengthen senses, foods, spices, flowers, etc.
 3. *Listening*: musical instrument, records, tapes, sound effects, nature sounds, children playing etc.
 4. *Tasting*: pickles, herbs, candy, foods etc.
 5. *Visual*: mirrors, colorful objects, movement, mobiles etc.

15. Reminiscence:

- The act of relating personally significant past experiences
- People recall objects, places, other people and their own self-reflections

16. Remotivation:

- Primarily for long term psychiatric, confused elderly in long care.
- Stimulates healthy personality development by focusing interaction around topics and interests that motivate the client to re-establish contact with the real world.
- Since people who are regressed, withdrawn, confused, or who have sustained a brain injury tend to focus on personal conditions, diverting attention from the illness to positive discussions of sports, hobbies, or current events increases self-respect, alleviates boredom, and stimulates social and cognitive functions.
- Remotivation is more commonly used in geriatric settings than in mental health and physical medicine and rehabilitation
- Four Step Program: a group process promoting the discussion of topics using picture, papers, magazines that relate to the real world, renewed interest in the environment & avoidance of stressful & emotional issues.
 - 1) Climate of acceptance
 - 2) Bridge to reality
 - 3) Sharing the world
 - 4) Appreciation of the world we live in

17. Processing/Debriefing:

- Verbal discussions of client behaviours, thoughts, feelings, etc.
- Helps clients become aware of their behaviours while contributing activity to the clients learning, adaptation and growth
- Helps the client generalize what was done in the activity to life and is essential to the appropriate and effective use of activities to facilitate change in clients
- Can occur beginning, middle or end of session

Counselling/Therapy Techniques

Gestalt Therapy:

- Psychotherapy with individuals or groups that emphasized treatment of the person as a whole
- This includes:
 - o a person's biological components and their organic functioning
 - o perceptual configuration
 - o interrelationships with the external world

Milieu Therapy:

- also known as environmental therapy or therapeutic milieu
- mental health facilities
- emotional problems are often the product of unhealthy interaction with one's environment
- staff are organized as a caring community
- primary therapist is whoever has the most effective relationship with the client

Approaches to Personality Development:

1. Psychodynamic:

- Emphasis on fixation or progress through the psycho-sexual stages; experiences in early childhood leave a lasting mark on adult personality.

2. Behavioral:

- Personality evolves gradually over life-span, not in stages. Responses followed by reinforcement become more frequent.
- Three therapeutic approaches, which have come to be viewed as entities unto themselves, are

related to the behavioral approach:

1. Assertiveness training
2. Progressive relaxation training
3. Social skills training

3. Humanistic:

- Children who receive unconditional love have less need to be defensive; they develop more accurate congruent self-concepts.

Basic Counseling Techniques:

- Client-Centered therapy
- Carl Rogers - Active listening
 - *attending*: pay attention, eye contact, posture, gestures, verbal affirmation of listening
 - *paraphrasing*: listen for basic message, restate in own words
 - *clarifying*: admit your confusion, ask for clarification
 - *perception*: checking; paraphrase what you think you heard
 - *probing*: questions directed to obtain information, to gain an understanding
 - *reflecting*: to reflect feelings received; interpreting;
 - *confronting*: point out what seems apparent in an honest manner without blame
 - *informing*: providing factual information
 - *affective listening*: voice, tone, volume
 - *summarizing*: to bring together ideas, to synthesize

Behavior Management Techniques:

- *Aversion therapy*: developing an aversion to a stimulus by pairing that stimulus with vividly imagined noxious stimuli.
- *Cognitive restructuring*: changing maladaptive behavior by demonstrating the irrationality of the assumptions on which the behavior is based and teaching the person more adaptive self-talk,
- *Backward chaining*: instruction starts with the last step in a sequence and when the client has acquired the last step, the next to last step is taught and so on until the first task in the chain is accomplished.

