"THE PICK OF THE LITTER?" UNDERSTANDING STANDARDIZED

ASSESSMENT TOOLS AND THE ASSESSMENT PROCESS WITH OLDER

ADULTS IN THERAPEUTIC RECREATION PRACTITIONERS

by

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Dedication

To Mom and Dad: This work would not have been possible without all of your love and support in helping me achieve my own dreams and happiness. I am grateful to you both for supporting me in my life and giving me the opportunity for education. It's a gift that can never be taken away.

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Abstract

Current therapeutic recreation research does not articulate how Certified Therapeutic Recreation Specialists (CTRS) complete the assessment process with older adults. A review of published research demonstrates various uses of theories, methodologies, unclear descriptions of populations of studies, and unknown competencies of researchers.

The purpose of this study was to explore what current assessment practice looks like for CTRS's that work with an older adult population. The study was guided by the principle of participatory action research and was completed with four participants using a semi-structured focus group. The participants' experiences revealed complexities in practice that were interwoven with each other. Time, challenges in practice, building capacity with clients and other TR practitioners along with evidence based practice were key issues. Recommendations as a result of this study include further development of diagnostic protocols and practice-based evidence to inform clinical decision making.

List of Abbreviations Used

CTRA – Canadian Therapeutic Recreation Association

CTRS – Certified Therapeutic Recreation Specialist

FAB – Frontal Assessment Battery

ICF – International Classification and Functioning, Disability and Health

LCM – Leisure Competence Measure

MARRCC – Measureable Assessment in Recreation for Resident-Centred Care

MMSE – Mini Mental Status Exam

MoCA – Montreal Cognitive Assessment

MOSES – Multidimensional Observation Scales for Elderly Subjects

NCTRC – National Council for Therapeutic Recreation Certification

PES-AD – Pleasant Events Schedule – Alzheimer's Disease

RT – Recreation Therapy

TR – Therapeutic Recreation

TRAILS – Trail Making Test

WHO – World Health Organization

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Chapter 1: Introduction

Persons with a disability comprise approximately 14.3% of the Canadian population (Statistics Canada, 2006). Older adults' compromise 13.9% of Canada's population and it is expected to increase to 25% in the late 2030's (Statistics Canada, 2009). Individuals who provide services to the public from lawyers, doctors, nurses, occupational therapists, physiotherapists, and therapeutic recreation practitioners are being held accountable to the public for their actions with people they serve. Professionals, including therapeutic recreation practitioners, provide services to the public by assessing their needs, planning what would be best for the individual, implementing the plan based upon the assessment and evaluating the outcome of service delivery provided (Stumbo, 2003). Demonstrating efficacy of service is relevant to today's health care practitioners, regardless of their professional practice. Health care users and providers are requiring quality assurances for services that are being provided. Professionals working in all aspects of healthcare need to demonstrate that they are delivering a service that is measurable and based on evidence and/or best practice (Wright, 2009; Stumbo, 2003). The process of assessment, planning, implementation and evaluation provides direction for this quality assurance. More specifically, "…quality assessment is the operational arm of quality assurance; it is the fundamental process by which the quality of patient-care services is measured" (Wright, 2009).

Like all other health care providers such as nurses, occupational therapists and physiotherapists, practitioners in therapeutic recreation are expected to clearly document

the assessment process, results, action taken and outcomes of such interventions. But being a full-time practitioner does not leave much room for being on top of the research world and always knowing what's new in practice. More specifically, as a practitioner, the challenge comes in finding time to ensure that what tools and interventions that are being used with a specific population are those recommended based on evidence-based practice.

Evidence can be as simple as the documentation recorded after an intervention with a client. This basic level of documentation supports accountability of the profession. Stumbo and Peterson (2004) say that "…accurate records are written evidence that services were provided or that plans for providing service are a reality" (p. 312). Practitioners work and see results in their everyday practice but do they write it down? Leblanc and Singleton (2008) indicate that the answer was no: "…the ball often dropped was research or documentation" (p. 196). So if therapeutic recreation practitioners are not documenting their process, who is? This lack of documentation and research by the practitioners in Leblanc and Singleton's (2008) study demonstrates the need to further explore the gaps between therapeutic recreation research and practice. If practitioners are not documenting and researching in their practice, how does therapeutic recreation as a profession make the move towards integration of research and practice (McCormack, Lee, & Van Puymbroeck, 2009).

One of the challenges associated with therapeutic recreation as a discipline and profession is that there is varying consistency amongst what qualifies you to practice in the profession. The only standard that is currently available is to become a Certified

Therapeutic Recreation Specialist (CTRS), overseen by the National Council for Therapeutic Recreation Certification (NCTRC). In fact, this certification was recognized and endorsed by the Canadian Therapeutic Recreation Association (CTRA) as the certification for therapeutic recreation practitioners in Canada (Canadian Therapeutic Recreation Association, 2010). The CTRS designation is the only designation in the therapeutic recreation profession that has a minimum level of competency required. Practitioners who are CTRS's have met "…established standards for certification which include education, experience and continuing professional development" (National Council for Therapeutic Recreation Certification, 2009, p. 1).

There are no consistent titles for people working in therapeutic recreation in Canada who are not a CTRS; examples range from recreation programmers, recreation specialists, recreation therapy associates, activity workers or directors. Some have degrees, others have recreation education from colleges; some are people trained in other professions. The inconsistency and diversity in education of practitioners potentially results in inconsistent practice and service delivery of therapeutic recreation in Canada.

While we have acknowledged the challenges of those working in the profession today, we naturally turn to those who work in the academic world, who complete research and help provide practitioners with the evidence they need to support continued practice and growth of the field. Yet there are few academics and/or researchers in Canada that hold and maintain the CTRS credential (J. Singleton, personal communication, August 25, 2010). Further encouragement for researchers and those working in academics to obtain the CTRS credential is essential for growth in the field of

therapeutic recreation. Advancement of the profession, particularly advocating for the CTRS credential and supporting licensure initiatives, protecting the title of recreation therapist, will support this standardization and shared competency amongst practitioners and researchers.

Examining and valuing research that has been a significant part of the foundation and development of the therapeutic recreation profession is essential, but recognizing where improvement is required and understanding the gaps in this research that has been completed is equally important. Creating awareness of the gaps in research on standardized assessment tools and the impact it has on therapeutic recreation practice and their use among therapeutic recreation practitioners is the focus of this study.

Purpose of the Study

The purpose of this study was to determine if and how standardized assessment tools are used by therapeutic recreation practitioners (CTRS) who are working with an older adult population.

Research Questions

The following research questions were explored in the study:

1. Do current therapeutic recreation practitioners (CTRS) who work with older adults use standardized assessment tools as part of their daily practice? Why or why not?

2. What are the standardized assessment tools that they use?

3. If they do use them, how effective are they in producing outcomes in their practice and/or do the tools need to be modified to use with the population / group with which they work?

4. If the tools do need to be modified, how are they and do they meet reliability and validity standards?

5. If the TR Practitioner is not using tools, how do they assess their clients and why do they find it more effective than current tools available?

6. If they have created their own assessment forms, what is the assessment process they have developed and do they meet reliability and validity standards?

Definition of Terms

Recreation therapy/therapeutic recreation: Defined by NCTRC (2009) as:

…a systematic process that utilizes recreation and other activity-based interventions based upon the assessed needs of individuals with illnesses and/or disabling conditions. The purpose of the RT process is to improve or maintain physical, cognitive, social, emotional and spiritual functioning in order to facilitate full participation in life (p. 1).

Therapeutic Recreation Practitioner: for the purpose of this thesis a therapeutic recreation practitioner is a person who is a CTRS for at least one year working with older adults.

Standardized Assessment tool: for the purpose of this thesis, a standardized assessment tool is a commercially available assessment tool that has evidence provided regarding reliability and validity of the tool.

Quality Assurance: Stumbo and Peterson (2004) indicate that quality assurance can be: …formal, documented mechanisms that will ensure accountability in the provision of quality patient services…such as patient care monitoring, utilization reviews, program evaluation, and performance evaluations (p. 134-135).

Reliability: the assessment tool provides consistent results when used with the same group of people under the same conditions

Validity: "…the extent to which it [the assessment tool] meets its intended purpose" (Stumbo, 2002, p. 32)

CTRS: a therapeutic recreation practitioner who has met the qualifications and criteria required by the National Council for Therapeutic Recreation Certification and successfully passed the examination and is in good standing.

Older adult: any individual over the age of 65 years.

Significance of the Study

Current therapeutic recreation service delivery for older adults is diverse due to the variation of the qualifications of individuals who are currently delivering services (Goncalves, 2012). This study specifically focused on therapeutic recreation professionals who are a CTRS and how they use standardized assessment tools in their

service delivery or why they do not use them. This criteria was selected so there would be a minimal competency achieved amongst study participants for consistency in qualifications of persons who are practicing therapeutic recreation due to the variability of education background in therapeutic recreation service delivery. The findings of this study will contribute ideas of what research needs to provide therapeutic recreation practitioners working with older adults and where improvement is required regarding assessment practices. The findings will assist in understanding what current CTRS's who work with older adults are doing in their daily practice in regards to the assessment process, how they complete standardized assessments, if they use them at all, and any modifications they make to those tools.

Limitations of the Study

Possible limitations to the study include the following:

1. The small sample size may impact the applicability of the results to reflect therapeutic recreation practitioners use of standardized assessment tools in general.

2. Therapeutic recreation practitioners involved only worked with an older adult population and this may not reflect the practice of those who work with other populations or groups.

3. Therapeutic recreation practitioners volunteered to participate in the study; they were not randomly chosen. This does not represent the practice of all therapeutic

recreation practitioners working with older adults and why the practitioners chose to volunteer is not explored.

4. The sample size was limited to those therapeutic recreation practitioners who are CTRS living and practicing in the Atlantic region of Canada. Further limitations of study participants may be reflected by the research study location.

Location of Self

As a therapeutic recreation professional (CTRS) for the past 6 years I have recognized the gap between theory, research and practice. I had the benefit of acquiring work that allowed me to be a practitioner with clients and a practitioner involved in research. The demands of daily practice demonstrated to me the limitations put on therapeutic recreation practitioners to complete timely and thorough assessments, particularly around the use of standardized assessment tools. This became more apparent to me when my role in a research project was to collect pre and post assessment results using standardized assessments and an outcome measure. I began to question how we, as therapeutic recreation professionals, document the efficacy of therapeutic recreation service, particularly around the issue of assessment. Repetition of use with the standardized assessment tools used in the research study sent me back to one of the investigators with a series of questions and challenges I had with these tools and using them with an older adult population. The response was not one I was prepared for: "It's the pick of the litter" I was told. Despite sending emails about why these tools were incorrect and how the research participants struggled with answering them, I was simply encouraged to write it down. I then began to keep track of all the challenges research

participants and I had with these tools, and quickly came to realize some consistent issues. I took my results to the investigators, and with my frustration in tow, questioned why no one else had shown evidence of these 'challenges' with standardized assessment tools through documentation. Surely practitioners explored how effective standardized assessment tools were? My naivety as a new therapeutic recreation practitioner was shocked to learn that therapeutic recreation practitioners really had not documented the use of assessment tools with older adults.

I then began to question how widely used were standardized assessment tools by therapeutic recreation practitioners and took my questions to the research journals and textbooks. My next reality check about standardized assessment tools was that there was very little research on the tools themselves, forget their use by practitioners. After reviewing the standardized assessment tools themselves, as well as tools that were researched using an older adult population (related to therapeutic recreation practice), a series of consistent gaps and challenges became apparent. Examples of such include: using a variety of theories, various methodology techniques were used, demographic characteristics were often incomplete and did not provide the reader with a complete sense of who the research participants were (e.g. no description of ethnicities, income levels). Another factor was the various professionals used to facilitate the research and assessment process because they were diverse in professional background and competencies were not made known to the reader. Many research studies do not describe the competencies or education of the professionals collecting the data. This leaves a gap in how the assessment process was completed, since the reader has not been provided knowledge of what, if any, training provided to the practitioners completing the study.

After reviewing the research and feeling even more overwhelmed with the seemingly apparent gaps in the therapeutic recreation profession in regards to assessment tools, I wanted to understand what the everyday practitioner did in regards to their assessment processes and tools. I wanted to know that if they used standardized assessment tools, how effective did they find them, do they change any part of the tools, and how do they ensure they linked to the service delivery outcomes? If the practitioners were not using standardized assessment tools, then I want to know how they complete their assessments, why they chose not to use standardized assessment tools and have they written down how the tools did not work for their population. It was felt that a focus group with therapeutic recreation practitioners who worked with older adults could help provide this writer with insight to these questions. The following literature review provides the reader with a more in-depth look at the research that was reviewed regarding therapeutic recreation assessment tools, to provide a greater understanding to the current issues that have been documented surrounding just a few of the assessment tools used with older adults.

Chapter 2: Review of the Literature

What is Recreation Therapy?

Recreation Therapy, as defined by NCTRC:

…is a systematic process that utilizes recreation and other activity-based
interventions based upon the assessment needs of individuals with illnesses
and/or disabling conditions. The purpose of the RT process is to improve or
maintain physical, cognitive, social, emotional and spiritual functioning in order
to facilitate full participation in life (National Council for Therapeutic Recreation
Certification, 2009, p. 1).

Research has demonstrated how recreation therapy can benefit and support people
who face health challenges (e.g. Caldwell, 2005; Carruthers & Hood, 2004; Driver,
Brown & Peterson, 1991; Hutchinson & Kleiber, 2005; Hutchinson, Loy, Kleiber &
Dattilo, 2003; Iwasaki, 2001; Iwasaki & Mannell, 2000). But the results from research
must be examined with scrutiny before put into practice. Stumbo (2003) articulates that
"…evidence must be gathered through well-designed and meaningful research efforts
with client groups and be applicable to daily practice" (p. 26). And similar to quality,
meaningful research, the assessment process that a therapeutic recreation professional
uses with a client should be designed based on best practice and be meaningful to the
particular client group to reflect the outcomes targeted by the client/professional. The
first step is to understand what current research provides practitioners with regarding

assessment tools and processes. The purpose of this review is to examine how assessment and assessment tools affect service delivery and to provide an understanding of what current research has been completed on assessment tools in the literature.

The Assessment Process

The role of the assessment process can be viewed as the crux of the entire service delivery process. The assessment results will provide the logic and plan for why certain services are provided to a client. The "decision points," as Wright (1987) describes, "…have an impact on the quality of both the process itself and the outcome of care" (p. 59). These decisions made by the practitioner can include the following questions at the time of assessment, as outlined by Wright (1987): "1) What type of treatment does the patient need? 2) What specific services should the patient receive? 3) What staff member should provide the basic services? 4) Who should manage the overall treatment plan?" (p. 59).

As the assessment process is a key component to daily practice, assessment tools should be placed under such scrutiny to ensure their accuracy in reliable and valid results. The importance of having and using tools that are reliable and valid cannot be underestimated, particularly with increasing demands in the kinds and types of health care provided to the public (Zabriskie, 2003). Assessment tools not only must be able to capture the targeted concept, but should be measureable and amenable to the population it is targeting. Chang and Card (1994) clearly remark that: "Demonstrating and improving TR service's quality and effectiveness may be a difficult task because of the lack of credible instruments" (p. 164). The implication of having assessment tools that

are not credible is detrimental not only to the profession of therapeutic recreation but to the clients. The role of assessment, as defined by Peterson and Stumbo (2009) is to ensure a:

> …systematic process of gathering and analyzing selected information about an individual client and using the results for placement in to a program(s) that is designed to reduce or eliminate the individual's problems or deficits with his or her leisure, and that enhances the individual's ability to independently function in leisure pursuits (p. 251)

More specifically, standardized assessment tools allow for improved research outcomes by capturing pre and post scores of clients. The outcomes, regardless of what they may be, provide important information to practitioners around effectiveness and efficacy in practice.

Identification of the challenges associated with the use of standardized assessments has been reported by Peterson and Stumbo (2009) including: a minimal number of tools designed specifically for therapeutic recreation, few reflect the diverse practice of therapeutic recreation professionals working today, they can be expensive to buy, they lack appropriate psychometric testing, lack appropriate training for their use, high client turn-over, and the use of integrated assessment tools with multidisciplinary teams. An example of this is clearly demonstrated in a review of three case histories involving older adults. Homes and MacNeil (1995) identified that ten different assessment tools were used between the three case studies, varying from leisure interests to psychosocial and cognitive measures to agitation and life satisfaction scales.

The lack of appropriate assessment tools usually forces therapeutic recreation practitioners to create their own assessment tool (Zabriskie, 2003). Ensuring reliability, validity and soundness in these measures is a daunting task for practitioners who are already overwhelmed with the number of responsibilities they manage (Leblanc & Singleton, 2008). Finding consistency in research that uses only therapeutic recreation specific standardized assessment tools remains a challenge. The following review exemplifies just some of the challenges in current therapeutic recreation research.

Therapeutic Recreation Standardized Assessment Tools

Standardized assessment tools for therapeutic recreation have been produced and compiled into one large book and several subsequent editions entitled '*Assessment Tools for Recreational Therapy and Related Fields*' by Burlingame and Blaschko (2002). The text provides a history of assessment tools in therapeutic recreation, assessment process and construction of tests, issues with assessments and tests, and information around documentation.

Burlingame and Blaschko (2002) found that in the 1950's there were no specific therapeutic recreation tools, which they believe is due to the lack of standardized knowledge within the profession resulting from people with miscellaneous education backgrounds. Although standardization of education began in the 1960's, it was not until the 1970's that an influx of assessment tools became available. Most of these tools were activity inventories and did not meet reliability or validity standards (Burlingame & Blaschko, 2002). The 1980's showed an increase in the use of assessment tools for research but most were based on measuring outcomes of participation in recreation

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therapy programs. Austin (1982) made the point that therapists were expected to assess their clients but were not provided with guidance on how to do so and that 'the lack of standardized assessment was a problem for the field' (p. 47) (as cited in Burlingame & Blaschko, 2002). Many of the therapeutic recreation standardized assessment tools known today were created in the 1980's and more were developed in the 1990's but minimal research has been completed with these tools. As a result there are many limitations to the use of these tools including, but not limited to, appropriate client population for use, meanings behind results of the outcomes of such tools and protocols for interventions. The following is a review of research that has been completed on therapeutic recreation standardized assessment tools.

Therapeutic Recreation Research on Standardized Assessment Tools

Voelkl and Hermann (1993) illustrated the inconsistencies that can be found in research applied to the Therapeutic Recreation assessment process. Their study focused upon the application of the Pleasant Events Schedule – Alzheimer's Disease (PES-AD) and the Multidimensional Observation Scales for Elderly Subjects (MOSES) as part of a case study on a 92 year old woman living in a nursing home. Voelkl and Hermann (1993) report that because the participant was not able "…to sustain lengthy conversations, the data on availability and frequency of participation was collected from the Director of Activities" (p. 54). The director could speak to the participant being involved with certain activities "…a few times" (p. 54). The education of the director (or any other staff at the nursing home) was not provided and how the director collected this information was not provided in the article. There is no indication that the participant had ever been

formally assessed by a recreation therapist. In fact the actual data collection and treatment plan were implemented by the second author, who was an undergraduate student in Leisure Studies.

There are two clear challenges with this methodology: first is implementation of the treatment plan was completed by a student who has not ascertained any minimum criteria to practice. Secondly, it was unclear what interactions the student had with the participant. The reader is only informed of the number of visits and approximate length of time spent with the participant. A third gap in this case study is that the authors changed the PES-AD tool by collapsing some of the categories to reduce the length of time required by the participant to answer questions (Voelkl & Hermann, 1993) but the implications for reliability and validity of modifying the tool are not discussed.

