FOR THERAPEUTIC RECREATION PROFESSIONALS IN CANADA, WHAT ARE THE SKILLS AND KNOWLEDGE REQUIRED FOR COMPETENT PRACTICE?

by

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The undersigned hereby certify that they have read and recommend to the Faculty of Graduate Studies for acceptance a thesis entitled "FOR THERAPEUTIC RECREATION PROFESSIONALS IN CANADA, WHAT ARE THE SKILLS AND KNOWLEDGE REQUIRED FOR COMPETENT PRACTICE?" by Tanea M. Goncalves in partial fulfilment of the requirements for the degree of Master of Arts.

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Signature of Author

DEDICATION

This thesis is dedicated to my wonderful husband Joe and my incredible son Alexandre,
You are the reason I am here now. I love you very much!

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ABSTRACT

The purpose of this study was to identify the knowledge and skills required for competent therapeutic recreation practice in Canada. Research participants were 244 members of therapeutic recreation professional associations in Canada. Results from this study indicated that significant differences in competency areas exist between certified and non-certified therapeutic recreation practitioners, between practitioners with a degree and diploma, between practitioners in varying demographic regions in Canada and between practitioners with varying years practicing in the profession of Therapeutic Recreation. Implications for therapeutic recreation practice and future research are presented for discussion.

LIST OF ABBREVIATIONS AND SYMBOLS USED

AAL	American Association for Leisure and Recreation
ARS	American Recreation Society
ATRA	American Therapeutic Recreation Association
ATAR – b	Alberta Therapeutic Recreation Association
BCTRA	British Columbia Therapeutic Recreation Association
CAAHEP	Commission on Accreditation of Allied Health Education Programs
CAHR	Council for the Advancement of Hospital Recreation
CARTE	Committee on Accreditation of Recreational Therapy Education
COA	Council on Accreditation
COAPRT	Council of Accreditation, Parks, Recreation, Tourism and Related Professions
CORPA	Commission on Recognition of Post Secondary Accreditation
CTRA	Canadian Therapeutic Recreation Association
CTRS	Certified Therapeutic Recreation Specialist(s)
ETS	Educational Testing Services
HRS	Hospital Recreation Section
NART	National Association of Recreational Therapists
NCTRC	National Council for Therapeutic Recreation Certification
NLTRA	Newfoundland/Labrador Therapeutic Recreation Association
NPRA	National Recreation and Parks Association
NRA	National Recreation Association
NSRPH	Nova Scotia Recreation Professionals in Health
NTRS	National Therapeutic Recreation Society
QAAP	Quebec Association of Activity Professionals
SARP	Saskatchewan Association of Recreation Professionals
SPSS	Statistical Package for the Social Sciences
TR	Therapeutic Recreation
TRAAC	Therapeutic Recreation Association of Atlantic Canada
TRO	Therapeutic Recreation Ontario
US	United States

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First, I would like to thank the 244 Therapeutic Recreation Professional/Practitioners who agreed to take part in this study. I hope the results of this study will aid in shaping the future of Therapeutic Recreation in Canada.

I have to thank the Therapeutic Recreation Associations who agreed to distribute my questionnaire to their members using Dillman's four wave reminder protocol: British Columbia Therapeutic Recreation Association, Alberta Therapeutic Recreation Association, Saskatchewan Association of Recreation Professionals, Manitoba Regional Members, Quebec Association of Activity Professionals, Therapeutic Recreation Association of Atlantic Canada, Nova Scotia Recreation Professionals in Health, Newfoundland Labrador Therapeutic Recreation Association and Canadian Therapeutic Recreation Association.

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Chapter 1

Introduction

Therapeutic Recreation (TR) in Canada is emerging as a profession (Singleton, et al, 2006). Currently there are ten TR organizations in Canada, from the Newfoundland Therapeutic Recreation Association to the British Columbia Therapeutic Recreation Association. Each association establishes criteria to become a member and members register with that association in order to gain recognition as a profession in that particular field. The establishment of each of the professions varies as illustrated in Figure 1.

The Development of Therapeutic Recreation Associations Across Canada

- 1985 ATRA: Alberta Therapeutic Recreation Association
- 1983 RTRA: Regina Therapeutic Recreation Association
- 1986 NLTRA: Newfoundland Labrador Therapeutic Recreation Association
- 1991 BCTRA: British Columbia Therapeutic Recreation Association
- 1992 QAAP: Quebec Association of Activity Professionals
- 1992 TRAQ: Therapeutic Recreation Association of Quebec (ceased in 2006)
- 1995 MTRA: Manitoba Therapeutic Recreation Association 1995 (amalgamated with Recreation Connections Manitoba in 2010)
- 1994 NSRPH: Nova Scotia Recreation Professionals in Health
- 1996 CTRA: Canadian Therapeutic Recreation Association
- 1999 NBTRA: New Brunswick Therapeutic Recreation Association
- 1999 TRAAC: Therapeutic Recreation Association of Atlantic Canada
- 1999 TRO: Therapeutic Recreation Ontario (Previously known as the Ontario Council on Therapeutic Recreation and Therapeutic Recreation for Ontario)

Figure 1 The Development of Therapeutic Recreation Associations Across Canada (Adapted from Singleton & Goncalves Presentation (2008) Development of Therapeutic Recreation in Canada: Putting the Puzzle Together, slide 4)

Therapeutic Recreation professional organizations are relatively young, being established during the 1980's and 1990's. To further reflect the diversity of these professional organizations, a variety of TR professional organizations have developed

standards of practice documents. The Canadian Therapeutic Recreation Association published "CTRA Members Manual – Standards of Practice" in 1996, Therapeutic Recreation Ontario published "Therapeutic Recreation Standards of Practice" in 2003, Newfoundland and Labrador Therapeutic Recreation Association published "Standards for the Practice of Therapeutic Recreation – Recreation Specialists" and "Standards for the Practice of Therapeutic Recreation – Recreation Workers" in 2004. In 2006 the Canadian Therapeutic Recreation Association revised their standards of practice document and published "Standards of Practice for Recreation Therapists and Recreation Therapy Assistants" in 2006. As well, in September that same year (2006) the Nova Scotia Recreation Professionals in Health and Therapeutic Recreation Association of Atlantic Canada co-published "Standards of Practice Recreation as a Therapy and Service." During this period we saw the emergence of educational opportunities from a variety of institutions from Universities; University of Alberta, University of Regina, University of Manitoba, Brock University, University of Waterloo, Concordia University, Dalhousie University and Memorial University to community colleges: Douglas Collage, Lethbridge Community College, NorQuest College, Seneca Collage, Saskatchewan Institute of Applied Science and Technology, Canadore College, Confederation College, Fanshawe College, Georgian College, Mohawk College, Niagara College, Nova Scotia Community College, Keyin College, Academy Canada (CTRA, 2012). How do we move TR as a profession forward in Canada when 10 organizations represent the members of that profession?

Professional development literature has identified eight attributes that should be reflected in a profession, based on a continuum of growth for the profession, and it includes: 1) a developed body of knowledge; 2) a demonstration of relevance to social

values; 3) a training period that was long, specialized, symbolic, and included education in a professions' sub-culture; 4) members that were service oriented; 5) autonomy that was present in the forms of certification and regulation or licensure; 6) members who demonstrated a long term commitment; 7) a strong sense of community. and 8) a developed codes of ethics (Pavalko, 1988).

A profession progresses through various stages of evolution. The initial stage, registration, is the process by which members from a professional group come together to create an organization to represent the interests of its members (Riley, 2004). The next stage, certification, is the process by which specific standards are established for a professional community and a competency examination is developed to ascertain a minimum entry level to practice in that profession (Riley, 2004). The National Council for Therapeutic Recreation Certification is an example of such a system. The final stage, licensure, is the process by which a provincial government grants licensure status to a professional group, based upon the need to ensure protection of the public. Individuals must meet the standards as delineated by the government agency to ensure that the professional is competent in their practice (Riley, 2004). Generally, a minimum entry level of education is required and at times, a competency examination can be used to determine if a member qualifies to be a licensed member of that professional group. The licensure process can result in title protection for a professional group, so that no other person can call themselves by that title (Riley, 2004). Professions such as Social Work and Nursing have made these transitions in their own histories. The process of professional development from registration, certification and onto licensure is a process professional groups complete as they move to being characterised as a fully developed profession.

The development of Therapeutic Recreation in Canada reflects the emergence of a profession from voluntary registration, certification to licensure. Each province reflects the evolution of professional development (registration, certification, licensure) in the development of Therapeutic Recreation. Historically, the leadership for TR education in the Western provinces emerged from community colleges (Douglas College, Malasapina College, Mount Royal College, Lethbridge College) while from Ontario to Eastern Canada the emergence of TR was at the university level (University of Waterloo, Brock University, Concordia University, Dalhousie University and Memorial University) and community colleges (Canadore College, Confederation College, Fanshawe College, Georgian College, Mohawk College, Niagara College, Nova Scotia Community College, Keyin College and Acadamy Canada).

The following questions have emerged related to TR professional development in Canada: How do we define Therapeutic Recreation? Which title should be used? What is TR's scope of practice? Which standards of practice should we follow? What is the basic curriculum required to educate future practitioners? Which credentialing systems, such as the NCTRC, should we use to demonstrate competence for individuals and institutions? Until the various TR organizations in Canada can reach a consensus and answer these basic questions, TR will continue to struggle to be recognized as a profession.

This study sought to examine the knowledge and competencies that TR professionals are demonstrating in their current occupations. This information will assist TR in Canada in understanding what current TR professionals are doing which may assist in determining what current competencies and skills are being demonstrated by individuals employed in "Therapeutic Recreation".

Why do we need to know the knowledge and competencies of people working in Therapeutic Recreation? The knowledge and competencies would assist in understanding how TR enhances the well-being of the clients that are served in Therapeutic Recreation. The current variability of what a TR professional is in Canada could impact how TR services are delivered to participants.

According to Statistics Canada (2006), persons with a physical, cognitive or emotional disability comprise 14.3% of the Canadian population and in Nova Scotia this rate increases to 20.0%. It was also reported that disability rates increase with age. In Canada, 3.7% of those less than 14 years of age have a disability; this increases to 11.5% of those aged 15-64 and then jumps to 43.4% of those aged 65 and older; and by 75 years of age, over half of the population (56.3%) reported to have a disability.

Throughout North America and Europe, a variety of professionals work with people with disabilities, such as recreation therapists, teachers, physiotherapists, occupational therapists, doctors, nurses and social workers. TR uses purposeful interventions to meet the recreation and leisure needs for individuals of all ages with physical, cognitive, emotional and/or social limitations, and is also used to prevent illness (Keller, 2000) in a variety of settings. Individuals who practice Therapeutic Recreation need to be highly competent in their practice, just as expected of other professions such as social work, physiotherapy, occupational therapy and nursing.

Therapeutic Recreation is an emerging profession. In the United States, TR has reached the equivalence of "young adult" status, meaning that the profession has reached a period of stability, achievement, commitment and competence (Carter, Van Andel & Robb, 2003). However, in Canada, it has been described as being in the "adolescent" stage of professional development (Singleton, et al., 2006), struggling to form its identity.

There has been a period of growth for the profession, as well as uncertainty (Carter et al., 2003). Provincial and national TR professional organizations across Canada have worked independently to add to the growth of TR by developing standards of practice, codes of ethics documents, registration systems (Singleton, et al., 2006). Since no "standardized" or "national" regulations, governing Therapeutic Recreation exist in Canada, it has not been possible to ensure a consistent standard of practice for Therapeutic Recreation services for persons with disabilities.

Variability in educational opportunities continues to exist in Canada. Canada's TR educational opportunities range from community colleges to university trained practitioners (Canadian Therapeutic Recreation Association (CTRA), 2005; CTRA, 2012). There are colleges offering Therapeutic Recreation curriculum at a diploma level, some universities offering a general recreation or leisure studies degrees with a few courses specific to Therapeutic Recreation and still other universities offering Therapeutic Recreation undergraduate degrees. This variability within the education systems in Canada exists due to the lack of knowledge related to the competencies being demonstrated by Therapeutic Recreation professionals.

Purpose of the Study

The purpose of this study was to determine what skills and knowledge base are currently being offered and demonstrated by Therapeutic Recreation practitioners across Canada and to identify the skills and knowledge required for competent Therapeutic Recreation practice in Canada.

Research Questions

The following research questions were explored in the study.

1) Do significant skills and knowledge differences exist in identified competency areas between individuals who are certified and non-certified TR practitioners?

2) Do significant skills and knowledge differences exist in identified competency areas between individuals with a degree versus a diploma?

3) Do significant skills and knowledge differences exist in identified competency areas between demographic regions in Canada?

4) Do significant skills and knowledge differences exist in identified competency areas between years practicing as a TR practitioner?

Significance of the Study

Defined competencies of Therapeutic Recreation professional practice have been identified as the basis for standards of practice, educational programs, certification and licensure programs (O'Morrow & Reynolds, 1989). Hare and Frisby (1989) conducted a job competency study in Ontario, surveying 250 Ontario Therapeutic Recreation Council members. They achieved a 69% response rate, which was reasonably high and indicative of the importance of identifying job competencies in Ontario. In 2006, the National Council for Therapeutic Recreation Certification (NCTRC, 2006) invited all Certified Therapeutic Recreation Specialists (CTRS) in Canada to participate in their job competency study and achieved a 59% response rate among Canadian CTRS's. This high response rate again demonstrated that identifying competencies continued to be a significant issue for TR practitioners in Canada. While certification was not a requirement in Canada (Singleton et al., 2006), 109 of 1100 TR practitioners in Canada did hold this certification as granted by the NCTRC (Riley, 2004). And as of April this year, there are approximately 250 CTRS's in Canada (B. Riley, Personal Communication, April 30, 2012).

A competency study in Canada surveying all Therapeutic Recreation practitioners had not previously been conducted. This study examined the skills and knowledge for competent TR practice in Canada. One strategy in establishing defined competencies for TR was to ask the practitioners in the field what elements were important in competent practice to ensure protection for the public and the acceptance and development of the profession. Measuring the skills and knowledge necessary for TR practice in Canada, would set the stage for further developments such as appropriate educational program needs, certification systems and standards of practice for the field of Therapeutic Recreation.

Limitations of the Study

The possible limitations of the study were: the convenience sample, challenges with sample access, number of individuals who were Certified Therapeutic Recreation Specialists, questionnaires, participants with more years of experience as a practitioner and translating the survey into French.

Limitation of a convenience sample - A convenience sample of Therapeutic Recreation professionals was used in this study, rather than a random sampling strategy. One of the problems that exist with convenience sampling is that participants may be uncharacteristic of the population (Loiselle, Profetto-McGrath, Polit & Beck, 2007). Convenience sampling is considered the weakest form of sampling strategies. The sample may be heterogeneous in nature and thus creates an increased risk of bias in the study and there is little or no way to evaluate those biases. The researcher has to be cautious when interpreting results and findings generalizing findings where convenience sampling is used.

Limitations of the Sample Access - The number of individuals who may have volunteered to participate in the study could have been upwards of 1100 Therapeutic Recreation practitioners from Therapeutic Recreation organizations across Canada. However the researcher needed to gain access to these individuals through their respective Therapeutic Recreation associations. Certain associations refused to allow the researcher early access to the members of that particular organization and may not have distributed the questionnaire as indicated in the study request, which may have influenced certain regional characteristics. As well, not all Therapeutic Recreation professionals belong to a Therapeutic Recreation association in Canada. So, the sample may not have been completely representative. At the time of the study, it was voluntary to be a member of a provincial or national Therapeutic Recreation association.

Limitations of individuals that were Certified Therapeutic Recreation Specialists (CTRS) – At the time of the study, only ten percent of the population were certified as a CTRS. This may have influenced comparisons made between certified and non-certified Therapeutic Recreation professionals in Canada. Statistically significant differences may not have been apparent due to the sample size comparison.

Limitations of questionnaires – The self report measure relied on the participant's recall, which could have been fallible (Jackson, 2003). What an individual indicated on the questionnaire may not have been representative of what they actually do; it may have been more idealistic (Jackson, 2003) and socially desirable (Blair & Coyle, 2005). As well, response rates for questionnaires tend to be lower than for interview methods (Jackson, 2003).

Limitations of participants with more years of experience as a practitioner – Experienced recreation practitioners may have demonstrated increased knowledge

regarding job competencies than their entry level counterparts. Personal growth through increased clinical experiences in the field of Therapeutic Recreation may have impacted their increased knowledge of competencies related to Therapeutic Recreation (Blair & Coyle, 2005) which may in turn have influenced the determination of statistically significant differences between groups.

Limitations may have existed regarding the translation of the survey into French. - The survey instrument was written in English. The translation of the instrument may have altered the meaning and interpretation of the instrument for French Canadians. The researcher had the instrument translated by volunteers and requested that the instrument be translated back to English to ensure that the translation was accurate.

Definitions of Terms

For the purpose of this study, the following definitions were used to operationalize concepts within the study:

The Canadian Therapeutic Recreation Association published a definition for TR within their Standards of Practice Document (2006). They defined TR as:

> A profession which involves the assessment of a client's strengths, needs, interests, medical condition, social history, legal status and/or ethnic values/needs; the development of an intervention plan to meet the goals and objectives identified in the assessment; the implementation of an intervention plan and an evaluation to determine whether a client's goals and objectives are met. The above mentioned roles of recreation therapy are completed with the end purpose to improve the quality of life of each individual client. (Canadian Therapeutic Recreation Association, 2006, p.4)

The term Therapeutic Recreation Professional is synonymous with Therapeutic Recreation Specialist, Recreation Therapist and Therapeutic Recreation Practitioner. In Canada, there is no one consistent title used to represent this position. In 2003, it was

determined that 26 job titles existed for members of the CTRA alone, with Recreation Therapist being used 56% of the time (Goncalves, 2004). In this study, Therapeutic Recreation Professionals referred to those professional members of Therapeutic Recreation associations across Canada. These individuals were responsible for the organization, delivery and evaluation of Therapeutic Recreation services to clients. The National Council for Therapeutic Recreation Certification (NCTRC) identified these individuals as a Certified Therapeutic Recreation Specialists (CTRS's). The CTRS designation was granted by the NCTRC and used to represent those Therapeutic Recreation professionals that have met the criteria for certification as delineated by the NCTRC. Note: The NCTRC head office is based in the United States; however, in recent years it has become an international certifying agency for Therapeutic Recreation.

Competencies were defined by Hare and Frisby (1989) as "the activities that an individual must undertake in order to be effective" (Hare & Frisby, 1989, p.15). Mobily and Ostiguy (1998 & 2000) described competency as the "integration of three elements: knowledge, skill and performance" (MacNeil, Teague, & Cipriano, 1989 as cited in Mobily & Ostiguy, 1989, p.6). The definition of competence constantly evolves, based on new research and discoveries. It is demonstrated by the ability to translate learning into efficient and effective action and be sustained through continued education opportunities (MacNeil, Teague, & Cipriano, 1989 as cited in Mobily & Ostiguy, 1998 & 2000).

Regions were defined for consistency purposes as the boundaries designated by the Canadian Therapeutic Recreation Association (CTRA). The Western region included British Columbia, Alberta and the Yukon. The Prairie region included Saskatchewan, Manitoba and the Northwest Territories. The Central region included Ontario, Quebec and Nunavut. The Atlantic region included New Brunswick, Nova Scotia, Prince Edward

Island and Newfoundland and Labrador. Boundaries were investigated for provincial representation on the CTRA Board of Directors when the organization was being established, and it was deemed that provincial representation would be accomplished through regional representation (D. Murphy, personal communication, June 8, 2007). Regional representation was based on geographical proximity rather than population parameters (D. Murphy, personal communication, June 8, 2007).

Summary

This study provided an opportunity for Therapeutic Recreation in Canada to conduct a nation-wide competency study. The study aimed to survey the experts in the field, all TR practitioners in Canada, and examined the skills and knowledge for competent TR practice. This study defined competencies for TR through the measurement of the skills and knowledge necessary for TR practice in Canada. Through this process, this study set the stage for further developments such as appropriate curriculum requirements, renewed standards of practice documents and credentialing systems such as certification, licensure and accreditation programs for the field of Therapeutic Recreation.

Chapter 2

Review of Relevant Literature

Professional Development Models

The purpose of this chapter was to review literature pertaining to professional development from the perspectives of the Sociology of Occupations, Adult Education and Therapeutic Recreation. Characteristics of professional development were discussed based upon the various disciplines. The literature was compared and contrasted related to the characteristics of a profession as identified by the various disciplines. Finally a discussion linked how the criteria related to Therapeutic Recreation professional development in Canada.

The study of professional development aimed to define the hallmark characteristics and processes of a fully recognized profession. At the time of my study, disciplines that had reached professional status included medical doctors, dentists and lawyers. But what characteristics were required to elevate an occupation to professional status? And why were so many occupational groups not able to reach the status of a fully recognized professional? Pavalko (1988) describes disciplines such as teachers, nurses and engineers as semi-professionals.

Professional Development from the Perspective of the Sociology of Occupations

Sociologists assigned specific meaning to a profession. They identified key characteristics that defined a profession. Some of the early work came from Hughes (as cited in Hodson & Sullivan, 1995) which defined a profession by four key hallmarks. They were abstract specialized knowledge, autonomy, authority over clients and a certain degree of altruism (Hodson & Sullivan, 1995). Sociology has developed many models

and identified key characteristics that define a profession. Two dominant theorists in the Sociology of Occupations were Pavalko (1971 & 1988) and Ritzer (1972).

Pavalko (1988) developed the attribute model to describe the characteristics of professional development while Ritzer (1972) used both processualists, and functionalists perspectives within the Sociology of Occupations to describe the characteristics of professional development. Processualists looked at social change rather than on static structure. They were interested in investigating how and why a profession moves on the continuum. Functionalists were interested in describing the characteristics of what differentiates a profession from a non profession. According to Ritzer, both processualists and functionalists could have worked together to describe how a profession moves on a professional continuum by identified characteristics that described the profession at that position on the continuum. A profession would be described by the number of professional characteristics and the degree of each of those characteristics (Ritzer).

Pavalko – Attribute Model (1988)

Pavalko (1988 & 1971) altered the title of his professional development model from "Occupation – Profession Continuum: A Conceptual Model" (1971) to the "Attribute model: Identifying Traits of Professions" (1988). Each characteristic of these models have been conceptualized on a continuum ranging from two extremes. The degree to which each characteristic was developed determined where the characteristic was on the continuum. The components of the attribute model were theory and intellectual technique, relevance to social values, training period, motivation, autonomy, commitment, sense of community, and development of a code of ethics.

Theory and intellectual technique referred to the degree to which there was a systematic body of knowledge on which the occupation was based. Sufficient knowledge

base was required for members to claim expertise. The knowledge base was usually the product of scientific research. It was important that the body of knowledge should have demonstrated a level of complexity for those occupations that were moving towards professionalism (Pavalko, 1988 & 1971).

Relevance to social values referred to the relationship of the profession to the values of a society. Professions aligned their service to the values of society. Professions claimed that their work was designed to maximize the realization of societal values (Pavalko, 1988 & 1971).

Training period referred to the amount of training and education involved in a particular discipline. Components of training were reflected in a fully developed profession: the length of the training, the extent of specialized training and knowledge, and the degree to which learning was symbolic or ideational. For a profession, an emphasis should have been placed on the mastering the ability to manipulate ideas, symbols, concepts and principles rather than physical objects. The learning of values, norms and beliefs as well as the occupational subculture was another aspect of importance within a professions training period (Pavalko, 1988 & 1971).

Motivation referred to what motivates people in the profession. Were members of the profession altruistic in nature and worked to serve their clients or was there an aspect of self-interest that motivated the profession? A profession that demonstrated a service orientation was more likely to be accepted by the public (Pavalko, 1988 & 1971).

Autonomy was identified as the most crucial characteristic in differentiating professional groups from occupational groups. Autonomy, self-regulation and self-control were what professionals strived to achieve. The membership organization sought to establish defined training of their members and demonstrated control as to who enters

the profession. At the professional end of the continuum, the profession developed competency procedures that were administered by an independent body as was designated by the professional organization. In some instances the professional group also sought to have legislative control over who practiced in the profession (Pavalko, 1988, & 1971).

Commitment referred to the members maintaining their commitment to an occupational group. Members, who took their involvement with the occupational group very seriously, developed a sense of commitment and loyalty which was strong. People who entered a profession generally were expected to continue in that discipline for their entire lifespan (Pavalko, 1988 & 1971).

Sense of community referred to the degree that work groups demonstrated the attributes of a community. The group had a common identity and a common destiny. Common values and a sense of identity were developed and once people were a part of the community, few left it (Pavalko, 1988 & 1971).

The code of ethics development referred to a system of norms that were an aspect of the occupational subculture. Rules, regulations and standards were developed to specify how members were expected to behave as part of the professional group. A code of ethics worked to increase professionalism by providing reassurance to clients that the professional group has an increased quality of service and only tolerated the best practice by its members (Pavalko, 1988 & 1971). Developing a code of ethics can heighten a professional group or disciplines' claim of autonomy. Through producing effective self-regulation, it demonstrated that "external control is unnecessary, inappropriate and wasteful" (Pavalko, 1988, p.29).

Criticism of Pavalko's (1988) Attribute Model

The criticism of the attribute model was that it provided an incomplete explanation of how a profession retains power (Hodson & Sullivan, 1995; Pavalko, 1988). Also, there was no priority associated in rating the importance of each characteristic in the development of a profession. There was no specific formula that an occupation can follow to make it a profession. Another issue was that professions were using these attributes as a scoring system. They did not realize that each attribute was a process of development for a profession. A profession needed to move along a continuum toward the maturation of that profession (Pavalko, 1971 & 1988).

Ritzer's Model of Professional Development (1972)

Ritzer (1972) also subscribed to the notion of a process model in defining a profession and explained that there were degrees of a profession. It was not as easy as the dichotomous relationship of a profession versus a non-profession. Processualists looked at social change rather than on static structure. They were interested in investigating how and why a profession moved along the continuum. However, functionalists were interested in describing the characteristics of what differentiated a profession from a non profession. According to Ritzer, both processualists and functionalists had worked together to describe how a profession moved on a professional continuum by identifying what were the characteristics that described the profession at that position on the continuum. So professions could be described by the number of professional characteristics and the degree of each of those characteristics.

Ritzer (1972) described six characteristics of professional development that should have been present in a fully recognized profession. They were; general systematic body of knowledge, authority over clients, community interest (rather than self interest),

self-control, recognition by both the community and the law as a profession and a distinctive culture.

A systematic body of knowledge was the base from which a profession was developed and recognized. A systematic body of knowledge was attained through a long period of training in a occupation specific school and by developed relationships with other established professionals. Professions acquired a specialized knowledge that individuals outside of the profession could not gain. This was difficult for semi-professions to achieve, as they gained their knowledge from a variety of disciplines (Ritzer, 1972).