Non-verbal behaviors:

Visual cues: physical appearance, use of jewelry, clothing, facial expression, eye contact, body movement, vocal cues, volume, pitch, availability, personal space

Leisure Education

Leisure Education:

- A broad category of services that focus on leisure-related skills, attitudes and knowledge
- For leisure to assist one's well-being and not just take up time
- Affirms what you know and what you can do
- Four areas including:
 1. **Leisure Awareness:**
 - Cognitive awareness of leisure and its benefits
 - A valuing of the leisure phenomenon and a conscious decision-making process to activate involvement
 - Four concepts:
 - 1) Knowledge of leisure
 - 2) Self-awareness
 - 3) Leisure and play attitudes
 - 4) Related participatory and decision-making skills
 2. **Social Interaction Skills:**
 - Three concepts:
 - 1) Communication skills

- 2) Relationship-building skills
 - 3) Self-presentation skills
 - 3. Leisure Resources:**
 - Knowledge of leisure resources and the ability to utilize these resources appears to be a significantly important factor in the establishment and expression of a leisure lifestyle.
 - Teaches both knowledge of the resource and the skills about how to use the resource for future leisure involvement
 - Five concepts:
 - 1) Activity opportunity
 - 2) Personal resources
 - 3) Family and home resources
 - 4) Community resources
 - 5) State and national resources
 - 4. Leisure Activity Skills:**
 - A repertoire of leisure activities and related interests is necessary for meaningful experiences
 - 1) Tradition leisure skills – sports, dance, music, arts and crafts, etc.
 - 2) Non-traditional leisure skills – fitness, relaxation, self-development, self-care
-

NCTRC Study Guide - Section Three: Organization of Therapeutic Recreation Service

Part A – TR Service Design

Program Design

- Is the written documentation of the strategies, intervention, or approach that will aid those who participate in the program to accomplish the stated goal
- Determining what is considered an effective therapeutic recreation intervention depends upon examining the relationships between various programs/treatment protocols for a specific illness/diagnostic category and the associated outcomes of those treatments.

Therapeutic Recreation Process:

- A sequential process
- Describes the procedures a professional uses to design programs and services to satisfy participant needs and accomplish specific predetermined goals and objectives
- Planning process (APIE):
 1. **Assess**
 2. **Plan** (goals, objectives, activity analysis)
 3. **Implement**
 4. **Evaluation and revise**

Therapeutic Recreation Accountability Model (TRAM):

- Shows major decision points in total program and conceptualization of connections between different tasks in delivery services.
- Designed to help therapeutic recreation specialists conceptualize the connections between different tasks in the delivery of services to clients.
- Purpose: to show the interrelationships between different tasks of providing intervention programs to clients
- A comprehensive system of accountable service provision
- Components:
 - **Comprehensive and Specific Program Design:**

- Collecting data about factors such as community, agency, departments, clients and profession that impact the program and its clients
- Implementation and evaluation plans are created to ensure that the right program will be delivered and reviewed systematically.
- o **Activity Analysis, Selection, and Modification:**
 - The process used to systematically review specific activities to determine whether they have the potential to help clients achieve targeted outcomes
- o **Protocols:**
 - clinical practices guidelines
 - the distillation of the best collective thinking from literature, from practicing clinicians and from academics on how to treat a particular medical situation
 - Meant to provide a blue print of treatment for a specific diagnosis or client problem and when validated through professional use and consensus, allow for program bench marks to be set
- o **Assessment Plan**
 - Client assessment is the process used to place clients into therapeutic recreation programs based on their individual needs, strengths and limitations
- o **Intervention Programs and Client Documentation**
 - Therapeutic recreation intervention programs are provided to clients based on need
 - The baseline for intervention is documented in a client assessment
- o **Program Evaluation/Program Outcomes**
 - The specialist must gather and analyse selected data in a systematic and logical manner for the purpose of determining the quality, effectiveness and or/outcomes of a program.
- o **Client Evaluation/Client Outcomes**
 - The focus is on the end result of the intervention designed on behalf of the client and it is one part of patient care monitoring.
 - **Patient Care Monitoring:** procedures which help ensure that the treatment planned and provided for patients is evaluated and updated according to the needs of the patients
- o **Quality Improvement and Efficacy Research**
 - Quality assurance, continuous quality improvement and performance improvement
 - Wide spectrum of activities ranging from determining an appropriate definition of care to establishment of actual standards of practice that if implemented, will result in acceptable levels of service.