In Searle and Mahon's (1993) study of the effects of a leisure education program on participants attending a senior's day hospital, forty-four participants had pre and post testing completed looking at the following concepts: locus of control, perceived competence and self-esteem. The hypotheses of the authors was that the participants who completed the leisure education program would have higher levels of each concept three months after completion of the program than those who were in the control portion of the study. The results showed the following: (1) the program participants had significantly higher scores on perceived leisure competence than the control group, (2) at the 3 month follow-up the control group scores stayed the same but the experimental group scores continued to gain in perceived competence, (3) control group participants who had high scores at the pretest stayed high at post testing, (4) participants in the leisure education

group who initially scored low in perceived leisure competence made significant gains at post testing, and (5) no significance was reported for the control and self-esteem measures.

Gaps associated with this research study included that not all of the variables collected from participants were reported in the study. It is crucial to have this information as factors such as marital status, sources of social support and health conditions of the participant impact the perception of the study to practitioners for the purpose of replicating the study. The outcome of the study may look very different if participants were married and perceived their health to be well when compared to participants who were single and viewed their health as quite poor. The authors did not report any diversity factors (e.g. cultural, ethnicity, language, religion), which again could greatly impact results. The terminology used may not be reflective of terms used in another culture and could, in fact, imply different meanings. Also no economic background, education levels obtained or social economic status information were reported. Again, the perception of leisure competence may vary greatly amongst people who are literate and illiterate, who have money to spend and enhance their leisure when compared to those who have low income and may not have the opportunity to engage in such leisure choices when basic life needs such as food, shelter or medication can be a financial challenge to meet.

Another gap in this research was that no information was provided about the qualifications or credentials of the recreation therapist who provided the leisure education program. Inconsistency in administration of the pre and post testing therefore

remains a factor to be considered. There was also no information provided around why

10 participants withdrew from the study and to which group they had been assigned. This

information would be useful to help future practitioners replicate the study and could

help prepare for potential participant withdrawal. Did participants withdraw because they

were not receiving the program? Or were there challenges in meeting the extra

requirements of participating in the experiential component? How long did it take to

complete the study? Another factor is whether or not there were other challenges that

may have occurred with the project. Was transportation to the facility an issue for this

population, or perhaps regular attendance at the program? This information would benefit

future replication of the study and enhancement for the profession. All research must be

transparent to ensure an accurate presentation of the project is being made and to ensure

duplication of the same mistakes does not occur.

Chang and Card's (1994) study provided similar gaps in their research testing the

reliability of the Leisure Diagnostic Battery Short Form Version B (Witt & Ellis, 1989).

The only information provided about the participants was that they were at least 65 years

of age and older, their mean age, gender and total number of participant. No cultural,

socio-economic, ethnicity, education or current health information/conditions were

provided. Although the Leisure Diagnostic Battery Short Form Version B (Witt & Ellis,

1989) results found significant reliability and normal distribution (See Appendix 1), the

process of obtaining the scores was unreliable. The authors used 2 residents to hand out

the assessment tool to other residents in the same public housing complex. Due to the

nature of this convenience sample, we do not know how the test was completed. The

authenticity of the data can be called into question as there is no valid evidence that the

assessment tool was completed as directed. Participants could have completed the tool

together, or simply have encouraged others to complete it for them. It would be

reasonable to suggest that there may in fact have been residents who were illiterate or

were not fluent in English. How would they have completed this tool without assistance?

Boothman and Savell (2004) tested the reliability and validity of a new

standardized computer-based assessment, called the Measurable Assessment in

Recreation for Resident-Centered Care (MARRCC) (Boothman, 2004) designed for

practitioners working in a long-term care environment. The purpose of the tool is "…to

provide TR professionals with a standardized assessment of a resident's functional level

in each of the physical, cognitive, social and emotional domains as related to recreation

participation" (Boothman & Savell, 2004, p. 383). The tool was used in eleven nursing

home facilities with a total of sixty-six participants who resided in the facility for a thirty

day minimum. No information besides mean age and gender was provided about the

participants. This was done deliberately "…to ensure that the sample was representative

of the population with which the domain scales of the MARRCC would ultimately be

utilized" (Boothman & Savell, 2004, p. 387). The tool was found to have content

validity, inter-rater validity and intra-rater validity, but the authors recommended further

research regarding criterion-related validity and predictive validity (Boothman & Savell,

2004).

Challenges with this research study include the lack of demographic information

provided to the reader. Information could have been collected that would contribute to

the diversity of the clients on which the MARRCC was used. Understanding key factors,

such as health and cognitive abilities, social support, culture and ethnic diversities cannot

be undermined. Each characteristic is relevant to therapeutic recreation practitioners as the population they serve is diverse and ever changing. As an example, the authors did not inform the reader of how informed consent was collected. This process can be challenging when working with people who are in a nursing home and require skilled care. The cognitive abilities of these residents may or may not allow them to fully appreciate and understand the research process.

Secondly there is no information provided about the education of the recreation directors who implemented the MARRCC on the residents and completed the assessment. This is particularly important with this tool as it is observation-based and the directors had to make clinical judgments about whether or not the resident exhibited the item for the domain based on the indicator provided.

Kloseck, Crilly, Ellis, and Lammers (1996) completed testing on the Leisure Competence Measure (cited in Kloseck & Crilly, 1997) for reliability and validity. In the pilot phase, the authors tested face validity by having five therapeutic recreation educators, two physicians, and eighteen therapeutic recreation practitioners answer four questions about the Leisure Competence Measure after having administered it. Similar to the other articles reviewed, minimal information is known about the reviewers. The only information provided about the therapeutic recreation practitioners were that they worked at psychiatric and rehabilitation facilities and that the average years of clinical work experience was six. No information is provided about their educational background, if anyone was a CTRS, nor how they were recruited to be involved with the project. Useful information would have been to know these factors, including the experience the

physicians had with therapeutic recreation as a service and their past experience with qualitative outcome tools.

The testing for reliability and validity was completed using patients at one of two units: the Geriatric Rehabilitation Unit or the Geriatric Day Hospital (Kloseck, Crilly, Ellis, & Lammers, 1996). Both reliability and validity scores were significant with these patient populations. The authors concluded that further testing is required amongst other populations with which therapeutic recreation practitioner's work.

The challenges with this research are somewhat similar to the other articles reviewed. A research assistant administered the Leisure Competence Measure to the one hundred and sixteen participants. No information regarding their educational background and experience was provided. It is unknown if the research assistant even has a background in recreation or therapeutic recreation.

One of the key factors to using a standardized assessment tool is that the process used to facilitate the tool is the same every time. But one of the challenges with the Leisure Competence Measure (Kloseck & Crilly, 1997) is that there is no method or standardization of how to collect the baseline information in order to get initial scores. The authors themselves note:

> In order to be of use, the scale must be: a) accurate (i.e. measure what it purports to measure); b) reproducible (i.e. produce closely similar measures from time to time and with different evaluators) and; c) dependable (i.e. have internal consistency and be constant across scenarios likely in clinical practice) (Kloseck, Crilly, Ellis, & Lammers, 1996, p. 24)

Yet with no consistent means to collect this data, how is the above description of a useful tool expected to be applied to the Leisure Competence Measure (Kloseck & Crilly, 1997)?

The second significant challenge is with the term competence. The authors say that "the LCM allows identification of basic competencies, or lack thereof, required for successful leisure functioning" (p. 24). There is no clear definition or observable criteria provided that can clearly articulate how someone is competent in terms of their leisure or what can guarantee their successful leisure experiences. In other words, are there behavioral cues or responses a CTRS should be looking for to ensure that their client is competent in their leisure? This information is not reported in the Leisure Competence Measure (Kloseck & Crilly, 1997) tool itself nor its research.

Reflecting on this, the argument could be made that unless someone scores perfectly at their baseline on the Leisure Competence Measure (Kloseck & Crilly, 1997), they therefore are not competent in their own leisure. More importantly the following question may be of more relevance to therapeutic recreation practitioners: Do you have to be competent in your leisure to enjoy it? (J. Singleton, personal communication, December 2009).

Gaps Identified

The review of these articles has demonstrated that there are consistent gaps in the literature and research about therapeutic recreation assessment tools. One positive factor was that of the five key articles reviewed all but one used a theory. Perhaps one of the challenging factors for practitioners is that there are a variety of theories used. All four articles had different theories, including attribution theory (Searle & Mahon, 1993),

Neulinger's leisure as a state of mind (Chang & Card, 1994), selective optimization and compensation (Boothman & Savell, 2004) competence from motivation, perceived competence, perceived control, self-efficacy, and learned helplessness (Kloseck, Crilly, Ellis, & Lammers, 1996). The lack of consistent theories may seem confusing or overwhelming to practitioners who may only practice based on one model/theory for service.

Even the methodologies were varied: from case study to field experiment to convenience samples, how the data was collected differed. Subject descriptions were particularly challenging in understanding an accurate picture of who the tools were tested with. The only study that gave sufficient background demographic information about the participant was Voelkl and Hermann's (1993) case study. All of the other research studies lacked in their reporting of participant information. Significant factors not reported included ethnicity, socio-economic statuses, health conditions, languages spoken, education, literacy levels, cognitive abilities and cultural differences. Improvement can be made by ensuring that as much information as possible is understood about participants so practitioners have a baseline of who the assessment tools have been used with and under what conditions. Otherwise practitioners are placed in a situation where there are tools available but are unsure if they are applicable, valid or reliable with the specific population they work with. Further research of these tools is required.

A gap that was found in every research study examined was that not any educational information was provided about facilitators, research assistants, practitioners or any one person who had been involved with administering the assessment tools. As

not one person was identified as a CTRS, the professional competency of each person

was unclear in regards to therapeutic recreation competency. As the CTRS designation is

the only minimum competency available today, it would seem logical that it be the

minimum requirement for practice and research so consistency and standard of

competency can be met.

Chapter 3: Methods and Procedures

The purpose of this study was to determine the use of standardized assessment tools amongst therapeutic recreation practitioners (CTRS) who were working with an older adult population. This chapter will describe the research design, participants and recruitment processes, methodology for obtaining data and data analysis and ethical considerations.

Research Questions

The following research questions were explored in the study:

1. Do current therapeutic recreation practitioners (CTRS) who work with older adults use standardized assessment tools as part of their daily practice? Why or why not?

2. What are the standardized assessment tools that they use?

3. If they do use them, how effective are they in producing outcomes in their practice and/or do the tools need to be modified to use with the population / group with which they work?

4. If the tools do need to be modified, how are they and do they meet reliability and validity standards?

5. If the TR Practitioner is not using tools, how do they assess their clients and why do they find it more effective than current tools available?

6. If they have created their own assessment forms, what is the assessment process they have developed and do they meet reliability and validity standards?

Research Design

Historically, most of the research completed in the therapeutic recreation and leisure fields has occurred in two separate domains: theory-based research completed by leisure researchers and practice challenges/case studies by practitioners (Hemmingway & Parr, 2000). Hemmingway and Parr (2000) infer: "Leisure research and leisure practice are conceived of here as independent professional paradigms, with no assumptions of a pre-existing link between them" (p. 140). LeBlanc and Singleton (2007) speculated it may be words that are the gap between research and practice. This study is designed to be driven by the practitioner and to understand his/her experiences; its purpose is to better understand if current therapeutic recreation practitioners (CTRS) assess older adult clients using standardized assessment tools and if not, what they are using for the assessment process and documentation of these results. The goal of this study is to help identify and document what current TR practitioners do when assessing older adults. This can inform future research initiatives helping to narrow the gap between research and practice.

This study is using the principles of Participatory Action Research to guide it. Participatory Action Research's purpose is "…for group members to gain authentic insight into their problems and to make decisions about future goals which are useful and empowering to themselves" (Chenoweth & Kilstoff, 1998, p. 177). It is a process that provides people with the opportunity to reflect on their current practices as well as those

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things that confine or restrict their practice (Kemmis & McTaggart, 2005). It is through this process that the goal is to understand the current assessment practice of CTRS's working with an older adult population and the role or lack thereof of standardized assessment tools and why this is so. It is through this process that an understanding of how things might change or could be changed for future practice will be explored by the author.

Focus Groups

The purpose of a focus group, according to Krueger and Casey (2009) "…is to listen and gather information. It is a way to better understand how people feel or think about an issue, product or service" (p. 2). Bryman, Teevan and Bell (2009) indicate that not only do focus groups provide opportunity to understand why people think the way they do, but also provides the opportunity for them to hear how others feel which can allow them to further their opinion by agreeing (or disagreeing) with how others think/feel, with ideas they may not have considered before. A factor to be considered when using focus groups, according to Bryman, Teevan and Bell (2009) is that "…meanings and understandings are not derived by individuals in isolation. Instead they develop out of interactions and discussions with others" (p. 168). Comfort to focus group participants is key: Krueger and Casey (2009) reinforce that a focus group must be a "…planned series of discussions designed to obtain perceptions on a defined area of interest in a permissive, nonthreatening environment" (p. 2). It is for this reason that using a focus group to obtain data was chosen by this author. It provided practitioners an

opportunity to talk about their practice and assessment processes in a supportive and safe environment to discuss their assessment processes and challenges.

In this environment the researcher wanted to understand what current practice looked like for these practitioners, not provide any indication of how it should look like or could look like; the goal was to capture current facts of every day practice. Secondly, there are a wide variety of tools available for practitioners to use with an elderly population; focus groups provide an opportunity for practitioners to explore their knowledge and understanding of these tools. This desire to understand how other practitioners work with assessment tools stems from the author's experience of feeling challenged by the available current standardized assessment tools in Therapeutic Recreation. These concerns include lack of research on a specific tool with a specific population; cost associated with obtaining assessment tools; applicability to the population and meaningful results. The researcher using an interview guide facilitated the focus group. The researcher welcomed "comments of all types – positive and negative. The interviewer is careful not to make judgments about the responses and to control body language that might communicate approval or disapproval" (Krueger & Casey, 2009, p. 6). It was decided by the Thesis Advisory Committee that the researcher should facilitate the focus group as the researcher was the most informed about the process and information sought. Another CTRS who was not participating in the focus group acted as a passive observer to take notes during each focus group session and to support the researcher during the focus group session. This support was completed in two ways: (1) Ensuring the researcher remained neutral in the conversation and (2) ensuring that each topic area was exhausted. This role allowed the researcher to be an active part of the

process but provided a safety net to ensure the researcher did not lead any conversations from participants. In reflection, it is the opinion of the author that this was an effective method of data collection as it provided a space for practitioners to speak freely and without judgement. Being a part of the focus group helped the researcher gain insights from the participant's experiences as well as an opportunity to reflect on the researcher's own experiences. A consideration of this is that all the participants in the study knew each other. It was observed that once one practitioner began discussing a topic, others became more open to disclosing their thoughts. Challenges with this method for future research might include practitioners feeling uncomfortable with discussing their thoughts or feelings in front of other practitioners, particularly if they do not know them. A possible solution to this could be to have participant's complete surveys or questionnaires independently but the researcher risks the topics not being fully explored as they would be in discussion group.

Participants

The participants were a convenience sample of therapeutic recreation practitioners who held the designation of Certified Therapeutic Recreation Specialists, as deemed by NCTRC. Participants were recruited through an email listserv of current TR professionals who worked with older adults that was used by the author's supervisor as well as through an advertisement via a local therapeutic recreation professional association, which supports practitioners working in the field of therapeutic recreation. Although one method of recruitment occurred through the means of the association,

participants were not required to be a member of the association. Participants were selected based on the following criteria:

1. They held current certification with NCTRC.

2. They had been practicing in the field of therapeutic recreation working with older adults for a minimum of one calendar year full time (75 hours/biweekly) or two calendar years at half time (37.5 hours/biweekly) and certified for this duration

3. They practiced in a clinical or community-based environment where 75% of their clients were over the age of 65 years

Participants were limited to those who were therapeutic recreation practitioners who were certified with NCTRC as it provided assurance of a minimum competency level for those practitioners involved. Obtaining certification indicates that the practitioner has achieved minimum competence in such practice areas of assessment, leisure theories and models of practice, lifespan development and impairments, facilitation techniques, and activity modifications (NCTRC, 2010). Once certified, NCTRC requires practitioners to maintain certification every year and to recertify every five years through two methods: (1) hours worked in therapeutic recreation professional experience and a minimum of 50 hours of continuing education or (2) re-examination (NCTRC, 2010).

The focus group was completed in two parts. The first focus group was used to obtain information from the participants about their assessment processes and tools used. Twenty-four hours after the first group, participants were sent a brief post group

reflection questionnaire. The second focus group was to collect feedback from participants about the themes that had been developed by the author and to ensure they reflected their voices and experiences. Two focus group guides were developed: one for the researcher to use for facilitation of the group and one for the focus group participants prior to participation of the first focus group. Focus group participants received the guide about what to expect in the focus groups prior to the first meeting to allow them opportunity to reflect on their practice and assessment processes. The guide was given seven days prior to the first focus group and only to participants who signed the informed consent form. The focus group guide for the researcher contained predetermined questions that were approved by the thesis committee to ask and explore with the participants.

Demographic information that was collected from the participants included: their gender, province in which they worked, years of practice, setting in which they worked (i.e. either a clinical or community-based setting), education institution where they received their training and method used to obtain certification through NCTRC (academic path, equivalency path A or equivalency path B). Any further information about the participants could potentially reveal their identities.

Data Collection Procedures

Any CTRS who met the study criteria and who volunteered to participate in the study was eligible to partake in the focus groups. Those who participated met all of the criteria and chose to be involved. To assist with recruitment of eligible participants for the focus groups, an email was sent to practitioners on a listserv that was currently held by the

author's academic advisor. The author's academic advisor emailed the listserv requesting permission of those interested to receive information via email about the research study by the author. The author had no access to this listserv. The email contained the Letter of Invitation (Appendix C) and the Recruitment Flyer (Appendix E). Those who granted permission contacted the author by email and the author provided them with the Focus Group Participant Guide (Appendix B), Letter of Invitation (Appendix C) and Informed Consent Form (Appendix D). An email was also sent to a local therapeutic recreation professional association, requesting an email notification of the research study to its members. The email contained the Letter of Invitation (Appendix C) and the Recruitment Flyer (Appendix E).

It took eight months to recruit 6 (six) eligible participants. An email was sent to all those participants that expressed interest and met the criteria of the study. The author sent a list of seven different days and times to each participant to determine a common time they would be available to participate in the focus group. Participants were asked to select the top two times which were convenient for him or her. If there was no common time amongst all the participants, the author will select the top two days/times that were given and ask participants to pick which works best for them. All participants were told through email which day and time the first focus group would occur, as well as where it would take place. The author held the focus group in a location not associated with any of the participants daily work habits but in location central to the majority of the participants, within an Atlantic Canadian city, due to the author's restrictions.

Five of the six participants identified a common time they were able to attend the focus group. As a result of a conflict of schedule, the sixth participant had to withdraw from the study.

Five participants indicated they would participate in the first focus group but only four participants attended. It is unclear why interest in participation in the study was low as there are a significant number of CTRS's that work within the area the research was completed. The purpose of the initial focus group was to collect information about the participants' assessment processes and assessment tools they use, as well as to gain insight into their knowledge around assessment tools available for the older adult population that relate to the therapeutic recreation process. This initial focus group was led by the researcher, and the non-participatory CTRS was in the room observing the focus group and taking notes, while supporting the researcher.

One week prior to the focus group, the participants were sent an email from the author that included Focus Group Participant Guide (Appendix B), detailing what to expect in the focus group experience and to provide topic related ideas to help each participant think about their assessment processes in their daily practice. The questions presented to the participants in this document were reviewed and approved by the Thesis Advisory Committee before being sent out to the participants. Several days before the focus group occurred the author met with their academic advisor to review the material for the focus group. This meeting provided an opportunity for the author to practice the process of the focus group and ensure a good flow of questions for the participants would

occur. Participants were sent an email notification two days prior to the focus group to remind them of the date, time and location.

The first focus group took approximately 2 hours to complete. The focus group was recorded and transcribed verbatim. Every participant was assigned a code during transcription. The transcript was reviewed by the author and the author's academic advisor to compare thematic analysis (see data analysis for full description of process). The passive observer reviewed the two sets of themes drawn by the author and the author's academic advisor with the author to ensure no major gaps could be identified from their perspective. Once this process was completed, a second focus group was held to review the summary of the themes with the participants.