Authority over clients was defined by two elements; the existence of a defined client and an authority over that client. Professions have clients, non professionals have customers. Customers had the ability to determine what service was best for him/her, however clients or individuals who were ill did not have the ability to make that judgment, and essentially they surrendered their ability to evaluate the quality of the service of a profession. Again the issues of a systematic body of knowledge were relevant for determining an authority over a client. Those individuals from occupational groups on the professional end of the continuum had greater authority over a client than a non professional group member, however authority was never absolute. Clients always had a right to assess the ability of professional occupations (Ritzer, 1972).

Community interest rather than self-interest also rated higher on the professional continuum. Professions were usually in positions to help others whereas their counterparts were more interested in helping themselves. Professionals sought symbolic rewards which represented their ability to help others and non-professionals strove for

economic rewards. Professionals would generally act with community in mind and non-professionals would act with self-interest in mind (Ritzer, 1972)

Self-control for a profession meant that the community gave the profession the authority to regulate the behaviour of its members in the organization. The profession was allowed to regulate or license whoever enters the profession, how members of that profession were formally trained in the specific occupational or professional education programs and informally trained in the occupational subculture or sponsorship systems. The profession developed a code of ethics and was able to judge individuals through the criteria of the professional organization. Professional organizations sought a monopoly granted by the community. If the community did not agree and resisted the professional organization, then the professional group would need to promote their profession through public relations in an attempt to convince the members of the public that the profession had a right to a monopoly (Ritzer, 1972).

Recognition by both the public and law as a profession was also sought by a profession. Power and privilege was sought by the profession in the forms of: authority over clients, self-control, security of income, right to gain personal and confidential information. Some of these processes were based on licensure and some were more informal. In an attempt to gain recognition by the public, the development of a systematic body of knowledge was viewed as the most important element for an occupation to gain. If an occupation had developed a strong foundation of knowledge, it is expected that they would win the recognition of the community as a profession (Ritzer, 1972).

A distinctive culture would be developed if a profession attained the previously described professional characteristics. Formal and informal groups within the profession

helped to develop a distinctive culture. Formal organizations worked and achieved a professional culture through professional organizations, training schools, and through the organizations that employed the professionals. The informal structures that helped to create a distinctive culture for an organization included the values, norms and symbols of the professional group. Values included their authority over clients, service to the community, self-control and theoretical objectivity. Norms for a profession included specific guides to professional behaviour or conduct. The symbols of a profession were the insignia, dress, history and its key people who have worked to advance the profession, the heroes. Professions were marked by a sense of common identity, values, language, clear boundaries, role definitions, power over members and that once in a profession, few leave that profession. However, it was important to note that even by achieving all the characteristics of professional development that have been described above, creation of a profession was not automatic, the community and the general public gave the occupation professional status. Public acceptance was key to a professional organization (Ritzer, 1972).

Criticism of Ritzer's (1972) Model of Professional Development

The criticism of Ritzer's (1972) model of professional development was: the characteristics did not have a priority rating and it was unknown whether any one characteristic was more important than another in the development of a profession. There were differences in individuals within a profession. Each individual member is different and they possess variations on each of the characteristics of professional development. Another criticism was that at any one time a profession evolved and its various elements were also changing, meaning that the characteristics that make a profession were constantly in flux. As well, he referred to power relations within professions and

individuals and his characteristics of professional development do not account for this dynamic.

Professional Development from the Perspective of Adult Education

Adult education was a process by which professionals through their "active lives of service, [worked] to refresh their own knowledge and ability and build a sense of collective responsibility to society" (Houle, 1980, p.2). Continuing education was a method for occupational groups to develop professional status. Lifelong learning assisted with pre-service learning and/or the active years of practice. Developed professional characteristics for individuals within a discipline were a place for the role of adult education (Houle, 1980).

Houle's Characteristics of Professionalism (1980)

Houle (1980) described 14 characteristics of professionalization. These characteristics were also described on a continuum of professional development. Educational goals were used to achieve these characteristics and developed along the professional life span in a variety of ways. He described these characteristics within three major categories; the conceptual characteristic, the performance characteristics and collective identity characteristics.

Conceptual characteristic.

The first characteristic of professionalization was that members were able to clearly articulate and define the professions' function, roles and mission. If a profession had difficulty in defining their central mission, it would have difficulty communicating that central mission and describing the appropriate professional function and roles to the public. Since professions were constantly evolving, developing and expanding their functions, roles and missions, adult education became an excellent tool that assisted the

profession to develop lifelong learning systems and assisted those professionals in gaining knowledge in their professions expanding role (Houle, 1980).

Performance Characteristics.

Mastery of theoretical knowledge was the second characteristic that Houle (1980) identifies for professionalization. Professionals should understand the fundamental theory and information that is specific to the knowledge base of the profession. Basic information for the profession should have been available in pre-professional coursework.

Capacity to solve problems was the third characteristic that Houle (1980) described for professionalization. The professional should have used the theoretical knowledge and practical experience to gain knowledge to deal competently with problems that were specific to a profession. In pre-professional education, the members of the discipline should have been exposed to realistic situations and problems that were specific to the profession.

Use of practice knowledge was the fourth characteristic as identified by Houle (1980) to describe the process of professionalization. Professionals or practitioners should have been exposed to a substantial body of knowledge and practice that has evolved from its disciplines grassroots, history, scope and processes. Professionalizing required the development of a substantial body of supporting knowledge which practitioners can refer to when performing practical or clinical applications.

Self-enhancement was Houle's (1980) fifth characteristic of professionalization. Practitioners should seek further knowledge, skills and understanding within their years of pre-service training that were outside the professional knowledge areas. Expanding

the professionals' knowledge base assisted in expanding their professional expertise and positively enhanced their ability to develop as a clinician.

Collective Identity Characteristics.

Collective Identity Characteristics were used to help a professionalizing occupation develop its structures and systems to create and maintain competency characteristics. Credentialing characteristics were commonplace in developing a professional collective identity (Houle).

Formal Training was Houle's (1980) sixth characteristic of professionalization. Formal actions were created to teach the fundamental body of knowledge and skills of a discipline to all known practitioners in their pre-service training and throughout their careers. Professionalizing occupations were excited and felt a sense of accomplishment when their discipline was accepted as a specialized department in a post secondary educational institution. Pioneers in the field worked to ensure that appropriate subjects were taught in a suitable manner by a qualified group of educators and those sufficient resources were provided to the program of study.

Credentialing was Houle's (1980) seventh characteristic of professionalization. Formal means were developed to test the knowledge and skills of individual practitioners and in some instances to license or regulate those who were qualified to practice. A formal credentialing system was key in the development and evolution of an individualized and unregulated practice into a fully recognized profession. The importance of the development of an acceptable system of certifying competence was expressed by the Oxford University Commission in 1852 when it stated that

> to render a system of Examination effectual, it is indispensable that there should be danger of rejection for inferior candidates, honourable distinctions and substantial rewards for the able and

> diligent, with Examiners of high character, acting under immediate responsibility to public opinion. (as cited in Houle, 1980, p. 54-55)

Licensure was the next form of credentialing and it was granted by government to ensure protection of the public. A committee for each profession set the examination policies and demonstrated their application.

Creation of a subculture was Houle's (1980) eighth characteristic of professionalization. An occupation should foster a subculture for its members with distinguishing elements: "lore, folkways, mores, traditions, role differentiations and relationships, variations in authority and power, personal prestige systems, language and special references not understood by the uninitiated and clusterings of people with distinctive functions" (Houle, 1980, p. 57). The profession developed into a secret society where acculturation grew.

Legal reinforcement was Houle's (1980) ninth characteristic of professionalization. Members within a professionalizing occupation indicated that their mandate had a particularly important significance to society and sought legislative support. Legal support protected the rights and privileges of practitioners by developing judicial support to develop systems that gave the professions, exclusive rights to practice, "the ability to perform legally binding acts, the right to maintain inviolable confidentiality in their relationships with their clients, and access to financial support for their research and training areas" (Houle, 1980, p. 59). Also, there were times professional groups attempted to curtail the actions of other groups that were practicing within their scope of service. The struggle to gain new legal rights or governmental regulation influenced the professions authority to contribute curricula requirements for pre-service educational programs.

Public acceptance was Houle's (1980) tenth characteristic of professionalization. The general public was made aware of the importance of the work that members of a particular profession perform. Public acceptance was difficult to achieve, and to alter the professions standing among other professional groups was even more challenging as the professionalization process was dynamic and constantly evolving. The efforts to alter public perceptions of a particular professional group may have been more beneficial in developing systems to make each individual practitioner stronger and more competent in their practice.

Ethical practice was Houle's (1980) eleventh characteristic of professionalization. Generally this was achieved through most professional groups by developing a formal code of ethics for that profession. Educational programs should have included an ethical component for new practitioners in their pre-service educational programs.

Penalties was Houle's (1980) twelfth characteristic of professionalization, which included developing systems that would deny the right to practice. A profession needed to establish and enforce standards of practice for professional members and have the ability to deal with those that were incompetent or that fail to perform in an ethical manner. This was achieved through legal regulation or the licensure of a profession.

Relations to other vocations was Houle's (1980) thirteenth characteristic of professionalization. The role that each profession plays in the care of clients or members of the public needed to be clearly established and articulated to allied professional groups. By clarifying a professions role, conflict was often reduced in determining which professional was allowed to do what service. The importance of a well established and consistent definition of the role relationships and mission of a particular professional

group was essential in maintaining and developing collaborative relationships for members in the health care industry.

Relations to users of service was Houle's (1980) fourteenth characteristic of professionalization. It was essential to define the relationship of practitioner to client. For each professionalizing occupation, rules needed to be established that govern the relationship between the individual(s) being served.

In Houle's (1980) description of the fourteen characteristics of professionalism, pre-service education and training were important to each characteristic, however, he also stressed that continuing education can help professions achieve these goals. For those emerging professions, continuing education programs had to be considered to assist professional members in performing in a competent manner.

Criticisms of Houle's (1980) Characteristics of Professionalism

The main criticism's of Houle's (1980) characteristics of professionalism was that none of the characteristics can be fully achieved. And to what degree each characteristic must be achieved in a fully recognised profession is unknown. No one characteristic is unique to the professionalization process. However, as a profession evolved and increased its level or performance regarding each of these characteristics, it's right to be a profession increased as does its right for the public to view it as a profession.

Professional Development from the Perspective of Therapeutic Recreation

Therapeutic Recreation professional development has borrowed from fields such as the sociology of occupations and adult education in defining characteristics of professional development. O'Morrow and Reynolds (1989) identified eight characteristics of professional development while Carter et al. (2003) described five characteristics of professional development.

O'Morrow and Reynolds Characteristics of Professional Development (1989)

O'Morrow and Reynolds (1989) identified the following in describing Therapeutic Recreation professional development: organizations; publications; education; standards; research; code of ethics; provides a needed service; and professional status.

According to O'Morrow and Reynolds (1989) a professional organization needed to be established and should have directed their efforts in developing systems to move towards the profession functioning autonomously. Individual members worked to develop policies and standards of practice. While an organization would use independent systems that would be developed for the self determination and control of professional actions. "A true profession [was] committed to maintain and improve its services and the welfare of its practitioners through an organized endeavor." (O'Morrow & Reynolds, 1989, p. 117)

O'Morrow and Reynolds (1989) also indicated that an organization worked to enhance professionalization by providing publications that added to the development of members though educational experiences and in-services. Publications included Therapeutic Recreation textbooks, professional and scientific journals and organizational newsletters specific to the professional group and information related to disability and illness.

The development of professional or formal education programs was another characteristic of professional development. Professional groups worked to make sure curriculum was geared toward educating future professions in theoretical knowledge and practice areas that were specific to Therapeutic Recreation to assist future practitioners to act in a manner which demonstrated intelligence and superior judgment. "Professional

study prepared people to act with minimum competence in the conduct of their occupation." (O'Morrow & Reynolds, 1989, p. 119)

O'Morrow and Reynolds (1989) identified standards as another characteristic in professional development for Therapeutic Recreation. Standards were minimal competency criteria or guidelines created by professional organizations to ensure, upgrade, or enhance the quality of education and practice present in the professional group. Standards took the form of credentialing and accreditation as well as program or practice standards. Credentialing ensured individuals and educational programs were meeting competency requirements as defined by the professional organization. Individual competencies may have taken the forms of certification and licensure. Practice standards referred to the quality of clinical practice or services that were provided to the public by practitioners through health and community organizations.

Benefits achieved from advocating for professional competency were important to professional members and the clients that they served. This hallmark gave professions a level of prestige, recognition and earning potential for the practitioners and enrollment power to the educational institution or department (O'Morrow & Reynolds, 1989).

Research was the next characteristic of professional development as described by O'Morrow & Reynolds (1989). The first task of professional groups, was to develop theories and concepts into an organized and defined body of knowledge that served as a guide to professional practice. Research was a method that guides, corrects or verifies theory or knowledge. They identified research as an important step in aiding to the development of a defined knowledge base for Therapeutic Recreation. They indicated that it is important for researchers to improve the quality of research in the field of Therapeutic Recreation.

O'Morrow and Reynolds (1989) considered the development of a code of ethics as an essential characteristic of professional development. A code of ethics communicated the ideals of the profession and created standards of professional conduct for its members. Standards were meant to protect the members of the professional group and to create better processes and services for the public.

O'Morrow and Reynolds (1989) identified the next characteristic of professional development as needed service to society. The awareness of a need created a certain moral obligation to respond to and meet that need. Societies' value system influenced the actions of a professional group in meeting the needs of the public. General support was required by the public in developing systems of certification, licensure and accreditation for a professional group. Professional groups had to be flexible and able to change, adapt and broaden their scope of service to meet the requirements and expectations of society.

Professional Status was the last characteristics that O'Morrow and Reynolds (1989) identified in the professionalization process and it was all encompassing. Professional status was achieved through the quality of the professional members practice and could not be self-seeking. Professionalism was a social construction of society that a particular professional group was given. The professional group of individuals that share a common identity and goals as well as ascribed to the same socially approved goal, whereby specific knowledge was learned and specialized skills were demonstrated. Therapeutic Recreation was progressively being more often accorded professional status. However, they caution that even though a particular discipline may have achieved professional status, it did not automatically give each member of that discipline professional status. Each individual within the discipline must agree and conform to the professional ideals of the discipline and attained the competence in the particular skills

and knowledge of that professional group as well as practiced in a manner that conforms to the disciplines professional standards of excellence. Professional status was achieved when a collective discipline adhered "to the ethical principles, the competence in practice, the quality of the service given, and the growth in the knowledge and skills of the profession" (O'Morrow & Reynolds, 1989, p.127).

Carter, Van Andel and Robb Characteristics of Professional Development (2003)

Carter et al. (2003) used the following five characteristics or attributes in determining whether Therapeutic Recreation (TR) had achieved professional status. The first characteristic of professional development, was that a profession must demonstrate service to society whereby the profession exhibits that members of that profession provide a necessary public service. The second characteristic was the development of professional organizations which consist of groups that have common goals and interests. The third characteristic of a profession was the establishment of professional standards at a personal, educational and practice level that were specifically aimed to protect the public. The fourth characteristic of professional development was the establishment of a body of knowledge based on accepted scientific theory and principles. The last characteristic of professional development was that the body of knowledge which has been identified by the professional group, lead to the development of formal education and training programs specific to that profession.

Differences and Similarities between these Varying Perspectives of what is a Profession

Some major commonalities existed between the definitions of these perspectives; however the terminology within each of these perspectives varied greatly (see Table 1). The professional development literature for adult learning and the sociology of occupations was similar, and appeared to inform the Therapeutic Recreation literature.

However, in examining the Therapeutic Recreation literature closely, it seemed that in reducing the characteristics of professional development they have failed to recognize some important aspects of professionalization which would help to inform processes leading to public and legal acceptance of the profession.

Table 1 *A comparison of overall characteristics of professional development from the Sociology of Occupations, Adult Education and Therapeutic Recreation*

Characteristics Professional Development	***Houle (14)***	***Ritzer (6)***	***Pavalko (8)***	***O'Morrow & Reynolds (8)***	***Carter, Van Andel & Robb (5)***
Consistent Message	*Members clarify functions, Relations to other Vocations & Relations to users of Service*				
Meets Social Need			*Relevance to Social Values*	*Provides a Needed Service*	*Service to Society*
Community Interest		*Community rather than Self Interest*	*Motivation*	*Provides a Needed Service*	
Professional Organization				*Organizations*	*Professional Organizations*
With a Sense of Community	*Creation of a Subculture*	*A Distinctive Culture*	*Sense of Community & Commitment*	*Professional Status*	
Body of Knowledge	*Mastery of Theoretical Knowledge*	*General Systematic Knowledge*	*Theory and Intellectual Technique*	*Publications & Research*	*Developing a Body of Knowledge*
Educational Processes	*Formal Training*	*General Systematic Knowledge*	*Training Period*	*Education*	*Training and Education*
Professional Standards			*Autonomy*	*Standards*	*Professional Standards*
Credentialing Systems	*Credentialing*	*Self-Control rather than outside control*	*Autonomy*	*Standards & Professional Status*	*Professional Organizations & Professional Standards*
Code of Ethics	*Ethical Practice*		*Code of Ethics*	*Code of Ethics*	*Professional Standards*
Public Acceptance & Licensure	*Public Acceptance & Legal Reinforcement*	*Recognition of Community & Law that the occupation is a profession*		*Professional Status*	
Administer Penalties	*Penalties*				

Note. (#) = indicates number of characteristics of professional development

Themes of professionalism that emerge from professional development literature include: demonstration of a societal need; community interest rather than self interest; the development of a professional organization; sense of community for the professional group; systematic body of knowledge; formal education process; development of professional standards; credentialing; development of a code of ethics; public acceptance and legal recognition of the profession (Carter et al., 2003; Houle, 1980; O'Morrow & Reynolds, 1989; Pavalko, 1988; Ritzer, 1972).

Demonstration of a societal need denoted that the profession ascribed to the values of society and provided a necessary public service. Pavalko (1988 & 1971) described this as demonstration of "relevance to social values" while O'Morrow and Reynolds (1989) used the term "provide[d] a needed service" and Carter et al. (2003) called it demonstration of "service to society".

Community interest rather than self-interest implied that the motivation for the profession was altruistic and that the profession demonstrated a service to the community rather than provided a service for person for financial gain. Ritzer (1972) described this characteristic as "community" rather than self interest, Pavalko (1988 & 1971) used the term "motivation" and Carter et al. (2003) described it within their "providing a public service to society" characteristic of professional development.

The development of a professional organization needed to be established in the process of professional development for an occupation. The profession put great effort into developing systems that made the profession function with autonomy. The professional group worked to develop polices and standards of practice. O'Morrow and

Reynolds (1989) referred to this step as “organization” while Carter et al. (2003) called it “professional organizations”.

Sense of community for the professional organization referred to the professional group that developed from a common identity, destiny and values. Houle (1980) called it the “creation of a subculture”, Ritzer (1972) described it as “a distinctive culture”, Pavalko (1988 & 1971) used the term “sense of community” and O’Morrow and Reynolds (1989) identified it in their description of “Professional status”.

The professional organization develops a systematic body of knowledge upon which the occupation was based. Knowledge should have been based on scientific research and it was important that the body of knowledge demonstrated a level of complexity. Houle (1980) described this stage as the “mastery of theoretical knowledge”, Ritzer (1972) used the term “general, systematic knowledge”, Pavalko (1988 & 1971) identified it as “theory and intellectual technique”, O’Morrow and Reynolds (1989) referred to it in the attributes “Publications” and “Research” while Carter et al. (2003) called it “development of knowledge”.

The systematic body of knowledge should have led to the formal education process. For a profession this should have been long, specialized, symbolic and ideational. It was also important that a professional master the ability to manipulate ideas, symbols, concepts and principles rather than physical objects. As well, the formal education process should have included the learning of values, norms, beliefs and the occupational subculture. Houle (1980) referred to this as “formal training”, Ritzer (1972) referred to this in his “general systematic knowledge” characteristic, Pavalko (1988 & 1971) called it “training period”, O’Morrow and Reynolds (1989) identified it as “education” while Carter et al. (2003) classified this as “training and education”.

Professional standards, at a personal, educational and practice level, were developed to assist in informing professional practice and were also aimed to protect the public. Pavalko identifies this attribute is his description of "autonomy" and "code of ethics" (1988 & 1971), O'Morrow and Reynolds (1989) called it "standards" and Carter et al. (2003) referred to it as "professional standards".

Credentialing was the formal means that was developed to test the knowledge and skills of individual practitioners. This should have been done by an independent organization as designated by a professional group or organization. A formal credentialing system was described as key to the evolution of an individualized and unregulated practice in advancing the professional development of a discipline. A method to certify competence of an individual was by using an outside agency to examine the skills of knowledge of the practitioner. Certifying the competence of individual practitioners could lead to development of a basis for legislative means in the form of credentialing called regulation. Houle (1980) called this "Credentialing", Ritzer (1972) referred to it as "self control rather than outside control", while Pavalko (1988 & 1971) described it within his "autonomy" characteristic, O'Morrow and Reynolds (1989) illustrated this in their "standards" and "professional status" categories and Carter et al. (2003) expressed this notion in their "professional organizations" and "professional standards" sections.

Development of a code of ethics referred to a system of norms that were an aspect of the occupational subculture. An established code of ethics assisted with the public perception that the organization has rules, regulations and standards that were important and that the professional group would only tolerate the best by its members. Houle (1980) referred to this as "ethical practice", Pavalko (1988 & 1971) and O'Morrow and

Reynolds (1989) called it the development of a "code of ethics" and Carter et al. (2003) described it in the "professional standards" characteristic.

A profession sought public acceptance and legal recognition. In an attempt to gain recognition by the public, the development of a systematic body of knowledge was viewed as important for an occupation to gain recognition of legitimate public relations efforts. Houle (1980) called this "legal reinforcement" and "public acceptance", Ritzer (1972) identified this as "recognition of community and law" and O'Morrow and Reynolds (1989) described this in the "professional status" characteristic.

Some unique characteristics within the comparison of the models of professional development from the sociology of occupations, adult education and Therapeutic Recreation existed and included: Houle's (1980) category where members clarified their functions. Members of professionally recognized disciplines should have been able to clearly articulate their role and purpose to clients. If a profession had difficulty defining their central mission, it would have difficulty communicating that mission to the public, organizing its members roles to achieve important duties that were relevant to the central mission; and develop penalties which would ensure that the professional group has systems in place that would deny the right to practice. A profession needed to enforce standards of practice for a professional and have been able to deal with those that were incompetent or that fail to perform in an ethical manner. This should have been achieved through the legal regulation of a profession.

Relations to other vocations as described by Houle (1980) referred to the clear articulation of the role and mission by an emerging profession to allied groups; and relations to users of service described the importance of the development of a professions rules to govern the relationship between the practitioner and the client; Ritzer's (1972)

authority over clients was also a unique characteristic that is not mentioned by other authors in the reviewed professional development literature. Authority over clients referred to the client surrendering the ability to make judgments on the quality of the service of the profession.

Overall characteristics of Professional Development

A profession should be able to deliver a consistent message, demonstrate that it meets the demand of a social need (Carter et al., 2003; O'Morrow & Reynolds, 1989; Pavalko, 1971 & 1988) acts in a manner of community interest (Carter et al.; Pavalko; Ritzer, 1972) and establishes a professional organization (Carter et al.; O'Morrow & Reynolds) with a sense of community (Houle, 1980; O'Morrow & Reynolds; Pavalko; Ritzer). The professional organization works to develop a sound body of knowledge, based on research, which inform formal educational processes (Carter et al.; Houle; O'Morrow & Reynolds; Pavalko; Ritzer) professional standards (Carter et al.; O'Morrow & Reynolds; Pavalko) credentialing systems and a code of ethics (Carter et al; Houle; O'Morrow & Reynolds; Pavalko; Ritzer). This will lead to public acceptance and legal recognition (Houle; O'Morrow & Reynolds; Ritzer) with the professional organization being able to administer penalties (Houle) to those that do not conform or meet the established requirements of that profession.

Gaps in Canadian Therapeutic Recreation Processes to Reflect the Proposed Professional Development Model

Therapeutic Recreation in Canada has been described as being in the adolescent stage of professional development, struggling to form its identity (Singleton et al., 2006). Each province in Canada has established professional organizations which have worked to achieve professional status. The next section of this chapter will reflect on the

achievements of Therapeutic Recreation in Canada and identify existing gaps with respect to the previously listed characteristics of professional development.

Able to deliver a consistent message:

Therapeutic Recreation professionals should be able to consistently communicate to clients, members of the public and other allied health professions what their mission and role is. With Canada being so geographically large, and having 13 Therapeutic Recreation membership groups, including one national association, (Singleton et al., 2006), there was not a consistent message being delivered across Canada to what Therapeutic Recreation is and what it is trying to achieve to clients, members of the public and other allied health professionals. Marketing should be consistent, with various professional groups communicating the same message.

Demonstrates that it meets the need and demand for society:

Therapeutic Recreation in the United States has demonstrated through its literature that it has met the need to facilitate and deliver Therapeutic Recreation services in the community and in institutions. The national associations American Therapeutic Recreation Association (ATRA) and the National Therapeutic Recreation Society (NTRS) have aligned themselves with the Americans with Disabilities Acts (Austin, 2004) and have started to unite to promote the service of Therapeutic Recreation on a national scale. In Canada, we have embraced the work that has been done in the United States; however, we have not specifically aligned ourselves nationally with health and community services legislation regarding the need of our services. As well, each provincial Therapeutic Recreation membership body has promoted their definition, vision and mission of Therapeutic Recreation (Singleton et al., 2006)

Act in a manner of community interest and service to society:

Therapeutic Recreation by nature was a discipline that works within a service orientation structure (Blair & Coyle, 2005). Services are provided to clients in health facilities and community settings.

Professional Organizations:

In Canada we currently have 13 Therapeutic Recreation membership organizations and there are three provinces in Canada where the Therapeutic Recreation membership organizations are divided even further. Provinces such as Saskatchewan, Quebec and Nova Scotia have two Therapeutic Recreation organizations representing Therapeutic Recreation professionals. A national Therapeutic Recreation organization exists in Canada called the Canadian Therapeutic Recreation Association, and is working to provide national leadership in Therapeutic Recreation in professional development matters. However each provincial group also works independently to advance Therapeutic Recreation (Singleton et al., 2006). The national group has begun to institute a new membership initiative whereby all members of each Therapeutic Recreation provincial group would automatically become members of the national association or have an opportunity to join the national association with their provincial membership renewal (D. Lesage. personal communication, April 15, 2007). It is important that Therapeutic Recreation organizations across Canada come together and promote the interests of Therapeutic Recreation; deliver a consistent message regarding Therapeutic Recreation and work together to develop systems that meet the needs of professional development for Therapeutic Recreation.