Factors which Influence Program Selection:

1. Clients
2. Agency
3. Resources
4. Community
5. TR profession

Program Structures:

- One-to-one
- Group
- Instructional classes
- Competition
- Specific events
- Mass activities
- Open facility
- Drop in

Group Development

Group Stages of Development:

1. Orientation: insecurity, reliance on the leader, need help to “break the ice”
2. Conflict: as people reveal themselves, values clash
3. Cohesion: resolve conflict, develop sensitivity
4. Performance or productivity: group members become functional and devote themselves to achieving individual and group goals

Tuckman’s Model:

1. Forming
2. Storming
3. Norming
4. Performing

Group Roles:**1.) Group Building & Maintenance:** (Social-emotive functions)

- Tone setting, harmonizing, tension reducing,
- Promoting group development

2.) Task functions:

- Promote the work or task of the group.
- Activities which help group members to achieve their goals (coordinating, testing, initiating)

3.) Negative Roles: (Non-functional behavior)

- Activities which interfere with the processes of the group
- Blocking, dominating, withdrawing etc.

Leading Activities: (DDADA)

- Describe
- Demonstrate
- Ask for questions
- Do the activity
- Adaptations

Small groups: role playing, brainstorming, fish bowl, case studies, committees.

Large groups: clinics, conferences, conventions, institutes, retreats, workshops.

Type of Service Delivery System**Therapeutic Recreation Leisure Service:**

- Primary goal = to participate in a leisure activity.

Health Services:

Physical health = i.e., Balance, strengths

Educational Services:

- learn something, i.e., social skills

Interdisciplinary Approaches**Multidisciplinary teams:**

- each assesses separately
- services are provided separately
- little interaction among members

Interdisciplinary team:

- group consensus
- regular staff meetings

- outcomes shared among members

Trans-disciplinary teams:

- everything interactive and integrated
- shared decision making
- crossing of role boundaries
- team shares knowledge and skills
- considered most advanced team structure

Methods for Interpretation

Standards:

- Predetermined elements against which aspects of quality treatment can be compared
- normally general in nature
- identify/define basic components
- evaluate quality of service
- used in analysis stage

Assessment Results:

- Able to document unique, useful, and meaningful baseline information into the clients records
- Need assessment content to reflect program content

Needs Assessment:

- A systematic process used to gather information about a given individual, group or community
- Information gathered pertains to matters such as subjects knowledge and attitude toward health
- Should include any health practices already used by the subject
- Socioeconomic factors
- Once info is gathered, it is then determined if a health education activity is called for and what kind of activity/program is should be.

Outcomes:

- The difference in the client from the beginning to end of treatment
- Important to state outcomes in terms of clearly written goals and objectives.
- Both participant and program result from the use of specific interventions and facilitation techniques
- They should be reported and documented in individual, service and agency plans.
- These outcomes should:
 - a) Be individually based
 - b) Indicate a change in the clients condition (or environment)
 - c) Stipulate short-term or long-term outcomes
 - d) Be measurable

Outcome Objectives:

- Also known as “health objective”
- Supports the goals of a program by stating a desired health change that will be brought about in a target community through an educational program
- Provides a time frame – usually 3-5 years

Outcome Criteria:

- Standards by which measureable goals or outcomes are objectively measured and evaluated.

Outcome Measurement:

- Is quantification of client outcome data in some way, either in absolute terms or in relative terms.

Typical Health Care Outcomes:

- Clinical status
- Patient - symptoms, BP and Temp
- Functional status
- Social and role functions
- Well-being or quality of life
- Satisfaction with care
- Cost or resource utilization
- Recidivism

Typical TR Outcomes:

- Increased emotional control
- Improved physical condition
- Decreased confusion and disorientation
- Improved coping and adaptation skills
- Increases awareness of barriers to leisure
- Improved ability to locate leisure partners for activity involvement
- Etc.

Leisure Competence Measure (LCM):

- Not an assessment, it is a standardized tool to measure outcomes.
- Designed to be an outcome measurement
- TR assessment sources: functional, leisure assessment, individual preferences
- Sources of information: client interview, interview with family, direct observation, chart review, team discussion.
- Looks at capability or readiness for community re-entry
- Adult rehab, geriatric, psychiatric, long-term care settings and young adults/adolescents 13+.
- Intended to complement other TR tools and to categorise and summarise information gained through the assessment process
- Measure what the client actually does, not what she/he ought to be able to do.
- Eight subsections:
 1. Leisure awareness:
 - clients knowledge and understanding of leisure
 2. Leisure attitude:
 - behaviour exhibited and/or feelings demonstrated by the client which suggest attitude toward leisure involvement
 3. Cultural/Social Behaviours:
 - specific cultural/social behaviour exhibited by the client which affect his/her ability to function effectively in leisure activities
 4. Interpersonal skills:
 - clients ability to participate within various types of inter-individual and/or group situation
 5. Community integration Skills:
 - application of antecedent skills for successful involvement in community leisure activities
 6. Social contact:
 - type and duration of social contact the client has with others
 7. Community participation:
 - clients overall leisure participation pattern within the community