Twenty four hours after the initial focus group, participants were sent an email from the author that requested each fill out a post reflection questionnaire (see Appendix G). Participants had ten days to complete the questionnaire and email it back to the author.

The decision for a second focus group's day and time occurred via the same process used to decide the first focus group. Prior to the second focus group the participants were forwarded the themes and subthemes identified by the author and academic advisor from the first session. This provided the participants with time to review the themes and an opportunity to provide feedback, clarification and elaboration of the themes to ensure they reflected what the participants shared in the first focus group. Participants who were unable to attend the follow up focus group provided written feedback to the author in lieu of attending the session. Only one participant attended the

second focus group, two participants sent feedback via email, and there was no response

from the fourth participant. There were no major revisions to the themes as a result of

participant feedback.

Data Analysis

Content analysis was used to analyze the focus group transcripts (Coffey &

Atkinson, 1996). The purpose to using content analysis, according to Downe-Wambolt

(1992) is "…to provide knowledge and understanding of the phenomenon under study"

(p. 1278) (as cited in Hsieh & Shannon, 2005). Specifically the author used conventional

content analysis as it is a common methodology when an area has minimally been

explored through research (Hsieh & Shannon, 2005). For coding purposes, the author

analyzed the data in three stages: open (breaking down the words and beginning to

categorize the data), axial (where connections will be made between categories) and

selective (identifying key themes from the data and supporting it with the previously

identified categories) (Bryman, Teevan, & Bell, 2005).

The author reviewed the initial research questions prior to analysis. The transcript

was read in its entirety, and then re-read while listening to the audiotape of the transcript.

This created the development of a draft coding scheme and theme analysis, while

listening to how the participants spoke, to ensure the context of the participant's voices

was captured. The author also noted their initial thoughts and ideas at this time (Hsieh &

Shannon, 2005). Pseudonyms for every participant were used to ensure anonymity. The

pseudonyms used were ones the participants themselves selected. On the third reading,

codes were categorized into themes and color coded on the transcript. Everywhere a

specific theme occurred, it was colored in the same color. This process of open coding (Bryman, Teevan, & Bell, 2009) allowed the author to capture common patterns/themes that occur within the data. The author then re-read the transcript and listened to the audio recording to ensure context of the participants conversation was kept in check with the themes identified.

The author had the academic advisor complete thematic analysis of the transcript since the academic advisor was not present for the focus group and was blinded to who participated in the study. The academic advisor is also a CTRS who is familiar with the terminology and issues in the field. Review of the two sets of themes drawn by the author and the academic advisor were reviewed and discussed with the CTRS who was the passive observer during the focus group to ensure accuracy. Both the academic advisor and the passive observer were already involved with the research, therefore limiting outside involvement to support anonymity of the participants and the confidentiality of the focus group discussions.

Once the author and academic advisor developed themes and these were reviewed with the passive observer, the author and academic advisor met to share and compare themes and codes that were identified. Each shared their findings and the author developed a diagram identifying each person's themes and to verify similarities, connections and differences found by each person. A consensus of the themes was agreed upon, and the author prepared a review document of the themes that was sent out to each participant for their feedback.

The second focus group occurred to provide the participants with an opportunity to review the themes, provide feedback and to ensure accuracy of the themes as demonstrated by content (e.g. quotations) used to support it. It also provided an opportunity for participants to add things they may have not thought of in the first focus group. This process of member checking provides credibility to the study to ensure the author is representing the reality of the participants' experience (Bryman, Teevan, & Bell, 2009). Feedback from participant members who were unable to attend the second focus group was reviewed at this time.

Ethical Considerations

The following protocol was used to ensure integrity of the study met the ethical guidelines of Dalhousie University. The study was reviewed by the Thesis Advisory Committee of the author as well as reviewed and approved by the Dalhousie University Health Sciences Research Ethic Board. In keeping with ethical practice, all participants were informed both verbally and in writing that the research study was voluntary and that participants could withdraw at any time. Participants were also provided with a full copy of the informed consent form, which provided all the details about the study, including any and all risks and harms associated with participation in the study. The consent form had to be returned to the author before participation in the study could begin. All participants were reminded that the conversation that occurred in the focus group experience should remain confidential but the author had no control if participants shared information outside the focus group. Participants were instructed that their identity would not be revealed in the transcripts and that each would be assigned a code name, chosen

by themselves. In keeping with ethical practice at Dalhousie University, only the author

and author's supervisor would have access to the audio recordings. The transcriber had

access during transcription and the tapes were returned to the author. All data was kept

secured in the author's supervisor's office under lock and key. When data analysis was

finished, the tapes were destroyed.

Chapter 4: Results of Focus Group

This chapter is designed to present the results of this study. The chapter is divided into the following sections: review of the research questions, focus group process, demographics of the participants of the study, theme identification process, themes and subthemes, and summary.

Research Questions

The purpose of this study was to explore how standardized assessment tools were used by therapeutic recreation practitioners (CTRS) who were working with an older adult population. The research questions for this study were:

1. Do current therapeutic recreation practitioners (CTRS) who work with older adults use standardized assessment tools as part of their daily practice? Why or why not?

2. What were the standardized assessment tools that they use?

3. If they do use them, how effective were they in producing outcomes in their practice and/or do the tools need to be modified to use with the population / group with which they work?

4. If the tools do need to be modified, how are they and do they meet reliability and validity standards?

5. If the TR Practitioner was not using tools, how did they assess their clients and why do they find it more effective than current tools available?

6. If they have created their own assessment forms, what was the assessment process they developed and do they meet reliability and validity standards?

Methodology

Focus groups were used to facilitate discourse related to the research questions. To understand the thoughts and experiences of the participants, the author has chosen to outline this chapter with the themes that were drawn from the focus group, supported by subthemes that were found in relation to each theme. This method better represents the words of the participants and their experiences while also addressing the research questions. The complexities and contexts of the voices of the participants were best represented when one thinks of the metaphor of weaving to illustrate the interactions of themes. The themes were interwoven with no one factor isolated or mutually exclusive from the other. Content and ideas frequently overlapped when participants were discussing their experiences in this study. As an example, time, although identified as a major theme, was illustrated in all the themes identified from the focus group. Although the voices of the participants are presented in themes and subthemes, it is important for the reader to recognize and understand that each theme or ideas were interwoven.

Focus Group Demographics

The focus group consisted of four CTRS's, the author and the passive observer. The passive observer was a CTRS who's role was to take notes during the focus group session and to support the researcher by ensuring neutrality of the researcher during the focus group and that each topic area was discussed to its capacity. Five participants were expected to attend. Only four attended and it was unknown to the author why the fifth participant did not attend. No further contact was made with the participant who did not attend the focus group and was considered withdrawn from the study. All the participants

were of one gender, worked in Atlantic Canada, and defined their work place setting as

clinical (versus community), and worked with older adults. Their work experience

ranged from 5-8 years and they all achieved their CTRS certification through the

Academic Path set out by NCTRC. Each participant selected her own pseudonym. The

pseudonyms selected were: Erica, Eva, Rowan and Tiffany. All direct quotations will end

with the pseudonym bolded in brackets.

Theme Identification Process

After completion of the first focus group, the audio recording was transcribed.

The author applied the concepts of content analysis for thematic analysis. The author

read the transcript and then re-read it while listening to the audio recording. This created

a draft coding scheme to assist the author in capturing concepts and themes that were in

the context of the participants voices and spoken experiences. The author also made

notes about initial thoughts, concerns and related it back to the research previously

explored. On the third reading of the transcript, the author color coded all the codes

identified and arranged them on a separate piece of paper so that all codes of the same

color were together. It was through this process of open coding (Bryman, Teevan, &

Bell, 2009) that initial theme development began. Once the author had completed initial

theme identification, the author re-listened to the audio-recording and re-read the

transcript simultaneously to ensure that the themes were in keeping with the conversation

that had occurred in the focus group.

The transcript was also reviewed by the author's academic advisor. The advisor

created a theme analysis using the open coding process. The author and the academic

advisor met and shared their initial findings. The following table (TABLE 1) illustrates the initial themes generated:

Table 1 – Initial Themes

Reviewer #1	Reviewer #2
Time Constraints	Fear of Assessment
Professional Identity	Characteristics of Assessment
Assessment Challenges	Characteristics of Therapist
Assessment Process	Short Term Results
Development of Rapport	Varieties of Tools
Assessment Tool Challenges	Scope of Practice
	Person-Centered
	Different Terms – Same Concepts

Upon sharing the initial theme findings there were many similar concepts that were captured by both reviewers, but used different words to express similar ideas. After discussion with the academic advisor, the author created a draft form of themes that was a combination of both sets of initial themes. The following table (TABLE 2) illustrates the results of these discussions.

Table 2 – Second Draft of Themes

Theme	Subtheme
Characteristics of Assessment Tools and Processes	Rapport dependent Processes used (recording it) Documentation required (lack of)
Challenges of Assessment Tools and Processes	Time Lack of Outcomes Difficulty measuring concepts, lack of specificity Ongoing process/Short term results Scope related to assessment Documenting Process and Outcomes
Challenges of Professional Practice	Time contraints/deadlines Documentation Standards Values/Expectations
Professional Identity and Characteristics	Team player, Contribution to the team, & value Need for Support Accountability Person-Centered

The author then met with the CTRS who was the passive observer in the focus group to share both sets of initial theme findings along with the summary of both. This person concurred with the themes that were generated. The author finalized the themes and sent a summary of the findings to the participants. The summary (see Appendix H) included each theme and subtheme identified along with direct quotations used to support them. The author left a comment space after each theme for participants to make remarks.

Through the process of the second focus group and the email feedback, the themes and subthemes were confirmed by the participants. The comments that were reported back from participants on the theme summary ranged from confirmation of

themes to their continued reflection of the conversation that occurred during the focus group. Examples of feedback received were:

This focus group has made me reflect on the way I practice. For example, are there areas where I can improve upon and/or change? It also made me question the use of "formal"/Red Book assessments. (**Eva**)

This sub-theme sums it up perfectly to me. Our assessment process is on-going, and as was mentioned previously a lot of the current standardized assessment tools are not practical for use with older adults. (**Erica**)

After review by the author, the academic advisor, the CTRS who observed the focus group and participants, the author identified four major themes. Each theme had several subthemes that were relevant to the overall theme category. After constant comparison of the themes and subthemes and details that were noted for each, the themes and subthemes were repackaged by the author to ensure better flow of the described issues discussed by the participants. This meant some themes and subthemes were merged or content was cleared under a new subtheme title. Table 3 illustrates the final four major themes along with the subthemes associated with each major theme.

Table 3 – Final Themes and Subthemes

Theme	Subtheme
Characteristics of Assessment Tools and Processes	Definition of Assessment Processes Used/Skills Rapport Environment/Dynamic Relationship Role of Non TR Assessment Tools Documentation
Time	Impact on Practitioner Impact on Client Impact & Limitations on Everyday Practice
Challenges of Assessment Tools and Processes	Challenges of Standardized TR Assessment Tools Measuring Concepts Documentation Awareness and Education
Challenges of Professional Practice	Values/Expectations/Team player Need for Support/Connections Professional Identity

Constant comparison of the themes and reflection of the focus group experience and the words of the participants was used in the data analysis of this study. The participants illustrated the complexity of the question in their discussions. Themes were integrated with each other as no theme is in isolation of each other. The metaphor of weaving attempts to illustrate this interaction. Figure 1 illustrates this interaction of the themes.

Figure 1: Assessment Impact in Recreation Therapy Practice
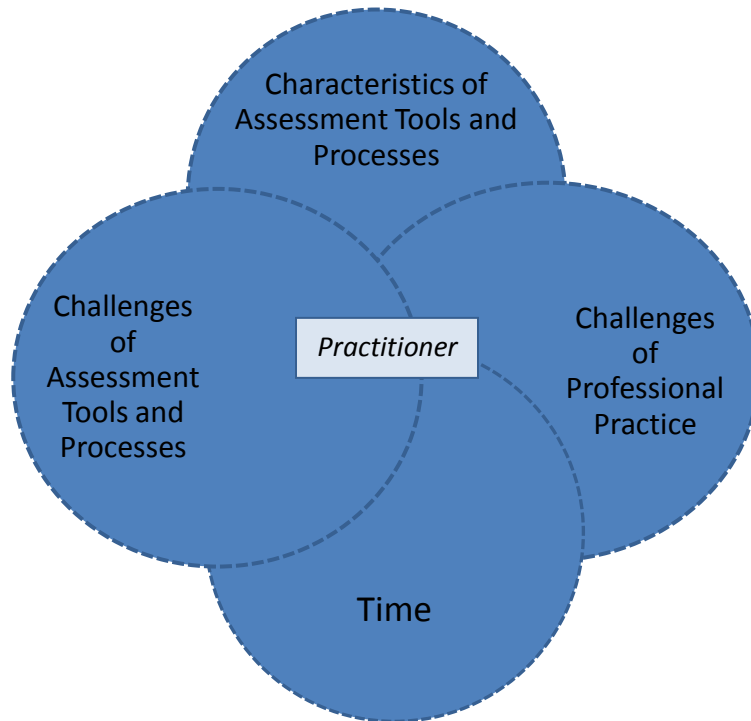
Each theme area is discussed in this chapter and supported by the subthemes. Included in the discussion of the themes, the author has included samples of statements participants made that are related to each perspective theme.

Theme #1: Characteristics of Assessment Tools and Processes

This theme was derived from the participants discussing about what assessment was to them, what processes it consisted of and how they interacted with their clients to complete an assessment to ensure appropriate therapeutic interventions were provided. The theme is divided into the following subthemes: (a) Definition of Assessment, (b) Processes Used/Skills, (c) Rapport, (d) Environment/Dynamic Relationship, (e) Role of Non-TR Assessment Tools and (f) Documentation.

Definition of assessment. The participants provided insights into the complexities of the term assessment. Participants were not provided a definition of assessment but were asked to define it. The following were examples of what participants reported:

> I think of assessment as the whole process of getting the information from the chart review, doing an interview, going through the actual assessment tool and then developing the plan and then evaluating the plan afterwards. (**Tiffany**)
>
> Similar to what Tiffany said, I think it's the same, except I guess I always start with the initial meeting of the patient and speaking also with the family, doing a screen, well chart review I guess, screen….I rely a lot on my initial meeting with the patient and then go from there. (**Eva**)
>
> …also chatting with like other staff, like nursing staff or other disciplines just to see, you know, that they may see different aspects of the client that I may not see. (**Erica**)

The participants were in relative agreement of how they gathered information to complete an assessment. All participants gathered information from initial meetings with the client, review of the health record, observing the client, speaking to other allied health staff and using standardized tools.

Assessment was felt by participants to be a continual or on-going process. Assessment was more than a tool or a one-time visit with a client. Some reported that completing assessments took days, while others felt it was a daily process in knowing how they would work with the client or even their approach with a client. Participants

made it clear that assessment was not any one tool in particular and that tools in fact were of limited use to them. The participants discussed a process of understanding who they were working with.

Processes used/skills. Participants were asked about what processes they used or what skill set was required to complete an assessment of a client.

The main part I think is doing your chart reviews and chatting with others and things like that but I think about delivering the assessment tool and interviewing you need to have really good people skills, you need to be a good listener and kind of be able to pick up on different, like you know different pieces of body language that you might see. (**Tiffany**)

Observation, listening and conversation skills, and reading body language were identified as important skills for a recreation therapist to possess. Eva stated: "I think you have to learn not to lead like I think that's critical, be patient." (**Eva**) Participants spoke about appreciating that clients were usually overwhelmed with the number of healthcare providers in to assess them and the large number of questions that were asked. Every participant spoke of one skill that they all used to complete an assessment with a client. That skill was in building rapport with their clients.

Rapport. From the beginning of the focus group, participants immediately and frequently spoke of the role rapport played in working with their clients. All of the participants were in agreement around the value of having rapport with a client and articulating that a great value and need was placed on a having a good rapport or relationship with a client.

You can read all you want in a chart or you can read whatever, but if you don't

have that rapport or you don't form some kind of relationship with the person you

can, no assessment in the world or nothing is going to get you anywhere. (**Eva**)

Rowan felt that the role of rapport was more significant for therapeutic recreation

practitioners simply due to the holistic nature of the practice of the profession.

I think just because we're such a holistic profession that that whole element of

rapport is more important. I mean if your questions are only relating to the

physical domain, or functional domain you don't need to explore or know the

person as much. I mean there's, not to say that a lot of the other team members do

not take a keen personal interest in the individual and show that, but in order to

assess them, physical functioning, or a functional level of performance, it doesn't

take as much rapport or trust. (**Rowan**)

Rapport was also felt to be a part of the assessment process and one participant felt

building rapport prior to asking assessment questions was important.

…I always like to kind of meet with the resident/client, once or twice before

doing the assessment just to start building rapport and that you're not just coming

the first time and asking all these questions of them. (**Erica**)

One participant spoke of how rapport has played a role in supporting a client emotionally

because the client felt comfortable sharing their thoughts and concerns with the recreation

therapist versus other team members because of the positive relationship that was

developed.

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Sometimes where they don't see our profession as being medical related they will tend to tell us stuff, how they really feel in the hospital, what's going on and sometimes they'll tell us those fears where we can go back, even though you're not breaking their confidence, but you can still go back to the team and say you know this is their concerns, whereas they may not get it out of somebody. (**Eva**)

Defining rapport, on the other hand, was not an easy task for participants. One participant reported it as "they feel comfortable with you." (**Tiffany**) Another said

like a good interaction or like make a trusting relationship, like a good, where you're not sitting in the room and staring at something. Someone where they can speak freely to and ask, non-threatening for both parties. (**Eva**)

While Eva suggested that rapport comes from ones personality, she further described it as:

…I always think about how you would feel if you were in their shoes, and you kind of just make, providing that comfort level and I don't know, making them feel secure and trust and that kind of stuff… (**Eva**)

Participants were asked about what they do if they struggled with building rapport with a client. Some said that they relied on their teams to help build that relationship with a client, particularly when the client may not see the benefit of recreation therapy services. Participants also felt that they did the same for their team members if they were having difficulty working with a client.

Participants were asked if they felt they needed to have rapport with a client in order to complete the assessment. Eva felt that it was necessary to develop rapport if the practitioner was seeking a "true reflection" of the client. Several of the participants spoke of the role of completing a social profile of the clients. It was felt that doing such gave all team members a better sense of who that client is as a person and to get to know them better. Erica described a social profile as a mini biography with pictures to help all of the staff at her place of work to get to know the client more as a person.

Rapport was not built solely on a relationship. The participants spoke about the environmental and physical context of building rapport with a client and the impact distractions could have on building rapport with the person.

Environment/dynamic relationship. Participants spoke not only of rapport but the importance of how they conduct assessments and the environment in which the initial conversations took place. Experience has taught Rowan that creating a formal process/environment impacts what the client will say. Rowan states: "I find as soon as you come into a room with a formal piece of paper on your lap, it just changes the whole conversation." (**Rowan**) Rowan's experience was that having a conversation with the client was much more beneficial than entering a room with paper and pre-set questions. Eva talked about how she completed the questions with clients and the use of frontloading her clients about why she wrote things down.

> Well I take notes, I just tell them what I'm doing. It's kind of like an informal
> conversation we're having, like I do it in my own head, like the questions that I
> ask, but I just tell them initially that I do this with everyone, I ask the same

questions, you know sometimes obviously the conversations veer off, but they're the same questions that are kind of to get started, and I ask them if they mind if I take notes. Cause I say I'll forget so you know, so it's kind of more, and they feel comfortable with it that way. (**Eva**)

Making sure clients were comfortable was important for the flow of the conversation. Even though some participants identified the impact of formalizing the assessment process, participants were asked if they used standardized therapeutic recreation assessments as a part of their practice. Each participant had used them at some point in their practice but no one used them on a regular basis. Participants did speak about using standardized therapeutic recreation assessment tools when they had students completing placements with them. Participants listed several assessments and an outcome measure, such as the Leisure Competency Measure (Kloseck, Crilly, Ellis, & Lammers, 1996), the Functional Assessment of Characteristics for Therapeutic Recreation Revised (Peterson, Dunn & Carruthers, 1983), and the Measurement of Social Empowerment and Trust (Witman, 1988). Although participants were aware of a variety of therapeutic recreation assessment tools, some participants chose not to integrate them into their practice.