Strong sense of community:

Therapeutic Recreation has achieved a strong sense of community for provincial and national Therapeutic Recreation organizations for those participating in committee levels and attending provincial and national conferences (Kelland, 1991). This sense of community and subculture, needs to be communicated within formal education programs for Therapeutic Recreation so future professionals in the field are aware of its importance. Members in Therapeutic Recreation organizations have not demonstrated that sense of commitment, that once in the profession, never does one leave the profession. Professional organizations needed to strive to develop a collective identity, destiny and values that would be embraced by its members.

A systematic and sound body of knowledge:

Therapeutic Recreation in Canada has yet to identify a systematic and sound body of knowledge. Therapeutic Recreation has discipline specific textbooks, and also has Therapeutic Recreation journals where research is communicated to Therapeutic Recreation professionals. Most provincial Therapeutic Recreation associations in Canada provide continuing education opportunities in the form of workshops or conferences for members to gain increased knowledge regarding new research and practices in Therapeutic Recreation. NCTRC had conducted three job analysis studies which have identified, from the perspective of the Therapeutic Recreation professionals, the skills and knowledge that are required for competent practice primarily in the United States. In Canada, Hare and Frisby (1989), conducted a job analysis study in Ontario that has contributed to the knowledge base of Therapeutic Recreation professionals in that province. This study has achieved a competency study for Therapeutic Recreation in Canada.

Formal and consistent education process:

At the time of the study, a formal and consistent education process has not been established for Therapeutic Recreation in Canada. Each province continues to educate their Therapeutic Recreation professionals differently; there is no set standard for a diploma versus degree or set course work that is based on the core body of knowledge for Therapeutic Recreation. Educational opportunities vary across Canada, some colleges offer Therapeutic Recreation courses and diplomas, some universities offer a few courses specific to Therapeutic Recreation and other universities offer Therapeutic Recreation undergraduate degrees. A recent review by CTRA illustrates the variation within curriculums in community colleges and universities (CTRA, 2005; CTRA 2012). Since a national competency study in Canada had not been completed until this study, there had been no specific research in Canada to support consistent coursework that informed educational processes for new professionals in a manner that demonstrated competence in Therapeutic Recreation.

Professional Standards:

In Canada, as of 2007, there were three professional standards of practice documents from the provinces of Ontario, Nova Scotia and Newfoundland/Labrador, two in the United States and in September, 2006, the Canadian Therapeutic Recreation Association (CTRA) released a Standards of Practice document that attempted to synthesize the information in these documents to inform Therapeutic Recreation practice for Therapeutic Recreation professionals and their assistants or aides. This competency study will help to inform standards of practice documents based on professionally identified competencies.

Credentialing:

Formal means are developed to test the knowledge and skills of individual practitioners with the intent of protection of the public. With regards to certification, the CTRA has investigated a system for Certification (the demonstration of individual competence) for Canadian Therapeutic Recreation since 2002. In 2008, the CTRA endorsed the NCTRC system of certification for Therapeutic Recreation in Canada. This individual demonstration of competence would assist the next stage of the professional development of Therapeutic Recreation in its movement toward licensure.

At the time of the study, provincial governments, to ensure protection of the public granted licensure. A college would be designated by the government to set standards to ensure that individual practitioners are competent in their practice. Alberta, Ontario and Nova Scotia provincial therapeutic recreation associations are in the process of submitting their licensure applications. Nova Scotia, has incorporated the NCTRC certification credential to demonstrate the competency of their members. At this time, neither Alberta nor Ontario have incorporated this credential in their licensure applications.

The last form of credentialing is accreditation for Therapeutic Recreation educational programs. This process evaluates the formal education programs and curriculums that exist for Therapeutic Recreation in Canada. At the time of this study, there are no accredited Therapeutic Recreation educational programs that exist in Canada that have met the Council on Accreditation (of National Recreation and Parks Association and the American Association for Leisure and Recreation (NRPA/AALR), the Council of Accreditation, Parks, Recreation, Tourism and Related Professions (COAPRT) or the Committee on Accreditation of Recreational Therapy Education

(CARTE) Therapeutic Recreation accreditation standards for Therapeutic Recreation curriculums.

Code of ethics:

By 2007, a majority of the professional groups in Canada have an ethical document which works to inform the public that its members meet certain ethical requirements and that as an organization, it is expected that members behave ethically with their clients. However, again, since each provincial organization has developed its own, independent codes of ethics document, the message again continues to be inconsistent across Canada.

Public Acceptance:

Professional organizations strive to achieve public acceptance. According to Houle (1980) the development of a systematic body of knowledge was viewed as the most important step for an occupation to gain recognition of legitimate public relations efforts. Since Therapeutic Recreation in Canada has not developed that core systematic body of knowledge, established formal education programs or developed systems of competency, it remains difficult for members of the public to accept public relations messages that are being created and distributed by Therapeutic Recreation membership organizations.

Legal recognition:

Legal recognition is achieved through systems of licensure. Three provincial Therapeutic Recreation groups, Alberta Ontario and Nova Scotia are in the process of application to their designated Health Professions Act. However since Therapeutic Recreation in Canada has neither an established core body of knowledge for Therapeutic Recreation, which have led to formal education programs for Therapeutic Recreation that

teach this specific body of knowledge to new professionals entering the field of Therapeutic Recreation; nor established a credentialing process to ensure that individual practitioners demonstrate competence regarding the skills and knowledge for Therapeutic Recreation, it remains difficult for Therapeutic Recreation to be legally recognized through licensure processes (Houle, 1980 & O'Morrow & Reynolds, 1989; Ritzer, 1972).

Penalties or a disciplinary process:

Penalties and a disciplinary process result from licensure processes. Until a profession can legitimately be recognized legislatively, it does not have the ability to legally discipline its members.

Summary

Professional development in Canada has been described as being in the adolescent stage of professional development, fraught with issues, instability, and through the efforts of the therapeutic membership organizations is going through a tremendous period of growth (Singleton et al., 2006).

Professional organizations in Canada have struggled to develop and establish multi-component criteria in the achievement of professionalism due to their primarily volunteer base. The process of professionalism for Therapeutic Recreation in Canada needs to be approached in a similar manner. Until Therapeutic Recreation is able to nationally deliver a consistent message, demonstrate that it meets the needs and demand for service to society, acts in a manner of community interest, establishes a professional organization with a sense of community, a sound body of knowledge that is based on research that informed formal educational process; professional standards; credentialing systems and a code of ethics that will eventually lead to public acceptance and legal recognition with the professional organization being able to administer penalties to those

that do not conform or meet the established requirements of a fully established profession that is marked with stability, achievement, commitment and competence.

Therapeutic Recreation in Canada had to achieve a consistent voice across Canada. A national competency study had to be conducted that included members of regional professional organizations, who acted to inform Therapeutic Recreation membership organizations and their membership, in understanding and defining the specific competencies that were required to build the profession of Therapeutic Recreation further into the future.

Pattern of Professional Education for Therapeutic Recreation in Canada

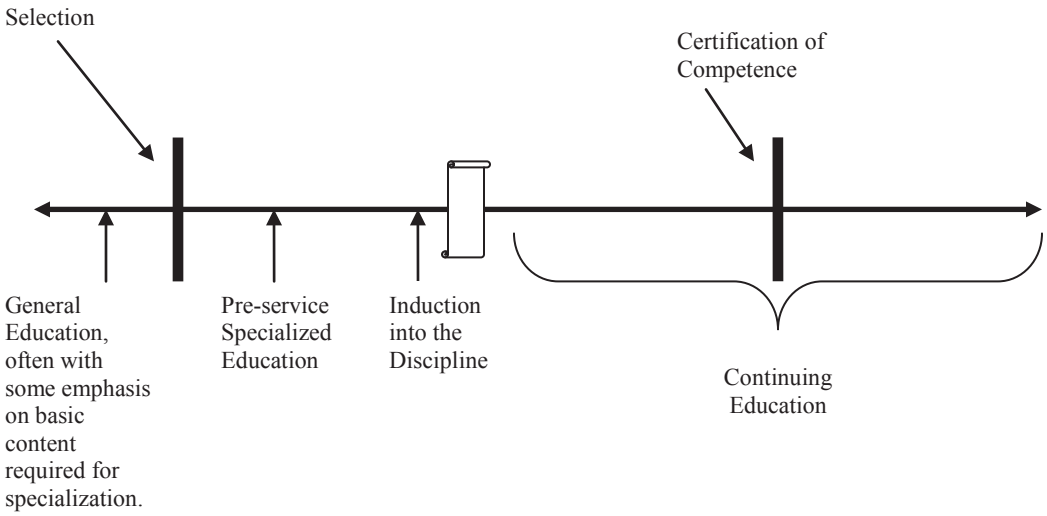

Figure 2 The Professional Development Model for Therapeutic Recreation in Canada (Adapted from Houle (1980) The Classic Model of Professional Education, p.4)

Houle (1980) identified that there was a general educational pattern for professional workers and it occurred along a continuum (see Figure 2). During the adolescent and young adulthood stage of development, and for some individuals at birth,

"a choice of occupation [was] made by the individual or by the controllers of his or her destiny" (Houle, 1980, p.2). This selection process may have had a number of influences; ancestral tradition, a sense of calling, economic advantage, an awareness of personal interests which can be employed, or it may be from a variety of reasons, either intentionally or arising by chance (Houle).

After the choice was made, an individual began a formal education process to gain the knowledge necessary to be employed in a particular discipline. Specialized study may have begun on a part-time basis and eventually the student was accepted to a course of study that required immersion in a specialized content and the development of a specialized skill set along with a complex value system. At the end of the formal period of study and after the reorientation of values, initial judgements were made regarding the competence of the individual, so generally this would be the educators in a particular field of study and then in most cases a larger group of authority, the Therapeutic Recreation professional membership organizations across Canada (Houle, 1980).

Each Canadian provincial Therapeutic Recreation association had criteria which members must have achieved to become a member of the designated provincial membership association (Singleton et al., 2006); this would be referred to as the process of induction by which the professional membership organization allows entry to the practice to the profession. Individuals met required membership criteria to become members within provincial or national Therapeutic Recreation professional organizations. Continued education was a method by which Therapeutic Recreation professionals could achieve the qualifications for credentialing in the form of certification. Thus, making it possible for Therapeutic Recreation professionals across Canada to demonstrate a consistent entry to practice.

Characteristics of Therapeutic Recreation Professional Development in the United States

How would one characterize a profession? Authors in Therapeutic Recreation used variations of the Pavalko's (1971 & 1988) attribute model (Carter et al., 2003; Myer, 1981; O'Morrow & Reynolds, 1989) when distinguishing characteristics of a profession. Carter et al. used the following five characteristics or attributes in determining whether Therapeutic Recreation had achieved professional status. The characteristics were: service to society whereby the profession demonstrated that they provided a necessary public service; the development of professional organizations which consisted of groups that have common goals and interests; the establishment of professional standards at a personal, educational and practice level aimed at protecting the public; establishment of a body of knowledge that was based on accepted scientific theory and principles that led to the development of formal education and training programs (Carter et al.; O'Morrow, 1976). Each characteristic was examined on a continuum to describe the growth in each of these areas in attempt to determine if the occupation had achieved "professional" status (Pavalko).

Therapeutic Recreation in the Health Care Field

The 1940's and 50's sparked the beginning of Therapeutic Recreation in the United States health care field with the development of the hospital recreation service. Hospital recreation was provided by the Red Cross recreation workers during WWII in an effort to provide recreation programs to soldiers in military hospitals. The movement continued after WWII, by providing recreation services to veterans in hospitals (Austin, 2004). At about this same time the hospital recreation service also offered recreation services to those institutionalized in hospital settings. The service was aimed at providing recreation opportunities for mental health patients and individuals with

developmental disabilities in attempts to satisfy the emotional and social needs of patients. In the later part of these decades, a second approach was discovered. It focused on using recreation as a therapy. It was intended for those individuals with mental health issues or disabilities to achieve some specific goals or purpose (Carter et al., 2003; O'Morrow, 1976).

These two philosophies continued to emerge throughout the field of Therapeutic Recreation and caused many debates as to the direction of Therapeutic Recreation philosophical positions. In the late 1960's, hospitals began changing. Rather than providing custodial services they moved to rehabilitation and education. Society also witnessed the downsizing of large institutions (Carter et al., 2003; O'Morrow, 1976).

The 1980's marked a time of change in the delivery of health care services. Government had to contain health care costs. So Therapeutic Recreation (TR) was required to demonstrate is rehabilitation potential and efficacy. TR had to provide services on an outpatient basis and begin to charge a fee for the TR service. During this decade, health care demonstrated a movement toward health promotion. Prevention of illness and disease were the new themes for the field. Therapeutic Recreation should have been able to fit well in these areas; however, the field did not make strides in these areas until the 1990's (Carter et al., 2003; Riley & Stalko, 1998).

The 1990's and the new millennium brought with it rapid change in health care service delivery. The major movement was to have much shorter stays in hospital and greater need for even more outpatient services in rehabilitation. The fee structure in the United States also changed. Rather than charging for each specific intervention or service, the new system charged a fee for the treatment of a particular disability. Therapeutic Recreation was able to provide services within this ever-changing field. The

prevention of disability and illness became an important focus for Therapeutic Recreation practice. Therapeutic Recreation specialists became advocates of this model as they grew to meet new roles in the ever-changing system of health care (Carter et al., 2003).

Therapeutic Recreation in the Community

Prior to the 1940's Governments in the United States began recognizing the need to provide social services and recreation to the poor and disadvantaged. In the late 1950's and 60's community programs for people with disabilities were established in several major cities. However, only a small portion of community organizations provided services for people with disabilities. Eventually, some specific national disability groups such as the National Easter Seal Society, the American Foundation for the Blind, and the United Cerebral Palsy Association aimed to provide recreation services to those in the community with disabilities (Austin, 2004; Carter et al., 2003; O'Morrow, 1976).

The Special Olympics program began in 1968, the Unified Sports Model and Let's Play to Grow programs were designed to integrate children with disabilities with children who did not have disabilities. Recreation was a method used to integrate individuals with disabilities into general society (Austin, 2004; Carter et al., 2003; O'Morrow, 1976). Again, Therapeutic Recreation became advocates for people with disabilities. Therapeutic Recreation professional expertise and knowledge were used to assist children with disabilities as well as individuals with developmental disabilities integrate in society through recreation.

The 1960's to the 1980's brought significant change in the attitude toward people with disabilities. Individuals with disabilities were no longer institutionalized. Education and parks and recreation legislation changed. Integration and normalization of people with disabilities were the main themes for this period. Therapeutic Recreation aligned

itself with this change since it could assist with assessment of leisure functioning for individuals with disabilities. Therapeutic Recreation provided specific, goal directed interventions within the school systems in some communities (Carter et al., 2003; O'Morrow, 1976; O'Morrow & Reynolds, 1989;)

In the 1990's and into the new millennium, an even greater movement existed to provide recreation opportunities for all persons in community recreation programs. Public recreation and parks agencies were responsible for offering comprehensive inclusive recreation services for people with disabilities. Therapeutic Recreation specialists were hired to develop specialized or inclusive services for persons with disabilities (Carter et al., 2003).

Professional Organizations in the United States

As hospital recreation workers grew, several professional organizations began to emerge. The American Recreation Society (ARS) in 1948 developed an interim committee to develop a Hospital Recreation Section (HRS). Their focus was providing recreation in institutions for the sake of recreation. Members included recreation workers from military veterans and public institutions. Also during this time the Recreation Therapy Section of the American Association for Health, Physical Education, Recreation and Dance developed a Recreation Therapy Section (1952). This organization focused on developing recreation and physical activity integration programs in the schools. The third organization, formed in 1953, was the National Association of Recreational Therapists (NART) which emerged from recreation therapists working in state hospitals and schools serving people with mental illness. They focused on using recreation as a tool for rehabilitation and treatment. The three organizations had different perspectives on service delivery, however they realized that they needed to work together to address

common problems. In 1953, representatives from each of the organizations came together to form the Council for the Advancement of Hospital Recreation. They will be discussed further in the certification section of this paper (Austin, 2004; Carter et al., 2003; O'Morrow, 1976; O'Morrow & Reynolds, 1989).

Development of the National Therapeutic Recreation Society

In 1965, after much negotiation and debate the National Recreation and Parks Association (NPRA) was created. And in 1966, the Hospital Section of the American Recreation Society and the National Association of Recreation Therapists renewed efforts to merge and become the National Therapeutic Recreation Society (NTRS) a branch of the NRPA. The issue regarding which philosophy Therapeutic Recreation subscribed to and what was the main principle of TR began to emerge (Austin, 2004; Carter et al., 2003; National Recreation and Parks Association (NRPA), 2006; O'Morrow, 1976). According to Meyer (1981), four purposes for Therapeutic Recreation were proposed, they were:

1. To provide opportunities for recreative experiences. This view was identified as the Recreation view.
2. To treat, change, or otherwise ameliorate effects of illness and disability. This view was identified as the Therapy view.
3. To enhance the therapeutic effects of the recreative experience. This view was identified as the Therapeutic view – note means/end contrast with the Recreation and Therapy views.
4. To eliminate leisure barriers, provide leisure skills and attitudes; and enable the independent leisure functioning and the recreative experience. This co-equal, multi-service view was identified as the

Service Continuum view. It should be noted that this view essentially includes all previous views and purpose. (Meyer, 1981, p.9).

In 1981, after much discussion and debate, the membership of NTRS decided that it would incorporate the Service continuum view. This became known as the leisurability purpose and philosophical position (Austin, 2004; Carter et al., 2003; NRPA, 2006, O'Morrow, 1976).

During this period, the profession made great strides, however financial constraints from the NRPA caused cutbacks in staffing to all NRPA branches including NTRS limiting the NTRS's ability to adequately address critical professional issues in health care reform (Austin, 2004; Carter et al., 2003). In 2010, the NRPA reorganized and announced a dissolution of its branches which included NTRS as an organization (NRPA, 2012).

The Development of the American Therapeutic Recreation Association.

Recreation therapists in health care settings such as hospitals and rehabilitation centers needed more from NTRS. They needed direction and representation for issues such as third party reimbursement, credentialing and working with external accrediting organizations such as the Joint Commission of Accrediting Health Organizations. These individuals wanted Therapeutic Recreation to be based on the therapy model (Austin, 2004; Carter et al., 2003; O'Morrow & Reynolds, 1989; Van Andel, 2006), the purpose for Therapeutic Recreation was "to treat, change, or otherwise ameliorate effects of illness and disability" (Meyer, 1982, p.9).

In 1984, The American Therapeutic Recreation Association (ATRA) was established. Since they did not have the issues from a parent organization, they were able to move to a decentralized structure with chapters as active components of the system.

Their goals were to promote networking of other health care agencies, support the value of TR in the health care delivery system, improve professional services and initiate a proactive approach to planning. ATRA philosophy changed to a modified therapy position. Also, for ATRA membership, it was important to include an aspect to improve the functional capacity, quality of life and or the overall health status of a client. ATRA has been significant in the role that it played in promoting TR as a legitimate health care service. (Austin, 2004; Carter et al., 2003; O'Morrow & Reynolds, 1989; Van Andel, 2006).

NTRS and ATRA as Allied Partners.

NTRS and ATRA were separate membership organizations representing Therapeutic Recreation professionals in the United States, however they each held varied philosophical positions. As mentioned above, NTRS membership adopted a leisurability perspective, meaning that the purpose of Therapeutic Recreation was to "eliminate leisure barriers, provide leisure skills and attitudes, and enable independent leisure functioning and the recreative experience" (Meyer, 1981, p.9) while ATRA adopted a therapy perspective, meaning that the purpose of Therapeutic Recreation was "to treat, change, or otherwise ameliorate effects of illness and disability" (Meyer, 1981, p.9).

In the mid 1990's the two organizations began aligning their resources, participating in movements to address critical issues regarding the growth of the profession of Therapeutic Recreation. In the early and mid 1990's, ATRA and NTRS created reimbursement and protocol documents. Membership was strengthened by the development of training, updated philosophical statements and publications of protocol documents. Both ATRA and NTRS worked together to addressed health care reform issues. In 1996, ATRA and NTRS established a Joint Task Force on Credentialing. Both

worked together to articulate the benefits and efficacy of professional practice and the use of technology to enhance professional skills and service delivery (Carter et al., 2003). As well, both organizations embraced the Americans with Disabilities Acts and became leaders for recreation inclusion (Austin, 2004).

Practice Standards and Code of Ethics Development for Therapeutic Recreation

In 1966, with the formation of the NRPA and in 1967, the formation of the NTRS, an Ad hoc committee was created to evaluate personnel standards and revise the Council for the Advancement of Hospital Recreation (CAHR) registration plan. In 1971, NTRS developed the Therapeutic Recreation Standards for psychiatric facilities. In, 1972, NTRS adopted a Code of ethics. In 1979, the "Standards for the Practice of Therapeutic Recreation Service" and "Guidelines for Community Based Recreation Programs for Special Populations" was published (NRPA, 2006).

In the 1990's, ATRA and NTRS (1994) created the interpretive guidelines. The standards of practice contained a self-assessment tool for program and administration practices. In 1998, NTRS approved Standards of Practice for Paraprofessionals in Therapeutic Recreation (NTRS, 2006). And field research substantiated the ATRA document as a professional accountability tool. Codes and standards developments were self regulatory demonstrating the professions autonomy; this was seen as greater evidence of a maturing profession (NRPA, 2006; Carter et al., 2003; Austin, 2004).

Certification.

The Council for the Advancement of Hospital Recreation (CAHR) moved to implement a Voluntary Registration plan in 1956 for recreation workers. Three levels of registration were created. They were; 1) hospital recreation director, 2) hospital recreation leader and 3) recreation aide. In order to become registered with CAHR, an

individual applied to their appropriate group with transcript or credentials, and a monetary fee (Connolly, n.d.). This credentialing system was used by the profession until 1969 when it was extensively revised (Carter et al., 2003).

In 1968, the NTRS adopted a Voluntary Registration Plan. Terminology evolved from the hospital recreation terminology for staff providing recreation opportunities within the institutional setting, to the Therapeutic Recreation terminology meaning that recreation professionals would provide goal oriented interventions via recreation activities to treat individuals within the institutional setting. This change reflected the way that the professionals were distinguishing themselves from the hospital recreation movement. NTRS modified the previous credentialing plan that was created by the CAHR to reflect changing education and training programs that were being established in the United States (Connolly, n.d.).

In 1981, the profession of Therapeutic Recreation saw the development of a separate group, the National Council on Therapeutic Recreation Certification (NCTRC) who was working to develop a certification plan (Carter, 1984). The NCTRC initiated a job analysis project in 1987, which attempted to identify entry-level knowledge through studies of curriculum and professional review. The NCTRC also hired Educational Testing Services (ETS) to develop a national certification exam and in 1990, the first exam was administered (Connolly, n.d.).

Two levels of competency existed for the NCTRC. However after the period from 1981–1992, the council determined that there were very few assistants seeking certification, and did not support the development of a certification examination for this group and they discontinued the assistant level program. 1993, NCTRC received a Federal Trademark registration for the Certified Therapeutic Recreation Specialist

credential and was accredited by the National Commission for Certifying Agencies (Austin, 2004). Their examination changed to reflect terminology changes (treatment vs. intervention). The field of Therapeutic Recreation required a focus on professional accountability. In November 2001, the first computerized exam test was administered by the NCTRC. A recertification program was also introduced. Recertification would occur every five years. Therapeutic Recreation Certificants provided documented experience, retesting or the accumulation of continuing education units as well as a payment of maintenance and renewal fees (Carter et al., 2003; O'Morrrow & Reynolds, 1989). "Certification and recognition of competency beyond the entry level of practice was not only viewed as important but as necessary for inclusion in today's health care environment." (Riley & Stalko, 1998, p. 71)

Accreditation.

In 1974, the Council of Accreditation, Parks, Recreation, Tourism and Related Professions (COAPRT) was established to accredit curriculum for park resources, leisure services and recreation programs (NRPA, 2012). In 1975, the NRPA and the American Association for Leisure and Recreation developed an accreditation process for reviewing college and university recreation and parks curricula – Council on Accreditation, (COA) of NRPA/AALR. A more specialized version of Therapeutic Recreation accreditation was developed in the 1977 and aimed to accredit TR programs at the undergraduate and graduate levels (O'Morrow, 1981). Recreation and Therapeutic Recreation curricula achieved a new level of acceptance as a discipline and as a profession. This was further advanced by the acceptance of the 1977 COA Therapeutic Recreation as an option in 1981. The Commission on Recognition of Post Secondary Accreditation (CORPA), officially recognized the NRPA-AALA Accreditation program in 1982. These

competencies were then upgraded again in 1990 to better reflect specific job competencies in the field of health and human services (Carter et al., 2003).

In 2008, in efforts to address the variability of the academic preparation of recreation therapists, Therapeutic Recreation educators and practitioners from North Carolina came together and formed the North Carolina Therapeutic Recreation Association Committee on Accreditation of Recreational Therapy Education (NCTRA CARTE) and they published document "Committee on Accreditation of Recreational Therapy Education (CARTE): Procedures for Education of Recreational Practice". In early 2010, this publication was used by the American Therapeutic Recreation Association (ATRA) to form its Committee on Accreditation (COA) program. In April 2010, the Commission on Accreditation of Allied Health Education Programs (CAAHEP) approved CARTE as an allied health profession and ATRA was accepted as a sponsor of CARTE. Later in 2010, the CAAHEP Board approved to accept the Standards and Guidelines for Accreditation in Recreation Therapy Education. These efforts have culminated in the development of the CARTE "Procedures for Accreditation of Recreation Therapy Education" document (CARTE, 2010).

In 2011, Therapeutic Recreation educators from across the United States united and developed "The Guidelines for Learning Outcomes for Therapeutic Recreation Education". These guidelines were constructed relative to the standards from the Council of Accreditation for Parks, Recreation, Tourism, and Related Professions (COAPRT). These guidelines were informed by a number of documents related to Therapeutic Recreation including the CTRA Standards of Practice that were used in this study (Anderson, L., et al., 2011)

Through the development of self-regulated standards of practice, codes of ethics, credentialing through certification and accreditation, the profession of Therapeutic Recreation was beginning to emerge due to the autonomy that these activities demonstrated.

Development of Therapeutic Recreation Research

In the 1950's and 1960's, studies examined the status of Therapeutic Recreation personnel in a variety of settings. Publications reported the effectiveness of recreation in health care settings. One particular report, found that recreation interventions contributed to shorter hospital stays, less need for medications and fewer negative side effects of hospitalization (Wolfe, 1957, as cited in Carter et al., 2003). These studies provided initial support for hospital recreation and recreation therapy during the early developmental years (Carter et al.; O'Morrow & Reynolds, 1989).

The period from 1963 to 1972, was marked for tremendous growth in research for the field of Therapeutic Recreation. However, the research quality became suspect. The research methods and skills of early researchers made their contributions trivialized. In future decades, research in Therapeutic Recreation began to employ appropriate research methods; instrumentation and design which were outcome focussed and investigated the efficacy of Therapeutic Recreation interventions (Carter et al., 2003; Riley & Stalko, 1998). More efficacy research was developed to include "Research in Therapeutic Recreation Concepts and Methods". NTRS and ATRA began providing significant research and training monies for the development of material and research in the field of Therapeutic Recreation (Carter et al., 2003).