Part B – Administrative Tasks

Evaluating Agency TR service Programs

Evaluation of a Program:

- Process of determining what a program has achieved compared to what it was supposed to achieve.
- Begins with program objectives – measurable statement of what the program was designed to achieve.
- **Process Objectives:**
 - Also known as administrative objectives
 - Supports the other objectives by specifying the tasks and plans necessary to achieve them.
 - Useful in preparing to implement program and assessing the program once it is in place.
 - Includes an action verb that describes a way to effectively measure a task or plan.
- Three evaluations:
 - Outcome evaluation:
 - Summative – determines if long-term goals were met
 - Impact evaluation:
 - Summative – measures immediate behaviour changes brought about by the program.
 - Process evaluation:
 - First level, used to identify strengths and weaknesses of a program

Impact Objective:

- Objectives that serve as a means to achieve the larger objectives and overall goals of a program
- Not intended to be the ultimate end result of a program
- Two main categories:
 1. *Behavioural Objectives*: describes an action that the target community will perform and the desired outcome of that action.
 - Contains three parts:
 - (1) **Conditions** – a ‘given’ or ‘restriction’, describes the conditions under which the performance is expected to occur
 - (2) **Criteria** – describes the level of competence that must be reached or surpassed
 - (3) **Performance** – describes what the learner is expected to do
 2. *Learner Objectives*: support behavioural objectives.
 - “Impact objectives” which identify specific changes in knowledge, attitude, or skill.
 - These changes must occur in order for the applicable behavioural objective to be met
 - An effectively written learner objective includes an action verb that describes an observable behaviour.

Types of Evaluation

Formative Evaluation:

- On-going evaluation using a step-by-step process of decision making relating to numerous specific aspects of a program rather than one final evaluation.
- Allows for immediate adjustments to ensure desired outcomes.
- Leads to immediate change: room temperature, supplies.

Summative Evaluation:

- Terminal & overall assessment of a program intended to judge its impact and effectiveness.
- A decision to continue or discontinue program is imminent.
- Done at end of program and leads to a decision regarding the future.
- Determines the effectiveness of specific interventions and facilitation techniques to achieve predetermined outcomes and benefits.

Discrepancy Evaluation Model:

- Evaluate what you intended to do & what actually happened.
- A comparison of what is, a performance, to and expectation of what should be a standard.
- If a difference is found = discrepancy
- If performance has exceeded the standard > it is a positive discrepancy.

- If performance is less than standard > it is a negative discrepancy.

Health Education Program Revision:

- Written report of evaluation:
 1. Reassess goals and objectives
 2. Identify areas which need additional effort
 3. Identify effective program strategies
 4. Determine the cost effectiveness of activities
 5. Renew program support
 6. End programs that were not effective

Quality Improvement Guideline and Techniques

Quality:

- Defined in various ways:
 - Stakeholders satisfied (satisfaction)
 - Consumer goal/objectives met (effectiveness)
 - Efficient use of resources
 - Appropriateness of services (utilization review)
 - Safe environment/limited risk
 - Standards of professional practice

Quality Management:

- The quality management process integrates the following components: monitoring and evaluation; peer review; risk/safety management; infection control; case review; and record documentation.

Quality Assurance (QA):

- Old term
- Quality health care
- Focus on structure and maybe process
- Monitors standard and performance
- Identifies strength and weaknesses
- Looks at problems

Continuous Quality Improvement (CQI):

- New term
- Quality health care
- Demonstrate the client has changes of a result of care
- Always room to improve
- Focus on outcomes
- Does not detect weakness but strives to improve performance as a team
- Emphasizes the organization and systems and processes within the organization rather than the individual

Total Quality Management (TQM):

- Entire facility works together
- Risk management
- Policy and procedures
- Continuing education
- Written plan of operation
- Code of ethics
- Certification policy

- A commitment to meeting the needs of the customer (clients and staff) at all levels within an organization
- **Critical paths** are a compilation of multidisciplinary input driven by a specific time oriented outcome

Utilization review:

- Program in a clinical agency attempts to demonstrate or document how effective the agency is at appropriately allocating its resources.