All of the participants frequently integrated information from non therapeutic recreation assessment tools that were completed by other allied health team members

Role of non-TR assessment tools. The participants indicated that non therapeutic recreation Assessment tools, such as the Mini Mental Status Exam (MMSE) (Folstein, Folstein, & McHugh, 1975) played a role in their practice but only as part of their

information gathering process. Tiffany stated that she did not facilitate or complete these tools but she did use them to find out information such a cognitive scores or the clients risk for falls. The participants felt it was not their role on the team to complete other standardized tools commonly used on their teams like the Mini Mental Status Exam (Folstein, Folstein, & McHugh, 1975) or the Montreal Cognitive Assessment (MoCA) (Nasreddine, 2003).

> I'm sure the LPNs, RNs do the MMSE, I never thought about doing it myself either to be honest with you, it's just something they always did. (**Erica**)
>
> I never really thought I could. You know I've never, I've been like told oh you can't do an MMSE. (**Tiffany**)

The participants provided differing perspectives related to filling out and completing non therapeutic recreation standardized tools. One participant felt it was not their role to complete some of these tools because recreation therapists are not a licensed profession in their province. "Yeah I thought the MMSEs had to be done by registered staff cause it's always asked by, or you know licensed staff." (**Eva**) But other participants reported that they would like to complete standardized non therapeutic recreation assessment tools like the MMSE (Folstein, Folstein, & McHugh, 1975) because they find the information so useful and it's something they already look for when completing initial data collection on a client. As stated by Tiffany "…you know if I could do the assessment I would. Sometimes they're not in there and I wonder you know what would their MMSE be." (**Tiffany**) Others reported it would be useful if they could do it because often times the MMSE on the health record of the client is out of date.

One participant said they would complete a non therapeutic recreation assessment tool but was quite happy to not have to spend time doing such tests.

> I'd feel happy doing it but you know what, I'm glad to have the 20 minutes to do something else with the person rather than administer the MMSE. I'm happy that it's not, I'm interested in the information but I'm, I certainly don't regret that I don't have to do that. (**Rowan**)

The participants did not identify any person/role/authority who told them they were not able to complete these standardized tools nor could they identify where permission would come from.

Although participants did not formally complete these non therapeutic recreation tools, one participant reported that they did use components of them as a cognitive intervention:

> **…**if I've had curiosities about them and how they're operating, I've just pulled out a TRAILS test (Trail Making Test, Reitan, 1955) right and just kind of treated it as sort of a cognitive intervention just to see where they're at and just ask them if they can, you know just like can you do this and just, to see where they're at. It's never like a formal thing but I've done them right and to see where they are because maybe I've tried to get them to do a puzzle or tried to get them to do something that requires sequencing and they seem to be having a problem, so the next time maybe I've brought in a trails (Trail Making Test, Reitan, 1955) just to see where they're at. (**Rowan**)

Participants discussed about how many of the concepts measured on standardized non therapeutic recreation assessment tools were in fact concepts used in activities similar to what they completed in programs with clients.

> I think informally you do it all the time, like part of the frontal assessment battery (FAB) (Dubois, Slachevesky, Litvan & Pillon, 2000) right, FAB is six animals that start with the letter F or whatever right and when we're doing gaming in the evening, you do those things, right, and so you're doing these components, and it's just like with the trails (Reitan, 1955), like you know they come out quiz books and different, and so it's more of a gaming type thing that we're doing but in some ways we're doing those same assessments but it's in a less intimidating way for them… (**Rowan**)

The participants identified a variety of methods used to collect information for an assessment that included chart reviews, interviews with the client/family, rapport building and speaking with other allied health team members. Summarizing and documenting their results is discussed next.

> **Documentation.** Participants discussed documentation standards at their places of work.

> I guess in terms of the length of time, the technical goal is to have our assessment or admissions assessment completed within a week or so, just because it just gives us some time to, you know, I always like to meet with the resident/client, once or twice before doing the assessment just to start building rapport and that you're not just coming the first time and ask all these questions of them. (**Erica**)

Participants discussed how the assessment process occurred over several visits with their clients and, as Erica described above, documentation of the assessment only occurred once it was completed. Participants did not speak of documenting on the health record about how they built rapport and the outcomes of that rapport building. Discussion occurred around what counted as assessment time for the participants. All participants counted rapport building and initial information gathering as assessment time. Rowan said:

> I do, in that those interviews, those initial interviews if you want to call them that, or initial conversations, as far as them allotting how my time is spent for the day, when I'm spending those initial conversations, I do put that as assessment time.
> **(Rowan)**

This section has provided an overview of the key characteristics the participants identified in the assessment process. The next theme explores the various challenges the participants identified with time.

Theme #2: Time

A key factor for every participant in this study was time. Time appeared in all contexts of discussion that occurred in the focus group. Issues with time were the one major factor that was integrated in every other theme identified. Participants were challenged with time across all domains of their practice. The author did not explore with participants their reasons for why time was an issue (i.e. were their caseloads larger than other team members, poor time management or if time was an excuse). According to the participants, time impacted patient care, service provision, expectations of practice,

work/life balance, research opportunities, ability to connect with fellow practitioners, and an inability to focus on one area of practice (e.g. assessment). This theme is divided into the following subthemes: (a) Impact on practitioner, and (b) Impact on Clients and (c) Impact and Limitations in Everyday Practice.

Impact on practitioner. Participants voiced feeling that they frequently did not have enough time to complete thorough assessments. In one example, a participant felt the crunch when patient admissions and discharges were high in their workplace.

> I mean time constraints sometimes limit us so that we never, or at least for myself, I never feel like I totally did a decent assessment on an individual because it could just be at a time of very high turnover in the workplace, meaning client turnover, so you just, you never feel like you have fully done, like done a full assessment on an individual. (**Rowan**)

Problem-solving and decision making were key elements to managing the challenges associated with time. For Tiffany, it was about caseload management and learning from her experiences as a practitioner to know how time should be spent.

> Well I guess so, knowing like what my case load is and how much time I have, and looking at like I don't have time for this and I have all these other people to see. (**Tiffany**)

There was discussion about work life balance as well as balancing all the tasks required on the job. Eva spoke of trying to find time to do everything in a day and be ready to come back and do it again. As a result of trying to find a balance, time connecting with other practitioners to learn and discover new things was limited.

I think it all comes down to time commitment because it's a lot of time. And when

people put in their 7.5 or 8 hour, whatever hours a day, you know it's, and then

when you want to leave to get away from this, so you can come back and do it

again the next day, but I think if there was maybe more time given at work, like

around that focus too and not just on a clinical level, and having more support,

maybe, but that doesn't seem to be given, so then maybe you could pursue that

kind of a little bit more and I think the alliance could be a lot, you never know the

results that you could get from it. (**Eva**)

Lack of time was also noted by Rowan to impact her ability to reflect on not only

her practice but issues that affect the profession as a whole and not just those working

with older adults. "I'd be very interested to hear because I think probably there are more

assessments being used in other areas." (**Rowan**)

Impact on clients. Participants voiced concern not only about how long it would

take them to complete a standardized therapeutic recreation assessment but how that time

impacted the client they were assessing, particularly when working with an older adult.

Eva was deterred from using them for this reason also. She also felt that she could

achieve the same results without using a standardized tool and it would require less time.

The impact of time pressures affected client care. Participants spoke how not

having enough time impacted the therapy they provided to their clients. Tiffany said:

"you don't always have the time to find those meaningful therapeutic interventions and

it's hard to balance everything." (**Tiffany**) Rowan agreed with this, and felt that the

impact of not having enough time was that "you just don't really get to know that

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individual." (**Rowan**) Since participants spoke significantly about the role of rapport building with clients, it is easy to see how not having time to get to know and work with the client would affect therapeutic recreation services.

Impact and limitations in everyday practice. One participant spoke of the pressures of working on a recreation therapy service. Reality she spoke of included large client caseloads, demands of client needs and providing full service provision with recreation participation programs.

I just feel like we're stretched so thin too. I mean case loads are so heavy, there's all these expectations to create this huge social atmosphere but then also it's like you have people with behavioral issues, and it's like what interventions do you want to do and how can you do everything and keep everybody happy? (**Tiffany**)

Another challenge with time was discussed by Eva, but not on having enough time to assess a client fully, but a lack of time to demonstrate outcomes.

I think we have a hard time with that as well cause we do goal attainment scaling. So it's really hard to measure when someone is with you for two weeks, like it's easier for like other disciplines and cause they can see the progression when they came in. This is where they are, where they were before, this is where they are now, two weeks down the road, this is where they are and yes they can go home. It's really hard to do that with leisure. We have, we're on the form and all that stuff, but it's really, you know what I mean, it's hard to define that and I struggle with that every week at rounds, but I mean we have it, like I came to grips with it, but I still find it hard because you can't really measure, you know what we do (**Eva**).

Rowan also felt that the lack of time impacted all areas of her practice, not just on assessment issues. Part of this challenge was deciding where the focus should be made.

> I find that we are torn in so many directions that if you try to focus it on some specific aspect and then, I mean, because assessment is so much greater, and like doesn't work. Well how do we know whether it's working? So it's more than just the assessment thing, it's like what happens with that individual, what are the outcomes and like there's a full circle right, so you never know which part of the pie to work with, right. Like which is most important to my practice right now? Like figure out this perfect assessment and just go with what I have because I really need to focus on the implementation part or, there's just not, there's never enough time to spend on all the parts. (**Rowan**)

This section has provided an overview of the key challenges reported by the participants about time. The next theme examines challenges associated with assessment tools and processes.

Theme #3: Challenges of Assessment Tools and Processes

The participants were clear that they faced a variety of challenges when it came to completing a client's assessment. Although they reported different types of challenges in regards to methodology of assessment process and information gathering, the participants were in consensus that all of these challenges affected each one of them. This theme is divided into the following subthemes: (a) challenges with standardized TR assessment tools, (b) measuring concepts, (c) documentation, and (d) awareness and education.

Challenges with standardized TR assessment tools. When asked if any of the participants used a standardized therapeutic recreation assessment tool as part of their regular assessment process/intake, not one participant said yes. When asked why, Tiffany stated: "I know from my experience in this population that asking you know questions about your leisure history for 10 or 15 minutes, seems to be long enough. They don't want to talk about it, their leisure attitude for an hour." (**Tiffany**) Participants were asked about what evidence they used to make decisions about whether or not to use a standardized therapeutic recreation assessment tool. Tiffany stated: "No, I think I just look at them and see how long they are and I think no one's going to want to answer all these questions." (**Tiffany**) Erica agreed that many of the standardized tools were too long for the clients she worked with and that they were difficult for the client to understand their purpose.

The formality of completing a standardized assessment with a client, as discussed in the first theme about characteristics of assessment tools and processes, was more evidence used by participants as to why they did not utilize them. Eva stated: "it's like anybody you kind of say, well I'm going to give you a test, you get that kind of test anxiety, or nobody really likes to, when its informal I find yah you'll spill your guts, but if it's kind of like, you clam up." (**Eva**)

Another challenge with the standardized therapeutic recreation assessment tools was, as identified by Erica above, that they were difficult for the client to understand its terminology or purpose. This lead to discussion about concepts in leisure and recreation that were frequently looked at in therapeutic recreation assessment tools.

Measuring concepts. When it came to discussion about what standardized therapeutic recreation assessment tools offered in term of capturing concepts, participants were clear that measuring a concept was not always relevant to either the client or themselves.

> A lot times there isn't a great understanding the whole concept of leisure so I think that makes it harder for them to understand sometimes the assessment interview, like the standardized assessment tool, I mean. (**Erica**)

The participants also identified with struggling to find tools that were relevant to their practice. Rowan acknowledged the breadth of area that is often covered in recreation therapy and assessing qualities that are holistic in nature was extremely challenging.

> It just seems that, I mean the struggle continues right to find a perfect way to jacket everybody that the perfect ten questions that you can ask that, but because I think recreation, your leisure, once again we're looking at such a holistic, like across the spectrum, group of characteristics that, it's very difficult to come up with one concrete time-efficient assessment that's going to describe that person or where they're going to fit into your practice where you can, it's not to say that there isn't an assessment tool out there that would work, um. Yeah. And I think there's things to be gained. (**Rowan**)

Participants were not against the use of tools but required them to be relevant. Erica felt that if a tool was available and useful, she would be open to using it: "if I knew it was really valuable, was going to give me really, all the information I can't get elsewhere then I would certainly be open to it"(**Erica**)

Participants agreed that creating a tool that was short in duration and relevant was difficult and felt that none existed at this time.

> So I mean I think, I think if tools were developed, if there was a tool that was developed and had a practical spin on it, that was concise and, I don't know but it's hard, does one size fit all I guess? (**Eva**)

The participants spoke of other professions and their assessment tools. The participants came to agreement that one of the challenges of therapeutic recreation is the holistic nature of the field and that areas involving emotions and social functioning are not as easily captured as a physical action or movement.

> I'm a little jealous if you look at people who are assessing more like physical functioning, it's a lot, it's almost like almost easier, than assessing like more emotional and social stuff. It's like oh so and so walked five feet today, next week, so and so walked seven feet, you know it's right there, and it's easy to measure, whereas some of the other things that we are looking at are very difficult to measure. (**Tiffany**)

Documentation. Documentation around assessment was reported to be a challenge in terms of feeling pressure to have a formalized assessment. Eva stated:

> But I think there's too much pressure maybe or you feel so much pressure to have it so formal, so I think you know when you hear formal and written, I kind of cringe, because then you say oh you have to have it done in this x amount of time when really you do it probably, if you broke down your day you probably do it more than what you know you even realize you're doing yourself. So, it's just that yah, it's not, I think for me personally I don't calculate that I do a full assessment

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unless I have it totally written out and printed right on the chart so I don't, which

is kind of stupid because in my head I know I have. (**Eva**)

Eva also discussed the impact of having deadlines for assessment completion and the

limitations associated with documenting with a standardized tool. She felt that

completing an assessment tool within the first few days would not reflect who that person

was since the therapist would not have developed a rapport with that client and that the

assessment may not represent that client's true thoughts, feelings and experiences.

 Awareness and education. Participants were asked how they maintained

awareness about assessment practices and new research, particularly since time to explore

that area of practice was limited. Tiffany said: "I don't. I have to go to a conference or

something to hear about it. I'm not really out there looking for them." (**Tiffany**) Erica

agreed with this. Rowan spoke about awareness from watching documentaries or reading

about an issue about the geriatric population in the newspaper. This frequently led her to

question whether the services she was providing were appropriate. Rowan also attended

conferences, but as Tiffany stated: "It's hit or miss if somebody's presenting on an

assessment" (**Tiffany**) so she felt it was not a reliable source to feel up-to-date.

 Eva spoke of a disconnect between practice and formal education about the use of

the 'red book' (Assessment Tools for Recreational Therapy and Related Fields,

Burlingame & Blaschko, 2002). Her experience has been that recreation therapy students

learn about this compendium of assessment tools but in practice, she was unaware of how

many practitioners actually used it.

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I guess the true validity of it is not really exposed if it's even good. Sometimes I,

people say the red book, it's like oh it's just a dust jacket, or something or you

know or it has more of a negative tone to it, we learn about it in school and yes

and we practice all this stuff. But in the real world, when you get into practice, I'd

like to pool how many people actually use stuff from the red book, so I kind of

wonder why is that, and why is it across the board? (**Eva**)

This section provided an overview the challenges participants identified with assessment

tools and processes. The next theme discusses challenges of professional practice.

Theme #4: Challenges of Professional Practice

Challenges of professional practice were common for all the participants and a

major theme identified from the focus group. Time, pressure to document, values and

expectations were key examples of the challenges the participants faced, many of which

were reported as challenges associated with assessment tools and processes. All of these

factors had a significant role on how these practitioners completed assessments and their

everyday functions and duties as a recreation therapist. This theme is divided into the

following subthemes: (a) values/expectations/team player, (b) need for

support/connections, and (c) professional identity.

Values/expectations/team player. One of the challenges participants identified

in regards to professional practice was their role of being a contributing member of their

interdisciplinary/multidisciplinary team and wanting to contribute something of value.

Many of the participants felt that they did not have a formalized assessment in place that

allowed them to be as efficient or as clear in demonstrating outcomes as other

professions. Rowan says:

> everybody else seems to have come up with something that works for them, that
>
> they can get this quick snapshot of what it is that they need to focus on that in two
>
> weeks they can stamp at the end a discharge or a performance, an outcome, or
>
> whatever, and say yes look I've met my goal. And I just never feel like I have that
>
> professional snapshot that I could put my stamp at the end of their stay or their
>
> time on our team. I just never feel like I'm putting that kind of stamp that says
>
> I've done, I've achieved my goals and outcomes with this individual and off they
>
> go. (**Rowan**)

Although participants felt frustrated about not having a therapeutic recreation

assessment that captured a "professional snapshot," as Rowan discussed, it was clear in

the discussion around the use of standardized non therapeutic recreation assessment tools

that these practitioners would prefer to feel like they are able to administer tools if they

chose to, acknowledging that some felt they preferred to have the time to do other work.

The majority of participants also said that by completing standardized non therapeutic

recreation assessment tools, they would feel like a "full-fledged" member of their team.

> …I just think you know it would be nice to know that you could do it. Like I
>
> mean not every person, not one person gets called on it, but say you're in a team
>
> and you know 10 people, that one person gets it all the time, it would be nice to
>
> divvy it up, like to know that you can do it, like you know if there's shift splitting
>
> workload or something that you can say well hey I can take this one, especially if

it's someone that you know you have a good rapport with and that they know, so I think that would be good then. I wouldn't want to say I want to do every one, you know. (**Eva**).

Contributing to the team was not only about completing assessment tools that other professions used. It was also about providing information from the therapeutic recreation perspective that was relevant and meaningful to the whole team. As Rowan stated:

the struggle continues right to find a perfect way to jacket everybody that the perfect ten questions that you can ask that, but because I think recreation, your leisure, once again, we're looking at such a holistic, like across the spectrum, group of characteristics that it's very difficult to come up with one concrete time efficient assessment that's going to describe that person or where they're going to fit into your practice. (**Rowan**)

It was also about recognizing that every team member has time constraints when it comes to learning pertinent information about each client.

I think time is of an issue for every profession, and I think people only go to parts that is well recognized, that they can see some sort of result I guess. To flip through everything is impossible and so I don't know how valid say if I did the leisure competency measure, what is that really telling other disciplines? You know, so what gives them any incentive for them to go look in the chart to see what that says so if we have a problem, if we're not doing it, my thing is what is really the purpose of the incentive, you know I mean what is that telling other disciplines about that client that is pertinent to them? So I think it has to benefit

everyone. Like for instance, what you just said, why do you go look for the

MMSE score or why do we go look for something so what is the incentive for

other disciplines to go look at any one of our screens or something, so and then

comes the whole piece of educating other people and we have to have it down pat

before others can kind of go, so that's my thought process anyway. So if I don't

really know why in the hell I'm doing this, why should someone else from

another discipline look at it? (**Eva**)

One participant spoke of concern around accountability of service that is required of all

health care professions and that therapeutic recreation was no exception to the growing

demand for evidence-based practice. Tiffany felt the profession could be at risk if unable

to demonstrate outcomes of service delivery:

I mean with the cutbacks and things that are happening, people are asking why,

you know we either show them why or you know we're not going to get, the

profession is not going to grow, or it's even going to be cut from certain areas, if

we can't show why. (**Tiffany**)

Communication with the team was important for the participants and frequently

used it as a method to discuss outcomes of a participants' involvement with the CTRS.

One participant provided an example of how they contributed to the team by reporting

back outcomes of their intervention but that this outcome was not a result of an

assessment tool:

I bring that back to team members that we were doing this and through this, you

know activity, intervention, whatever, I discovered this. So I do bring the

information back around but its yah, not a formal documentation process as part

of that, a tool, using a tool to assess. (**Rowan**)

Frustration was evident in Eva who felt strongly that she did her job well but the lack of a

formalized document that identified the therapeutic recreation assessment and outcome

made it seem like her job had not been done.