Journals and publications for the field of Therapeutic Recreation.

The 1950's and 60's saw the development of journals and other publications related to recreation. The Hospital Recreation Society (HRS) published "Recreation in Treatment Centers" from 1954 until 1969, National Association for Recreation Therapists published "Recreation for the Ill and Handicapped" from 1957 – 1967 (Carter et al., 2003; O'Morrow & Reynolds, 1989).

In the 1970's, the NTRS published two new publications, the "Therapeutic Recreation Journal" and the "Therapeutic Recreation Annual" (Austin, 2004). The Annual only printed five volumes and discontinued in 1972. Also during this period, the Journal of Leisurability (1974-2000) and the Journal of Leisure Research were published. These journals increased opportunities for researchers to be published from the field of Therapeutic Recreation (Carter et al., 2003; O'Morrow & Reynolds, 1989).

In the early 1990's, the Annual in Therapeutic Recreation (ATRA) was developed. As well a major publication was produced that would assist the profession in identifying and communicating its place in the health care field. This publication, the "Benefits of Therapeutic Recreation a Consensus View" defined the role of Therapeutic Recreation in rehabilitation. Also, the advancement of the internet, made publications and conference papers more accessible (Carter et al., 2003).

Development of Educational Programs in the field of Therapeutic Recreation

In 1909 the first known recreation course was taught. In 1926 the National Recreation Association Leadership School was established. And the most significant development in the field of Therapeutic Recreation was after WWII, when the first Masters program from the University of West Virginia and Minnesota emerged in 1951 (O'Morrow & Reynolds, 1989). Formal training in hospital recreation was available in

the early 1950's, at the University of Minnesota and the University of North Carolina. By 1953, the Hospital Recreation Society (HRS) identified six colleges and universities with graduate or undergraduate degree programs in hospital recreation (Kraus as cited in Carter et al., 2003). As more degree programs in Therapeutic Recreation were established, leaders became concerned about their content (Mobily, 1983). A study in 1959 examined the state of training in higher education and in 1961 the National Recreation Association (NRA) held a conference to explore the degree requirements and general competencies of recreation personnel (Carter et al., 2003; O'Morrow, 1976).

In 1969, Stein listed 35 institutions offering a Therapeutic Recreation specialty at the undergraduate level and 26 at the graduate level (Stein, 1970). Ten years later there were 109 undergraduate TR options, 59 masters programs and 14 at the graduate level. There was huge growth in the area of Therapeutic Recreation. However, by 1989, the curriculum program numbers decreased in all the levels previously identified. In 1989, there were 98 undergraduate programs, 45 masters programs and 13 doctorate programs (Stewart & Anderson, 1990). By 1999, there were 118 undergraduate programs, 41 masters programs and 10 doctorate programs in Therapeutic Recreation. The development of education programs began to stabilize due to student demand and shifting government priorities (Anderson, Ashton-Shaeffer & Autry, 2000).

In the 1990's lack of curriculum standardization continued to be identified as an issue. Committees were developed to review standardization of curriculums (Riley & Stalko, 1998). A document was developed that identified course competencies for use in curriculum development and continuing education. In 2000, standards were developed to require faculty to possess a credential in their respective expertise areas. Students were required to write outcome-oriented goals, to display competence in cultural diversity, and

to comply with regulatory standards. However, even after this significant advancement, consensus on curriculum competencies still remained an issue (Carter et al., 2003).

Summary

Therapeutic Recreation had emerged as a profession in the United States. It had substantiated its role in society within the health care and community services domain. It created two professional organizations that advocated for the importance of Therapeutic Recreation. Therapeutic Recreation developed self-regulated standards of practice and codes of ethics as well as created credentialing bodies for certification of professionals in the field as well as accreditation organizations for education programs in the field. It has also defined a body of knowledge which was unique, distinguishing itself from other professional groups. As well, there had been great advancement for therapeutic educational institutions and professional conferences, as they educated future professionals entering the field of Therapeutic Recreation and those current professionals in an advancing and ever changing field.

Lessons learned from the United States

Therapeutic Recreation in the United States has struggled to define its role as a professional group. What could other countries learn from their struggle? It was important and more effective to create a certifying organization that was a separate body. Its board structure needed to be outside of the control of a professional organization. A certifying body was required to make decisions for the benefit of the profession, which may not have been the most popular choice for organizational membership (Early & National Association for Competency Assurance, 1998).

The need for competence measures which were based on research that examined professional activities of members in the profession. The NCTRC had conducted three

job analysis studies. And after each, they altered their competency examination to reflect changes in the industry (NCTRC, 2007).

Curriculum development and advancement had to occur. Base knowledge and education needed to be standardized. Accreditation bodies were important to determine whether education programs provided the required curriculum for future professionals to have the base competency to practice in the field of Therapeutic Recreation. The field developed education programs that represented what the professional was required to complete in their jobs (Carter et al., 2003; Houle, 1980; O'Morrow & Reynolds, 1989; Pavalko, 1971 & 1988, Ritzer, 1971,).

The last lesson that Canadian Therapeutic Recreation could learn from the struggle in the United States was that professional organizations that represent Therapeutic Recreation Specialists had to unify in order to advance the profession. By uniting their voices, they were better able to move the profession forward to the advancements that it required (Carter et al., 2003, Houle, 1980; O'Morrow & Reynolds, 1989).

The field of Therapeutic Recreation was growing around the world. Professional organizations representing recreation therapy specialists could learn from the struggle of professional development in the United States. The United States may have existed within a different system of health care service delivery. However, parallels could be made with countries that have experienced health care system reform that was more accountable and businesslike and had resulted in reduced or eliminated Therapeutic Recreation services. In the United States Therapeutic Recreation has thrived and professionalization of the field has been the outcome (Carter et al., 2003).

Health Promotion and Prevention within Therapeutic Recreation

Health promotion and prevention had been a focus of North American governments in recent years. In the United States, *Healthy People 2010,* was a nationwide strategy and framework specifically targeting health promotion and disease prevention. Its main purpose was to articulate methods to improve the health of individuals in the United States during the first decade of the millennia (Howard, Russoniello & Rogers, 2004). The two main goals of the *Health People 2010* strategy were to "[a] increase life expectancy and improve the quality of life of individuals of all ages, and [b] to eliminate health disparities between different segments of the U.S. population" (Howard, Russoniello & Rogers, 2004, p. 116). In Canada, the federal, provincial and territorial health ministers have developed and adopted *The Integrated Pan-Canadian Healthy Living Strategy* as their health promotion and disease prevention strategy. This plan provided a nationwide conceptual framework for *Healthy Living*. Its goals were to "improve the overall health outcomes and reduce health disparities" (Public Health Agency of Canada, 2005, ¶ 2). The *Healthy Living* strategy had been developed to assist members from all sectors to align and coordinate their services to respond to the health needs of Canadians (Public Health Agency of Canada, 2005).

Defining Therapeutic Recreation

Therapeutic Recreation uses purposeful interventions to meet the recreation and leisure needs for individuals of all ages with physical, cognitive, emotional and/or social limitations, and has been used to prevent illness (Keller, 2000) in a variety of settings. Much debate had occurred regarding simply defining Therapeutic Recreation and each professional membership organization had slight variations to this definition. Mobily and Ostigey (2004) have identified four key elements in defining Therapeutic Recreation:

They were: “systematic process, favourable changes, use of recreation and leisure modalities, and populations served” (Mobily & Ostigey, 2004, p. 15). These authors defined Therapeutic Recreation as a “systematic process that use[d] recreation and leisure activities to bring about favourable changes in the persons served” (Mobily & Ostigey, 2004, p. 15). The National Therapeutic Recreation Society (2007) defined Therapeutic Recreation as “Therapeutic Recreation (TR) use[d] treatment, education, and recreation services to help people with illnesses, disabilities, and other conditions to develop and use leisure opportunities in ways that enhance[d] their health, functional abilities, independence, and quality of life” (National Therapeutic Recreation Society, 2007, ¶ 1). Recently the Canadian Therapeutic Recreation Association also defined Recreation Therapy in their Standards of Practice Document (2006). They defined Recreation Therapy as:

> A profession which involves the assessment of a client’s strengths, needs, interests, medical condition, social history, legal status and/or ethnic values/needs; the development of an intervention plan to meet the goals and objectives identified in the assessment; the implementation of an intervention plan and an evaluation to determine whether a client’s goals and objectives are met. The above-mentioned roles of recreation therapy are completed with the end purpose to improve the quality of life of each individual client. (Canadian Therapeutic Recreation Association, 2006, p.4)

These definitions cover some important attributes of Therapeutic Recreation; however they had not identified the use of Therapeutic Recreation in the prevention of disability and illness which was currently an important health movement for North America governments.

Methodology Information

The next portion of this chapter will review literature as related to the methodology used in this study.

How were Competencies in Nursing Measured?

With the movement of allied health professions moving toward licensure processes, the need for research in the area of competencies had been important for Nursing in England. In 2005, researchers investigated the competencies of qualifiers from nursing programs in England at one, two and three years after graduation. A cross-sectional research design was used in the study. Researchers administrated a *Nursing Competency Questionnaire* to investigate nursing competencies at one, two and three years after graduation (Clinton, Murrells, Robinson, 2005).

Dillman – Tailored Design (2000)

The Dillman Tailored Design was a survey procedure that had demonstrated an increased response rate for survey design methods. The Tailored Design was based on principles of Social Exchange Theory. This theory suggested that the "actions of individuals were motivated by the return of these actions and are expected to bring and in fact usually do bring from others." This did not refer to an economic exchange, but rather a social exchange. The three basic elements to Social Exchange Theory were rewards, costs and trust. Rewards referred to what an individual expected to gain from an activity. Costs were what an individual gave or had to pay to obtain the reward. Trust was the expectation that the perceived rewards would outweigh the perceived costs for participation. The Tailored Design identified specific characteristics of survey design which increased the response rate based on the principles of rewards, costs and trust (Dillman, 2000).

Dillman (2000) identified strategies to generate increased participation in response rate by answering the following questions: How can we increase the rewards for responding for individuals? How can perceived costs be reduced and how can trust be

established so that ultimate reward outweighs the costs of responding? Four basic elements were the basis of the Tailored Design strategies; multiple contacts, respondent friendly questionnaires, carefully constructed communications which highlighted the surveys usefulness and importance of the responses from each person and an increased response rate. Thesis elements lead to specific strategies that the Tailored Design had evaluated to lead to increased reward, decreased cost and increased trust for survey respondents (Dillman).

Multiple contacts were essential to Tailored Design. It was important that several opportunities were provided to connect with participants within survey design. These multiple contacts resulted in an increased cognitive understanding of what was being requested of respondents. Multiple contacts also provided increased opportunities to motivate the participants to reply to the survey request. It was important to employ personalized contacts and an implementation system which preceded and/or followed additional communications. Dillman (2000) recommended four carefully timed mailings, the first to introduce the questionnaire, the second a thank you for participating, the third a reminder to complete the questionnaire, the forth a final reminder to participate in the survey. By providing an opportunity for multiple contacts, the Tailored Design has repeatedly provided an increased response rate (Dillman, 2000).

Respondent friendly questionnaires, carefully constructed communications and increased response rate were important aspects to Tailored Design. People needed to clearly understand what was being requested of them if they were to respond. Participants go through a process of comprehension, retrieval, deciding and reporting when they participated in a survey. As well, participants must be motivated to participate in the process of understanding and responding to each question and returning the

questionnaire to the survey administrator or researcher. The survey administrator/designer had to be conscious of the motivational qualities of surveys and mail-out materials. These influenced the response rates of self administered questionnaires. Dillman recommended that all communication be personalized; questions carefully considered; and the questionnaire was visually arranged in an attempt to ease participant response (Dillman, 2000).

Web-based Questionnaires

In an age where technology advancements have made the personal computer accessible to both the researcher and participants, web-based questionnaires were an ideal research method (Dillman, 2000). The web-based questionnaire was an invaluable tool that was used to generate information across a large, geographically dispersed sample. It was also economical and offered the researcher ease in administration and offered the participants involved in the study the benefit of anonymity (Loiselle et al., 2007).

Chapter 3

Methodology

The purpose of this study was to identify the skills and knowledge required for competent Therapeutic Recreation practice in Canada. This chapter described the methodological approach, research design, participants, data collection methods and procedures used for data collection, pre-test information and data analysis of the study.

Methodological Approach

The importance of research was to add to the body of knowledge and understanding for a particular field of inquiry. A post-positivist paradigm was used for this study. Guba and Lincoln (1994) described the ontology of post-positivism as critical realism and its epistemology as modified dualist/objectivist. Reality existed but it was impossible to have complete objectivity in measuring reality and it was impossible to understand and know reality with total certainty (Loiselle et al., 2007). Post-positivists sought evidence to understand a particular phenomenon, with the highest degree of probability (Loiselle et al., 2007). The methodology of this paradigm was modified experimental/manipulative (Guba & Lincoln, 1994). So a systematic research method was used in order to gather empirical evidence. The evidence was gathered numerically and analyzed through statistical procedures. This method also increased the researcher's ability to generalize the results (Loiselle et al., 2007).

Research Design

Several research methods could have been utilized in identifying the pertinent job skills and knowledge for competent (TR) practice in Canada. One option was to query a large sample of professionals in the field of TR (Canadian TR professional association members) and use applicable job competencies to determine the level of agreement

among the experts in the field. A sample that represented a large percentage of TR professionals would enhance the representation of competence in a range of practice areas and would also to increase the ability to generalize the study results (Riley, 2007).

In an age where technology advancements had made the personal computer accessible to the researcher and participants, web-based questionnaires were an ideal research method (Dillman, 2000). The web-based questionnaire was an invaluable tool that was used to generate information across a large, geographically dispersed sample. It was also economical and offered the researcher ease in administration and offered the participants involved in the study the benefit of anonymity (Loiselle et al., 2007).

Participants

A convenience sample of TR professionals in Canada was surveyed. The sample was current members of their provincial and/or national TR associations and they may or may not have held a Certified Therapeutic Recreation Specialist designation as granted by the National Council for Therapeutic Recreation Certification. Associations included: Newfoundland/Labrador Therapeutic Recreation Association (NLTRA), Nova Scotia Recreation Professionals in Health (NSRPH), Therapeutic Recreation Association of Atlantic Canada (TRAAC), Quebec Association of Activity Professionals (QAAP), Therapeutic Recreation Ontario (TRO), Saskatchewan Association of Recreation Professionals (SARP), Alberta Therapeutic Recreation Association (ATRA-b), British Columbia Therapeutic Recreation Association (BCTRA) and the Canadian Therapeutic Recreation Association (CTRA). The only criterion for the participants involved in this study was that they were required to have up to date registration in their designated professional Therapeutic Recreation association.

The researcher planned to make the instrument available to approximately 1100 professional Therapeutic Recreation members across Canada (Singleton et al., 2006) through the Dalhousie Opinio Survey Service. Dillman's four-wave reminder protocol was used to enhance response rate.

Data Collection Procedures

In investigating suitable survey instruments, four studies were identified that could be appropriate for this study. Three were conducted by the National Council for Therapeutic Recreation Certification (NCTRC) in 1987, 1997 and 2006. The studies have been the basis of the NCTRC certification exam. The fourth study was conducted by Hare and Frisby (1989) in Ontario.

Hare and Frisby's (1989) instrument utilized the competencies endorsed by the National Therapeutic Recreation Society in 1984 and added additional competencies relevant to community-based practice. A total of twenty-seven competencies were queried and a seven-point bipolar scale was developed. Participants were asked to rate each competency from "1 - extremely unimportant" to "7 - extremely important" and participants were asked to identify other competency areas (Hare & Frisby). No reliability or validity information was reported for the survey instrument.

This study used the current Canadian national Therapeutic Recreation standards of practice document for Recreation Therapy to form the questionnaire for this study. The CTRA standards of practice document was created and evaluated by 40 experts in the field residing in Canada (CTRA, 2006). It was the most beneficial document for this study as participants would be able to inform practice by evaluating competencies based on the national practice standards used by Canadian Therapeutic Recreation professionals.

The CTRA Standards of Practice Document for Recreation Therapists and Recreation Therapy Assistants had 11 Standards of Practice areas for Recreation Therapy practitioners that were used to form the questionnaire. The study questionnaire had demographic information, 45 knowledge statements and 72 skill areas for Therapeutic Recreation as identified by the CTRA, (CTRA, 2006). For each knowledge and skill statement, participants were asked to rate the following question, "How important is competence in the following knowledge/skill area for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?" A five-point scale "1 – of no importance" to 5- very important was used for each of the scale items. The full questionnaire used in this study can be viewed in Appendix A (see Appendix B for the full French version of this questionnaire).

Procedures

1. The researcher sent a letter of request outlining the study (see Appendix C) addressed to the president or chair of each of the provincial and national TR associations in Canada asking for permission and assistance in delivering a recruitment package to its membership list in electronic form or by mail at the expense of the researcher. Each organization was informed of the modified Dillman Tailored Design (2000) method to increase survey response rate and requested to agree to deliver the survey electronically to its membership on four occasions as specified by the researcher.
2. Upon agreement from the professional organization, the organization provided the researcher with the contact information for the organizations administrative individual who was responsible to electronically deliver this message (see Appendix D).

3. The administrative individual responsible to complete this task received detailed instructions regarding the dates for the survey delivery to participants as well as a reporting form to track the number of individuals that were sent the survey and the number of surveys that were electronically returned to their organization due to e-mail inboxes being full or e-mail addresses changing (see Appendices E, F, G and H).
4. The administrative individual signed and returned a form that indicated that they agreed to follow the outlined procedures for organizational participation in this study.
5. A pilot study was conducted using ten individuals to identify any issues with accessibility and readability of the survey.
6. The participant recruitment e-mail consisted of an electronic recruitment message along with a document that outlined the ethical information regarding the study, which included: contact information of the researcher, purpose of the study, participant requirements, participation requirements, potential risks and benefits of the study, the voluntary nature of the study, how the study ensured anonymity and confidentiality and information regarding informed consent (Dalhousie, 2003). This information was provided in both French and English (see Appendices I and J).
7. This initial web page of the questionnaire restated the importance of informed consent and that by completing this questionnaire informed consent was assumed.
8. A check box was used as an indicator that the participant has read the informed consent document and agreed to participate in the survey.
9. Two links were listed to access the questionnaire, a link for the French version of the questionnaire and a link for the English version of the questionnaire. And a link was provided for those who did not wish to complete the questionnaire.
10. The participant completed the survey.

11. Upon completion of the survey, the participant received a thank-you message for participation in the study.
12. The questionnaire was electronically available during a three-month period of time using the Dalhousie University survey service (Dalhousie University, 2007). The participants were asked to electronically complete the questionnaire within five weeks.
13. A modified Dillman method (2000) was used to remind the participants to complete the survey. Participants were e-mailed a consent form and the French and English links of the web address of the survey. One week later a reminder e-mail was forwarded to the participants and two weeks later another reminder was e-mailed and two weeks later a final reminder was e-mailed. Each reminder had the informed consent information and the links to the survey in both French and English.

The Dalhousie Opinio Survey service could be accessed for multiple individuals from the same site. As well, multiple responses from the same individual/computer terminal could be tracked with IP address during data cleaning. The data was extracted from the Dalhousie server and the test instrument web page was destroyed to ensure that the study instrument was not available for use by other persons or organizations without the permission of the researcher.

Pre-testing of Survey Instrument

Prior to the survey being sent out to all participants of Therapeutic Recreation professional associations, a small group of individuals from around the country were asked to complete the survey to identify any issues that participants may encounter from across the country. These individuals were the provincial or national Therapeutic Recreation association administrative assistant. This test group completed an evaluation

form to identify any issues regarding the administration and readability of the survey instrument. Pre-testing process went smoothly; the pre-testing group recommended no changes to process.

Data Analysis

The Statistical Package for the Social Sciences 17.0 (SPSS 17.0) was used to analyze the data. Data was entered into the statistical package by the researcher. Mean, standard deviation (with finite population correction factor), frequency distribution, chi-squared and gamma calculations were completed for each of the demographic, knowledge and skill statements. For further details regarding study mean and standard deviation for knowledge and skill statements see Appendix K. Cronbach's Alpha for the study was calculated as 0.919 meaning that the questionnaire had internal consistency or that the questionnaire was measuring what it was intended to measure. Comparisons were generated to determine whether there was a statistical significance in the identified competency areas between certified and non-certified TR professionals, participants with a degree versus a diploma, between regions or between years of work experience. Regions were defined by the same boundaries as the Canadian Therapeutic Recreation Association. The Western region includes British Columbia, Alberta and the Yukon. The Prairie region includes Saskatchewan, Manitoba and the Northwest Territories. The Central region includes Ontario, Quebec and Nunavut. The Atlantic region includes New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador.

Chi-squared and gamma calculations were recommended by the Dalhousie University consulting statistician for this study. As the sample was non-parametric, meaning the sample was atypical and in this case skewed, the non-parametric test, Chi-

squared is best useful to determine the probability that a relationship exists between groups, specifically for the study; between Certified and non-Certified, Degree and. non degree, regions and years of experience of the participants. A level of significance of $p \leq .05$ was used to test the null hypothesis. The null hypothesis for this study would be that no differences exist between groups. The gamma calculation provides additional information for the study in determining the degree of the strength of the association of the relationship between variables, the higher the gamma coefficient, the greater strength of association between variables.

Funding for the project was the responsibility of the researcher. Costs were minimized due the electronic administration of the questionnaire. Analysis software instruments were available to graduate students of the Health and Human Performance department at Dalhousie University.

Ethical Considerations

The following procedures were employed to address ethical issues:

- A Thesis Advisory Committee, as well as the Social Sciences and Humanities Human Research Ethics Board from Dalhousie University provided ethical review of the study.
- Organizations and participants were informed in writing regarding the study purpose and their right to withdraw from the study at any time.
- Informed consent information was provided to the participant and they were requested to print off informed consent documents for their own records.
- Participants were told explicitly that informed consent was assumed with participation in the study and a check off box was used for the participant to indicate that they had read the informed consent document.

- Levels of risk were minimal based on the survey design.
- Confidentiality and anonymity was maintained as participants were not asked to provide distinguishing information. Dalhousie Opinio survey services automatically provided a random ID code to each survey participant, date and time survey was initiated and completed and the language survey was accessed along with applicable respondent data.
- The agency/employer information was not requested

Organizations and participants were encouraged to contact the researcher with any questions about the study at any time and the researcher did her best to answer all questions as they arose from organizations or participants.

Summary

This study used a quantitative method of inquiry. A questionnaire was made available to a convenience sample of TR practitioners in Canada. Data was collected through electronic means. Analysis was done with SPSS 17.0. A broad perspective of Canadian TR practitioners was reflected in this study. This was the first time that all Canadian TR practitioners were given the opportunity to act as a united voice to add to the body of knowledge related to competencies of TR. By measuring the skills and knowledge of competent TR practice in Canada, the stage was set for further developments such as appropriate educational programs needs, certification systems and standards of practice for the field of Therapeutic Recreation.

Chapter 4

Results

Chapter four presents the finding of this study. The chapter will present the demographics of the respondents, the research questions that framed the study and a summary of the results.

Demographic Findings

The demographics of the participants in the study are presented in Table 2 and include information such as: participants gender, ethnic background, years practicing in Therapeutic Recreation, highest level of education achieved, CTRS designation, current role, primary service setting, primary level of care, primary population, primary age group, current case load, regional information and the mean age.

Table 2 *Summary of demographic findings*

Gender			**Current Role**		
Male	21	(8.6%)	Recreation Therapist	115	(47.7%)
Female	221	(91.3%)	Recreation Therapist/Supervisor	63	(25.7%)
Missing	2		Recreation Therapist/ Administrator	13	(5.4%)
			Recreation Leader Programmer	14	(5.8%)
Ethnic Background			Administrator	10	(4.1%)
Chinese	2	(.8%)	Educator	10	(4.1%)
South Asian	1	(.4%)	Not currently employed in TR	17	(7.1%)
Latin American	1	(.4%)	Missing	3	
Black	1	(.4%)			
First Nations	2	(.8%)	**Primary Service Setting**		
Multi-Racial	5	(2.1%)	Hospital	77	(32.1%)
Caucasian	230	(95.0%)	Long Term Care	76	(31.7%)
Missing	2		Residential/Transitional	12	(5.0%)
			Parks & Recreation Org	1	(.4%)
Years Practicing in TR			Outpatient/Day Treatment	10	(4.2%)
Less than 1 yr	20	(8.3%)	Academic	2	(.8%)
1-3 yrs	29	(12.0%)	Health Centre	10	(4.2%)
4-6 yrs	24	(9.9%)	Educational Institution	7	(2.9%)
7-9 yrs	27	(11.2%)	Day Support Centre	9	(3.8%)
10-14 yrs	40	(16.5%)	Private Practice	4	(1.7%)
15-19 yrs	50	(20.7%)	Community	17	(7.1%)
20 plus yrs	46	(19.0%)	Other	15	(6.3%)
Not Employed in TR	6	(2.5%)	Missing	4	
Missing	2				

Highest level of Education			**Primary Level of Care**		
Certificate	1	(.4%)	Long Term Care	84	(34.9%)
Diploma	60	(24.9%)	Rehabilitation Care	44	(18.3%)
Degree	151	(62.7%)	Acute Care	25	(10.4%)
Master's Degree	17	(7.1%)	Community	28	(11.6%)
Doctorate	3	(1.2%)	Home Health Care	2	(.8%)
Other	9	(3.7%)	Combination of Settings	36	(14.9%)
Missing	3		Other	22	(9.1%)
			Missing	3	
CTRS Designation					
Yes	39	(16.3%)	**Primary Population**		
No	201	(83.8%)	Mental Health	65	(27.1%)
Missing	4		Geriatric	115	(47.9%)
			Physical Disabilities	22	(9.2%)
Regional Information			Developmental	4	(1.7%)
Western (BC, AB, NWT)	110	(45.8%)	Disabilities		
Prairie (SK, MB, YK)	16	(6.7%)	Chronic Illness	6	(2.5%)
Central (ON, PQ, NU)	77	(32.1%)	Other	28	(11.7%)
Atlantic (NB, NS, PEI, NF/L)	37	(15.4%)	Missing	4	
Missing	4				
			Primary Age Group		
Age			Adults/Older Adults	97	(40.2%)
Mean	38.4	Yrs	Adults	53	(22.0%)
			Older Adults	57	(23.7%)
Current Caseload			Adolescents	5	(2.1%)
1-10	21	(9.3%)	Paediatrics/ Adolescents	4	(1.7%)
11-20	28	(12.3%)	Paediatrics	2	(.8%)
21-40	69	(30.4%)	All age groups	18	(7.5%)
41-60	38	(16.7%)	Other	5	(2.1%)
61-100	32	(14.1%)	Missing	3	
100 plus	39	(17.2%)			
Missing	17		**Total Participants**	244	

did not indicate how many years they had been practicing in Therapeutic Recreation.