Risk Management:

- Any actions that the specialist might take to reduce the potential liability in the delivery of a program
- i.e. staff to client ratios
- A risk management plan would include:
 - o *Insurance:*
 - type/amount available for staff the drive
 - Professional liability/malpractice insurance
 - o *Waivers:*
 - For trips or use of other facilities
 - To participate in an activity
 - o *Facility Equipment Inspections*
 - o *Emergency plans:*
 - Operation of fire extinguishers
 - Restraint training
 - Client elopement plans
 - o *Orientation/training plans*
 - o *Accident/incident reports*

Plan of Operation

Agency plan:

- goals, objectives, policies and programs so that performance can be measures
- describes the services offered by the agency and how to various services interact and interrelate
- involvement in patient management and program management concerns

Operational Plans:

- Documents developed in accordance with agency plans
- Outline the vision, mission, goals and procedures to manage the therapeutic recreation service

Management

Responsibilities:

- Department manuals:
 - o mission
 - o philosophy
 - o goals of TR department
 - o written protocols
 - o Human resource planning takes into consideration staffing patterns, scheduling options, budget constraints, historical background of staffing needs and availability, diversity of client population served, personnel policies, educational and experiential levels of staff, mix of titles or classifications, and fluctuation in programs or seasonal offerings
- references
- job descriptions
- risk management
 - o safety issues
- policy and procedures

- plan for staff evaluation
- orientation
- education

Types of Management:

Consensual Management:

- Manager presents problem to team for discussion/input and encourages them to make decisions
- Increase in team member commitment

Democratic Management:

- Participative management approach
- Manager and team make decisions jointly

Autocratic Management:

- Manager makes all decisions and exercises tight control over the team

Disruptive Management:

- Manager tends to destroy unity of the team

Laissez-faire Leadership:

- “hands-off”
- Manager provides little or no direction and gives employees as much freedom as possible

Authoritarian Management:

- Manager tells team what is expected of them, provides specific guidance on what should be done

Combative Management:

- Manager displays an eagerness to fight or be disagreeable over any given situation

Conciliatory Management:

- Manager is friendly and agreeable and attempts to unite all parties involved to provide compatible working teams.

Types of Leaders:

- **Direct Service:** face to face, direct work with clients
- **Supervisory:** Middle management level, facilitate agency service
- **Administrative:** Executive, major focus on planning and development

Leadership Styles:

- **Bureaucratic:** follows organizational rules exactly and expects everyone else to
- **Autocratic:** authoritarian, directive style, close supervision, responsibility with leader, appropriate for groups of people with psychiatric problems, MR/DD, confusion, etc.
- **Democratic:** participative, involves group decision making & ideas, Use with participants not needing direction but, able or needing to make choices, develop decision making skills, self-esteem, self-confidence.
- **Laissez-faire:** minimal control of leader, open style, permissive, participants make decisions. Useful for group problem solving, team building and does not exercise authority.
- **Charismatic:** depends on personal charisma to influence people and may be very persuasive but may engage “followers” and related to one groups rather than the organization.
- **Consultative:** presents decision and welcomes input and questions although decisions rarely change.

Payment Systems

Retrospective Payment Systems:

- Traditional cost based system
- Cost determined by hospital
- Per diem – room rate plus ancillary services
- Hospital submit bill and cover all reasonable costs regardless of length of stay

Prospective Payment Systems:

- Cost determined by 3rd party
- Based on Diagnosis Related Groups (DRG)
- Make money if early discharge
- Lose money if late discharge
- Medicare reimburses on length of stay (LOS) whether or not patient is in the hospital the designated time

Health Maintenance Organizations (HMOs):

- Received payment for services rather than the traditional pay-for-service Medicare payment system

Preferred Provider Organizations (PPOs):

- Provide discounted rates for those on Medicare who choose healthcare providers from a list of those who have agreed to accept Medicare assignment.