Well I think it's a standard for all professions that you have to have assessment,

assessment, assessment, and if you don't have it, you feel maybe inadequate or

not, that you're, you haven't done your official job. So that's why I really hate

that because I know I put 110% into knowing the patient. I may not have some

formal document that states this, but I know I can, I probably know them better

than when somebody has this assessment. (**Eva**)

Need for support/connection. Participants discussed how daily work demands

impacted their ability to explore research or to connect with other practitioners,

something that was identified to be very important to the participants. Part of the

challenge was that there was not much support in making time during the work day to do

research or connect with other practitioners. Eva also spoke of how a lack of time

impacted her ability to spend time reviewing research or even connecting with other

practitioners:

I think I need time to look at the research or if there's no research, kind of talk to

my co-workers and go over what's been successful for them, what I've found

successful and then go from there. I just don't think there's time. (**Eva**)

Challenges within the profession, whether about assessment in particular or any

other issue, were felt by participants that these were things they could not achieve in

isolation. Tiffany felt that as she discovered challenges, she did not know what to do with

her findings.

> I wouldn't even know who to report to. I think you're right we should be getting
>
> back to someone saying this isn't working, this is working, but its not like I have a
>
> researcher I report to…. (**Tiffany**).

Professional identity. One of the challenges about working as a TR professional

was that people often did not know about what they did or what their role was as a

member of a health care team. This challenge included working with an older adult

population, as not only did some clients not value leisure or recreation in their own life,

but they did not understand what the role or purpose of recreation therapy was, unlike

understanding other professions. Eva spoke of experiences when clients associated

recreation therapy with exercises and she was required to explain what her role was and

that exercises would be completed with physiotherapy. Professionally, it was the opinion

of some practitioners that it was a challenge to work with older adults who may not have

valued leisure or recreation in their life and therefore these patients are harder to assess.

> …I don't know, people in long term care they may not really value or understand
>
> what leisure is per se, cause maybe they didn't value it as much, they might focus
>
> on working and that type of thing. (**Erica**)

Participants described their professional scope as leisure but that they frequently

supported team goals. Tiffany describes:

if physio was trying to increase their functioning, you might also bring them, you might work alongside of them and have them leisure relate if there is a physical activity that they enjoy and also helps to enhance their physical functioning (**Tiffany**)

Part of the challenge, as identified in the assessment challenges, was that recreation therapy was viewed by participants as a holistic profession that looks at the client as a whole, which required more in-depth exploration of who the client was, versus a profession that might ask or assess physical functioning solely. There was agreement from the participants that there was overlap between recreation therapy and the other professionals on their teams. They also agreed that overlap occurred particularly in the domains of physical and social functioning. Rowan talked about her focus is on the cognitive, affective, social and emotional domains.

There's a lot of overlap. And even with the social, there's a lot of overlap, but I focus and I think my programming primarily reflects that, that I focus more on affective, cognitive and social. And I think that's where the team comes looking for information from me is more in that area (**Rowan**)

Recognizing the role therapeutic recreation plays in contributing to health and wellbeing is one challenge, but working day to day in a profession that is not always acknowledged or looked to is also challenging. Eva described having a team that recognized her work and role but she frequently was challenged with coming to terms with her own acceptance of the challenges faced in therapeutic recreation practice:

I don't find it disheartening I just find it's hard. Because I mean the team knows

and I know, you know that you made an impact, you know you really do, but it

would be nice to see like you know if you looked at it on a graph like you know

what I mean, you still have it, so I find, but I don't think we'll ever have that, like

I don't, you know so, it's just a different discipline and it's just how we are. So I

don't know but it's harder to measure. (**Eva**)

Despite all the challenges that the participants discussed, they also talked of the

importance of their profession, its roles on their teams and how they contribute to patient

care.

Summary

This chapter described the four major themes and their subthemes that were a

result of a focus group with four current CTRS practitioners working with older adults.

The four major themes included: (1) Characteristics of Assessment Tools and Processes,

(2) Time, (3) Challenges of Assessment Tools and Processes, and (4) Challenges of

Professional Practice. The themes and subthemes were interrelated with each other.

Figure 1 was an attempt to illustrate how these issues impacted the practitioner. Chapter

five will illustrate how the findings of this study are related to previous literature and

practice.

Chapter 5: Discussion

The purpose of this study was to determine if and how standardized assessment tools are used by therapeutic recreation practitioners (CTRS) who are working with an older adult population. This chapter will discuss the findings of the focus group and relate them to the literature available at the time of this study, identify gaps that exist between research and practice in relation to the assessment process and provide recommendations for future practice and research.

Research Questions

The research questions for this study were as follows: (1) Do current therapeutic recreation practitioners (CTRS) who work with older adults use standardized assessment tools as part of their daily practice? Why or why not? (2) What are the standardized assessment tools that they use? (3) If they do use them, how effective are they in producing outcomes in their practice and/or do the tools need to be modified to use with the population / group with which they work? (4) If the tools do need to be modified, how are they and do they meet reliability and validity standards? (5) If the TR Practitioner is not using tools, how do they assess their clients and why do they find it more effective than current tools available? (6) If they have created their own assessment forms, what is the assessment process they have developed and do they meet reliability and validity standards?

The research questions provided a framework to interpret the information collected from the participants of the focus group. Although the research questions did not change during the research, the themes identified from the focus group process reflect

the reality of the participants and their practices but do not provide direct answers to every research question. The information reflected experiences that are not isolated and are in fact intertwined throughout the questions. Upon reflection of the complexities of stories and experiences spoken by the participants and review of the current literature, a gap was demonstrated between what practitioners say they are doing and what research indicates what should be happening. Figure 2 illustrates the disconnect between current research and the practice of current practitioners.

Figure 2: Disconnect between Research and Practice
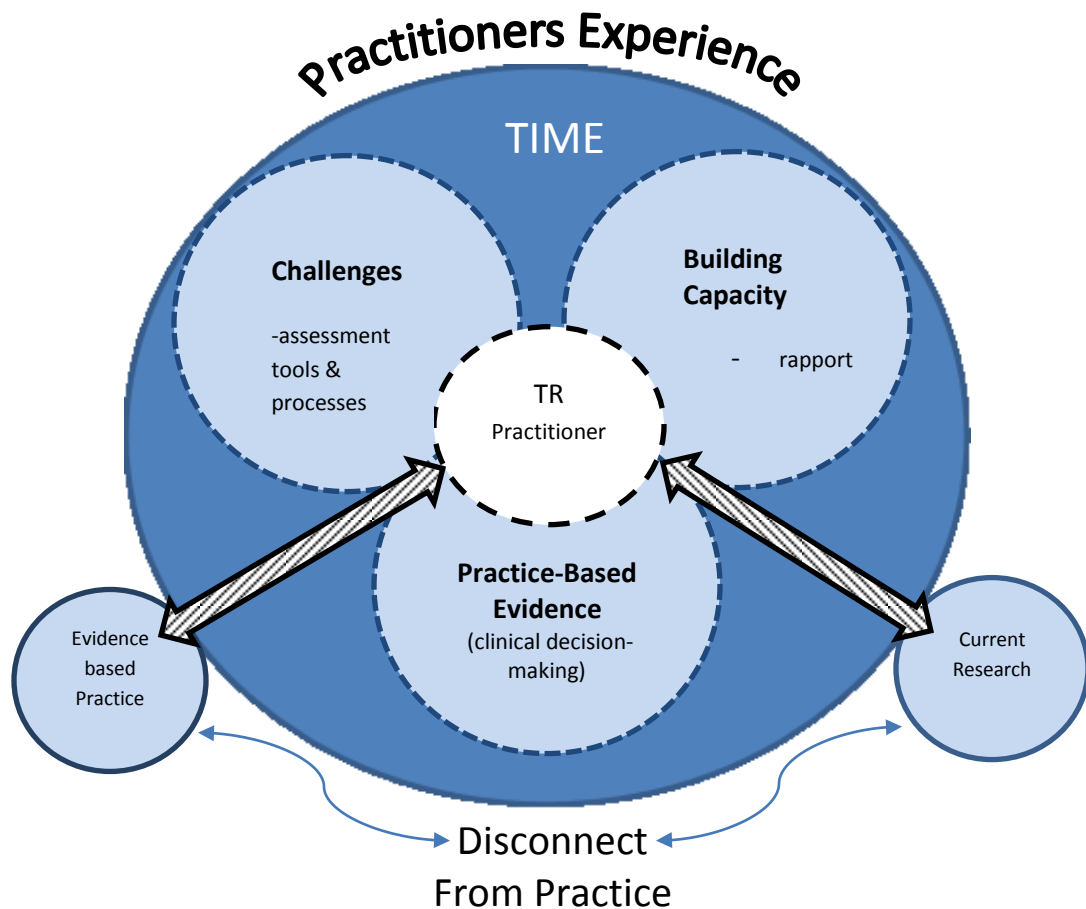
This model illustrates the complexity of the themes that emerged in this study and will be used to guide discussion in this chapter. The participants were able to articulate what was

working in practice and what was not and how these impacted their everyday practice. As an example, the participants discussed the important role of rapport building and being valued team member (i.e. building capacity) and the challenges they faced with assessment tools and processes (i.e. lack of tools, appropriateness for clients, concepts). As it stands today, current research and evidence do not reflect current practitioner experience. Evidence-based practice and research were disconnected from their everyday practice.

This chapter reflects challenges the study participants identified and how they compare to the literature and what gaps currently exist between the literature and the results of this study. It will also explore and discuss recommendations for improvements of assessment procedures and the role of protocols related to quality assurance and how to improve the gap between research and practice. In this chapter, it is the author's goal to articulate clearly the challenges associated with assessment in therapeutic recreation practice when working with older adults and provide recommendations for future change based on the findings of this study.

Role of Rapport Building/Building Capacity

Rapport building, as part of a therapeutic relationship, was described by Leach (2005) as "the first and most important objective of any client-practitioner interaction is the establishment of client rapport" (p. 262). Participants in this study spoke of building rapport with their clients as an important and valuable part of their assessment and everyday practice. Austin (1991) wrote that building rapport with a client was one of the three key purposes of interviewing a client as it allowed the therapeutic relationship to

develop. Some participants reported it as an essential part of truly understanding and knowing their clients. Leach (2005) described therapists who approach clients as friendly and understanding end up having improved therapeutic relationships with clients than therapists who do not demonstrate these qualities. Leach (2005) identified those therapists who developed rapport in the initial moments of meeting a patient established trust between the therapist and client quicker than those who do not. Rapport and relationship building with clients, for therapeutic recreation professionals, seems to be an important and attainable task. Austin (1991) stated:

> Developing rapport is not usually a major hurdle for the therapeutic recreation specialist, who is customarily seen by clients as a nonthreatening person. In highly clinical settings clients may feel particularly alienated by the surroundings and too frightened to approach the doctor or nurse. In such situations the unique role of the therapeutic recreation specialist often comes to the forefront. With the therapeutic recreation specialist clients usually feel that they can relax, "drop their guards," and "be themselves" (p. 158-159).

Leach (2005) identified key elements that help professionals build rapport with clients, which in turn allows clients to feel they are able to safely disclose information to the practitioner. They included: a quiet environment in which the therapist can actively listen to the client and ensure the therapist demonstrates body language that they have time and interest in hearing the clients words. Leach (2005) also identified four skills that are important for practitioners to reflect to their clients that demonstrate active listening. These included open questioning, reflecting back what the client told you, paraphrasing

their response and summarizing. Austin and Crawford (1996) identified three aspects important for therapeutic recreation professionals to have to support building a therapeutic relationship. They included genuineness, unconditional positive regard and empathy. The question is how are these terms operationalized for the practitioner to develop the rapport?

Participants spoke of the value of building rapport with their clients and how it helped them in the assessment process. An example of this was stated by Erica: "…I always like to kind of meet with the resident/client, once or twice before doing the assessment just to start building rapport and that you're not just coming the first time and asking all these questions of them." (**Erica**) Pedlar, Hornibrook and Haasen (2001) attribute this as a benefit to truly listening to their clients. They stated:

> The difference between being truly present with a patient and merely looking for answers is key. Therapists who validated the patient's experience were rewarded with valuable information about the patient as they felt supported in their expression (p. 24).

It is not known how participants of this study learned the skills of how to actively listen to a client and build rapport. There is no academic requirement for this learning via the National Council for Therapeutic Recreation Certification. Development of competencies around this skill would be useful if this component remains in trend in therapeutic recreation assessment. Further elaboration and research of the role of rapport building as a component of the assessment process is required.

Challenges in Practice

The participants revealed that there were challenges in every day practice. Review of the literature demonstrates that few of these concepts, such as challenges associated with standardized assessment tools, have been captured in research. The following sections review challenges that were identified by participants in this study and compare with what research has found.

Defining assessment. Previous scholars have defined the role of assessment in the therapeutic recreation process. Wilhite and Keller (1992) defined assessment as:

The process through which knowledge is obtained about clients, and their functional abilities related to school, work, leisure and family. It establishes a baseline or starting point and provides a foundation for identifying needs, determining interests, formulating goals, selecting appropriate activities, developing intervention strategies, and evaluating progress (pg. 7)

Austin (1991) wrote that:

The purpose of therapeutic recreation assessment must remain clear. Therapeutic recreation assessment is not conducted in order to label or categorize the client. Instead, we assess to gain information that is useful in helping the client to profit from our services. Assessment should aid us to determine client strengths, interests, and expectations and to identify the nature and extent of problems or concerns (p. 142)

Kraus and Shank (1992) described three key questions therapeutic recreation professionals should remember when completing assessments:

> In carrying out assessments, therapeutic recreators should make several key decisions in advance of the actual process. They must decide *why* they are conducting an assessment, *what information* is essential and how it can reasonably be attained and *what will be done* with the information gathered (p. 97).

This is representative of what the participants in the study reflected when asked about defining what information they collected to complete an initial assessment. Information that was collected and methodology of collection relied heavily on rapport building with the client and listening to the clients' words to understand their needs and strengths. Participants of this study however also identified that assessment was an on-going process and how frequently clients were assessed depended on the needs of each client or the criteria outlined by their agency. This on-going process is not reflected in the above definitions.

Methods and challenges. Participants in the focus group identified various methods to obtaining information to complete their assessments. Examples of these methods included: chart/health record reviews, rapport building, interviewing, using assessment tools and screens, observation of clients and their body language, and communicating with other interdisciplinary team members. Challenges discussed by the study participants included: challenges of using standardized tools that frequently were not relevant to the client and/or service provided; the length of time required to complete

an assessment tool; the formality of completing standardized assessment tools; challenges for clients understanding the terminology used in many of the standardized assessment tools; the holistic nature of the profession (e.g. looking at the social, physical, spiritual, cognitive and emotional domains); and documentation of a formalized assessment.

Pedlar, Hornibrook and Haasen (2001) interviewed both patients and recreation therapists regarding the assessment process and experience in their study, and the participants voiced similar challenges. The patients involved in physical rehabilitation, mental health and acute care (not age specific) found similar challenges articulated by those who participated in this study. It was the experience of the therapeutic recreation practitioners in the Pedlar, Hornibrook and Haasen (2001) study that "therapists who included and informed their patients by asking straightforward questions, and explained exactly why and what they were writing down during the 'assessment,' significantly reduced the anxiety of their patients" (p. 26). This technique was also used successfully by the practitioners in this study who reported that explaining to patients why they were writing things down helped to ease the visual stress on the client and create a more comfortable atmosphere.

Pedlar, Hornibrook and Haasen (2001) found that practitioners also struggled with feeling like they were not able to produce measurable outcomes. This is in keeping with the struggles study participants spoke of regarding the challenges they faced with articulating clear, concise outcomes or achievements of goals that were meaningful to the rest of their team members.

Participants in this study spoke of how approach to the person impacted the assessment process. This is similar to the recommendation made by Wilhite and Keller (1992):

> There is no one approach that can be used with all individuals. The decision on which approach to use is influenced both by characteristics of a client and by the ability of a specialist to utilize and interpret accurately the results of a given procedure (p. 12).

Understanding the individual the therapeutic recreation practitioner is working with is essential. While part of that understanding stems from what approach works best, how is any therapeutic recreation practitioner to know or understand which approach is best and how is this determined? It remains unclear how therapeutic recreation practitioners make these decisions and needs to be further explored in research.

Gaps Between TR Assessment Research and Practice

There was no evidence in the literature of how current CTRS practitioners complete the assessment process when working with older adults. This was also acknowledged by Anderson and Heyne (2013) in their conceptual paper about using a strengths approach to the therapeutic recreation assessment process.

Upon reflection on the conversation of the participants of this study, many of the challenges that were faced over twenty years ago are still active challenges for today's practitioner working with older adults. The practitioners' spoke of challenges associated with time, appropriateness of standardized tools for older adults, and limitations in ability

and time to use standardized tools. This is similar to what was also reported in two research studies with recreation therapists (Leblanc & Singleton, 2008; Pedlar, Hornibrook, & Haasen, 2001). In the study by Pedlar, Hornibrook, and Haasen (2001),the recreation therapists, who are not reported to be CTRS's, found that therapeutic recreation assessment tools "…were often found to be confusing, time consuming, and inappropriate" (p. 21) and that scales based on leisure interests were often difficult for clients to complete and ask repetitive statements. Participants in this study also commented on the amount of time standardized assessment tools took and the difficulty many of their clients had in understanding the concepts being asked of them in the standardized tools.

Research did not discuss some of the main findings that practitioners spoke of being a significant part of their practice, including rapport building and the value of that relationship and its implications on the assessment process, the role of the environment and creating a non-formalized setting. Dunn (1989) stated: "further growth is still needed in the understanding, location, evaluation and appropriate use of existing assessment procedures" (p. 59). Almost twenty-five years later, there is still a gap in this understanding, based on the results of this focus group.

Participants did not speak about specific methodologies of observing clients for assessment purposes but did articulate reporting back to their interdisciplinary teams observations from patient participation in programs. Stumbo (1997) stated: "The field needs more and better research describing and measuring the leisure behavior of clients. This, in turn, will improve the ability to standardize and validate tools to measure

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baseline and progressive information" (p. 367). The ability to better articulate client behavior would have a significant impact at all four stages of therapeutic recreation process of assessment, planning, implementation and evaluation. It is clear that there are still gaps in the literature about the assessment process in concept and what practitioners do. The term assessment is described in the literature as a one-time process, and frequently as a tool versus a systematic process, as was described by the participants in this study.

Description of these processes is a gap in therapeutic recreation research and such gaps have been demonstrated as a result of this research study. Examples of these gaps include: how does a therapeutic recreation practitioner develop rapport (what are the characteristics of this, how does a therapeutic recreation practitioner know they've achieved this with a client), and how do therapeutic recreation practitioners standardize observations of their clients? Further exploration of these issues is needed.

The participants of the study were also an example of practitioners who felt unable or not permitted to complete other standardized assessment tools but felt they had the competency to do so. Wilhite (1992) discussed the need for therapeutic recreation practitioners to ensure they could accurately complete and interpret the assessment tool and have time to do so. Lack of time is still an issue for the practitioners who participated in the focus group. Exploration of what qualifies a therapeutic recreation practitioner (i.e. what competencies need to be demonstrated) to administer such tools needs to be further explored.

Participants also spoke of the challenges of keeping up to date with new information and research about assessment. Participants relied mostly on professional conferences to learn about new practices or tools that were relevant to their practice and that this process was "hit or miss" as it depended on what the conference was offering. This is in keeping with Stumbo (1997) who stated: "Keeping abreast of current information about assessment and related issues is essential, although largely a difficult and fragmented enterprise" (p. 367).