The majority of individuals, 62.7%, responded that their highest level of education is was Baccalaureate degree, 24.9% responded that their highest level of education was a diploma, 7.1% responded that their highest level of education was a Master's Degree, 1.2% responded that their highest level of education was a Doctorate, 0.4% responded that their highest level of education was a certificate, 3.7% indicated that their highest level of education was other and three did not indicated their highest level of education.

The majority of individuals, 83.8%, who participated in this study reported that they did not hold a CTRS designation as granted by the National Council for Therapeutic Recreation Certification.

The majority of individuals, 45.8% reported that they resided in Western Canada (British Columbia, Alberta, Northwest Territories), 32.1% reported that they resided in Central Canada (Ontario, Quebec, Nunavut), 15.4% reported that they resided in Atlantic Canada (New Brunswick, Nova Scotia, Prince Edward Island, Newfoundland/Labrador) and 6.7% reported that they resided in the Prairies in Canada (Saskatchewan, Manitoba, Yukon).

Therapeutic Recreation Association Membership Numbers Across Canada

- 300 (16.4%) BCTRA: British Columbia Therapeutic Recreation Association
- 416 (22.7%) ATRA: Alberta Therapeutic Recreation Association
- 80 (4.4%) SARP (TR Specific): Saskatchewan Association of Recreation Professionals
- 90 (4.9%) RCM (TR Specific): Recreation Connections Manitoba
- 633 (34.7%) TRO: Therapeutic Recreation Ontario (R/TRO and Professional)
- 100 (5.5%) NSRPH: Nova Scotia Recreation Professionals in Health
- 114 (6.2%) NLTRA: Newfoundland Labrador Therapeutic Recreation Association 1999
- 93(5.1%) TRAAC: Therapeutic Recreation Association of Atlantic Canada
  Total provincial memberships 1,826
- 523 CTRA: Canadian Therapeutic Recreation Association
  Total memberships 2349

Figure 3 Therapeutic Recreation Association Membership Numbers across Canada as reported at the Provincial Presidents meeting held at the Canadian Therapeutic Recreation Conference, June 14, 2012.

The sample distribution of this study is reflective of distribution of Therapeutic Recreation in Canada (see Figure 3). Membership numbers were collected during the June 14, 2012 Provincial Presidents meeting as part of the reporting period from all

Provincial Association Therapeutic Membership groups in attendance (CTRA, 2012). Percentages in Figure 3 are reported for provincial membership groups only.
Since the study was completed, CTRA and the some of the provinces have developed a joint membership program; therefore a person could be a member of CTRA and a provincial association at the same time. The total 2349 could represent members being counted twice, once as a member of the provincial association and once as a member of CTRA.

BCTRA/ATRA were reported to have 716 members or 39.7%, SARP/TRM (TR Specific) were reported to have 170 members or 9.3%, TRO was reported to have 633 members or 34.7% (no report or members was present from either Quebec TR Associations at the meeting). NSRPH/NLTRA/TRAAC were reported to have 307 members or 16.8% of provincial members in Canada. These percentages are very similar to the regional percentages in the study (see Table 2, p.76-77) indicating that the sampling distribution of this study is reflective of distribution of Therapeutic Recreation in Canada.

The majority of individuals, 47.7%, indicated that their current role is a recreation therapist, 25.7% indicated that their current role is a recreation therapist/supervisor, 5.8% indicated that their current role is a recreation leader/programmer, 5.4% indicated that their current role is a recreation therapist/administrator, 4.1% indicated that their current role is an administrator, 4.1% indicated that their current role is an educator, 7.1% indicated that they are not currently employed in the field of Therapeutic Recreation.

The majority of participants, 32.1%, indicated that their primary service setting is a hospital, 31.7% indicated that their primary service setting is a long term care centre, 7.1% indicated that their primary service setting is the community, 5.0% indicated that

their primary service setting is residential/transitional, 4.2% indicated that their primary service setting is outpatient/day treatment, 4.2% indicated that their primary service setting is a health centre, 3.8% indicated that their primary service setting is a day support centre, 2.9% indicated that their primary service setting is an educational institution, 1.7% indicated that their primary service setting is private practice, 0.8% indicated that their primary service setting is academic, 4.2% indicated that their primary service setting is a parks and recreation organization.

The majority of participants, 34.9% indicated that their primary level of care is long term care. 18.3% indicated that their primary level of care is rehabilitation care, 14.9% indicated that their primary level of care is a combination of settings, 11.6% indicated that their primary level of care is community, 10.4% indicated that their primary level of care is acute care, 0.8% indicated that their primary level of care is home health care, 9.1% indicated that their primary level of care is other.

A majority of participants, 47.9% indicated that the primary population that they serve is Geriatrics. 27.1% indicated that the primary population that they serve is mental health, 9.2% indicated that the primary population that they serve is individuals with physical disabilities, 2.5% indicated that the primary population that they serve is chronic illness, 1.7% indicated that the primary population that they serve is individuals with developmental disabilities and 11.7% indicated that the primary population that they serve is other.

A majority of participants, 40.2% indicated that the primary age group they serve is adults/older Adults. 23.7% indicated the primary age group they serve is older adults, 22.0% indicated the primary age group they serve is adults, 7.5% indicated the primary age group they serve is all age groups, 2.1% indicated the primary age group they serve is

adolescents, 1.7% indicated the primary age group they serve is paediatrics/adolescents, 0.8% indicated the primary age group they serve is paediatrics, 2.1% indicated the primary age group they serve is other.

A majority of participants, 30.4% indicated that their current caseload is 21-40 clients, 17.2% indicate that their current caseload is more than one hundred clients, 16.7% indicate that their current caseload is 41-60 clients, 14.1% indicate that their current caseload is 61-100 clients, 12.3% indicate that their current caseload is 11-20 clients and 9.3% indicate that their current caseload is one to ten clients.

Research Question 1:

Do significant skills and knowledge differences exist in identified competency areas between certified and non-certified TR practitioners?

The CTRA standards of practice skill and knowledge statements were used to in this study. Chi-squared and gamma correlations were calculated in the study for each of the responsibility statements and knowledge areas found within the CTRA Standards of Practice. Comparisons were generated to determine whether there is a statistical significance in the identified competency areas between certified and non-certified TR professionals.

Significant differences are reported at $p \leq .05$. Table 3 provides a summary of chi-squared, $p \leq .05$ and gamma correlations between certified and non-certified TR professionals who participated in the study. In Table 3, when comparing certified and non-certified respondents, seven knowledge and skill statements met a level of significance, $p \leq .05$. Differences exist in agreement that these knowledge and skill statements are important for competent practice between Certified and non-certified participants in this study.

The following were found to be significant at $p \leq .05$ level:

Table 3 *Summary of chi-squared (X^2), $p \leq .05$ and gamma (γ) correlations between certified and non-certified TR professionals who participated in the study*

Standard (K/S Area)	Knowledge/Skill Statement	Level of Significance X^2 ($p \leq .05$)	Level of Correlation γ
Standard 2: Intervention Plan Development – K	V41 – The principles of accessibility	.023	.024
Standard 2: Intervention Plan Development – K	V42 – The mission and operations of all facilities in the community which are accessible for persons with disabilities	.032	.016
Standard 2: Intervention Plan Development – S	V54 – Educate the client and caregiver(s), if necessary, about ways to become involved in the community	.050	.094
Standard 3: Intervention Plan Implementation – S	V62 – Encourage clients, caregiver(s) and significant others to participate	.044	.675
Standard 6: Interdisciplinary Collaboration – S	V86 – Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client	.016	.034
Standard 6: Interdisciplinary Collaboration – S	V87 – Refer clients to other disciplines if necessary	.026	.107
Standard 7: Professional Development – S	V94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary	.027	.019

Note: K = Knowledge Area, S = Skill Area, X^2 = Chi square; γ = Gamma

Standard 2: Intervention Plan Development, three knowledge and skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 41-The principles of accessibility, which resulted in a chi squared value of .023 and a gamma value of .024. Variable 42 - The mission and operations of all facilities in the community which are accessible for persons with disabilities, which resulted in a chi squared value of .032 and a gamma value of .016 and Variable 54 - Educate the client and caregiver(s), if necessary, about ways to become involved in the community, which resulted in a chi squared value of .050 and a gamma value of .094.

Within Standard 3: Intervention Plan Implementation, one skill statement demonstrated a level of significance of $p \leq .05$. It was; Variable 62 – Encourage clients, caregiver(s) and significant others to participate, which resulted in a chi squared value of .044 and a gamma value of .675.

Within Standard 6: Interdisciplinary Collaboration, two skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 86 – Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client, which resulted in a chi squared value of .016 and a gamma value of .034 and Variable 87 – Refer clients to other disciplines if necessary, which resulted in a chi squared value of .026 and a gamma value of .107.

Within Standard 7: Professional Development, one skill statement demonstrated a level of significance of $p \leq .05$. It was: Variable 94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary, which resulted in a chi squared value of .027 and a gamma value of .019.

Research Question 2:

Do significant skills and knowledge differences exist in identified competency areas between individuals with a degree versus a diploma?

Table 4 provides a summary of chi-squared, $p \leq .05$ and gamma correlations between professionals with a degree versus a diploma who participated in the study. When comparing Therapeutic Recreation professionals who have attain a degree or higher versus diploma level respondents, 13 knowledge and skill statements met a level

Table 4 *Summary of chi-squared (X^2), $p \leq .05$ and gamma (γ) correlations between professionals with a degree versus a diploma who participated in the study*

Standard (K/S Area)	Knowledge/Skill Statement	Level of Significance X^2 ($p \leq .05$)	Level of Correlation γ
Standard 1: Assessment - K	V22 – Assessment processes, procedures and instruments specific to individual clients	.033	.042
Standard 2: Intervention Plan Development - K	V42 – The mission and operations of all facilities in the community which are accessible for persons with disabilities	.022	.008
Standard 2: Intervention Plan Development - S	V49 – Review and modify interventions or services to ensure that client goals and objectives are met	.012	.016
Standard 2: Intervention Plan Development - S	V54 – Educate the client and the caregiver(s), about ways to become involved in the community	.050	.050
Standard 6: Interdisciplinary Collaboration - K	V80 – The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery	.036	.021
Standard 6: Interdisciplinary Collaboration – S	V85 – Promote the importance of recreation therapy to other disciplines	.041	.262

Standard (K/S Area)	Knowledge/Skill Statement	Level of Significance X^2 ($p \leq .05$)	Level of Correlation γ
Standard 7: Professional Development – S	V94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary	.004	.003
Standard 10: Sensitivity to Diversity – K	V117 – The Universal Declaration of Human Rights	.047	.055
Standard 10: Sensitivity to Diversity – S	V119 – Alter verbal and non-verbal communication depending on the client	.035	.283
Standard 10: Sensitivity to Diversity - S	V122 – Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship	.016	.005
Standard 11: Risk Management – S	V134 – Ensure that recreation therapy areas are clean, safe, and properly maintained in keeping with health, fire and safety codes	.043	.027
Standard 11: Risk Management – S	V136 – Document any risk management issues or incidents in accordance with organizational policy	.031	.021
Standard 11: Risk Management – S	V138 – Apply do not resuscitate codes (DNR's) depending on the client and/or caregiver's wishes	.022	.014

Note: K = Knowledge Area, S = Skill Area, X^2 = Chi square; γ = Gamma

of significance, $p \leq .05$. Differences exist in agreement that these knowledge and skill statements are important for competent practice between Degree level and Diploma level participants in this study.

The following were found to be significant at $p \leq .05$ level:

Within Standard 1: Assessment, one knowledge skill statements demonstrated a level of significance of $p \leq .05$. It was: Variable 22 – Assessment processes, procedures and instruments specific to individual clients, which resulted in a chi squared value of .033 and a gamma value of .042.

Within Standard 2: Intervention Plan Development, three knowledge and skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 42 - The mission and operations of all facilities in the community which are accessible for persons with disabilities, which resulted in a chi squared value of .022 and a gamma value of .008. Variable 49 – Review and modify interventions or services to ensure that client goals and objectives are met, which resulted in a chi squared value of .032 and a gamma value of .016 and Variable 54 - Educate the client and caregiver(s), if necessary, about ways to become involved in the community, which resulted in a chi squared value of .050 and a gamma value of .050.

Within Standard 6: Interdisciplinary Collaboration, two knowledge and skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 80 – The role of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery, which resulted in a chi squared value of .036 and a gamma value of .021 and variable 85 – Promote the importance of recreation therapy to other disciplines, which resulted in a chi squared value of .041 and a gamma value of .262.

Within Standard 7: Professional Development, one skill statement demonstrated a level of significance of $p \leq .005$. It was: Variable 94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary, which resulted in a chi squared value of .004

and a gamma value of .003. This may indicate that the value of attaining and completing of additional competencies and knowledge is very different for Therapeutic Recreation professional with a degree versus a diploma.

Within Standard 10: Sensitivity to Diversity, three knowledge and skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 117 - The Universal Declaration of Human Rights, which resulted in a chi squared value of .047 and a gamma value of .055. Variable 119 – Alter verbal and non-verbal communication depending on the client, which resulted in a chi squared value of .035 and a gamma value of .283 and Variable 122 – Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship, which resulted in a chi squared value of .016 and a gamma value of .005.

Within Standard 11: Risk Management, three skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 134 – Ensure that recreation therapy areas are clean, safe and properly maintained in keeping with health, fire and safety codes, which resulted in a chi squared value of .043 and a gamma value of .027. Variable 136 – Document any risk management issues or incidents in accordance with organizational policy, which resulted in a chi squared value of .031 and a gamma value of .021 and Variable 138 – Apply do not resuscitate codes (DNR's) depending on the clients and/or caregiver's wishes, which resulted in a chi squared value of .022 and a gamma value of .014.

Research Question 3:

Do significant skills and knowledge differences exist in identified competency areas between demographic regions in Canada?

Table 5 provides a summary of chi-squared, $p \leq .05$ and gamma correlations between professionals in varying demographic regions in Canada who participated in the study. As well, due to the small sample size of respondents in the prairie region, data analysis required that certain knowledge and skill statements combine the respondents from the Prairie region and the Western region. When comparing Therapeutic Recreation professionals from varying demographic regions in Canada, eight knowledge and skill statements met a level of significance, $p \leq .05$. Differences exist in agreement that these knowledge and skill statements are important for competent practice between participants from varying regions in this study.

Table 5 *Summary of chi-squared (X^2), $p \leq .05$ and gamma (γ) between professionals in varying demographic regions in Canada who participated in the study*

Standard (K/S Area)	**Knowledge/Skill Statement**	**Level of Significance X^2 ($p \leq .05$)**	**Level of Correlation** γ
Standard 1: Assessment – S	V28 – Gather information from caregiver(s) or significant others as required	.048	.061
Standard 2: Intervention Plan Development – S	V50 – Create discharge plans and provide follow-up services when necessary	.049	.290
Standard 2: Intervention Plan Development - S	V54 – Educate the client and the caregiver(s), about ways to become involved in the community	.022	.110
Standard 4: Documentation - S	V68 – Complete documentation in accordance with the organization's standards in an accurate and professional manner, using agency specific terminology***	.045	.197

Standard (K/S Area)	Knowledge/Skill Statement	Level of Significance X^2 ($p \leq .05$)	Level of Correlation γ
Standard 4: Documentation - S	V73 – Complete workload measurement in accordance with the organization's standards	.004	.004
Standard 8: Research – K	V98 – Outcome oriented and evidence based research practices	.023	.190
Standard 8: Research – S	V104 – Support, assist or participate in research related to recreation therapy	.006	.417
Standard 8: Research – S	V108 – Evaluate, analyze and interpret research results before announcing the findings to the public***	.031	.607

*Note: K = Knowledge Area, S = Skill Area, X^2= Chi square, γ = Gamma, *** Combined Western and Prairie Regions*

The following were found to be significant at $p \leq .05$ level:

Within Standard 1: Assessment, one skill statement demonstrated a level of significance of $p \leq .05$. It was: Variable 28 – Gather information from caregiver(s) or significant others as required, which resulted in a chi squared value of .048 and a gamma value of .061.

Within Standard 2: Intervention Plan Development, two skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 50 – Create discharge plans and provide follow-up services when necessary, which resulted in a chi squared value of .049 and a gamma value of .290 and variable 54 – Educate the client and caregiver(s), if necessary, about ways to become involved in the community, which resulted in a chi squared value of .022 and a gamma value of .110.

Within Standard 4: Documentation, two skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 68 – Complete documentation in accordance with the organization's standards in an accurate and professional manner,

using agency specific terminology, which resulted in a chi squared value of .045 and a gamma value of .197 and variable 73 – Complete workload measurement in accordance with the organization's standards, which resulted in a chi squared value of .004 and a gamma value of .004.

Within Standard 8: Research, three knowledge and skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 98 – Outcome oriented and evidence based research practices, which resulted in a chi squared value of .023 and a gamma value of .190. Variable 104 – Support, assist or participate in research related to recreation therapy, which resulted in a chi squared value of .006 and a gamma value of .417 and variable 108 – Evaluate, analyze and interpret research results before announcing the findings to the public, which resulted in a chi squared value of .031 and a gamma value of .607. This high gamma value suggests there is a high association between the variables.

Research Question 4:

Do significant skills and knowledge differences exist in identified competency areas between years of experience practicing as a TR practitioner?

Table 6 provides a summary of chi-squared, $p \leq .05$ and gamma correlations between respondent's years of experience practicing as TR practitioners who participated in the study. When comparing Therapeutic Recreation respondents years of experience practicing as TR practitioners, six knowledge and skill statements met a level of significance, $p \leq .05$. Differences exist in agreement that these knowledge and skill statements are important for competent practice between participants with varying years of experiences in this study.

Table 6 *Summary of chi-squared (X^2), $p \leq .05$ and gamma (γ) between respondent's years of experience practicing as a TR practitioner who participated in the study*

Standard (K/S Area)	Knowledge/Skill Statement	Level of Significance X^2 ($p \leq .05$)	Level of Correlation γ
Standard 1: Assessment – S	V25 – Select and implement assessment instruments based on the individual client in accordance with organizational policies	.029	.104
Standard 3: Intervention Plan Implementation - K	V57 – How to supervise and manage leisure programs within clients capabilities, resources, agencies and/or community resources	.012	.007
Standard 5: Evaluation - K	V74 – Objective outcome measurement instruments and methods	.042	.686
Standard 8: Research – K	V100 – Ethical guidelines for involving human subjects	.009	.048
Standard 8: Research – S	V107 – Follow requirements stated in the ethical guidelines for involving human subjects (ex. By obtaining the approval and consent of research participant(s), ensuring his/her confidentiality and respecting his/her right to withdraw from the study)	.030	.072
Standard 9: Ethics - S	V112 – Report unethical incidences to the appropriate personnel within the organization	.035	.003

*Note: K = Knowledge Area, S = Skill Area, X^2= Chi square, γ = Gamma, *** Combined Western and Prairie Regions*

The following were found to be significant at $p \leq .05$ level:

Within Standard 1: Assessment, one skill statements demonstrated a level of significance of $p \leq .05$. It was: Variable 25 – Select and implement assessment

instruments based on the individual client in accordance with organizational policies, which resulted in a chi squared value of .029 and a gamma value of .104.

Within Standard 3: Intervention Plan Implementation, one knowledge statement demonstrated a level of significance of $p \leq .05$. It was: Variable 57 – How to supervise and manage leisure programs within clients capabilities, resources, agencies and/or community resources, which resulted in a chi squared value of .012 and a gamma value of .007.

Within Standard 5: Evaluation, one knowledge statement demonstrated a level of significance of $p \leq .05$. It was: Variable 74 – Objective outcome measurement instruments and methods, which resulted in a chi squared value of .042 and a gamma value of .686. This high gamma value suggests there is a high association between variables.

Within Standard 8: Research, two knowledge and skill statements demonstrated a level of significance of $p \leq .05$. They were: Variable 100 – Ethical guidelines for involving human subjects, which resulted in a chi squared value of .009 and a gamma value of .048 and variable 107 – Follow requirements stated in the ethical guidelines for involving human subjects (ex. By obtaining the approval and consent of research participant(s), ensuring his/her confidentiality and respecting his/her right to withdraw from the study, which resulted in a chi squared value of .030 and a gamma value of .072.

Within Standard 9: Ethics, one skill statement demonstrated a level of significance of $p \leq .05$. It was: Variable 112 – Report unethical incidences to the appropriate personnel within the organization, which resulted in a chi squared value of .035 and a gamma value of .003.

Summary

This chapter provided insights into the four research questions:

1) Do significant skills and knowledge differences exist in identified competency areas between certified and non-certified TR practitioners?

2) Do significant skills and knowledge differences exist in identified competency areas between individuals with a degree versus a diploma?

3) Do significant skills and knowledge differences exist in identified competency areas between demographic regions in Canada?

4) Do significant skills and knowledge difference exist in identified competency areas between years practicing as a TR practitioner?

The findings are summarized in Table 7:

Table 7 *Summary of the CTRA Standards of Practice as related to the research questions used in this study*

CTRA Standard of Practice	CTRS/Non CTRS	Degree/non degree	Regions	Years of Experience
1: Assessment		V22	V28	V25
2: Intervention Plan Development	V41, V42, V54	V42, V49, V54	V50, V54	
3: Intervention Plan Implementation	V62			V57
4: Documentation			V68, V73	
5: Evaluation				V74
6: Interdisciplinary Collaboration	V86, V87	V80, V85		
7. Professional Development	V94	V94		
8. Research			V98, V104, V108	V100, V107

CTRA Standard of Practice	CTRS/Non CTRS	Degree/non degree	Regions	Years of Experience
9. Ethics				V112
10. Sensitivity to Diversity		V117, V119, V122		
11. Risk Management		V134, V136, V138		

Note: V22 – Assessment processes, procedures and instruments specific to individual clients
V28 – Gather information from caregiver(s) or significant others as required
V25 – Select and implement assessment instruments based on the individual client in accordance with organizational policies
V41 – The principles of accessibility
V42 – The mission and operations of all facilities in the community which are accessible for persons with disabilities
V49 – Review and modify interventions or services to ensure that client goals and objectives are met
V50 – Create discharge plans and provide follow-up services when necessary
V54 – Educate the client and caregiver(s), if necessary, about ways to become involved in the community
V57 – How to supervise and manage leisure programs within clients capabilities, resources, agencies and/or community resources
V62 – Encourage clients, caregiver(s) and significant others to participate
V68 – Complete documentation in accordance with the organization's standards in an accurate and professional manner, using agency specific terminology
V73 – Complete workload measurement in accordance with the organization's standards
V74 – Objective outcome measurement instruments and methods
V80 – The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery
V85 – Promote the importance of recreation therapy to other disciplines
V86 – Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client
V87 – Refer clients to other disciplines if necessary
V94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary
V98 – Outcome oriented and evidence based research practices
V100 – Ethical guidelines for involving human subjects
V104 – Support, assist or participate in research related to recreation therapy
V107 – Follow requirements stated in the ethical guidelines for involving human subjects (ex. By obtaining the approval and consent of research participant(s), ensuring his/her confidentiality and respecting his/her right to withdraw from the study)
V108 – Evaluate, analyze and interpret research results before announcing the findings to the public
V112 – Report unethical incidences to the appropriate personnel within the organization
V117 – The Universal Declaration of Human Rights
V119 – Alter verbal and non-verbal communication depending on the client
V122 – Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship
V134 – Ensure that recreation therapy areas are clean, safe, and properly maintained in keeping with health, fire and safety codes
V136 – Document any risk management issues or incidents in accordance with organizational policy
V138 – Apply do not resuscitate codes (DNR's) depending on the client and/or caregiver's wishes

Chapter five will relate these finding to the current literature, make recommendations for the TR profession in Canada and make recommendations for future research in the area of TR related to knowledge and skills of TR practitioners.

Chapter 5

Discussion and Recommendations

The purpose of the study is to identify the skills and knowledge required for competent Therapeutic Recreation practice in Canada. This chapter will relate the findings from the study to the current literature, make recommendations for the Therapeutic Recreation profession in Canada and make recommendations for future research in the area of TR related to competencies for TR practitioners.

Research Questions

The following research questions were explored in the study.

1) Do significant skills and knowledge differences exist in identified competency areas between certified and non-certified TR practitioners?

2) Do significant skills and knowledge differences exist in identified competency areas between individuals with a degree versus a diploma?

3) Do significant skills and knowledge differences exist in identified competency areas between demographic regions in Canada?

4) Do significant skills and knowledge difference exist in identified competency areas between years practicing as a TR practitioner?

Table 7, p.93-94 presents a summary of the CTRA Standards of Practice as related to the research questions used in this study. Significant skill and knowledge differences exist between; certified and non-certified, degree level and diploma level, regionally and with varying years of experience in the therapeutic recreation profession.

Of the 11 Standards of Practice for Recreation Therapists (CTRA, 2006) the following standards and related competencies were found to have significant differences related to the research questions. Standard 1 “Assessment”, Standard 2 “Intervention

Plan Development", Standard 3 "Intervention Plan Implementation", Standard 4 "Documentation", Standard 5 "Evaluation", Standard 6 "Interdisciplinary Collaboration", Standard 7 "Professional Development", Standard 8 "Research", Standard 9 "Ethics", Standard 10 "Sensitivity to Diversity", Standard 11 "Risk Management". Each of these Standards of Practice and related competencies were found to be significant related to one of the research questions used in the study. Meaning that, differences exist when comparing groups in this study, between; Certified vs. non-certified, Degree level vs. Diploma level, Regions and varying years of experiences as analyzed in this study. This reflects the emergence of Therapeutic Recreation Canada due to access to a four-year degree education versus diploma and the emerging development of TR professional groups across Canada. The following will address each of the significant findings and discuss the competencies that were found to be different related to each of the research questions.

Results and Discussion

Studies related to competencies in TR professional practice is emerging. These studies will influence TR standards of practice, educational programs, certification programs and licensure programs (O'Morrow & Reynolds, 1989). In Ontario, Hare and Frisby (1989) conducted a job competency study, specific to Ontario. They surveyed 250 Ontario Therapeutic Recreation Council members and achieved a 69% response rate. In 2006, the National Council for Therapeutic Recreation Certification (NCTRC, 2006) invited all Certified Therapeutic Recreation Specialists (CTRS) in Canada to participate in their job competency study and achieved a 59% response rate among Canadian CTRS's. These studies and their high response rates are indicative that defined competencies continue to be a significant issue for TR practitioners in Canada.

This study provides additional insights from the perspective of the Canadian Therapeutic Recreation Professionals who responded to this study, measuring the skills and knowledge statements necessary for competent TR practice in Canada. The results from this study will set the stage for further developments in the field of TR practice related to appropriate educational program needs, certification systems and standards of practice.