Private Insurance Pay-for-Service:

- Contracted by Medicare and may provide more benefits
- The patient is required to work individually with the insurance company to determine benefits
- May be assessed an additional monthly fee

Facility and Equipment Management

- Part of the implementation descriptions delineates the necessary facilities and objects
- Of value to have a master list of all needed items at the beginning of the program materials

Budgeting/Fiscal Responsibility**Types of Budgets**

- Capital budget:
 - o Determines which capital projects will be allocated funding for the year (such as remodeling, repairing, or purchasing of equipment or buildings).
 - o Usually based on a cost-benefit analysis and prioritization of needs.
- Operating Budget:
 - o Used for daily operations and includes general expenses such as salaries, education, insurance, maintenance, depreciation, debts, and profit.
 - o This budget has three elements: statistics, expenses and revenue.
- Cash Balance:
 - o Projects cash balances for a specific future time period, including all operating and capital budget items.
- Master Budget:
 - o combines operating, capital and cash balance budgets as well as any specialized or area-specific budgets
 - o

NCTRC Study Guide - Four: Advancement of the Profession**Historical Development of TR****Stages:**

- 1.) Prehistoric Civilizations (5000 to 700 BC)
- 2.) Rational Medicine (700 to 400AD)
- 3.) Sacred Influence (400 to 1700)

- 4.) Institutionalization with Treatment (1700 to 1900)
- 5.) Recreation Movement of the 20th century (1900 to present)

Accreditation Standards/Regulations

Accreditation:

- Assuring quality of educational standards and criteria

JCAHO:

- Independent, non-for profit organization
- Accredited approx. 16000 agencies in the US
- Started in 1951
- Mission: to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.
- Standards:
 - Related to quality of patient care
 - Related to quality of the environment of that care
 - Based on consensus and state of art
 - Always in transition
 - Must be reasonable and "survey-able"

Clinical Privileging:

- JCAHO defines as permission to provide medical or other patient care services in the granting institution, within well-defined limits, based on individual's professional license, experience, competence, ability and judgement

Commission on Accreditation of Rehabilitation Facilities (CARF):

- Formed in 1966
- Own agency
- First accreditation body to look at outcome measures
- Includes: aging services, adult day care, assisted living, employment and community customer service, blind rehab, skills training, job-site training, family/respite services, etc.

Council on Accreditation (COA):

- Body that reviews and accredits baccalaureate programs in recreation, parks resources and leisure services including academic programs that have therapeutic recreation options

Commission for Accreditation of Park and Recreation Agencies (CARPA):

- Initially approved standards in 1993 to review and accredit agencies providing recreation programs to the public
- TR may fall under this is a public park and recreation department

Center for Medicare and Medicaid services (CMS):

- Formally the Health Care Financing Administration (HCFA)
- A governmental agency in the department of health and human services
- Oversees Medicare and Medicaid programs

Professionalism

Professional Behaviour:

- Decision-making model for Ethical Situations:

- Identify behaviour
- Determine professional relevance
- Differentiate personal/professional ideals
- Consider legal duties
- Assess ethical obligations
- Define action

Professional Development:

- Get certified
- Read at least one TR book/article per month
- Read at least one book/article related to TR services (i.e. stress management) per month
- Read at least one book/article on disability issues (i.e. inclusion) per month
- Visit at least one internet site related to TR per week
- Read profession newsletters
- Read NCTRC certification newsletter
- Visit professional web sites regularly
- Keep track of later research

Requirements for TR Creditatio

(<http://www.nctrc.org/aboutnctrc.htm>)

Requirements for Certification:

- Professional path = 18 hours of required course work, 9 hours of TR
- Professional equivalency path = 18 hours of upper level recreation courses, 9 must be TR, 24 credit hours of supportive coursework

Certification:

- A professional credential - CTRS

Licensure:

- Granted by state governments
- NTRSA/ATRA – professional organizations
- NCTRC – not a professional organization
- Restrictive: only “we” can do what we do
- Permissive: permits us to get licensed but, does not stop others from doing the work

Advocacy for Persons Served

Advocacy:

- For the disabled - Recreation for all
- Advocacy is a means of pleading for the cause of another.
- “a process directed toward improving the quality of goods and services rendered to consumers”
- From this perspective, the purpose or basis for advocacy is first and foremost consumer-oriented.”