One of the larger issues in the therapeutic recreation world is the ongoing disconnect between researchers and practitioners. This is not a new idea to the field and has been cited as a challenge in previous literature (Austin, 2001; LeBlanc & Singleton, 2008; Stumbo & Peterson, 2004). The practitioners in this study spoke about trying to balance everything in their practice and often felt they did not have enough time to complete everything or document outcomes as they would like. This was also cited as key issues in the study completed by Leblanc and Singleton (2008). As it stands, there is no one reference manual or protocol guide a practitioner can turn to in seeking solutions to these challenges. With new ideas and concepts being developed in the research world, it is often difficult for practitioners to turn these conceptual ideas into practical, usable tools or processes in practice.

An example of this challenge was illustrated within Anderson and Heyne's (2013) conceptual paper about using the strength's based approach to assessment in therapeutic recreation. Anderson and Heyne (2013) write that the deficits or problem-based approach to clients assumes the medical model and that the client has something wrong with them

and have to be "fixed." As a practitioner who works in a medical-oriented institution, I can whole heartedly say that I do not feel that I fix people nor do I think they have something wrong with them. Clients, who can have all types of medical complications, often need support in navigating the illness process. Clients often need "help" in accessing community resources or in understanding the role leisure and recreation can play in their recovery and life. If they did not need help, they would not be referred to the service. Many therapeutic recreation practitioners use clients' strengths to help them but an "overall strengths approach" may not be feasible or appropriate for many clients. I do not disagree that concepts need to be explored, but publishing information that assumes a translation to practice with no guidelines, protocols, or demonstrated use with a specific population is misleading to practitioners. The authors do not acknowledge any limitations of their work but provide global recommendations to therapeutic recreation practice. In regards to the strengths approach, they state:

> Looking for deficits, even in one's strengths, contradicts the strengths philosophy. Once the assessment data is collected, the assessment report and plan must also be written in a way that is framed in a strengths approach (p. 105).

This narrow assumption of all or nothing is challenging to therapeutic recreation practitioners. The theories used to support the strengths approach are not limited to this one method or approach. It was clear from the participants in this study that their focus was on who the person was (building rapport) and understanding that person and their needs to provide appropriate service delivery. Participants in the study were challenged enough by a lack of time, large caseloads, and meeting a variety of needs; the idea that

therapeutic recreation practitioners can help people achieve their dreams and aspirations, while ambitious, is likely not realistic to practitioners working with older adults, many of whom are not even able to verbalize or articulate leisure interests due to illness.

Another gap in therapeutic recreation assessment research and practice is simply the overall lack of clinical research in therapeutic recreation. Although some work has been completed in regards to diagnostic guidelines (i.e. Buettner & Fitzsimmons (2003) work on dementia practice guidelines), Richeson, Buettner and Fitzsimmons (2009) acknowledged that many of the recommendations come from research that has been completed by other professions. It is the concern of Richeson, Buettner and Fitzsimmons (2009) that if therapeutic recreation does not increase its evidence based research and practice, and continues to rely on the research of other disciplines, the strength and legitimacy of the profession is at risk.

It is these types of gaps that are significant challenges between what researchers and educators produce and what therapeutic recreation practitioners need or want. There are solutions to these challenges. Possibilities and examples of solutions are discussed next.

Solutions to Gaps in Research and Practice

After review of the study results and analysis of the literature, it is this author's opinion that solutions to the challenges that were articulated by the study participants, prior research and by the author herself can perhaps be addressed with the use of therapeutic recreation protocols in practice and development of outcome measures. It is this author's belief that further development of protocols and outcome measures,

supported with and by case study examples published by current CTRS practitioners, along with completion of research that is collaborative between researchers and practitioners may address gaps and provide improved and cohesive knowledge to not only current practitioners but to current and future students of the profession.

Diagnostic protocols. One area that therapeutic recreation practitioners can be clearer in is articulating how assessment is completed when working with clients. The development of diagnostic protocols is one way the profession can articulate common needs of clients when therapeutic recreation practitioners work with a specific population. Recognizing that therapeutic recreation practitioners work with a diversity of individuals in various environments (e.g. hospital, community, long term care facilities), the techniques provided in a protocol would help guide practitioners to ensure that their assessment methodology and content area was most applicable to the clients they are working with and provide recommended interventions and expected outcomes. A diagnostic protocol would act as a resource guide to practitioners and support them in ensuring that their assessment methods and information gathering and interventions was relevant to each client and supported with research.

Protocols are ways the professionals of therapeutic recreation can ensure consistent, predictable outcomes of service provided. Knight and Johnson (1991) described them as approaches that simply outline what service is provided and what the expected outcome of such service provision is, allowing a clear and distinct role of how therapeutic recreation can support a person's treatment. Stumbo (2004) defined protocols as:

…documents that describe the "best practice" of a specific intervention as applied to a specific group of clients or client needs that have been standardized and result from recent research evidence (p. 236).

Development of assessment protocols might be of assistance to therapeutic recreation practitioners working with older adults, or perhaps, any population or diagnostic group. In conjunction and support of interviews that focus mostly on interests and rapport building with clients, an assessment protocol, as part of working with a specific client group, may be of value to therapeutic recreation practitioners. This assessment protocol would allow therapeutic recreation practitioners to build rapport with a client, but also provide the therapist with key factors to observe or probe further for, such as behavior, mood, motivation, barriers to leisure engagement or whatever common needs of that diagnostic grouping are. For example, if working with a client who has been diagnosed with vascular dementia, a protocol might list what observations to look for and how to track behavior, common functional impairments and how to assess for them and what methodologies work best. It would also recommend interventions and provide expected outcomes from those interventions. As a result of this process, therapeutic recreation practitioners would have measurable information to help them re-assess their clients and articulate goal completion or need for re-assessment.

Assessment methodologies in diagnostic protocols. Many of the assessment methodologies (i.e. observation, interviewing) used in therapeutic recreation can be used with various client groups. But what the therapeutic recreation practitioner is looking to assess or determine may look different for each diagnosis. Understanding how each

methodology could be used with various client groups would be a key component to diagnostic protocols. An example of this is looking at the role of observation in a therapeutic recreation assessment.

Observation of clients is one way of understanding client behaviour in regards to their leisure needs. O'Morrow and Reynolds (1989) expressed that observation is of importance in the practice of Therapeutic Recreation as it is frequently the only approach of learning or understanding many clients a therapeutic recreation practitioner would work with. In order for observation to be objective, O'Morrow and Reynolds (1989) identified four key categories therapists should capture: general appearance, interpersonal interaction, motor activity and body language. These are similar criteria to which Stumbo (2002) identified, which include: documenting performance or behavior (appropriate or inappropriate behaviors), using observation to verify previous assessment results, or to compare behavior of one client to another's. Stumbo (2002) identified criteria to which it is inappropriate to use observation as a method for assessment. Stumbo (2002) stated:

It is inappropriate to use observations when the specialist wants to address client interests, attitudes, or knowledge, or evaluate the meaning of client behavior and actions. The client's underlying feelings, thoughts, or motives will not be revealed (p. 217).

Observation criteria or protocols, as a component of diagnostic protocols, may be of great assistance to therapeutic recreation professionals working with older adults.

How protocols can help. The development of diagnostic protocols would help address some of the key areas the participants in this study identified. These areas

include: (1) Time – having a protocol removes the guess work of optimal goals for a client. A protocol would guide therapeutic recreation practitioners of common areas they can address with a client, how to assess for it and outcomes expected; (2) Evidence – protocols are developed from research and are representative of best practice at the time. therapeutic recreation practitioners could use these protocols to help provide the client, families, interdisciplinary teams and management with evidence that informs their practice and role; (3) Professional identity – participants spoke about wanting to better articulate their role and provide clarity to the services they provide. A protocol would outline the various areas the therapeutic recreation professional could address and provide a clear focus for service delivery. Therapeutic recreation protocols based on evidence and best practice is providing quality, measurable outcomes and would help keep therapeutic recreation identified as an accountable health care provider.

Connolly and Keogh-Hoss (1991) discuss the role and value of having such protocols to guide therapeutic recreation practice:

> The purpose of the proposed protocol design is to write, process and outcome criteria for specific diagnoses which: (a) serve as quality assurance tools to measure and evaluate independent therapeutic recreation practice; (b) serve as references when planning and documenting care; (c) are utilized as instructional tools when reinforcing therapeutic recreation practice (p. 123).

An example provided as protocol criteria by Connolly and Keogh-Hoss (1991) included: diagnostic grouping, specific diagnosis, specific problems related to therapeutic recreation, assessment criteria, objectives, process and outcome criteria, and references.

The assessment criteria Connolly and Keogh-Hoss (1991) described is explained as the areas the therapist assesses the client for and to provide information on which standardized tools are used. Assessment, as described by the participants in this study, is a process not a tool. Development of future protocols must capture this reality.

Quality assurance, protocols, and articulation of services. The need for quality assurance is perhaps more than ever required of all health care professionals. Wright (2009) and Stumbo (2003) noted that every profession in healthcare is responsible for providing service that are measurable and are based on evidence and/or best practice. Part of quality assurance is being able to provide clear protocols for assessment, planning, implementation and evaluation of services provided. Outcome measurement has been found to be a process to help address and ensure quality assurance provided by qualified practitioners. Riley (1991) described how protocols, when linked to outcomes, can support achieving quality assurance:

> Specific to a definition of outcome is the notion that it is the client/patient behavior that is being measured, not the provider's. In the context of therapeutic recreation, outcome measurement addresses the degree to which the patient has benefited from a given program or intervention. It assumes that specific strategies or protocols are implemented with the assurance that such procedures will produce certain predictable results (p. 58).

Protocols can be designed to either focus on the treatment or the diagnostic group (Stumbo, 2004). Specific program plans represent an example of treatment protocols. Both protocols are of great value to the therapeutic recreation profession. While treatment

protocols are detailed information about specific interventions, diagnostic protocols are

an excellent resource to help practitioners understand what services they could provide

and how to assess for such with a client. Figure 2 demonstrates the differences between

treatment protocols and diagnostic protocols.

Figure 3: Treatment versus Diagnostic Protocols

Treatment Protocol	Diagnostic Protocol
• Purpose • Goals and Objectives • Outcomes • Content & Process • Evaluation • Entrance/Exit criteria • Risk Management/Safety • Equipment • Size • Costs	• Diagnostic Group • Characteristics of illness/disease • Problem Areas • Assessment criteria (what to assess for) • Recommended interventions • Outcomes

The significance of specific program plans cannot be undermined, as they clearly

outline goals and objectives of the activity, content and process used, and define entrance

and exit criteria of the activity for clients. In other words, clients are not simply attending

for the sake of attending. The assumption that simply participating in recreation programs

means positive outcomes is unreliable and immeasurable. This is reflected in Connolly's

(2012) presentation:

This focuses on the provision of services based on a preference for leisure

involvement rather than a direct approach to treating client needs. Just because

someone "feels" better or "happy" after an activity, doesn't mean their health or quality of life has improved.

The notion that participation equals outcomes is one that is not measurable. Practitioners need to have a baseline assessment and measurable outcome in order to state that involvement with services had an effect. In fact, it is the process of assessment, planning, intervention and evaluation with each program that differentiates a client participating for goal achievement or simply for enjoyment (Stumbo, 2012). Riley (1991) stated that therapeutic recreation practitioners must observe their clients and regularly document these outcomes, whether they be subjective and/or quantifiable measures. Regardless of the methodology that therapeutic recreation practitioners use to assess their clients, as clients needs always vary, assessment must be documented and consist of measurable goals and objectives in order to state outcomes of therapeutic recreation interventions.

Role of activity and task analysis. The use of activity and task analysis, skills that are already an area of strength for therapeutic recreation practitioners, is one that should be combined with both treatment protocols (i.e. specific program plans) and individual activity interventions (either as a recommended intervention in a protocol or in general practice). Breaking down an activity into the steps required to complete it will help the therapeutic recreation practitioner understand what the client needs to be successful in participation of the intervention. It also helps a practitioner articulate the needs of the client for activity participation and should be looked to as a component of the assessment process as well as documentation of the outcome of the intervention.

The areas of activity and task analysis would be improved with including components of the International Classification of Functioning, Disability and Health (ICF) as developed by WHO (World Health Organization) in 2001. For therapeutic recreation, Van Puymbroeck, Porter, McCormick and Singleton (2009) state it "provides an integrated framework, in terms of body functions, body structures, and activity and participation, that can be used to identify, organize, and interpret information about the client" (p. 52). The ability to better identify needs of clients based on the client's individual experience and environment could help improve service delivery and goal achievement for the client. It also helps therapeutic recreation practitioners better articulate in documentation the assessment results and expected outcomes of interventions. Integration of the ICF into activity and task analysis leads not only to a better ability to describe needs for participation, but also produces clearer outcomes of service delivery. Clearer outcomes articulate accountability of service delivery and that there are measurable changes as a result of interventions. As difficult as it may be to organize and change our thinking, therapeutic recreation practitioners need to move towards outcome measurement to ensure that their services are accountable and produce changes in their clients. Integration of the ICF will be challenging, but I do not believe we need to integrate all of it into our practice. The coding associated with the ICF is extremely overwhelming and at some points, difficult to apply to practice, particularly in Canada where service is not based on fee for service. If therapeutic recreation practitioners integrate the help the ICF can provide simply by using it as a guide to better understand the client's needs and ability to identify areas for improvement, we will move the profession forward.

Reflecting on the above recommendations I feel it is important to acknowledge the requests these suggestions place on the already overwhelmed practitioner. Riley (1991) stated:

> Simply stated, defining outcomes for use in quality assessment must be done with realistic expectations in mind. Outcomes should be measurable, reflect the nature of the service and be easily obtainable with respect to data collection (p. 62).

Completing quality, practice-related assessments that are achievable by every therapeutic recreation practitioner is no easy task. Riley (1991) acknowledged the challenges associated with demonstrating direct links between assessment, interventions and outcome, but reinforces this is not one that therapeutic recreation practitioners have a choice in. The wealth of information that could be shared amongst the therapeutic recreation profession could substantiate easily to the further development of therapeutic recreation protocols with specific diagnostic groups. This is a challenge I would put forth to today's therapeutic recreation practitioners to make the jobs of future therapeutic recreation practitioners more consistent, reliable and accountable for outcomes.

Summary of Recommendations and Solutions for Therapeutic Recreation Practice

This process of hearing the words of fellow practitioners and reviewing and evaluating research has provided insight to the author about all the different challenges that therapeutic recreation practitioners face daily in practice. There is a significant amount of information available and there is no one consistent message for practice. This document clearly represents this. As a practitioner, I feel responsible to take all of the information that was collected through this process and summarize what next steps could

be made to help improve practice for therapeutic recreation professionals working with older adults.

Role of rapport building. The participants of this study and the literature both acknowledge the role that rapport building plays in therapeutic recreation practice, particularly in regards to assessment. Is this a unique assessment method for therapeutic recreation practitioners? While I do not believe rapport building is isolated to therapeutic recreation practitioners, as many client-therapist relationships would involve rapport building, it would be valuable to explore further how therapeutic recreation practitioners, as Austin and Crawford (1996) stated, embrace and represent characteristics of genuineness, unconditional positive regard and empathy. How does a therapeutic recreation practitioner know they've achieved rapport with a client? Is it more than a feeling of being a nice person? Further exploration of this skill would be beneficial not only to current therapeutic recreation practitioners, but to future learners as well. A challenge for the profession will be ensuring that current CTRS's have the skills necessary to develop a rapport with a person and how the profession can support continued education in this area of rapport building through professional conferences or webinars. It will also be important for both researchers and educators to take into consideration the role of rapport building and how future professionals can demonstrate competency in this area during their education.

Improving measurement in assessment practice. The participants in this study confirmed many of the ongoing challenges in completing a client assessment. In reflection of Riley's (1991) work, I think therapeutic recreation practitioners owe it to the

profession, our clients, educators and researchers, the public, future students and any person with a vested interest in the field to demonstrate our accountability and ability to show clear outcomes based on the process of assessment practices. I believe this can be achieved in three ways: development of further observation based assessments (particularly for older adults), development of protocols for service delivery based on diagnostic groupings and enhancing our assessments, interventions and outcome measurement by including the ICF components into our process of activity and task analysis. In particular, I would encourage the development of protocols as they would not only guide practice and interventions based on evidence, but would ensure consistent service delivery for those diagnostic groups provided by competent therapeutic recreation practitioners.

The ICF may play another role in therapeutic recreation practice. Van Puymbroeck, et. al, (2009) indicate that the ICF may be useful to therapeutic recreation practitioners as it used by various health disciplines and would help provide consistency in language and terminology that is used amongst professions and discontinue the more generic use of domains of health more commonly used in therapeutic recreation language. This may help with the translation and understanding of what practitioners are doing in their practice with other team members. Improving this communication may help therapeutic recreation practitioners feel more like they are contributing valuable information to their team and could communicate their outcomes in manner that make sense to all interdisciplinary team members.

Improving service delivery is a challenge but one that is necessary. In an attempt to capture all the recommendations provided, I have developed a model to help demonstrate understanding of how improving current practice could help with both the integration of the current practitioner experience along with how to become more accountable in demonstrating outcomes.

Figure 4: Improvement of the Therapeutic Recreation Process
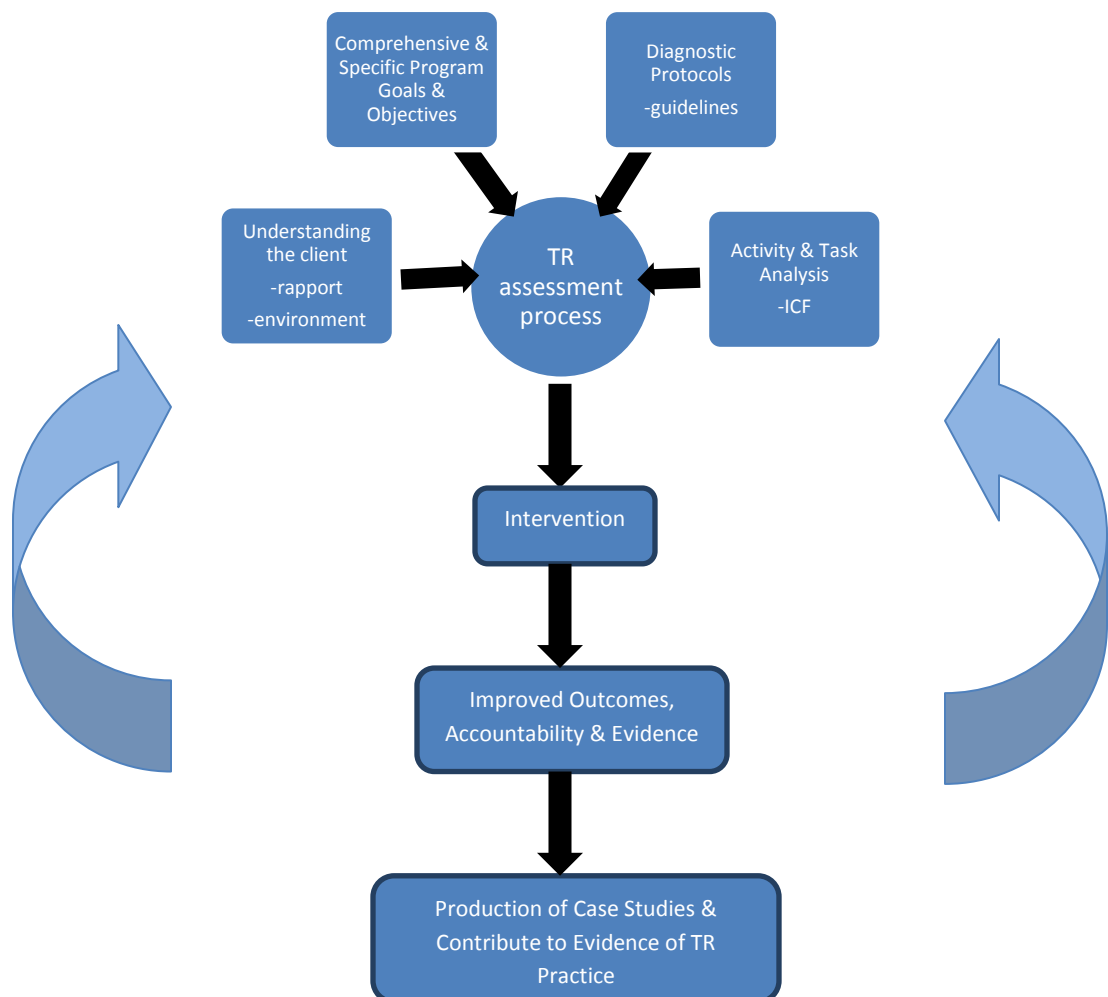
This task is neither simple nor easy but it is attainable. The findings of this study reflect the concerns of previous research (Leblanc & Singleton, 2008). Current therapeutic recreation practitioners need to complete measurable assessments and produce measurable outcomes. If this occurred it would be easier for therapeutic recreation practitioners to participate in the research process (i.e. case studies) and speak in terms the researchers might use to demonstrate the efficacy of TR service. This would be a step forward in addressing the gap between current research and practice (Austin, 2001; Leblanc & Singleton, 2008; Stumbo, 2004).