Research Question 1

Do significant skills and knowledge differences exist in identified competency areas between certified and non-certified TR practitioners?

In this study, the following seven knowledge and skill statements were found to be significant between certified and non-certified respondents. Meaning, differences exist in agreement that these knowledge and skill statements are important for competent practice between certified and non-certified participants in this study.

Standard 2: Intervention Plan Development

- Knowledge Statement - The principles of accessibility
- Knowledge Statement - The mission and operations of all facilities in the community which are accessible for persons with disabilities
- Skill Statement - Educate the client and caregiver(s), if necessary, about ways to become involved in the community

Standard 3: Intervention Plan Implementation

- Skill Statement - Encourage clients, caregiver(s) and significant others to participate

Standard 6: Interdisciplinary Collaboration

- Skill Statement - Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client
- Skill Statement - Refer clients to other disciplines if necessary

Standard 7: Professional Development

- Skill Statement - Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary

The findings of this study found a significant difference between those individuals who were CTRS versus non-CTRS related to the Knowledge Statements and Skill Statements.

Differences in responses expressed in this study regarding the skill and knowledge statements may be attributed to the additional course requirements that certified Therapeutic Recreation specialists are required to meet to gain certification. A Certified Therapeutic Recreation Specialist's (CTRS's) coursework may highlight the importance of the skill and knowledge statements related to Interdisciplinary Collaboration, whereas professionals working in Therapeutic Recreation, who are not certified, may not have that coursework and knowledge.

Additionally, CTRS's complete a competency measure, the NCTRC Certification exam. Its' purpose is to evaluate their entry to practice knowledge regarding Therapeutic Recreation practice and is based on research that examines the professional activities of its Certificants in the Therapeutic Recreation profession. The NCTRC has conducted three job analysis studies, which have been used to inform their competency examination

and is said to reflect the evolving nature of the Therapeutic Recreation industry (NCTRC, 2007). These competencies are used in the education of Therapeutic Recreation students.

As well, CTRS's undergo a recertification program every 5 years. Therapeutic Recreation Certificants are required to provide documented experience, retesting or the accumulation of continuing education units (O'Morrrow & Reynolds, 1989; Carter et al., 2003). "Certification and recognition of competency beyond the entry level of practice is not only viewed as important but as necessary for inclusion in today's health care environment." (Riley & Stalko, 1998, p. 71)

Research Question 2

Do significant skills and knowledge differences exist in identified competency areas between individuals with a degree versus a diploma?

In this study, the following 13 knowledge and skill statements were found to be significant between individuals with a degree versus a diploma. Meaning, differences exist in agreement that these knowledge and skill statements are important for competent practice between Degree level and Diploma level participants in this study.

Standard 1: Assessment

- Knowledge Statement - Assessment processes, procedures and instruments specific to individual clients
- Knowledge Statement - The mission and operations of all facilities in the community which are accessible for persons with disabilities
- Skill Statement - Educate the client and the caregiver(s), about ways to become involved in the community

Standard 6: Interdisciplinary Collaboration

- Knowledge Statement - The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery
- Skill Statement - Promote the importance of recreation therapy to other disciplines

Standard 7: Professional Development

- Knowledge Statement - Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary

Standard 10: Sensitivity to Diversity

- Knowledge Statement - The Universal Declaration of Human Rights
- Skill Statement - Alter verbal and non-verbal communication depending on the client
- Skill Statement - Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship

Standard 11: Risk Management

- Skill Statement - Ensure that recreation therapy areas are clean, safe, and properly maintained in keeping with health, fire and safety codes
- Skill Statement - Document any risk management issues or incidents in accordance with organizational policy
- Skill Statement - Apply do not resuscitate codes (DNR's) depending on the client and/or caregiver's wishes

Differences in responses expressed regarding these skill and knowledge statements may be attributed to the additional course requirements that that Therapeutic Recreation professionals with a degree possess versus TR professionals with a diploma. A Therapeutic Recreation professional with a degree may have the knowledge from this additional coursework as well as the ability to critically evaluate the importance of the skill and knowledge statements, whereas professionals working in Therapeutic Recreation with a diploma, may not have this coursework and knowledge related to Interdisciplinary Collaboration, Sensitivity to Diversity and Risk Management.

Canada's Therapeutic Recreation educational opportunities currently range from community college level to university level programs (Canadian Therapeutic Recreation Association (CTRA), 2005). Variability within these education opportunities within Canada exist due to the lack of knowledge related to competencies in Therapeutic Recreation. Until Therapeutic Recreation in Canada defines a standard for entry to practice and uses this knowledge in its development of its education curriculum, Therapeutic Recreation will continue to debate the need for standardization in Therapeutic Recreation education curriculum.

For advancement, Therapeutic Recreation in Canada needs to undergo curriculum development. Curriculum development needs to be based upon the knowledge and competence being demonstrated by professionals. The profession of Therapeutic Recreation needs to come to a consensus regarding the unified body of knowledge required for Therapeutic Recreation as well as develop standardized and accredited education curricula. From this, the field can then develop curriculum which represent the entry to practice need for professionals based on their positions (Carter et al., 2003; Houle, 1980; O'Morrow & Reynolds, 1989; Pavalko, 1971 & 1988; Ritzer, 1971).

Research Question 3:

Do significant skills and knowledge differences exist in identified competency areas between demographic regions in Canada?

In this study, the following eight knowledge and skill statements were found to be significant between individuals between demographic regions in Canada. Meaning, differences exist in agreement that these knowledge and skill statements are important for competent practice between participants in varying regions in this study.

Standard 1: Assessment

- Skill Statement - Gather information from caregiver(s) or significant others as required

Standard 2: Interventions Plan Development

- Skill Statement - Create discharge plans and provide follow-up services when necessary
- Skill Statement - Educate the client and the caregiver(s), about ways to become involved in the community

Standard 4: Documentation

- Skill Statement - Complete documentation in accordance with the organization's standards in an accurate and professional manner, using agency specific terminology
- Skill Statement - Complete workload measurement in accordance with the organization's standards

Standard 8: Research

- Knowledge Statement - Outcome oriented and evidence based research practices
- Skill Statement - Support, assist or participate in research related to recreation therapy
- Skill Statement - Evaluate, analyze and interpret research results before announcing the findings to the public

Demographic regions were identified as per the Canadian Therapeutic Recreation Association (CTRA) classification system. The Western region: British Columbia, Alberta and the Yukon; the Prairie region: Saskatchewan, Manitoba and the Northwest Territories; the Central region: Ontario, Quebec and Nunavut and the Atlantic region: New Brunswick, Nova Scotia, Prince Edward Island and Newfoundland and Labrador.

Professional Organizations:

In Canada, there are 13 Therapeutic Recreation membership organizations. The Canadian Therapeutic Recreation Association is dedicated to providing national leadership in professional development matters, however each provincial group also works independently in this area (Singleton et al., 2006). It is vital that Therapeutic Recreation in Canada comes together to support the interests of Therapeutic Recreation and advances professional development.

To date, a formal and consistent education curriculum for Therapeutic Recreation has not been established in Canada. Therapeutic Recreation practitioners are educated differently from province to province. As well, a standard between diploma versus degree has not been established. Educational opportunities continue to vary across Canada. A recent review by CTRA demonstrates the variation within curriculums in

community colleges and universities (CTRA, 2012). This review identified ten institutions providing a Degree and 14 institutions providing a diploma. This review did not address the number of classes being taught in Therapeutic Recreation or the content of the TR classes. The review provided insights to the number of degree programs in each region which may affect the response to this question.

Some of the differences in responses expressed regarding these skill and knowledge statements between regional groups may be attributed to the educational institutions that are available in certain demographic areas in Canada. During my research, Therapeutic Recreation programs at a university level were lacking in the western and prairie regions. A Therapeutic Recreation professional being educated in Central or Atlantic Canada may have benefited from the knowledge gained from a university level Therapeutic Recreation curriculum, which in-turn, may have provided those individuals with the additional knowledge regarding the importance of the CTRA Standards of Practice. An example is that in 1990, Dalhousie University ensured that its Therapeutic Recreation curriculum enabled its students to be eligible to meet the NCTRC standards for certification.

As well, each professional association within different regions in Canada has varying levels of professional associations. Some professional associations are more organized, offering its members continued education opportunities on an annual basis, e.g. Alberta Therapeutic Recreation Association, Therapeutic Recreation Ontario, Therapeutic Recreation Association of Atlantic Canada, Nova Scotia Recreation Professionals in Health and the Newfoundland Therapeutic Recreation Association. As well, the Alberta Therapeutic Recreation Association also introduced a Continued Education Unit requirement in to membership renewal in 2001 (ATRA, 2012).

Most provinces have Therapeutic Recreation specific membership organizations; however some associations are still operating under general parks and recreation organizations, Saskatchewan Association of Recreation Professionals, Recreation Manitoba, Quebec Association of Activity Professionals.

Research Question 4:

Do significant skills and knowledge differences exist in identified competency areas between years of experience practicing as a TR practitioner?

In this study, the following six knowledge and skill statements were found to be significant between years of experience practicing as a TR practitioner. Meaning, differences exist in agreement that these knowledge and skill statements are important for competent practice between participants with varying years of experiences in this study.

Standard 1: Assessment

- Skill Statement - Select and implement assessment instruments based on the individual client in accordance with organizational policies

Standard 3: Intervention Plan Implementation

- Knowledge Statement - How to supervise and manage leisure programs within clients capabilities, resources, agencies and/or community resources

Standard 5: Evaluation

- Knowledge Statement - Objective outcome measurement instruments and methods

Standard 8: Research

- Knowledge Statement - Ethical guidelines for involving human subjects

- Skill Statement - Follow requirements stated in the ethical guidelines for involving human subjects (ex. By obtaining the approval and consent of research participant(s), ensuring his/her confidentiality and respecting his/her right to withdraw from the study)

Standard 9: Ethics

- Skill Statement - Report unethical incidences to the appropriate personnel within the organization

One of the reasons that there was less variability in responses can be attributed to the personal growth that individuals with increased clinical experience in the field of Therapeutic Recreation may have as compared to their entry to practice counterparts (Blair & Coyle, 2005). As Therapeutic Recreation practitioners gain experience, their knowledge and understanding is expanded to understand the importance of the CTRA Standards of Practice or Professional Standards of Practice. However, some of the variability in responses expressed by the respondents regarding the skill and knowledge statements may be attributed to the educational background that may have been available to students over 15 years ago. Curriculums in Canada have altered significantly in recent years, as more Therapeutic Recreation coursework becomes available and certification standards are refined by NCTRC (e.g. Douglas College, University of Regina, Brock University.

Experienced recreation professionals may demonstrate increased knowledge regarding job competencies than their entry level counterparts. Personal growth through increased clinical experience in the field of Therapeutic Recreation may have impacted their increased knowledge of competencies related to Therapeutic Recreation (Blair &

Coyle, 2005) which in turn may have influenced determining statistically significant differences between groups.

As well, ethical guidelines for research have increased in recent years. Respondents may not be familiar with this change in standard as they have been clinicians not researchers.

Additional Points for Discussion

In 2006, when the Canadian Therapeutic Recreation Association developed their Standards of Practice document for Recreation Therapists and Therapeutic Recreation Assistants, three new standards were introduced in Therapeutic Recreation different from previous provincial Therapeutic Recreation standards of practice documents. Interdisciplinary Collaboration, Sensitivity to Diversity and Risk Management were added to reflect the changing practice and nature of Therapeutic Recreation in Canada.

The findings are summarized in Table 8 relative to the Standards of Practice: Interdisciplinary Collaboration, Sensitivity to Diversity and Risk Management. When comparing CTRS vs. Non-CTRS and Degree vs. Diploma respondents, ten statistically significant knowledge and skill statements were from these additional standards of practice areas.

Table 8 *Summary of Significant Results relative to Standards of Practice: Interdisciplinary Collaboration, Sensitivity to Diversity and Risk Management*

CTRS/Non CTRS Knowledge/Skill Statements, p. 77	**Degree/Diploma Knowledge/Skill Statements, p. 80**
Standard 6: Interdisciplinary Collaboration: V86, V87	Standard 6: Interdisciplinary Collaboration: V80, V85 Standard 10: Sensitivity to Diversity: V117, V119, V122 Standard 11: Risk Management: V134, V136, V138

Note: V80 – The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery

V85 – Promote the importance of recreation therapy to other disciplines
V86 – Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client
V87 – Refer clients to other disciplines if necessary
V117 – The Universal Declaration of Human Rights
V119 – Alter verbal and non-verbal communication depending on the client
V122 – Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship
V134 – Ensure that recreation therapy areas are clean, safe, and properly maintained in keeping with health, fire and safety codes
V136 – Document any risk management issues or incidents in accordance with organizational policy
V138 – Apply do not resuscitate codes (DNR's) depending on the client and/or caregiver's wishes

Even more interesting, when examining the differences in identified competency areas between individuals with a degree versus a diploma, eight statistically significant knowledge and skill statements identified emerged from these three new Standards of Practice: Interdisciplinary Collaboration, Sensitivity to Diversity and Risk Management. One might postulate that additional education needs to occur around these standards of practice for Therapeutic Recreation practitioners in Canada.

In this study, three knowledge and skill statements demonstrated repeated statistically significant results within comparison groups. The findings are summarized in Table 9. Differences exist in agreement that these knowledge and skill statements are important for competent practice, between; Certified and non-certified, Degree level and Diploma level, regions of the country and by of years of experience.

Standard 2: Intervention Plan Development: Knowledge Statement: The mission and operations of all the facilities in the community which are accessible for persons with disabilities emerged when comparing CTRS and non-CTRS and when comparing Degree and Diploma respondents.

Table 9 *Summary of Significant Results relative to Repeated Variables*

CTRS/Non CTRS Research Question 1 Knowledge/Skill Statements, p. 77	**Degree/Diploma Research Question 2 Knowledge/Skill Statements, p. 80**	**Regions Research Question 3 Knowledge/Skill Statements, p. 83**
Standard 2: Intervention Plan Development: V42, V54 Standard 7: Professional Development: V94	Standard 2: Intervention Plan Development: V42, V54 Standard 7: Professional Development: V94	Standard 2: Intervention Plan Development: V54

Note: V42 – The mission and operations of all facilities in the community which are accessible for persons with disabilities
V54 – Educate the client and caregiver(s), if necessary, about ways to become involved in the community
V94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary

Standard 2: Intervention Plan Development: Skill Statement: Educate the client and caregiver(s) around, if necessary, about ways to be involved in the community emerged when comparing CTRS and non-CTRS, when comparing Degree and Diploma respondents and when comparing Regional Groups.

Standard 7: Professional Development: V94 – Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary differed when comparing CTRS and non-CTRS, and when comparing Degree and Diploma respondents.

Additional research may need to go into examining these specific knowledge and skill statements to determine the need for inclusion within curriculum advancement for Therapeutic Recreation in Canada.

Recommendations for the Therapeutic Recreation Profession in Canada

Therapeutic Recreation in Canada has been described as being in the adolescent stage of professional development, struggling to form its identity, fraught with issues and instability (Singleton et al., 2006). Each Therapeutic Recreation membership

organization is working diligently to achieve professional status (Singleton et al., 2006). The following are recommendations for the Therapeutic Recreation profession in Canada in its journey in achieving the status of full adulthood from the perspective of professional development literature and the findings of this study.

A consistent message that demonstrate that it meets the demand of a social need:

Therapeutic Recreation professionals in Canada should consistently communicate to clients, members of the public and other allied health professions what their mission and role is a profession. Professional organizations would benefit by unifying and ensuring their marketing and promotional messages tie into health and well being actions of the Canadian health care strategies. Healthy Living 2010 (Russoniello & Rogers, 2004; Public Health Agency of Canada, 2005) is an excellent initiative that organizations use to ensure that their health services messages align with Canadian Health Policy. The results of this study illustrate the diversity of knowledge and competencies across Canada. If Therapeutic Recreation wants to be consistent in its standards the profession needs to replicate this study to ensure that the public is receiving consistent standards of practice across Canada.

A systematic and sound body of knowledge:

It is important for Therapeutic Recreation in Canada to identify a systematic and sound body of knowledge. Currently, Therapeutic Recreation has discipline specific textbooks and Therapeutic Recreation journals where current research is disseminated to Therapeutic Recreation practitioners. A number of provincial Therapeutic Recreation associations in Canada make opportunities for continuing education available to their members in the form of conferences and/or workshops. Members attend these sessions in

hopes to gain additional knowledge related to new research and Therapeutic Recreation practice.

The NCTRC, an international credentialing organization, whose Certificants for the most part reside and practice in the United States, has conducted three job analysis studies in 1987, 1997 and 2007 (NCTRC, 2007). These studies have been used to identify the skills and knowledge that Certificants report are required for competent practice. In Ontario, Canada, Hare and Frisby (1989), conducted a job analysis study, which has contributed to the knowledge base of Therapeutic Recreation practitioners specific to Ontario. The findings of this study demonstrates that a gap exists between CTRS's and non-CTRS's, between degree and non-degree, between regions and between those with varying degrees of experience in the profession of Therapeutic Recreation.

Formal and consistent education process:

Therapeutic Recreation in Canada has not established a formal and consistent education process. Therapeutic practitioners are educated differently from province to province. Entry to practice still remains at the diploma level for certain professional organizations in Canada while others are beginning to move to a degree requirement. As well, Therapeutic Recreation in Canada has not determined a standard for curriculum development based on a designated core body of knowledge. Educational opportunities continue to vary across Canada; colleges offer Therapeutic Recreation curriculum at a diploma level, some universities offer a general recreation or leisure studies degree with a few courses specific to Therapeutic Recreation and still other universities offer Therapeutic Recreation undergraduate degrees. CTRA currently lists TR education programs available to students on their website; however they do not indicate the variation within curriculums from community colleges and universities (CTRA, 2012).

This study found that based upon the knowledge and competence being demonstrated by professionals, significant differences exists in respondents with a CTRS credential and those non-CTRS's as well as significant differences exist greatly between respondents with a degree and those with a diploma. Both giving credibility to the notion that minimum competency for education curriculum and are required for Therapeutic Recreation in Canada.

Professional Standards:

Currently, in Canada, three professional standards of practice documents exist within the provinces of Nova Scotia, Newfoundland/Labrador and Ontario, one from the American Therapeutic Recreation Association in United States and one from the Canadian Therapeutic Recreation Association (CTRA). The CTRA Standards of Practice (2006) document aimed to fuse the information in each of these documents with the goal of informing Therapeutic Recreation practice for recreation therapists and their assistants.

This study found that significant differences exist between those respondents with a CTRS credential and those and those without, between those respondents with a degree and those with a diploma, between regional differences and between those with varying years of experience in the field of Therapeutic Recreation. Due to Canada's varying standards of practice documents, professionals in the field may be muddled as to which standards of practice they should follow and may not be aware of the changing needs of Therapeutic Recreation and the recent enhancement in professional standards. Therapeutic Recreation professionals in Canada should use the data from this study to help inform a future version of a Canadian National Standards of Practice Document which is based on practitioner identified competencies and work to ensure that all Canadian organizations adopt one Standards of Practice for Therapeutic Recreation.

Credentialing:

In an effort to protect the public, formal means are established to test the knowledge and skills of individual practitioners. With regards to certification, in 2008, the CTRA announced the endorsement of the NCTRC credential for certification in Canada and the CTRS as the "qualified provider". This standard of competence will assist professional organizations in their next stage of the professional development, licensure. Licensure is granted by government agencies to ensure protection of the public. Governments designate a provincial college to establish examination policies and ensure individual practitioners are competent in their practice. Currently Alberta, Ontario and Nova Scotia are moving forward with licensure applications. Nova Scotia has designated the NCTRC certification standard within their application to demonstrate competence of their individual members. However, Alberta and Ontario have not indicated how their systems to demonstrate the competency of each individual member. Accreditation is the last form of credentialing for professional groups. The goal of accreditation is to evaluate the formal education curriculums that exist for Therapeutic Recreation in Canada. At this time, there are no accredited Therapeutic Recreation curriculums in Canada that meet the Council on Accreditation of Parks, Recreation, Tourism and Related Professions, the Council for Higher Education Accreditation standards or the Commission on the Accreditation of Allied Health programs (CAAHEP) or Committee on Accreditation of Recreational Therapy Education (CARTE).

This study found that differences exist in competency areas for those with a CTRS credential and without, those with a degree and those with a diploma, those within various regions in Canada as well as those with varying years of work experience. Therapeutic Recreation in Canada would benefit from the adopting the CTRS credential

as a minimum set standard for competency nationwide. This would aid professional organizations in the goal toward licensure by ensuring their members have demonstrated and achieved an established base level of knowledge, skill and competence for entry to practice which is consistent throughout Canada.

Therapeutic Recreation in Canada would benefit from the adopting the CTRS credential as a minimum set standard for competency nationwide. This would aid professional organizations in the goal toward licensure by ensuring their members have demonstrated and achieved an established base level of knowledge, skill and competence for entry to practice which is consistent throughout Canada. CTRA, membership in 2009, endorsed CTRS (NCTRS) as a minimum entry to practice. Nursing was confronted with similar issue in 1980 and endorses BSCN as entry to practice by year 2000. TR professionals in Canada may want to consider this for each province based upon educational resources available to assist in this transition.

Lessons learned from the United States

From this study we have learned that differences in competency areas exist between those with a CTRS credential and those non-CTRS's, those with a diploma and those with a degree, with those within various regions in Canada and with those with varying levels of years of experience working in the profession of Therapeutic Recreation. These findings provide support for professional organizations learning from the growth and development from Therapeutic Recreation in the United States.

Similar to Canada, Therapeutic Recreation in the Unites States has struggled in efforts to define its role as a professional occupation. What can professional organizations in Canada as well as other Countries learn from their struggle? In the process of certification, we know from the NCTRC, it is important that your certification

body be independent from a professional membership organization. As a certifying body makes standard changes to ensure protection of the public (Early & National Association for Competency Assurance, 1998).

Another area that Canadian Therapeutic Recreation can learn from the NCTRC is the importance of adopting a competency measure which is based on research that examines the professional practice of its Certificants. To date, NCTRC has undertaken three job analysis studies. In an effort to reflect the changing needs in the industry, they have used the information from their studies to alter their competency examination (NCTRC, 2007). Canada can use the information gathered from this study to support professional organizations in their effort to adopt a system of certification that is based on measuring the changing needs of Therapeutic Recreation based on professional expertise as well supporting membership organizations in their efforts to increase their professional standard to the CTRS designation and support the certification system of the NCTRC.

This study also supported the need for curriculum development and advancement. This study demonstrated that differences in competency areas exist between CTRS's and non CTRS's, between those with a degree and a diploma, between those in varying regions and between those with varying years of experience. Base knowledge for Therapeutic Recreation education needs to be identified and standardized. It is important to have accreditation bodies working to determine whether education programs are providing an appropriate curriculum for future Therapeutic Recreation professionals to demonstrate the base competency to practice in the field. The professions also need to develop education curricula which represent the professional knowledge and skills required to complete in their positions (Carter et al.; Houle, 1980; O'Morrow & Reynolds, 1989; Pavalko, 1971 & 1988; Ritzer, 1971).

Future Research in the area of Therapeutic Recreation related to Competencies

This study was effective in understanding that a relationship exists in identified competency areas between varying Therapeutic Recreation groups in Canada: CTRS's and non-CTRS's, those with a degree and those with a diploma, those in varying regions in Canada and those with varying years of experience in the field of Therapeutic Recreation.

Future Therapeutic Recreation research into competencies can be aided by replicating this study every five years. This would generate a comparison point to determine whether demographics, additional knowledge or skills areas have altered. Additionally, it is also recommended that an ANOVA calculation for non-parametric samples such as the Kruskal-Wallis analysis test be used as a method of data analysis to determine the directional relationship between groups.

Additional demographic information can be collected to gain knowledge regarding the type of degree respondents hold. It would be interesting to investigate specifically whether individuals hold a general recreation degree, a TR specific degree or another degree. This information will add to the knowledge base of TR in Canada and be used to assist in determining if differences exist between those with varying type of degree as well as whether identified competencies are different between these groups.

Also, if this study were replicated, it is recommended that the data be grouped by province of the respondents rather than group respondents regionally. This information would be beneficial to assist in cross comparisons between provincial and regional groups to determine how to identify education needs in each province based upon the respondents. Because this study grouped provinces by regions, the knowledge and skill difference between provinces were not able to be discussed.

Future studies should include demographic variable regarding job title, type of work setting, salary and full time equivalency (FTE) information for professionals in the field. In the past five years, there have been queries by professionals in the field to investigate job titles, TR annual salaries across the country as well how FTE's, caseload and work setting (i.e. youth, mental health, aging) may relate to position descriptions and standards of practice.

This study can also be replicated for Therapeutic Recreation assistants to aid in practice changes for that group based on the results generated.

Pattern of Professional Education for Therapeutic Recreation

A relationship was found between individual's whom had a degree and diploma relative to knowledge and competencies. The following model, Goncalves Professional Education Model for Therapeutic Recreation in Canada (see Figure 4), was developed building upon Houle's conceptual model to develop systems and processes to make each individual practitioner more competent in their practice (Houle, 1980).

Houle (1980) has defined a general pattern of education that emerges for professionals, which occurs along a continuum. It usually begins by a period of "Selection", where individuals make a choice of occupation (Houle, 1980). This study has informed the "Selection" process for Therapeutic Recreation in Canada, as the findings of this study provide information regarding the skills and knowledge important for competent practice. This study provided insights into the future direction for research into competencies by recommending replicating the study every five years to gain knowledge for cross comparisons and growth.

The findings of this study also provided insight as to the current variability of the "General Education" pattern Therapeutic Recreation in Canada and more specifically that

differences exist in identified competency areas between Degree and non Degree individuals, individuals in varying regions, individuals with varying years of experience and CTRS and non CTRS individuals. In future it will be important to further investigate what courses are offered at Universities and Community Colleges in Canada as well as investigating what are job titles that individuals employed TR gain after completing particular patterns of study.