Professional Standards/Ethical Guidelines

Five core competencies:

1. Provide patient centered care
2. Work in interdisciplinary teams
3. Employ evidence-based practice
4. Apply quality improvement
5. Utilize informatics

Public Relations

Four Ps of Marketing:

- 1.) *Product* – actual physical product
- 2.) *Promotion* – making the target population aware through advertising, brochures, fliers, etc.
- 3.) *Placement* – how and where the program will be delivered
- 4.) *Price* – of program including materials, services, staff, etc.
 - o Weight the cost of the program to the provider against the cost for the target population and anticipated cost savings

Resources and References – Maintain/Upgrading Professional Competencies

Online Sources of Information for Health educators:

1. Medline:
 - Premier database from the US National Library of Medicine
2. Education Resources Information Center (ERIC):
 - A database for journals related to education particularly k-12
3. Combined Health Information Database (CHID)
 - Useful source of information about health education programs in progress
4. Cumulative Index for Nursing and allied Health Literature (CINAHL)
 - An index for major health education journals

Professional Associations and Organizations

National Therapeutic Recreation Society (NTRS):

- Brand of the National Recreation and Park Association (NRPA)
- Formed in 1966 to serve professionals and organizations involved in therapeutic recreation services

American Therapeutic Recreation Association (ATRA):

- Formed in 1984
- A non-profit national professional membership organization
- To advance the professional of therapeutic recreation

National Council for Therapeutic Recreation Certification (NCTRC):

- Non-for profit national level organization
- Formed in 1981
- Issues the credential for CTRS and verifies the competence of those individuals

Certified Therapeutic Recreation Specialist (CTRS)

- Refers to one who is certified to practice at the professional level by NCTRC

Partnerships with Higher Education:

- Internships
- Produce, understand and interpret research

Research:

- Organized way of gathering information
- Can be used to gather data about any number of areas, including values, behaviour, and relationships.

Focus groups:

- 8-12 people
- Interviews

- Informal conversations
- Interview guide
- Standardized open-ended questions
- Closed quantitative interview

Data Collection:

- 1.) Nominal data:
 - o Variables used to name categories
 - o No numeric value
 - o Each sample unit falls into only one category
 - o i.e. hair colour, marital status
- 2.) Ordinal data:
 - o variables which name categories and rank data
 - o allows for assessments of intensity or severity
 - o i.e. poor, middle and upper class
- 3.) Interval Scale data:
 - o variables name categories and rank data using equal steps between rankings
 - o equal differences between measures represent equal differences between values
 - o no “true” zero
 - o i.e. Fahrenheit or Celsius
- 4.) Ratio Scale data:
 - o Similar to interval scale data
 - o The unit of measurement does have a “true” zero
 - o Differences between measurements can be used to calculate ratios
 - o i.e. length, height, weight, temp.

Data Analysis:

- collapse data into smaller more manageable sizes

Quantitative:

- head counts
- questionnaires/surveys
- closed-ended
- forced-choice
- two types:
 1. inferential analysis: mathematical techniques that allow generalizations about the population
 2. descriptive analysis: provide description of respondents thoughts, feelings and attitudes

Qualitative:

- review documents and records
- observation
- open observer
- case studies
- structured or flexible

Continuing Education/In-Service Training

Continuing Education Credit:

- courses, conferences, workshops, taking academic courses, publishing articles, making conference presentations
- The CTRS may earn continuing education credits for authoring professional publications, giving professional presentations, and completing academic courses
- 45 CEUs for three credit courses

- 24 if class is audited

Recertification:

- every 5 years
- requires 50 hours of continuing education and 480 hours of work

NCTRC Study Guide – Miscellaneous

Five Theories - Psychological Perspectives:

- 1) Physiological: To achieve organic homeostasis.
- 2) Psychodynamic: To uncover and work through conscious conflicts.
 - No free will; you are who you are because of what has happened to you, your experiences.)
- 3) Learning (behavioral):
 - To learn new, adaptive responses to replace old maladaptive responses.
4. Cognitive: To learn new ways of thinking and behavior.
- 5) Humanistic: (Maslow/Rogers) Personal Growth, including self-acceptance, increased honesty with self and others, clarification of values and goals...people want “to do good.”

Four key vital signs:

1. Temperature
2. Pulse (or heart) rate
3. Blood pressure
4. Respiratory rate

Healthy People 2010:

- Comprehensive nationwide health promotion and disease prevention agenda
- 28 chapters
- Goals and objectives for each chapters
- “targets of desired level or standard of health for the nation
- Key chapters:
 - o 6 – Disability and secondary conditions
 - o 7 – educational and community based programs
 - o 22 – physical activity and fitness
 - o 26 – substance abuse

U.S Surgeon General’s report – Healthy People 2012

- Top five causes of death
 - o Heart disease – 31.4% of all deaths
 - o Cancer – 23.3%
 - o Stroke – 6.9%
 - o Chronic obstructive pulmonary disease – 4.7%
 - o Unintentional injuries – 4.1%

Epidemic

- Rapid spread of disease among a population or specific area

Endemic

- Constant presence of a disease of infectious agent among a certain population or specific area

Pandemic

- An epidemic that has spread to a wider geographic area and is affecting a large number of people

Prevalence

- Refers to the number of people who currently have a disease or medical condition

Incidence

- Refers to the number of people who have a disease or medical condition within a given year

Confidentiality:

- Right to share privileged information with HC provider
- Information not divulged by provider
- Patients identity, condition, emotional state and financial state
- Right to be free from unnecessary probes into personal affairs.