Collaboration between practitioner and researcher. This study produced results that were similar to what other research has stated: there is a gap between therapeutic recreation research and actual practice (Austin, 2001; Leblanc & Singleton, 2008; Stumbo, 2004). Improvement will not depend solely on academics, educators or practitioners. It is clear from the literature reviewed and the words of the participants in this study as well as others (Leblanc, 2003; Pedlar, Hornibrook & Haasen, 2001) that improvement will not come in isolation. Stumbo's (2002) challenge to practitioners on how they were going to improve the issues about assessment by the means of reading journals, practice using tools, or going to a conference is an example of this. Assessment processes and practices will improve with collaboration between researchers, educators and therapeutic recreation practitioners to produce viable, usable methods and protocols. This, in turn, would allow therapeutic recreation practitioners to better describe and measure patient behaviour, leading to consistent practice and improved quality assurance.

An example of how to improve this gap can be made by improving collaboration between practitioners and researchers by looking at the concepts of practice-based evidence and evidence-based practice. Practitioners in this study frequently used their own practice to help guide their clinical decision making processes. Although not proven through documented research, their experiences are valuable. Researchers have the ability to complete validated research but what they research may not be of value to practitioners in terms of direct application to practice. Collaboration of what practitioners find beneficial in their practice with appropriate research methodologies and guidance from researchers would produce valuable evidence to the profession. Figure 5 demonstrates this relationship.

Figure 5: Relationship between Practice-Based Evidence and Evidence-Based Practice

The need for evidence-based practice. The need for clinical research that provides direct evidence for practice cannot be underestimated. Without it, therapeutic recreation practitioners cannot provide a direct link between intervention and outcome of

service delivery. West (2009) said: "recreational therapists are more likely to consistently and predictably achieve outcomes valued by stakeholders by demonstrating consistent, relevant competencies and by practicing consistent, evidence-based care" (p. 252).

One of the challenges, acknowledged by West (2009), of achieving evidence based practice in therapeutic recreation is that practitioners are not educated in specific pathologies of illness and the impact on the body or the direct link with therapeutic recreation interventions. West (2009) clearly indicates that the evidence cannot rely on practitioner experience or opinion, but evidence of outcomes (the evaluation of service delivery) is an appropriate measure. This evaluation includes documentation of risk management, interventions that demonstrate consistent outcomes, use of literature to support interventions, regular evaluation of service and treatment modalities and demonstration of cost-effectiveness.

The need for both practice-based evidence and evidence-based practice are essential to the longevity and survival of therapeutic recreation. But much of the demonstration of 'evidence' falls onto the already heavy laden shoulders of therapeutic recreation practitioners. Struggling to meet various client needs, professional roles, and simply a lack of time has now been documented previously in research (Leblanc & Singleton, 2008) and with the completion of this research. The responsibility to produce evidence cannot fall solely onto practitioners but must be a shared responsibility with researchers.

A contribution to help address this gap can be made by practitioners by completing case studies in their practice and publishing them. Case studies are excellent

demonstrations of practice and provide readers with the opportunity to learn why something did or did not work with a client. McCormick stated: "Case study research provides one such viable approach to contributing valuable information to the theoretical, practical, and technical knowledge of the profession" (p. 251).

Time. As a final note, it would be interesting for further research to be completed around the challenge of time and the impact it plays on therapeutic recreation practitioners. As demonstrated in this study and in Leblanc and Singleton's (2008) study, time is identified as a challenge to practitioners. The author did not explore with the participants why time was such a challenge or the reasons they were challenged with it in their service delivery. Deeper exploration about how therapeutic recreation practitioners are challenged by time and the causes for it would be interesting to investigate. Did they perceive time as a challenge because they were unclear about their scope of therapeutic recreation practice? Did they spend more time on other issues in practice, such as advocacy of therapeutic recreation, leaving them with less time to complete assessments? Or was time an excuse to not fully explore or complete in-depth assessments?

Chapter 6: Conclusions

West (2009) discussed the role of systematic reviews and their role in evaluating current literature to advance therapeutic recreation practice. If systematic reviews are valuable to therapeutic recreation practice, they must also be valuable to therapeutic recreation research. I hope that this document demonstrates this.

The original motivator of wanting to answer this research question came as a result of frustration from lack of answers in practice and research. It seemed impossible that little to no documentation existed about challenges with assessment tools and processes. The review of the literature demonstrated various gaps in therapeutic recreation research about assessment and the little guidance it provided to therapeutic recreation practitioners. Listening and hearing the experiences of the participants of this study demonstrated the challenges that practitioners are facing in their practice – they are overwhelmed, under resourced, short on time, and struggle to document the work they do. The movement toward evidence based practice grows stronger, but much of the therapeutic recreation research is depending on practitioners to produce evidence. This is not a task that can be done in isolation.

As a result of completing this research, I hope several things will result. First, the design of this study was to be participatory action research. I hope that this motivates therapeutic recreation practitioners to continue the momentum of improving our assessment practices and making others aware of the challenges practitioners face daily. Secondly, I hope that this provides insight to therapeutic recreation researchers and educators not only to the challenges practitioners identify, but to their role in the

continued development of research and evidence based practice. Collaboration is

essential and improvement in documented evidence and research will not occur unless

there is a partnership between researchers and practitioners.

I recognize that this is a small study based on one area in Canada, but it does not

make the experiences of these recreation therapists any less valuable. I hope one day

someone is able to complete a larger scale version of this study to capture the experiences

of recreation therapists practicing in Canada, the United States and the world.

Appendix A: Focus Group Interview Guide

Introduction:

The assessment process is crucial to our entire therapeutic process with our clients, regardless of where we work. It is where we begin to understand who clients are as people, their strengths and needs and how therapeutic recreation can support them in achieving their goals. Consider the job task analysis results from the National Council for Therapeutic Recreation Certification (NCTRC): obtaining referrals, records review, assessment method, completing assessment of various domains, understand results, share and document results).

Questions for the Focus Group to Discuss:

How do you define assessment?

1. How do you maintain awareness of new assessment methods/tools?

    a. How does it impact your practice/service provision, if at all? How often do you receive education about assessment tools and processes?

2. What are current assessment processes in your workplace? (Identify all and how frequently each are used)

3. Do you use standardized TR assessment tools?

    a. If yes, which ones? How reliable do you find them? How frequently do you use them? Are the results reflected in your documentation? What made you decide to use (each specific) standardized assessment tool?

    b. If no, why not? Have you tried using a standardized TR assessment tool? What evidence made you decide to not use them?

4. Do you use non-TR standardized assessment tools in your practice?

   a. If yes, which ones? How do they contribute to your assessment results? Do you feel they would benefit other TR practitioners? What made you decide to use them?

   b. If no, why not? Have you tried using them? Do you feel you have the ability/knowledge to use them?

5. Do you feel that standardized assessment tools have a role in our assessment process? Do you see that role increasing or decreasing as the profession grows and there is an increasing demand for evidence-based/outcome based practice?

6. Do you see yourself, as a TR practitioner, contributing to advancing knowledge about assessments and the assessment process? How would you do this?

7. How would you, as a TR practitioner, want to receive information/education about new information in assessment tools? What would you need in terms of support to change assessment protocols in your practice area?

Thank the group for their contributions and participation in this exploratory research study.

Appendix B: Focus Group Participant Outline

Thank you for consenting to participant in the focus group for the research study "The Pick of the Litter:" Understanding Standardized Assessment Tools and the Assessment Process with Older Adults in Therapeutic Recreation Practitioners. The following questions are to help you begin to think about the topic of the focus group which will discuss standardized assessment tools and the assessment process when working with older adults in the profession of Therapeutic Recreation (TR). Please consider the following questions that will help facilitate discussion at the focus group:

1. Think about your assessment process from beginning to end. What does it include?
2. What TR standardized tools, if any, do you use to help with your assessment findings? Do you use non-TR standardized tools?
3. If you do not use them, consider why you do not. What evidence have you based on your decision on?

Please remember that goal of this focus group is to learn what TR practitioners are currently doing in their assessment process and that no judgment is based on an individual's practice. The discussion and reflection provided by all focus group participants is the purpose of this research.

Thank you again for agreeing to participate in this focus group. I look forward to participating with you in this unique exploration of Therapeutic Recreation practice. Please do not hesitate to contact me at 473-8658 or email Andrea.King@cdha.nshealth.ca with any questions. You may also contact my academic supervisor, Dr. Jerry Singleton at 494-1166 or email Jerome.Singleton@Dal.ca

Sincerely,

Andrea King

Appendix C: Informed Consent Letter

Andrea King
c/o Dalhousie School of Health and Human Performance
Halifax, N.S.
B3H 4H6
Telephone: (902) 473-8658 option #1   Fax: (902) 473-3558
Email: Andrea.King@cdha.nshealth.ca
Date:

To:

I invite you to take part in an exploratory research study which is being conducted by Andrea King, CTRS, Master of Arts (Leisure Studies) candidate at Dalhousie University's School of Health and Human Performance, in completion of a thesis research project.

The title of the study is: "The Pick of the Litter?" Understanding Standardized Assessment Tools and the Assessment Process with Older Adults in Therapeutic Recreation Practitioners. The purpose of the study is explore if and how standardized assessment tools are used by Certified Therapeutic Recreation Practitioners (CTRS) working with older adults. There is minimal research or information about how standardized assessments are used in Therapeutic Recreation practice by CTRS's.

Andrea King is the principal investigator for this project with support from academic supervisor Dr. Jerry Singleton. The role of principal investigator is to ensure the research process occurs ethically and in the manner that you agreed to, ensuring minimal risk to all participants. Andrea will be present for all data collection and focus groups processes. Stephanie Wood, MA, CTRS will be facilitating the focus groups. Stephanie is experienced in qualitative research projects and familiar with focus group processes.

Participation in this study is completely voluntary. Data collected from this study will be only be used for the purposes of this study. Participation in this study is optional and you may withdraw at any time. If you choose to withdraw, please contact the principal investigator.

The following describes who may participate in research project, the research study and will inform you of any risks, discomfort or inconveniences you may experience. Feel free to contact Andrea with any questions or concerns about this.

You can take part in this study if the answer is YES to <u>all</u> of the following:

4. You are currently a Certified Therapeutic Recreation Specialist

5. You have been practicing in the field of Therapeutic Recreation for a minimum of one calendar year and certified for that year

6. You work a minimum of 37.5 hours biweekly as a Therapeutic Recreation Practitioner

7. You practice in a clinical or community-based environment where 75% of your clients are over the age of 65 years

The study will entail attending two focus groups. The first focus group will last for approximately 2-2.5 hours and the second will last for approximately 1 hour. The first focus group will be held within 2-4 months of the initial contact and will occur in a neutral setting that is not the workplace of any participant. This is to preserve anonymity and confidentiality of all participants. All participants will be notified by email of the dates for both focus groups. The second focus group will occur in the same neutral setting, at a time decided by participants during the first focus group. The first focus

group's purpose will be to obtain information from the participants about their

assessment processes and tools used. The second focus group's purpose will be to share

the themes drawn from the first focus group by the researcher to allow the practitioners

to discuss the themes further to ensure accuracy and allow elaboration or clarification.

Both focus groups will be audiotaped and transcribed. All participants will be assigned a

code at the first focus group to protect anonymity and only codes will be used in the

transcription.

All participants will be asked to maintain confidentiality by respecting that the

conversation that occurs within the focus groups remains confidential. Please note that

the researcher has no control if participants share information outside the focus group.

Only the researcher and academic supervisor will have access to the audio recordings

which are securely stored in the office of the academic supervisor. The transcriber will

have access during transcription and the tapes will be returned to the researcher. When

data analysis is finished, the tapes will be destroyed.

As the purpose of the research is to understand the use of standardized assessment tools

and the assessment process in TR practice, the study may not directly benefit you as a

participant. Participating may allow you to feel a sense of pride or satisfaction by

contributing to research in this area.

Andrea will be contacting you if you have identified interest in participation or returned a

signed consent form. Further information and details regarding participation in the study

is available at this point of contact. Please feel free to contact Andrea at 473-8658 or

email Andrea.King@cdha.nshealth.ca or Dr. Jerry Singleton at 494-1166 or email Jerome.Singleton@Dal.ca with any questions you may have.

Thank you so much for considering being a part of this research study. Should you have any concerns about any aspect of participating in this study or during participation, you can contact the Office of Research Ethics Administration (Human Research Ethics) at Dalhousie University for further assistance: 902-494-3423.

With much appreciation,

Andrea King, CTRS
(Master of Arts candidate)

Appendix D: Informed Consent Form

I understand that participation in the study "Pick of the Litter? Understanding Standardized Assessment Tools and the Assessment Process with Older Adults in Therapeutic Recreation Practitioners" is completely voluntary and that I can withdraw at any time from the study.

I have read and understood the attached letter and have kept a copy for my own records. I have been provided with opportunities to discuss participation and all questions have been answered to my satisfaction.

I will send a signed electronic copy of this consent form within 10 days of receiving it and will keep a copy for my own records. I will sign in person a copy of the consent form upon arrival of the first focus group.

Please check the following as they apply:

- o I **agree** to consent to participation in this research study

- o I **agree** to audiotaping during the focus groups

- o I **agree** to be re-contacted for the second focus group

- o I understand my name will not be used in transcript and my personal identity will not be revealed in any records or publications of this study

- o I **do not consent** to participation in this research study

_____

Signature of Study Participant   Date Signed

_____

Signature of Principal Investigator/   Date Signed

Person Conducting Consent Discussion

**DALHOUSIE
UNIVERSITY**
Inspiring Minds

WANTED: CERTIFIED THERAPEUTIC RECREATION SPECIALISTS FOR A RESEARCH STUDY!

Study Title: "The Pick of the Litter?" Understanding Standardized Assessment Tools and the Assessment Process with Older Adults in Therapeutic Recreation Practitioners

You are invited to participate in this research study if:

- You are currently a Certified Therapeutic Recreation Specialist
- You have been practicing in the field of Therapeutic Recreation working with older adults for a *minimum* of one calendar year full time (75 hours/biweekly) or two calendar years at half time (37.5 hours/biweekly) and certified for this duration
- You currently work a minimum of 37.5 hours biweekly as a Therapeutic Recreation Practitioner
- You practice in a clinical or community-based environment where 75% of your clients are over the age of 65 years

Participants will partake in 2 focus groups and a brief post group reflection. The expected time commitment for the entire project is 3-3.5 hours. There is compensation for your participation in the study.

If you are interested in participating and would like more information please contact: **Andrea King, Principal Investigator**

Andrea.King@cdha.nshealth.ca

(902) 473-8658

Appendix F: Critical Review Chart

Author	Year	Rationale for Study	Theory	Methodology	Subject description	Results	Conclusion	Gaps
Voelkl& Hermann	1993	-to show tx issues when working with people with dementia & depression -to examine the use of PES-AD & MOSES	None	Used PES-AD & MOSES for ax, case study	N=1, 92 year old female, had high school and 2yr teachers college, was married(husband died), had one son(who died in his 30's of a stroke) & only surviving relatives were a nephew & cousins, staff report had few visitors. -lived in nsg home, dx with irregular heartbeat, arthritis, hypothyroidism, edema. She lived on Intermediate care unit for 1 week, had several falls, moved to skilled care unit. Staff reported signs of dementia (forgetfulness) and depression (withdrew from others, sad affect)	PES-AD – could not respond about enjoyability, but could id interests/non interests MOSES- disorientation, depression, withdrawal	(1)PES-AD- too long, needed to be shortened, recommended use with caregiver who has knowledge of person (2)MOSES – easy to use, gave overview of day to day functioning	-collected data from 'director of activities' re: participation in activities who said pt had been involved with 12 activities. What does **involved** mean? What is the director's education background? -The author who worked with the pt is an undergrad, not a CTRS -interactions with pt not clear -'collapsed' items in PES-AD..what are the implications on reliability/validity
Searle & Mahon	1993	The effects of leisure intervention had not been explored in a	Attribution theory	Field experiment (expvs control); used perceived leisure control scale, perceived	Sig. female, N=44 Min score of 24 of MMSE, age, marital status, days of hospital	(1) exp group had higher perceived competence scores (2) Control group	(1)Leisure ed had modest long term impact (2) need more	-unknown background of Rec Therapist -no cultural/languag

				leisure competence, self esteem scale	attendance, health condition, gender, social supports	with high competence scores at pretest stayed high; exp group with low competence scores at pretest had significant gains (3)no change in control or self-esteem in either group	research for efficacy/efficiency of leisure ed at day hospital (3) increase intensity of intervention (more frequent & longer) (4) Participants need to carry out action plan themselves (5) use double blind and single case study methods	e /religion diversity identified -no SES identified -challenges with population (eg attendance, transportation) -no reason for why people withdrew from project
		day hospital setting before						
Chang & Card	1994	LDB short form version B had not been tested for reliability with other populations (no test-re-test had been completed)	Neulinger's Leisure as a state of mind	Used surveys, test-retest; convenience sample First test had 41/71, retest had 32/44	N=71, 60 females, 11 males, mean age 78.5 years (all 65 or older), lived in public housing	First test reliability .95, retest was .93 & .94. Retest alpha coefficients were .95 &.95. First test Normal distribution was .97, retest was .98	(1) Internal consistency measured high, (2) reliability was low for ax healthy older people, (3) recommend testing over different periods of time to test stability of tool & having a larger *n*	-no characteristics about n provided (education, illness impact, culture/ethnicity, SES). -b/c 2 residents handed out the test, we don't know how the test was completed (did people group together, copy off each other?)
Boothman&Savell	2004	TR professionals require ax tools with	Selective optimization and compensa	11 Raters (from the 11 nsg facilities) ax'edparticipnts	N=66 (17 male, 43 female final), from 11 Skilled Nsgfacilities in	-3 of MARRCC domains (physical 0.68, social 0.62, and cognitive	(1) MARRCC has content validity, inter-rater validity &	-does not say how they got informed consent

		theoretical/conc eptual foundations, should measure health and physical, cognitive, & psycho-social needs, and it must measure change over time	tion (which includes role theory, continuity theory, & activity theory) -Leisure Ability Model	using MARRCC and MOSES. They were provided instructions on how to obtain a random (each to get 6 people) and timelines to complete ax.	California, had to be residents for min 30 days, used random number table with pt census to get participants randomly Ages between 48-103 yrs old, average 79.08 years	0.88) had moderate correlation with the MOSES domain scores. Emotional correlated at 0.39 -Correlation for test-retest were: physical 0.97, cognitive 0.99, social 0.98 and emotional 0.95	intra-rater validity (2)Further criterion-related validity of MARRCC and predictive validity should be completed (3)Rec professionals can interpret scores with "little to no assistance beyond instruction"(p.3 89) in the manual.	-doesn't give education background on the Recreation Service Directors who implemented the tools & completed ax
Kloseck, Crilly, Ellis, & Lammers	1996	(1)description of development of tool, (2) determine reliability in various scenarios	Competen ce from motivatio n, perceived competen ce, perceived control, self-efficacy, learned helplessn ess **Reliabilit y/Validit y Testing:** Generaliz ability theory	Used developmental process FIM used [pilot, trial, implementation, revision] **Reliability/Validi ty Testing:** Used Life Satisfaction Index B, Geriatric Depression Scale, Folstein MMSE, LCM	pilot phase used: 5 TR educators, 2 Drs, 18 TR practitioners (rehab & psych) avg year of practice was 6., Trial phased was "extensive multisite use"., more reliability/validity testing with geriatric rehab testing **Reliability/Validit y Testing:** 114 participants (47 male, 67 female), mean age 77 +/- 7.63 years (SD), in either	**Pilot:** Content-related evidence of validity good; Kendall's coefficient of Concordance (interrater reliability) was acceptable except for social appropriateness;, feasibility deemed satisfactory, **Trial:** reported by practitioners to be useful in documenting gains, pt centered, **Reliability/Valid**	Significant correlations found with measures of depression & cognition, lcm correlated significantly with life satisfaction BUT conceptual linkages not well founded in theory, produced reliable scores, identifies basic competencies; further research to establish link	-education of testers not given (were they CTRS's?) **Reliability/Vali dity Testing:** RA background not provided, testing limited to geriatric rehab population, analysis of factors that impact TR services, no def. what competence in leisure is/

			[classical test theory]		Geriatric Rehab unit, or GDH (both in London, Canada); 42% geriatric rehab, 58% GDH, provided primary diagnoses, 79% lived at home, 21% admitted from acute care, living companion statuses given	**ity Testing:** Inter rater reliability: r = .91, internal consistency was .92, rater agreement ranged from .71-.91; deemed dependable between rater (0.897-0.974) significant validity	between leisure competence, leisure satisfaction and life satisfaction	impact it has on cog. impaired older adults; do you have to be competent to enjoy leisure? What criteria are observed to demonstrate competency? What behavioral cues/responses the CTRS should be looking for? There's NO standardized process of obtaining information to gain a baseline

Appendix G: Post Reflection Questionnaire

Thank you for participating in the first focus group for the research study "The Pick of the Litter?" Understanding Standardized Assessment Tools and the Assessment Process with Older Adults in Therapeutic Recreation Practitioners.