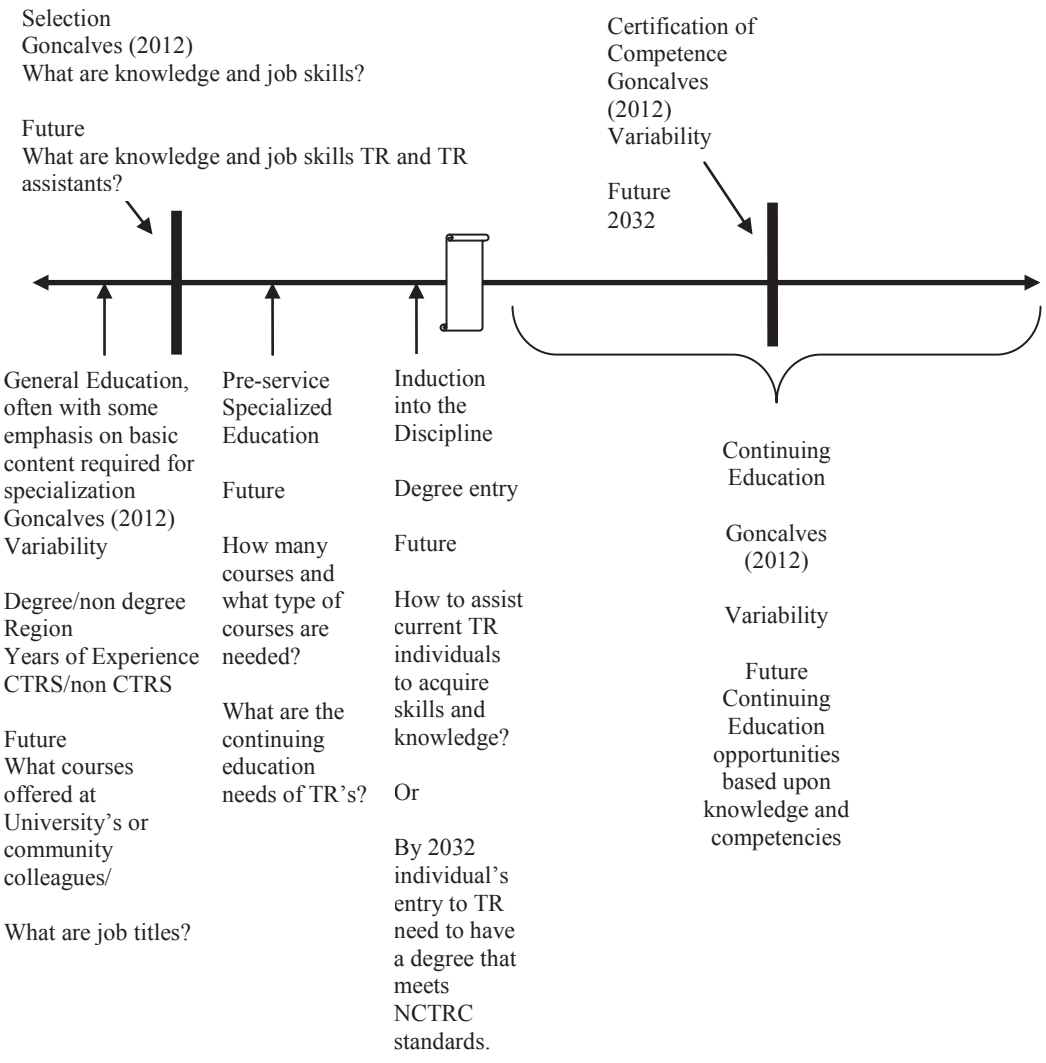

Figure 4 Goncalves Professional Education Model for Therapeutic Recreation in Canada (Adapted from Houle (1980) The Classic Model of Professional Education, p.4.)

According to Houle (1980), individuals begin the "Pre-service Specialized Education" period to gain the knowledge and skills necessary to practice in that particular discipline (Houle, 1980). This study has shed light on the importance of determining some curriculum parameters for Therapeutic Recreation study, such as how many and type of courses are required to be employed in the field of therapeutic recreation. As well, it will be important to determine the continuing education needs for TR professionals in Canada.

Houle postulates that the "Induction into the Discipline" occurs, whereby an individual has demonstrated competence in the profession (Houle, 1980). For Therapeutic Recreation, provincial Therapeutic Recreation associations have identified membership criteria as the entry to practice standard, which individuals must meet to gain acceptance into that membership organization. The insights gained from this study identify that differences exist between those individuals with a degree and those with a non degree. It is recommendation that TR in Canada move to a consistent entry to practice that is at least a degree level not a professional membership category. In future, Therapeutic Recreation in Canada will need to find methods to assist individuals to acquired skills and knowledge to meet entry to practice recommendations. Another possibility is for TR in Canada to make a universal decision, that by 2032 throughout Canada individuals entering the field of Therapeutic Recreation are required to have and degree that meets the NCTRC standards for Certification. This is based upon the Nursing profession professional development. In 1982 all provinces and territories Canada agreed that a Baccalaureate Degree in Nursing would be the entry to practice standard for the profession (Canadian Nurses Association, 2004). The Atlantic Provinces set out to meet this goal by 2000 (Thompson, 2000). To date most provinces and territories have made

this transition (Canadian Nurses Association (2011). This would provide a framework for moving TR entry to practice forward in Canada.

The Houle (1980) model describes a method for Therapeutic Recreation practitioners throughout Canada to demonstrate a consistent entry to practice standard through "Continuing Education". From this study we know that a relationship exists in identified competency areas between those practicing within varying years of experience within Canada and between those with a CTRS and non CTRS designation. We also know that variability exists throughout Canada in terms of the Certification of competence for TR. As only three of the therapeutic recreation provincial associations suggest minimum competency of certification to practice within their standards of practice documents (NLTRA, NSRPH, TRAAC). Ideally for the growth of TR, it would be advantageous for TR in Canada make a decision that by 2032, those individuals entering the field of Therapeutic Recreation are required to have and degree that meets the NCTRC standards for Certification. This decision would provide time for educational curriculums to explore and develop programs to meet the future educational needs for entry to practice throughout Canada.

Continued education is an option for Therapeutic Recreation professionals to achieve additional qualifications for credentialing purposes such as speciality certification through the National Council for Therapeutic Recreation Certification and allow provincial organizations to have its members within that organization demonstrate the competence required to achieve the goal of licensure. At the time of the study, variability best described the continued education opportunities for TR in Canada. However in the future, TR in Canada can develop continuing education opportunities that are based upon the knowledge and skills for competent practice.

As the model illustrates, the variability of education programs provided in Canada could be related to practice. Education opportunities vary across Canada from University to Community College, professionals entering the field in Therapeutic Recreation in the 1970's, 1980's and 1990's were dependent upon the availability of education institutions. In Western Canada primary access to education in TR was through Community College programs while in Eastern Canada both Community College and University were available to entering practitioners. The model illustrates that the variability of professional development and educational opportunities provides the public with differing perceptions of what is the role and function of TR in enhancing the well-being of persons across the lifecourse. The results of this study illustrate the variability of knowledge and competencies being provided by practitioners' educational level, years of experience and whether they are certified or not certified. TR is emerging along the Houle continuum of professional acceptance, similar to what Nursing was confronted with in the 1980's.

Summary

Therapeutic Recreation is an emerging profession. We know that in the United States, TR has achieved young adult status, meaning that the profession has achieved a period of stability, commitment and competence (Carter, Van Andel & Robb, 2003). In Canada, however professional development in Therapeutic Recreation has only achieved the adolescent stage (Singleton, et al., 2006), struggling to form its identity. This is a tremendous period of growth for the profession as well as a period of uncertainty (Carter et al., 2003). Provincial and national TR professional organizations across Canada have worked independently to add to the growth of TR by developing standards of practice, codes of ethics documents, registration systems (Singleton, et al., 2006). It is impossible

to ensure a consistent standard of practice for Therapeutic Recreation services since regulations do not exist that govern Therapeutic Recreation practice in Canada.

We know defined competencies of Therapeutic Recreation practice are the basis for educational curriculums, standards of practice, certification, licensure and accreditation programs (O'Morrow & Reynolds, 1989). This competency study surveying all TR practitioners in Canada has now been conducted. This study examined the skills and knowledge for TR practice in Canada. We asked the practitioners in the field of Therapeutic Recreation what elements are important to competent practice to ensure protection for the public. This study measured the knowledge and skills necessary for TR practice in Canada. The results of this study provides a framework for further developments in Therapeutic Recreation practice such as appropriate formal educational program needs, certification systems and standards of practice for the field of Therapeutic Recreation in Canada.

The findings of this study indicate regional differences, differences between varying years of experience, differences between degree and diploma TR professionals and differences between certified and non-certified TR professionals. The TR field in Canada needs to build upon these findings in relation to developing a consistent educational process, based upon knowledge and competencies current TR professional are providing to clients. This information has the potential to begin a dialogue with Universities and community colleges in regard to what are the knowledge and competencies that degree versus diploma practitioner can provide to clients. The study also provided insights on several Knowledge Areas (see Table 8) Standard 1 "Assessment", Standard 2 "Intervention Plan Development", Standard 3 "Intervention Plan Implementation", Standard 5 "Evaluation", Standard 6 "Interdisciplinary

Collaboration", Standard 8 "Research", Standard 10 "Sensitivity to Diversity" were found to be significantly different between degree and diploma, region, varying years of experience and between certified and non-certified participants.

The findings of this study suggest that the future understanding of the role and function of TR in Canada, should be based upon the knowledge and competencies being demonstrated by practitioners in the field. This information can be used to support curriculum development and enhancement by professional organizations and educational institutions offering TR programs in Canada.

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Appendix A

Questionnaire for Study titled: For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Practice?

I understand that my participation in the study entitled For Therapeutic Recreation Professionals in Canada, What are the Knowledge and Skills Required for Competent Therapeutic Recreation Practice is entirely voluntary and that I may refuse to participate or may withdraw from the study at any time.

I have read the attached letter and have retained a copy for my files. I have been given the opportunity to discus it and my questions have been answered to my satisfaction. I understand that by completing the questionnaire, informed consent is assumed.

If you have any questions, do not hesitate to contact Tanea Goncalves at 506-440-8275 or e-mail Tanea.Goncalves@dal.ca or my Academic Supervisor: Dr. Jerome Singleton at (902) 494-1166 or e-mail Jerome@dal.ca

- ○ Click here if you consent to participate in the study.

SURVEY INTRODUCTION

Welcome to the survey for the study entitled "For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge required for Competent Practice"

ABOUT THE SURVEY
The survey is simple to complete. Questions just take moments to answer. The survey will take approximately 30 – 60 minutes to complete.

The survey consists of the following sections:
Section 1: Demographic Information
Section 2: Knowledge and Skill Areas
Section 3: Knowledge and Skill Expansion

PROGRESS BAR
A progress bar is located at the bottom of each page to aid in your completion of the survey.

HOW TO SAVE YOUR WORK AND SUBMIT YOUR COMPLETED SURVEY
At the end of each page click the "Next Page" button, your answers will be saved and you will be progress to the next set of questions. After the last question of the survey, you will be asked to click a button marked "Submit Survey".

HOW TO EXIT AN INCOMPLETE SURVEY
If you cannot finish the entire survey at one sitting, exit using the "Save" button, this will ensure that your work is saved. You will be prompted to provide an e-mail address where a link will be forwarded for you to re-enter survey. When you are prepared to return to the survey, go to the e-mail message and click in the survey link. The survey will continue from where you left off.

TECHNICAL ASSISTANCE
If you encounter difficulties with completing the survey or have any questions regarding the survey content, you may contact us. Email: Tanea.Goncalves@dal.ca or (506) 440-8275. Please leave a voice mail message.

Questionnaire for Study titled: For Therapeutic Recreation Professionals, What are the Skills and Knowledge Required for Competent Practice?

Section 1: Demographic Information

1. Please indicate whether you are:
   - O Male
   - O Female

2. Please indicate your ethic and racial background:
   - O Chinese
   - O South Asian
   - O Black
   - O Filipino
   - O Latin American
   - O Southeast Asian
   - O Arab
   - O West Asian
   - O Korean
   - O Japanese
   - O First Nations/Innu/Metis
   - O Multi-racial/Multi-ethnic
   - O Caucasian

3. How many years have you been practicing as a Therapeutic Recreation professional?
   - O Less than 1 year
   - O 1-3 years
   - O 4-6 years
   - O 7-9 years
   - O 10-14 years
   - O 15-19 years
   - O 20 or more years

4. What is your highest level of education completed?
   - O Certificate
   - O Diploma
   - O Baccalaureate Degree
   - O Masters Degree
   - O Ph.D
   - O Other

5. Do you currently hold the Certified Therapeutic Recreation Specialist designation as granted by the National Certification for Therapeutic Recreation Certification?
   - O Yes
   - O No

6. What is your age? _____

7. What is your current role?

- ○ Recreation Therapist
- ○ Recreation Therapist/Supervisor
- ○ Recreation Therapist/Administrator
- ○ Recreation Leader/Programmer
- ○ Administrator
- ○ Educator
- ○ Not currently employed in TR

8. What is your primary service setting?

- ○ Hospital
- ○ Long Term Care Centre
- ○ Residential/transitional
- ○ Parks/recreation organization
- ○ Outpatient/Day treatment
- ○ Health Centre
- ○ Educational Institution
- ○ Day support centre
- ○ Private Practice
- ○ Correctional institution
- ○ Professional Organization
- ○ Other

9. What is the primary level of care you serve?

- ○ Long-term care
- ○ Rehabilitation care
- ○ Acute Care
- ○ Community
- ○ Home Health Care
- ○ Combination of settings
- ○ Other

10. What is the primary population you serve?

- ○ Mental Health
- ○ Geriatric
- ○ Physical disabilities
- ○ Developmental disabilities
- ○ Chronic Illness
- ○ Other

11. What is the primary age group you serve?

- ○ Adults/Older Adults
- ○ Adults
- ○ Older Adults
- ○ Adolescents
- ○ Paediatrics/Adolescents
- ○ Paediatrics
- ○ All age groups
- ○ Other

12. What is your current caseload

- O one to ten
- O eleven to twenty
- O twenty-one to forty
- O forty-one to sixty
- O sixty-one to one hundred
- O over one hundred

13. What region do you work in?

- O Western (includes BC, AB and NWT)
- O Prairie (includes SK, MB and YK)
- O Central (includes ON, PQ and NU)
- O Atlantic (includes NB, NS, PEI and NF/L)

Section 2: Knowledge and Skill Areas

Area of Practice in Therapeutic Recreation 1: Assessment

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Leisure theories, models, and principles to address issues such as the client's functional ability, leisure awareness and leisure interests	O	O	O	O	O
2. Assessment processes, procedures and instruments specific to individual clients	O	O	O	O	O
3. Assessment techniques which may include observation, interview, or other means	O	O	O	O	O
4. The clients medical condition, social history, legal status and ethnic values	O	O	O	O	O

Area of Practice in Therapeutic Recreation 1: Assessment

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Select and implement assessment instruments based on the individual client and in accordance with organizational policies	O	O	O	O	O
2. Inform the client and/or caregiver(s) of the assessment process and procedure when suitable	O	O	O	O	O
3. Determine the client's physical, social, cognitive, emotional, spiritual and cultural needs and/or values	O	O	O	O	O
4. Gather information from caregiver(s) or significant others as required	O	O	O	O	O
5. Educate the clients and/or caregiver(s) about recreation therapy services that are offered and the funding available for these services	O	O	O	O	O
6. Communicate assessment results to the client, caregiver(s), recreation therapy assistant and health care team members	O	O	O	O	O
7. Coordinate and update intervention or service waiting lists with other service providers for timely access	O	O	O	O	O
8. Schedule re-assessments when necessary	O	O	O	O	O

Area of Practice in Therapeutic Recreation 2: Intervention Plan Development

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Recreation therapy models and organizational procedures as they relate to creating an intervention plan	O	O	O	O	O
2. The effects of the client's medical condition, social history and ethnic values and how this will impact his or her participation	O	O	O	O	O
3. The client's needs based on analysis and interpretation of the assessment results with input from the client and his or her caregiver(s)	O	O	O	O	O
4. The leisure experiences that would best facilitate achievement of the client's goals and objectives	O	O	O	O	O
5. Adaptations and/or interventions that can be used to enable, minimize or mitigate constraints	O	O	O	O	O
6. Social attitudes (ex. stereotypes) which exist	O	O	O	O	O
7. Principles of behavior and how they relate to individual clients	O	O	O	O	O
8. A client's right to inclusion within the community and how to incorporate inclusive practices	O	O	O	O	O
9. The principles of accessibility	O	O	O	O	O
10. The mission and operations of all facilities in the community which are accessible for persons with disabilities	O	O	O	O	O
11. Advocacy techniques and methods to build community capacity for clients	O	O	O	O	O
12. How various service interest groups and legislation acts (ex. For individuals with disabilities or seniors) can offer support to a client	O	O	O	O	O

Area of Practice in Therapeutic Recreation 2: Intervention Plan Development

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Apply recreation therapy models in the development of the intervention plan	O	O	O	O	O
2. Develop specific program protocols and procedures which are specific to the needs of the client	O	O	O	O	O
3. Apply information from the assessment to synthesize short-term and long-term goals and objectives that are measurable and achievable	O	O	O	O	O
4. Communicate the intervention plan to the client, caregiver(s), recreation therapy assistant and healthcare team when necessary	O	O	O	O	O
5. Review and modify interventions or services to ensure that client goals and objectives are met	O	O	O	O	O
6. Create discharge plans and provide follow-up services when necessary	O	O	O	O	O
7. Perform task analysis	O	O	O	O	O
8. Develop partnerships with a variety of service providers in the community	O	O	O	O	O
9. Determine inclusive community leisure opportunities	O	O	O	O	O
10. Educate the client and the caregiver(s), if necessary, about ways to become involved in the community	O	O	O	O	O

Area of Practice in Therapeutic Recreation 3: Intervention Plan Implementation

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. The effects of a client's medical condition, social history and ethnic values and how this will impact his or her participation	O	O	O	O	O
2. How to implement interventions that will meet the needs of a client considering his or her strengths and abilities	O	O	O	O	O
3. How to supervise and manage leisure programs within clients capabilities, resources, agencies and/or community resources	O	O	O	O	O
4. Facilitation techniques	O	O	O	O	O

Area of Practice in Therapeutic Recreation 3: Intervention Plan Implementation

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Develop and utilize a variety of intervention protocols to facilitate desired change in clients	O	O	O	O	O
2. Direct client interventions relating to leisure education, functional intervention and/or recreation participation and/or supervise recreation therapy assistants and volunteers as they direct client interventions relating to recreation participation	O	O	O	O	O
3. Coordinate facilities, funding, and intervention logistics	O	O	O	O	O
4. Encourage clients, caregiver(s) and significant others to participate	O	O	O	O	O
5. Review the progress of the client and in collaboration with the client and/ or caregiver(s) modify goals and objectives when necessary	O	O	O	O	O
6. Facilitate participation in community facilities that are accessible for persons with disabilities	O	O	O	O	O

Area of Practice in Therapeutic Recreation 4: Documentation

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Methods of documentation used by the organization	O	O	O	O	O
2. Organization documentation policies and procedures	O	O	O	O	O
3. Accountability that results from completing documentation	O	O	O	O	O

Area of Practice in Therapeutic Recreation 4: Documentation

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Complete documentation in accordance with the organization's standards in an accurate and professional manner, using agency specific terminology	O	O	O	O	O
2. Complete a summary of recreation therapy services provided for each client and when appropriate a discharge summary	O	O	O	O	O
3. Include the frequency, duration, intervention, facilitation, and nature of client participation in the document	O	O	O	O	O
4. Periodically review and update documents in accordance with the organization's standards	O	O	O	O	O
5. Document fund allocation and expense records	O	O	O	O	O
6. Complete workload measurement in accordance with the organization's standards	O	O	O	O	O

Area of Practice in Therapeutic Recreation 5: Evaluation

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Objective outcome measurement instruments and methods	O	O	O	O	O
2. Formal evaluation techniques and procedures in accordance with the organization's policies	O	O	O	O	O

Area of Practice in Therapeutic Recreation 5: Evaluation

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Interpret and analyze a client's level of engagement and whether the intervention goals and objectives are achieved based on outcome oriented measures	O	O	O	O	O
2. Determine whether to maintain, amend or discontinue intervention goals and objectives based on the evaluation results	O	O	O	O	O
3. Formalize the input from a client, caregiver and significant others in the evaluation process and/or in preparation for the transition or end of services and communicate these findings to relevant other professionals	O	O	O	O	O
4. Prepare the client and caregiver(s) for transition, end of service or follow-up	O	O	O	O	O

Area of Practice in Therapeutic Recreation 6: Interdisciplinary Collaboration

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery	○	○	○	○	○
2. Importance of other professionals and their unique contributions to a client's medical, social, psychological, emotional, physical and spiritual needs, etc	○	○	○	○	○

Area of Practice in Therapeutic Recreation 6: Interdisciplinary Collaboration

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Communicate in such a way to avoid presenting inaccurate or misleading information	○	○	○	○	○
2. Address conflict in a professional and respectful manner in order to promote positive working relations	○	○	○	○	○
3. Collaborate with other professions when appropriate, including assessments, creating individual intervention plans, implementing program plans, creating documentation, and writing evaluations	○	○	○	○	○
4. Promote the importance of recreation therapy to other disciplines	○	○	○	○	○
5. Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client	○	○	○	○	○
6. Refer clients to other disciplines if necessary	○	○	○	○	○

Area of Practice in Therapeutic Recreation 7: Professional Development

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. The recreation therapy standards of practice and related agency practices and theories	O	O	O	O	O
2. Recreation therapy organizations which exist locally, provincially, nationally and internationally	O	O	O	O	O

Area of Practice in Therapeutic Recreation 7: Professional Development

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Follow guidelines addressed in the recreation therapy standards of practice	O	O	O	O	O
2. Conduct self-assessment and/or performance appraisals to identify and improve knowledge, skills and abilities necessary to perform job responsibilities	O	O	O	O	O
3. Plan and participate in in-service training and staff development sessions	O	O	O	O	O
4. Seek out and pursue educational opportunities	O	O	O	O	O
5. Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary	O	O	O	O	O
6. Share new knowledge and skills with colleagues, students and volunteers	O	O	O	O	O
7. Supervise and support future therapists (students)	O	O	O	O	O

Area of Practice in Therapeutic Recreation 8: Research

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Methods to access applicable research relevant to recreation therapy	O	O	O	O	O
2. Outcome oriented and evidence based research practices	O	O	O	O	O
3. Research methods and protocols used by the organization, the scientific community and/or the government	O	O	O	O	O
4. Ethical guidelines for involving human subjects	O	O	O	O	O
5. Relevant research agencies that may be accessed for support and assistance	O	O	O	O	O

Area of Practice in Therapeutic Recreation 8: Research

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Retrieve and critically analyze the content of academic based research through literature reviews	O	O	O	O	O
2. Apply evidence based research to professional practice	O	O	O	O	O
3. Support, assist or participate in research related to recreation therapy	O	O	O	O	O
4. Access required resources through funding proposals, when engaging in a research study	O	O	O	O	O
5. Develop relationships with relevant research agencies	O	O	O	O	O
6. Follow requirements stated in the ethical guidelines for involving human subjects (ex. by obtaining the approval and consent of research participant(s), ensuring his/her confidentiality and respecting his/her right to withdraw from the study)	O	O	O	O	O
7. Evaluate, analyze and interpret research results before announcing the findings to the public	O	O	O	O	O

Area of Practice in Therapeutic Recreation 9: Ethics

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. The CTRA code of ethics as well as the organization's policies regarding ethical conduct	○	○	○	○	○

Area of Practice in Therapeutic Recreation 9: Ethics

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Comply with the CTRA ethical codes of conduct	○	○	○	○	○
2. Ensure that a client's confidentiality, dignity, and autonomy are respected and upheld	○	○	○	○	○
3. Report unethical incidences to the appropriate personnel within the organization	○	○	○	○	○

Area of Practice in Therapeutic Recreation 10: Sensitivity to Diversity

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Principles of equity, fairness and social justice	O	O	O	O	O
2. What diversity means and how to access resources which will enhance appreciation of the concept	O	O	O	O	O
3. His/her own personal biases and how to turn these biases into understanding	O	O	O	O	O
4. The Canadian Charter of Rights and Freedoms	O	O	O	O	O
5. The Universal Declaration of Human Rights	O	O	O	O	O

Area of Practice in Therapeutic Recreation 10: Sensitivity to Diversity

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Value and respect each client for his/her inherent worth	O	O	O	O	O
2. Alter verbal and non-verbal communication depending on the client	O	O	O	O	O
3. Advocate for equal treatment of all clients	O	O	O	O	O
4. Be sensitive to a client's values and how they affect his/her decision making	O	O	O	O	O
5. Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship	O	O	O	O	O
6. Recognize calendar events which are relevant to specific cultures	O	O	O	O	O
7. Maintain an environment which is sensitive to diversity	O	O	O	O	O

Area of Practice in Therapeutic Recreation 11: Risk Management

How important is competence in the following KNOWLEDGE AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must have a thorough understanding of:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. The potential risks that exist within the organization and the client's community and how to prevent them from causing harm	O	O	O	O	O
2. The potential risks of various leisure experiences	O	O	O	O	O
3. The organization's policies, practices, and procedures in regards to risk management incidences	O	O	O	O	O
4. Emergency procedures for environmental, situational, or behavioral crisis	O	O	O	O	O
5. Infection control, hazards, fire safety and prevention	O	O	O	O	O
6. Pertinent national, provincial or territorial laws related to health and safety	O	O	O	O	O

Area of Practice in Therapeutic Recreation 11: Risk Management

How important is competence in the following SKILL AREAS for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?

A recreation therapist must be able to:	Of no importance	Of little importance	Of moderate importance	Important	Very Important
1. Review and update policies that relate to risk prevention procedures annually	O	O	O	O	O
2. Develop a risk management plan which identifies likelihood and severity of risk, assesses the environment and plans a course of action	O	O	O	O	O
3. Communicate potential risks to clients and recreation therapy assistants	O	O	O	O	O
4. Ensure that recreation areas are clean, safe, and properly maintained in keeping with health, fire, and safety codes	O	O	O	O	O
5. Respond to emergency situations while maintaining composure	O	O	O	O	O
6. Document any risk management issues or incidents in accordance with organizational policy	O	O	O	O	O
7. Perform cardiopulmonary resuscitation (CPR) and first aid procedures in the event that medical staff are inaccessible	O	O	O	O	O
8. Apply do not resuscitate codes (DNRs) depending on the client and/or caregiver's wishes	O	O	O	O	O

Section 3: **Knowledge and Skill Expansion:**

1. Please provide any additional KNOWLEDGE AND SKILL AREAS that may be relevant for competent Therapeutic Recreation practice?

   And please rate these KNOWLEDGE AND SKILL AREAS on this five-point scale:

Additional suggested KNOWLEDGE AREAS	of no importance	of little importance	moderately important	important	very important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
Additional suggested SKILL AREAS	of no importance	of little importance	moderately important	important	very important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

2. What do you see as being important KNOWLEDGE AND SKILL AREAS for competent Therapeutic Recreation practice in the next five years?

   And please rate those future KNOWLEDGE AND SKILL AREAS on this five-point scale:

Future KNOWLEDGE AREAS	of no importance	of little importance	moderately important	important	very important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
Future SKILL AREAS	of no importance	of little importance	moderately important	important	very important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

Thank you very much for completing this survey!

Appendix B

French Translation of Questionnaire for Study titled: For Therapeutic Recreation Professionals, What are the Skills and Knowledge Required for Competent Practice?