Health Insurance Portability Accountability Act (HIPPA):

- 1996
- Developed by the US dept. of Health and Human Services
- Protect the privacy of personal health information
- First ever federal privacy standards
- Took effect April 14, 2003

Definition of disability:

- Inability to engage in substantial gainful activity by reason of any medically determined physical or mental impairments
- expected to result in death or expected to last for a continuous period of no less than 12 months
- Cannot make more than \$740 monthly
- Must be severe enough to interfere with basic work activities
- Listed in "Blue Book"

International Classification of functioning, disability, and health (ICF):

- Provides standard language for health and disability
- First version – 1980: focus on impairment, disability and handicap
- Revised – 2002: focus on health and functioning vs. disability
- ICF Checklist:
 - Standardized interdisciplinary assessment
 - Completed after team conducts their assessment of needs and strengths
 - Produces task by task score
 - Criterion references

International Statistical classification of diseases related to health problems:

- Provides diagnosis
- Diagnosis alone does not predict service needs, length of hospitalization, level of care or functional outcomes
- Complementary to ICF

World Health Organization (WHO):

- United nations agency
- Establish 1948
- Highest possible level of health – not just absence of disease

Efficacy research

- Studies that document the effectiveness of therapeutic programs and services and validate the outcomes of specific interventions

InterQual Products Groups:

- Criteria statement designed by the medical community to define the level of rehabilitation care by the:
 - Intensity of the service
 - Severity of illness

- o Discharger screens
- o (ISD)

Protocol:

1. Procedures or policies specific to agency regulations
2. Defined plans for participant interaction

Non-Profit Community Agencies:

- Purpose: to promote good citizenship and promote social goals for those they serve and the community at large
- Education and citizen development
- Supported by membership fees and fundraising
- Two general types
 1. Religious – YMCA/YWCA
 2. Nondenominational – Boy Scouts, Boys and Girls Club

Public, Governmental Organization:

- Purpose: to provide a broad spectrum of parks, recreation facilities and programs to meet the basic needs for constructive leisure
- Supported by tax funds
- Three types:
 1. Federal – national park service, forest service
 2. State-historical monuments, campgrounds
 3. Local – parks, county and municipal recreation

Armed Forces Recreation:

- Purpose: to promote morale, fitness, and overall well0being of members of the military and their dependants
- Programs include sports, hobbies, outdoor recreation etc.
- Supported by government appropriated funds

Commercial Recreation:

- Purpose: to serve people while making a profit. Profit = main goal
- Five types
 1. Outdoor: skiing, hunting, etc,
 2. Water-based: white water rafting
 3. Fitness centers – goodlife
 4. Family play centers – Disney
 5. Other adult ventures – sports bars, theaters

Campus Recreation:

- Purpose: to promote student health and well0being and satisfaction with campus life
- Goals:
 - o Orientation
 - o Academic growth
 - o Degree of control for students
 - o Enhance image, appeal and recruitment
 - o Positive means of improving quality of life

Utilitarian ethical approach – most good for the most people

Confidentiality may be violated when the client poses a threat

1. to themselves
2. or to other

Pre-transfer = physical cognitive, emotional status

Contingent feedback = acknowledge the effort the person makes. Avoid direct negative statements

Motivational feedback = provide positive feedback. Words, smiling and nodding

Informational feedback = specific information to do a task or to correct errors

PPE = personal protective equipment including: gown, mask, goggles, and gloves

Dual relationships – the CTRS has a relationship with the client outside of the therapeutic environment – client should be reassigned.

Conflict of interest – self-interest interferes with the professional role of the CTRS

Boundary violation – when the professional boundary between the CTRS and client is breached such as sexual behaviour, gift giving, etc.

Confidentiality – keep personal information private