I would like you to take a few minutes to reflect on the experience to ensure I can capture the main themes that resulted from yesterday's focus group.

Please consider the following:

1. After the discussion, has your definition of assessment changed in any way?

2. Have your thoughts on TR specific standardized assessment tools changed in any way since yesterday? How? What factor/issue caused this change to occur?

3. Has your opinion about the role of standardized assessment tools changed? How?
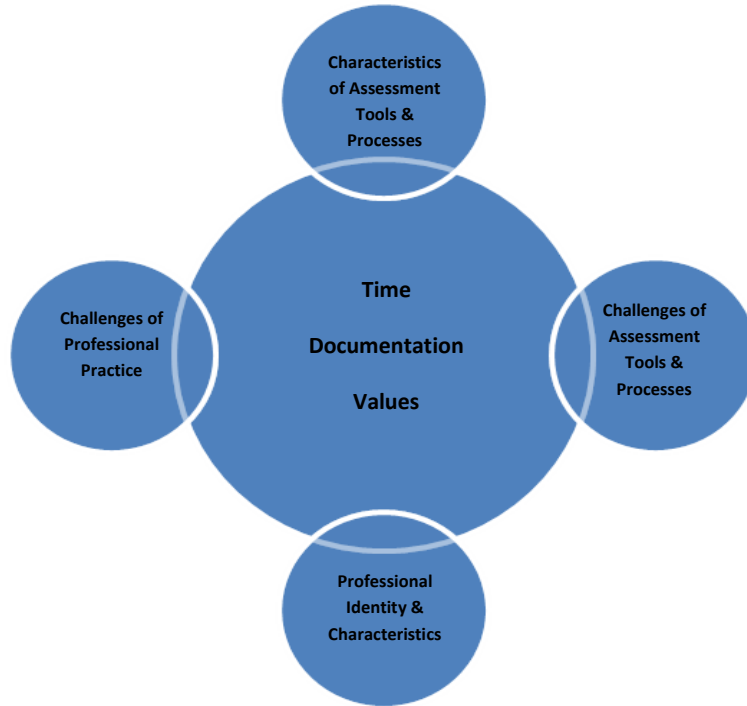
Appendix H: Theme Summary for Participants

Thank you for participating in the focus group for the research study: *"The Pick of the Litter?" Understanding Standardized Assessment Tools and the Assessment Process with Older Adults in Therapeutic Recreation Practitioners*. This is a follow up to our meeting, providing you with the themes that emerged from the focus group session. Upon review of the transcript many of the themes seemed to represent all those who participated in some way. In respect for your time, I am providing you a written copy of the themes and subthemes that emerged, for you to review and comment on. This is how the information will be presented to you at the second meeting.

The following diagram is an attempt to capture the interactivity of the themes that merged from the focus group discussion. I want to ensure that this reflects the discussion of the focus group. Please provide comments and your insights to the diagram so it reflects our conversation.

Comment areas follow each section. Please use this as a space to include your thoughts and insights.

THEME DIAGRAM

- Characteristics of Assessment Tools & Processes
- Challenges of Professional Practice
- Time
- Documentation
- Values
- Challenges of Assessment Tools & Processes
- Professional Identity & Characteristics

COMMENTS:

SUBTHEMES:

Time constraints

> I mean time constraints sometime limit us so that we never, or at least for myself, I never feel like I totally did a decent assessment on an individual because it could just be at a time of very high turnover in the workplace, meaning client turnover, so you just, you never feel like you have fully done, like done a full assessment on an individual. (Rowan)

> you don't always have the time to find those meaningful therapeutic interventions and it's hard to balance everything (Tiffany)

> knowing like what my case load is and how much time I have, and looking at like I don't have time for this and I have all these other people to see (Erica)

> I think time is of an issue for every profession (Eva)

> I just feel like we're stretched so thin too. I mean case loads are so heavy, there's all these expectations to create this huge social atmosphere but then also it's like you have people with behavioral issues, and it's like what interventions do you want to do and how can you do everything and keep everybody happy? And not complain about what you do? (Tiffany)

> I think, I do know partially why and it may not be, it was my impression I guess is what I need to say, I think it all comes down to time commitment because it's a lot of time. And when people put in their 7.5 or 8 hour, whatever hours of a day, you know it's, and then when you want to leave to get away from this, so you can come back and do it again the next day, but I think if there was maybe more time given at work, like around that focus too and not just on a clinical level, and having more support, maybe (Eva)

> I think I need time to look at the research or if there's no research, kind of talk to my co-workers and go over what's been successful for them, what I've found successful and then go from there. I just don't think there's time. (Eva)

> I find that we are torn in so many directions that if you try to focus it on some specific aspect and then, I mean, because assessment is so much greater, and like doesn't work. Well how do we know whether it's working? So it's more than just the assessment thing, it's like what happens with that individual, what are the outcomes and like there's a full

circle right, so you never know which part of the pie to work with, right. Like which is most important to my practice right now? Like figure out this perfect assessment and just go with what I have because I really need to focus on the implementation part or, there's just not, there's never enough time to spend on all the parts. (Rowan)

Documentation

But I think there's too much pressure maybe or you feel so much pressure to have it so formal, so I think you know when you hear formal and written, I kind of cringe, because then you say oh you have to have it done in this x amount of time when really you do it probably, if you broke down your day you probably do it more than what you know you even realize you're doing yourself. So, it's just that yah, it's not, I think for me personally I don't calculate that I do a full assessment unless I have it totally written out and printed right on the chart so I don't, which is kind of stupid because in my head I know I have. (Eva)

Values/Expectations

everybody else seems to have come up with something that works for them, that they can get this quick snapshot of what it is that they need to focus on that in two weeks they can stamp at the end a discharge or a performance, an outcome, or whatever, and say yes look I've met my goal. And I just never feel like I have that professional snapshot that I could put my stamp at the end of their stay or their time on our team. I just never feel like I'm putting that kind of stamp that says I've done, I've achieved my goals and outcomes with this individual and off they go. (Rowan)

Well I think it's a standard for all professions that you have to have assessment, assessment, assessment, and if you don't have it, you feel maybe inadequate or not, that you're, you haven't done your official job. So that's why I really hate that because I know I put 110% into knowing the patient. I may not have some formal document that states this, but I know I can, I probably know them better than what somebody has this assessment. (Eva)

It's always a lot of tools we use on leisure-related, and I don't know people in long term care they may not really value or understand what leisure is per se, cause maybe they didn't value it as much, they might focus on working and that type of thing. A lot times there isn't a great understanding the whole concept of leisure so I think that makes it harder for them to understand sometimes the assessment interview, like the standardized assessment tool, I mean. (Erica)

COMMENTS:

<center>**THEME: Characteristics of Assessment Tools and Processes**</center>

SUBTHEMES:

Rapport

The value of rapport:

you can read all you want in a chart or you can read whatever, but if you don't have that rapport or you don't form some kind of relationship with the person you can, no assessment in the world or nothing is going to get you anywhere. (Eva)

Sometimes where they don't see our profession as being medical related they will tend to tell us stuff, how they really feel in the hospital, what's going on and sometimes they'll tell us those fears where we can go back, even though you're not breaking their confidence, but you can still go back to the team and say you know this is their concerns, whereas they may not get it out of somebody (Eva)

I think just because we're such a holistic profession that that whole element of rapport is more important. I mean if your questions are only relating to the physical domain, or functional domain you don't need to explore or know the person as much. I mean there's, not to say that a lot of the other team members do not take a keen personal interest in the individual and show that, but in order to assess them, physical functioning, or a functional level of performance, it doesn't take as much rapport or trust (Rowan)

I think if you want a true reflection of what this person is, you have to have a good rapport with someone (Eva)

What is rapport?

a good interaction or … a trusting relationship….Someone where they can speak freely to (Eva)

They feel comfortable with you (Tiffany)

Processes used/Skills

I think of assessment as the whole process of getting the information from the chart review, doing an interview, going through the actual assessment tool and then developing the plan and then evaluating the plan afterwards. (Tiffany)

I always start with the initial meeting of the patient and speaking also the family, doing a screen…. rely a lot on my initial meeting with the patient (Eva)

<center>125</center>

Well I'd use those little like pre-assessment tool conversations we were talking about and I'm kind of providing some orientation to the individual as well so they know why you're there and where you're coming from, and chart review, observation, talking with other staff and then doing their actual assessment tool and then writing it down. (Tiffany)

Yah, chart reviews, families, conversation, observation (Rowan)

I think so. I mean I'm always looking for them when I do my chart review, to find out their cognitive levels, or their physical ability (Tiffany)

The main part I think is doing your chart reviews and chatting with others and things like that but I think about delivering the assessment tool and interviewing you need to have really good people skills, you need to be a good listener and kind of be able to pick up on different, like you know different pieces of body language that you might see. (Tiffany)

It seems like it's ongoing almost, you know. You're always assessing, and it might even be different one day from the next. Say if you kind of change your approach (Tiffany)

I think you have to learn not to lead like I think that's critical, be patient. (Eva)

Documentation required

the technical goal is to have our assessment or admissions assessment completed within a week (Erica)

Role of Non-TR Assessment Tools

I don't do them but I like to look at scores from their MMSC or the MOKA, or you know like falls risk or something like that, but I don't use them (Tiffany)

I never really thought I could. You know I've never, I've been like told oh you can't do an MMSE (Tiffany)

I'm sure the LPNs, RNs do the MMSE, I never thought about doing it myself either to be honest with you, it's just something they always did (Erica)

Yeah I thought the MMSEs had to be done by registered staff cause it's always asked by, or you know licensed staff (Eva)

I'd feel happy doing it but you know what I'm glad to have the 20 minutes to do something else with the person rather than administer the MMSE. I'm happy that it's not, I'm interested in the information but I'm, I certainly don't regret that I don't have to do that (Rowan)

I've never even thought about wanting to do those assessments because I use the information, but I've never thought, but I have just personally like with a patient, if I've had curiosities about them and how they're operating, I've just pulled out a TRAILS test right and just kind of treated it as sort of a cognitive intervention just to see where they're at and just ask them if they can, you know just like can you do this and just, to see where they're at. It's never like a formal thing but I've done them right and to see where they are because maybe I've tried to get them to do a puzzle or tried to get them to do something that requires sequencing and they seem to be having a problem, so the next time maybe I've brought in a TRAILS just to see where they're at. (Rowan)

No I'll just ask them, you know, this is a puzzle, a game, you know. And can you do this and so I use it in an informal way sometimes just to see where they're at as far as then is it fair to be asking them to do it. (Rowan)

I think informally you do it all the time, like part of the frontal assessment battery right, FAB is six animals that start with the letter F or whatever right and when we're doing gaming in the evening, you do those things, right, and so you're doing these components, and it's just like with the TRAILS, like you know they come out quiz books and different, and so it's more of a gaming type thing that we're doing but in some ways we're doing those same assessments but it's in a less intimidating way for them and they're trying them and so we use them that way and the Scattergories and those things are all components of other assessment tools right, or a lot of them are. (Rowan)

COMMENTS:

SUBTHEMES:

Time

time constraints sometime limit us so that we never, or at least for myself, I never feel like I totally did a decent assessment on an individual (Rowan)

you don't always have the time to find those meaningful therapeutic interventions and it's hard to balance everything (Tiffany)

I think we do assessments every day, like when you meet somebody initially. But I think there's too much pressure maybe or you feel so much pressure to have it so formal, so I think you know when you hear formal and written, I kind of cringe, because then you say oh you have to have it done in this x amount of time when really you do it probably, if you broke down your day you probably do it more than what you know you even realize you're doing yourself. So, it's just that yah, it's not, I think for me personally I don't calculate that I do a full assessment unless I have it totally written out and printed right on the chart so I don't, which is kind of stupid because in my head I know I have. (Eva)

They're long (Tiffany)

very long and it's hard for people to understand them and, a lot of times (Erica)

and some of them in the end, I'm like if I go through this whole long process see if there's answer how is this going to help me anyway, you know. (Tiffany)

for me personally, it's a time factor and what is it really proving? I think I can get to the same results or get you know than using it (Eva)

Well I guess so, knowing like what my case load is and how much time I have, and looking at like I don't have time for this and I have all these other people to see and I know from my experience in this population that asking you know questions about your leisure history for 10 or 15 minutes, seems to be long enough. They don't want to talk about it, their leisure attitude for an hour. (Tiffany)

Lack of outcomes

> I'm like if I go through this whole long process and get this answer how is this going to help me anyway, you know. (Tiffany)

Measuring concepts

> always a lot of tools we use on leisure-related, and I don't know people in long term care they may not really value or understand what leisure is per se, cause maybe they didn't value it as much, they might focus on working and that type of thing. A lot times there isn't a great understanding the whole concept of leisure so I think that makes it harder for them to understand sometimes the assessment interview, like the standardized assessment tool, I mean. (Erica)

> I'm a little jealous if you look at people who are assessing more like physical functioning, it's a lot, it's almost like almost easier, than assessing like more emotional and social stuff. It's like oh so and so walked five feet today, next week, so and so walked seven feet, you know it's right there, and it's easy to measure, whereas some of the other things that we are looking at are very difficult to measure. (Tiffany)

> It just seems that, I mean the struggle continues right to find a perfect way to jacket everybody that the perfect ten questions that you can ask that, but because I think recreation, your leisure, once again we're looking at such a holistic, like across the spectrum, group of characteristics that, it's very difficult to come up with one concrete time-efficient assessment that's going to describe that person or where they're going to fit into your practice where you can, it's not to say that there isn't an assessment tool out there that would work, um. Yeah. And I think there's things to be gained. (Rowan)

> So I mean I think, I think if tools were developed, if there was a tool that was developed and had a practical spin on it, that was concise and, I don't know but it's hard, does one size fit all I guess, you know what I mean so I don't know (Eva)

Continual process, short term results, usefulness

> it's ongoing almost, you know. You're always assessing, and it might even be different one day from the next (Tiffany)

> if I knew it was really valuable, was going to give me really, all the information I can't get elsewhere then I would certainly be open to it (Erica)

No, I think I just look at them and see how long they are and I think no one's going to want to answer all these questions. (Tiffany)

Scope of Practice related to assessment

I never really thought I could. You know I've never, I've been like told oh you can't do an MMSE or (Tiffany)

I thought the MMSEs had to be done by registered staff cause it's always asked by, or you know licensed staff. (Eva)

Documentation of process & outcomes

I bring that back to team members that we were doing this and through this, you know activity, intervention, whatever, I discovered this. So I do bring the information back around but its yah, not a formal documentation process as part of that, a tool, using a tool to assess. (Rowan)

Environment/dynamic relationship

also I find as soon as you come into a room with a formal piece of paper on your lap, it just changes the whole conversation (Rowan)

Well I take notes, I just tell them what I'm doing. It's kind of like an informal conversation we're having, like I do it in my own head, like the questions that I ask, but I just tell them initially that I do this with everyone, I ask the same questions, you know sometimes obviously the conversations veer off, but they're the same questions that are kind of to get started, and I ask them if they mind if I take notes. Cause I say I'll forget so you know, so it's kind of more, and they feel comfortable with it that way (Eva)

COMMENTS:

THEME: Professional Identity and Characteristics

SUBTHEMES:

Value & Contribution to the team

I don't find it disheartening I just find it's hard. Because I mean the team knows and I know, you know that you made an impact, you know you really do, but it would be nice to see like you know if you looked at it on a graph like you know what I mean, you still have it, so I find, but I don't think we'll ever have that, like I don't, you know so, it's just a different discipline and it's just how we are. So I don't know but it's harder to measure. (Eva)

And on a selfish note, you want to be a full-fledged team player like the rest (Eva, talking about doing the MMSE see page 16)

I think time is of an issue for every profession, and I think people only go to parts that is well recognized, that they can see some sort of result I guess. To flip through everything is impossible and so I don't know how valid say if I did the leisure competency measure, what is that really telling other disciplines? You know, so what gives them any incentive for them to go look in the chart to see what that says so if we have a problem, if we're not doing it, my thing is what is really the purpose of the incentive, you know I mean what is that telling other disciplines about that client that is pertinent to them? So I think it has to benefit everyone. Like for instance, what you just said, why do you go look for the MMSE score or why do we go look for something so what is the incentive for other disciplines to go look at any one of our screens or something , so and then comes the whole piece of educating other people and we have to have it down pat before others can kind of go, so that's my thought process anyway. So if I don't really know why in the hell I'm doing this, why should someone else from another discipline look at it. (Eva)

But I think with that said, like when you think about it, like there's someone who does it and I just think you know it would be nice to know that you could do it. Like I mean not every person, not one person gets called on it, but say you're in a team and you know 10 people, that one person gets it all the time, it would be nice to divvy it up, like to know that you can do it, like you know if there's shift splitting workload or something that you can say well hey I can take this one, especially if it's someone that you know you have a good rapport with and that they know, so I think that would be good then. I wouldn't want to say I want to do every one, you know. (Eva)

but sometimes you don't realize the value that you had because it's an everyday occurrence, that oh yah, so and so did this, but then you know when someone, when you are talking and then it sparks some things, like wow that is really significant you know (Eva)

Need for Support

Rowan's other complaint is that Rowan doesn't seem to have time to reflect on his or her profession, but what's missing around the table too are other areas. I'd be very interested to hear because I think probably there are more assessments being used in other areas. (Rowan)

I think I need time to look at the research or if there's no research, kind of talk to my co-workers and go over what's been successful for them, what I've found successful and then go from there. I just don't think there's time. (Eva)

Accountability

I just feel like we're stretched so thin too. I mean case loads are so heavy, there's all these expectations to create this huge social atmosphere but then also it's like you have people with behavioral issues, and it's like what interventions do you want to do and how can you do everything and keep everybody happy? (Tiffany)

I mean with the cutbacks and things that are happening, people are asking why, you know we either show them why or you know we're not going to get, the profession is not going to grow, or it's even going to be cut from certain areas, if we can't show why (Tiffany)

Person-centered

I always think about how would you feel if you were in their shoes (Eva)

COMMENTS:

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