Je comprends que ma participation dans l'étude qui s'intitule : « Quelles sont les aptitudes et les connaissances requises pour une pratique compétente en loisir thérapeutique au Canada? » est entièrement volontaire et que je peux refuser d'y participer ou me désister à tout moment.

J'ai lu et je comprends la lettre ci-incluse. J'en ai gardé une copie pour mes dossiers. J'ai eu l'occasion de discuter de l'étude et je suis satisfait(e) des explications que j'ai reçues. Je comprends également qu'en complétant le questionnaire, mon consentement est sous-entendu.

Si vous avez des questions, n'hésitez pas à me contacter au (506) 440-8275 ou par courriel : Tanea.Goncalves@dal.ca. Vous pouvez également rejoindre Dr. Jerome Singleton (superviseur académique) au (902) 494-1166 ou à Jerome@dal.ca

- ○ Cliquer ici si vous consentez à participer à l'étude.

INTRODUCTION A LE SONDAGE

Bienvenue au questionnaire relatif à l'étude qui s'intitule: "Quelles sont les aptitudes et les connaissances requises pour une pratique compétente en loisir thérapeutique au Canada?"

S'il vous plaît, assurez-vous d'avoir bien lu les instructions sur cette page avant de débuter le sondage. En guise de référence, il vous serait peut-être utile de faire imprimer cette page.

LE SONDAGE :
Le sondage est très facile à remplir : plusieurs questions ne prennent que quelques secondes à répondre. Le sondage ne durera pas plus que 60 minutes.

Le sondage comporte les sections suivantes:
Section 1: Historique et informations générales
Section 2: Connaissances/aptitudes areas = Domaines d'aptitudes et de connaissances
Section 3: Knowledge and Skill Expansion = Connaissances et développement de compétences

BARRE DE PROGRÈS :
Une barre de progrès se trouvera en bas de chaque page, ce qui vous donnera une indication visuelle du pourcentage du sondage qu'il vous restera à compléter.

COMMENT SAUVEGARDER ET SOUMETTRE UN SONDAGE COMPLÉTÉ :
Chaque fois que vous cliquez sur le bouton «Page suivante», vos réponses seront enregistrées et vous serez transféré aux items suivants. Une fois le sondage complété, cliquez sur le bouton «Soumettre le sondage».

COMMENT QUITTER UN SONDAGE INCOMPLET
Si vous n'êtes pas en mesure de compléter le sondage au cours d'une seule séance, quitter la page web en cliquant sur le bouton « enregistrer », ce qui assurera l'enregistrement de votre progrès. Vous serez alors invité à procurer une adresse courriel. Une fois l'adresse courriel soumise, un lien qui vous permettra de retrouver votre sondage incomplet vous sera envoyé. Lorsque vous voudrez poursuivre la complétion du sondage, ouvrez le message courriel et cliquer sur le lien indiqué. Le sondage reprendra là où vous l'aurez arrêté.

AIDE TECHNIQUE

Si vous avez des difficultés à compléter le sondage ou pour toute question relative au contenu du sondage, veuillez prendre contact avec nous. Par courriel : tanea.goncalves@dal.ca ou par téléphone au (780) 719-4781. (S'il-vous-plaît, laisser un message vocal.)

Questionnaire pour l'étude: Quelles sont les aptitudes et les connaissances requises pour une pratique compétente en loisir thérapeutique au Canada?

Section 1: INFORMATION DÉMOGRAPHIQUE

1. De quel sexe êtes-vous?

   O Homme
   O Femme

2. SVP décrivez votre ethnicité et vos origines:

   O Asiatique
   O Asie du Sud
   O Canadien-Africain
   O Philippin
   O Hispanique
   O Au Sud-est Asiatique
   O Arabe
   O Asie de l'Ouest
   O Coréen
   O Japonais
   O Premières Nations /Innu/Métis
   O Multiethnique
   O Caucasien

3. Depuis combien de temps travaillez-vous en loisir thérapeutique?

   O Moins d'un an
   O 1à 3 ans
   O 4 à 6 ans
   O 7 à 9 ans
   O 10 à 14 ans
   O 15 à 19 ans
   O Plus de 20 ans

4. Quel est le plus haut niveau de scolarité que vous détenez?

   O Certificat
   O Diplôme
   O Baccalauréat
   O Maîtrise
   O Doctorat
   O Autre

5. Etes-vous présentement détenteur de la certification émise par la *National Council for Therapeutic Recreation Certification* vous désignant Spécialiste Certifié en Loisir Thérapeutique?

   O Oui
   O Non

6. Quel âge avez-vous?

   _____

7. Quel est votre rôle actuel?

- O Thérapeute en Loisir
- O Thérapeute en Loisir/Superviseur
- O Thérapeute en Loisir/Administrateur
- O Leader/Programmeur en Loisir
- O Administrateur
- O Éducateur
- O Je ne travaille pas en loisir thérapeutique

8. Quel est votre milieu de travail principal?

- O Centre Hospitalier
- O Centre Centre de soins de longue durée
- O Soins à domicile ou de transition
- O Administration des parcs et loisirs
- O Soins externes / centre de traitement de jour
- O Académique
- O Centre de santé
- O Établissement académique
- O Centre de jour
- O Clinique privée
- O Établissement correctionnel
- O Organisme professionnel
- O Autre

9. Quel est le niveau primaire des soin de vous servir?

- O Longue Durée
- O Réadaptation
- O Soins Aigus
- O Communauté
- O Soins à Domicile
- O Une combinaison de secteurs
- O Autre

10. Quelle est la population principale vous servir?

- O Santé Mentale
- O Gériatrie
- O Handicaps Physiques
- O Troubles du Développement
- O Maladie Chronique
- O Autre

11. Quelle est le principal group d`âge vous servir?

- O Adultes/personnes âgées
- O Adultes
- O Personnes âgées
- O Adolescents
- O Pédiatrie/Adolescents
- O Pédiatrie
- O Tous les groupes d'âge
- O Autre

12. Quel est votre charge de dossier actuelle?

- O 1-10
- O 11-20
- O 21-40
- O 41-60
- O 60-100
- O Plus de 100

13. Dans quelle région travaillez-vous?

- O La région de l'ouest (inclut la Colombie-Britannique, l'Alberta et les territories du Nord-Ouest)
- O La région des Prairies (inclut la Saskatchewan, le Manitoba le territoire du Yukon)
- O La région centrale (inclut l'Ontario, le Québec et le Nunavut)
- O La région Atlantique (inclut le Nouveau-Brunswick, la Nouvelle-Écosse, L'Île du Prince Édouard, Terre-Neuve et le Labrador)

Section 2: Domaines d'aptitudes et de conaissances

Champ de pratique en loisir thérapeutique 1: Évaluation initiale

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Théories, modèles et principes en matière de loisirs permettant d'aborder des questions telles que les capacités fonctionnelles du client, la sensibilisation aux loisirs et les intérêts dans le domaine des loisirs.	○	○	○	○	○
2. Processus, procédures et outils d'évaluation spécifiques à chaque client	○	○	○	○	○
3. Techniques d'évaluation initiale incluant l'observation, l'entrevue et d'autres moyens	○	○	○	○	○
4. État de santé, antécédents sociaux, statut juridique et valeurs ethniques du client	○	○	○	○	○

Champ de pratique en loisir thérapeutique 1: Évaluation initiale

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Sélectionner les outils d'évaluation initiale et les mettre en oeuvre selon les besoins de chaque client et conformément aux politiques de l'organisme	O	O	O	O	O
2. Informer, au besoin, le client ou le soignant du processus et des procedures d'évaluation initiale	O	O	O	O	O
3. Déterminer les besoins et les valeurs d'ordre physique, social, cognitif, 4. émotionnel, spirituel et culturel du client	O	O	O	O	O
5. Recueillir des renseignements auprès des soignants et d'autres intervenants selon les besoins	O	O	O	O	O
6. Informer le client et les soignants sur les services récréothérapeutiques offerts et sur les subventions disponibles	O	O	O	O	O
7. Communiquer les résultats de l'évaluation initiale au client, aux soignants, à l'assistant en récréothérapie et aux membres de l'équipe de soins de santé	O	O	O	O	O
8. Coordonner et mettre à jour les listes d'attente conjointement avec les autres fournisseurs pour garantir un accès à temps aux services	O	O	O	O	O
9. Prévoir, au besoin, des réévaluations initiales des clients	O	O	O	O	O

Champ de pratique en loisir thérapeutique 2: Élaboration d'un plan d'intervention

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Modèles récréothérapeutiques et procédures organisationnelles en ce qui a trait à la création d'un plan d'intervention	O	O	O	O	O
2. Incidence de l'état de santé, des antécédents sociaux et des valeurs ethniques du client sur sa participation	O	O	O	O	O
3. Besoins du client d'après l'analyse et l'interprétation des résultats de l'évaluation initiale et l'apport du client et des soignants	O	O	O	O	O
4. Expériences de loisirs qui faciliteraient le plus la réalisation des buts et des objectifs du client	O	O	O	O	O
5. Adaptations et interventions pouvant servir à minimiser ou à atténuer les contraintes	O	O	O	O	O
6. Attitudes sociales (p. ex. stéréotypes)	O	O	O	O	O
7. Principes de comportement et leur relation avec la situation de chaque client	O	O	O	O	O
8. Droit du client de s'intégrer au sein de la collectivité et méthodes de mise en oeuvre de pratiques d'intégration	O	O	O	O	O
9. Principes d'accessibilité	O	O	O	O	O
10. Mission et utilisation de toutes les installations au sein de la collectivité qui sont accessibles aux personnes handicapées	O	O	O	O	O
11. Techniques et méthodes de défense des intérêts des clients afin de renforcer leur capacité au sein de la communauté	O	O	O	O	O
12. Manière dont les différents groupes d'intérêts et les règlements (p. ex., concernant les personnes handicapées et les aînés) peuvent fournir un appui aux clients	O	O	O	O	O

Champ de pratique en loisir thérapeutique 2: Élaboration d'un plan d'intervention

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Appliquer les modèles récréothérapeutiques à l'élaboration du plan d'intervention.	O	O	O	O	O
2. Élaborer des protocoles et des procédures de programmes particuliers destinés adaptés aux besoins des clients.	O	O	O	O	O
3. Appliquer l'information provenant de l'évaluation initiale de manière à dégager des buts et des objectifs à court et à long terme qui sont mesurables et réalisables.	O	O	O	O	O
4. Communiquer les détails du plan d'intervention au client, aux soignants, à l'assistant en récréothérapie et à l'équipe des soins de santé, au besoin.	O	O	O	O	O
5. Revoir et modifier les interventions ou les services pour s'assurer que les buts et les objectifs sont atteints.	O	O	O	O	O
6. Planifier les autorisations de sortie et fournir les services de suivi au besoin.	O	O	O	O	O
7. Effectuer une analyse des tâches	O	O	O	O	O
8. Développer des partenariats avec divers fournisseurs de services au sein de la collectivité.	O	O	O	O	O
9. Déterminer les occasions en matière de loisirs participatifs au sein de la collectivité.	O	O	O	O	O
10. Informer le client et les soignants, si nécessaire, des moyens de participation à la communauté.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 3: Mise en oeuvre d'un plan d'intervention

H Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Incidence de l'état de santé, des antécédents sociaux et des valeurs ethniques du client sur sa participation.	O	O	O	O	O
2. Méthode de mise en oeuvre des interventions visant à répondre aux besoins du client compte tenu de ses forces et de ses capacités.	O	O	O	O	O
3. Méthode de supervision et de gestion des programmes de loisirs, compte tenu des capacités des clients et des ressources des organismes et de la collectivité.	O	O	O	O	O
4. Techniques de facilitation.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 3: Mise en oeuvre d'un plan d'intervention

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Élaborer et utiliser divers protocoles d'intervention pour favoriser le changement désiré chez les clients.	○	○	○	○	○
2. Orienter les initiatives liées à l'éducation en matière de loisirs, à l'intervention fonctionnelle et à la participation aux activités récréatives et superviser les assistants en récréothérapie et les bénévoles dans leurs interventions auprès des clients en ce qui a trait à la participation aux activités récréatives.	○	○	○	○	○
3. Coordonner la logistique des installations, du financement et des interventions.	○	○	○	○	○
4. Encourager les clients, les soignants et les personnes clés à participer.	○	○	○	○	○
5. Passer en revue les progrès du client et, en collaboration avec ce dernier et les soignants, modifier au besoin les buts et les objectifs.	○	○	○	○	○
6. Faciliter l'utilisation des installations de la collectivité qui sont accessibles aux personnes handicapées.	○	○	○	○	○

Champ de pratique en loisir thérapeutique 4: Documentation

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Méthodes de documentation utilisées par l'organisation.	○	○	○	○	○
2. Politiques et procédures de documentation de l'organisation.	○	○	○	○	○
3. Responsabilité qu'implique le fait de remplir des documents.	○	○	○	○	○

Area of Practice in Therapeutic Recreation 4: Documentation

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Remplir les documents conformément aux normes de l'organisation de façon précise et professionnelle, en utilisant la terminologie propre à l'organisme.	○	○	○	○	○
2. Rédiger un sommaire des services de récréothérapie fournis à chaque client et, au besoin, un sommaire d'autorisation de sortie.	○	○	○	○	○
3. Indiquer dans le document la fréquence, la durée et la description de l'intervention, ainsi que l'activité de facilitation et la nature de la participation du client.	○	○	○	○	○
4. Examiner et mettre à jour périodiquement les documents conformément aux normes de l'organisation.	○	○	○	○	○
5. Documenter les attributions de fonds et les dépenses.	○	○	○	○	○
6. Mesurer la charge de travail conformément aux normes de l'organisation.	○	○	○	○	○

Champ de pratique en loisir thérapeutique 5: Évaluation

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Instruments et méthodes de mesure objective des résultats.	○	○	○	○	○
2. Techniques et procédures d'évaluation officielle conformément aux politiques de l'organisation.	○	○	○	○	○

Champ de pratique en loisir thérapeutique 5: Évaluation

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Interpréter et analyser le niveau de participation du client et déterminer si les buts et les objectifs d'intervention sont atteints d'après les mesures orientées sur le résultat.	○	○	○	○	○
2. Déterminer s'il faut conserver, modifier ou supprimer les buts et les objectifs compte tenu des résultats de l'évaluation.	○	○	○	○	○
3. Adopter formellement l'apport du client, des soignants et des autres personnes clés au processus d'évaluation ou à la préparation de la transition ou de la cessation des services et communiquer les conclusions aux professionnels pertinents.	○	○	○	○	○
4. Préparer le client et les soignants à la transition, à la cessation des services ou au suivi.	○	○	○	○	○

Champ de pratique en loisir thérapeutique 6: Collaboration interdisciplinaire

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Rôles du récréothérapeute et de l'assistant en récréothérapie en tant que membres d'une équipe interdisciplinaire.	○	○	○	○	○
2. Importance des autres professionnels et de leur contribution en ce qui a trait aux besoins médicaux, sociaux, psychologiques, émotionnels, physiques et spirituels du client.	○	○	○	○	○

Champ de pratique en loisir thérapeutique 6: Collaboration interdisciplinaire

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Communiquer de façon à éviter de présenter des renseignements imprécis ou trompeurs.	○	○	○	○	○
2. Aborder les conflits avec professionnalisme et respect afin de promouvoir des relations de travail positives.	○	○	○	○	○
3. Collaborer avec d'autres professions quand cela est approprié, aux évaluations, à la création de plans d'intervention individualisés, à la mise en oeuvre de plans de programmes, à la production de documents et à la rédaction des évaluations.	○	○	○	○	○
4. Promouvoir l'importance de la récréothérapie auprès des autres disciplines.	○	○	○	○	○
5. Traiter avec respect les idées et les capacités provenant de chaque discipline professionnelle, membre du personnel ou bénévole prodiguant des soins au client	○	○	○	○	○
6. Orienter les clients vers d'autres disciplines, au besoin.	○	○	○	○	○

Champ de pratique en loisir thérapeutique 7: Perfectionnement professionnel

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Normes de pratique en récréothérapie et pratiques et théories des organismes connexes.	O	O	O	O	O
2. Organisations oeuvrant dans le domaine de la récréothérapie à l'échelle locale, provinciale, nationale et internationale.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 7: Perfectionnement professionnel

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Suivre les lignes directrices établies conformément aux normes de pratique en récréothérapie.	O	O	O	O	O
2. Procéder à des autoévaluations et à des évaluations du rendement afin de déterminer et d'améliorer les connaissances, les aptitudes et les habiletés nécessaires à l'accomplissement des responsabilités inhérentes au poste.	O	O	O	O	O
3. Planifier la formation interne et les séances de perfectionnement du personnel et y participer.	O	O	O	O	O
4. Repérer et poursuivre des possibilités en matière de formation.	O	O	O	O	O
5. Obtenir et renouveler les accréditations requises par les associations professionnelles nationales ou provinciales et les organismes d'emploi.	O	O	O	O	O
6. Partager les nouvelles connaissances et aptitudes avec les collègues, les étudiants et les bénévoles.	O	O	O	O	O
7. Superviser et appuyer les futurs thérapeutes (étudiants).	O	O	O	O	O

Champ de pratique en loisir thérapeutique 8: Recherche

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Méthodes d'accès aux recherches pertinentes dans le domaine de la récréothérapie.	O	O	O	O	O
2. Pratiques de recherche orientées sur les résultats et fondées sur l'expérience clinique.	O	O	O	O	O
3. Méthodes et protocoles de recherche utilisés par l'organisation, le milieu scientifique et le gouvernement.	O	O	O	O	O
4. Lignes directrices éthiques pour la recherche relative à des sujets humains.	O	O	O	O	O
5. Organismes de recherches pertinents pouvant fournir soutien et assistance.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 8: Recherche

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Repérer et analyser de façon critique les travaux de recherches académiques par un examen ciblé.	O	O	O	O	O
2. Appliquer les recherches fondées sur l'expérience clinique à la pratique de la profession.	O	O	O	O	O
3. Participer à des initiatives de recherche en récréothérapie et fournir soutien et assistance dans ce domaine.	O	O	O	O	O
4. Accéder aux ressources requises, par des propositions de financement, lorsqu'il est question d'entreprendre une étude de recherche.	O	O	O	O	O
5. Développer des relations avec les organismes de recherches pertinents.	O	O	O	O	O
6. Observer les exigences énoncées dans les lignes directrices éthiques pour la recherche relative à des sujets humains (p. ex., en obtenant l'approbation et le consentement des participants, en garantissant la confidentialité des renseignements et en respectant le droit d'un participant de se retirer de l'étude).	O	O	O	O	O
7. Évaluer, analyser et interpréter les résultats des recherches avant de les annoncer au public.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 9: Déontologie

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Code de déontologie de l'ACLT et politiques de l'organisation en matière d'éthique.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 9: Déontologie

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Se conformer aux codes de déontologie de l'ACLT.	O	O	O	O	O
2. S'assurer que la confidentialité, la dignité et l'autonomie du client sont respectées et préservées.	O	O	O	O	O
3. Signaler les cas de conduite non-éthique à la personne appropriée au sein de l'organisation.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 10: Sensibilité envers la diversité

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Principes d'équité, d'impartialité et de justice sociale.	O	O	O	O	O
2. Signification de la diversité et comment accéder aux ressources qui approfondiront la compréhension de cette notion.	O	O	O	O	O
3. Ses préférences personnelles et comment les transformer en outil de compréhension.	O	O	O	O	O
4. La Charte canadienne des droits et libertés	O	O	O	O	O
5. Déclaration universelle des droits de l'homme.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 10: Sensibilité envers la diversité

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Apprécier et respecter chaque client pour sa valeur inhérente.	O	O	O	O	O
2. Modifier ses techniques de communications verbales et non verbales en fonction du client.	O	O	O	O	O
3. Militer en faveur d'un traitement égal pour tous les clients.	O	O	O	O	O
4. Faire preuve de sensibilité envers les valeurs du client et tenir compte de la manière dont celles-ci influent sur ses décisions.	O	O	O	O	O
5. Reconnaître la vulnérabilité d'un client et le traiter de manière à renforcer la relation récréothérapeutique.	O	O	O	O	O
6. Connaître les dates du calendrier correspondant à des événements spéciaux pour différentes cultures.	O	O	O	O	O
7. Maintenir un environnement propice au respect de la diversité.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 11: Gestion des risques

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique /thérapeute en loisir au Canada dans les DOMAINES DE CONNAISSANCES suivants?

Un récréothérapeute doit avoir une compréhension approfondie de ce qui suit:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Risques potentiels dans l'organisme et dans la collectivité du client et comment éviter qu'ils causent un danger.	O	O	O	O	O
2. Risques potentiels des diverses expériences de loisirs.	O	O	O	O	O
3. Politiques, pratiques et procédures de l'organisation en ce qui concerne la gestion des risques.	O	O	O	O	O
4. Procédures d'urgence pour les situations de crise environnementale, circonstancielle ou comportementale.	O	O	O	O	O
5. Prévention des infections, des dangers et des incendies.	O	O	O	O	O
6. Lois nationales, provinciales ou territoriales pertinentes en matière de santé et de sécurité.	O	O	O	O	O

Champ de pratique en loisir thérapeutique 11: Gestion des risques

Quelle importance accordez-vous à la compétence d'un praticien en loisir thérapeutique/ thérapeute en loisir au Canada dans les DOMAINES D'APTITUDE suivants?

Un récréothérapeute doit être en mesure d'accomplir les fonctions suivantes:	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
1. Examiner et mettre à jour annuellement les politiques relatives à la prévention des risques.	O	O	O	O	O
2. Élaborer un plan de gestion des risques permettant de déterminer les probabilités et la gravité des risques, d'évaluer le contexte et de planifier une ligne de conduite.	O	O	O	O	O
3. Communiquer les risques potentiels aux clients et aux assistants en récréothérapie.	O	O	O	O	O
4. S'assurer que les aires de loisirs sont propres, sécuritaires et adéquatement entretenues conformément aux codes relatifs à la santé, à la sécurité et à la prévention des incendies.	O	O	O	O	O
5. Réagir adéquatement aux situations d'urgence tout en gardant son sangfroid.	O	O	O	O	O
6. Documenter toutes les questions relatives à la gestion des risques et les incidents conformément à la politique de l'organisation.	O	O	O	O	O
7. Effectuer les procédures de réanimation cardio-respiratoire (RCR) et de premiers soins au cas où le personnel médical est inaccessible.	O	O	O	O	O
8. Appliquer les ordres de ne pas réanimer selon les souhaits du client ou du soignant.	O	O	O	O	O

Section 3: **Connaissances et développement de compétences**

1. S'il-vous-plaît, indiquer d'autres DOMAINES D'APTITUDE ET DE CONNAISSANCES qui pourraient être pertinents à la pratique compétente du loisir thérapeutique.

   De plus, veuillez s'il-vous-plaît coter ces DOMAINES D'APTITUDE ET DE CONNAISSANCES à considérer sur cette échelle en cinq points.

Vos suggestions de DOMAINES DE CONNAISSANCES supplémentaires	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
Vos suggestions de DOMAINES D'APTITUDE supplémentaires	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

2. Quels domaines D'APTITUDE ET DE CONNAISSANCES percevez-vous comme importants à considérer dans la pratique compétente du loisir thérapeutique au cours des cinq prochaines années?

   De plus, veuillez s'il-vous-plaît coter ces DOMAINES D'APTITUDE ET DE CONNAISSANCES à considérer dans le futur sur cette échelle en cinq points.

DOMAINES DE CONNAISSANCES à considérer dans le futur.	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
DOMAINES D'APTITUDES à considérer dans le futur.	N'a pas d'importance	De peu d'importance	D'une importance modérée	Important	Très important
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○
	○	○	○	○	○

Je vous remercie beaucoup d'avoir rempli ce sondage!

Appendix C

Professional Organization Introductory Letter

Tanea Goncalves
c/o Dalhousie School of Health and Human Performance
Halifax, Nova Scotia
B3H 4H6
Telephone: (506) 440-8275
E-mail: Tanea.Goncalves@dal.ca
Date:

Dear

Your organization is invited to participate in a research study being conducted by Tanea Goncalves who is a M.A. graduate student in Leisure Studies at Dalhousie University. The title of the study is called: For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Practice? The purpose of the study is to identify the skills and knowledge required for competent Therapeutic Recreation practice in Canada.

The following research questions will be explored in the study: 1) Do significant skills and knowledge differences exist in identified competency areas between certified and non-certified TR practitioners? 2) Do significant skills and knowledge differences exist in identified competency areas between individuals with a degree versus a diploma? 3) Do significant skills and knowledge differences exist in identified competency areas between demographic regions in Canada? 4) Do significant skills and knowledge differences exist in identified competency areas between years of experience practicing as a TR practitioner?

Defined competencies of Therapeutic Recreation (TR) professional practice are the basis for standards of practice, educational programs, certification and licensure programs (O'Morrow & Reynolds, 1989).

A competency study in Canada surveying all TR practitioners has never been conducted. This study will examine the skills and knowledge for TR practice in Canada. One strategy in defining competencies for TR is to ask the practitioners in the field what elements are important to competent practice to ensure protection for the public. Measuring the skills and knowledge necessary for TR practice in Canada will set the stage for further developments such as appropriate educational program needs, certification systems and standards of practice for the field of TR.

The study will consist of participants completing a web-based or if necessary a postal mail questionnaire adapted from the Canadian Therapeutic Recreation Association Stardards of Practice (2006). The researcher plans to make the instrument available to approximately 1100 professional Therapeutic Recreation members across Canada (Singleton et al., 2006) through the Dalhousie Opinio Survey Service during the period of October to November 2007. Dillman's four-wave reminder protocol will be used to enhance response rate.

Taking part in this study is completely voluntary. At no time will data generated from the study be used for any other purpose than for the study. Your members may withdraw from the study at anytime, should they decide. The study is described below. The description tells your organization about any risks, inconveniences, or discomfort you members may experience. Feel free to discuss any questions with me.

Those to be involved in the study will be current members of their provincial or national TR associations. The only criterion for the participants involved in this study is that they will require up to date registration to their designated professional Therapeutic Recreation association.

In Canada there are three professional standards of practice documents from the provinces of Ontario, Nova Scotia and Newfoundland/Labrador, two in the United States and in September, 2006, the Canadian Therapeutic Recreation Association (CTRA) released a Standards of Practice document that attempted to synthesize the information in these documents to inform Therapeutic Recreation practice for Therapeutic Recreation practitioners and their assistants or aides. In the process of developing this synthesized document a panel of experts was consulted to determine the content validity of the Standards of Practice.

The questionnaire will have demographic information, competency statements and knowledge areas as defined from the CTRA 2006 Standards of Practice document. For each professional knowledge area and competency statement, participants will be asked to rate the following question, "How important is the competency in the following knowledge/competency areas for a Therapeutic Recreation Practitioner/Recreation Therapist in Canada?" A five-point scale "1 - of no importance" to "5 - very important" will be used for each of the scale items.

The demographic information requested in the study will have questions related to whether the participant is a CTRS or non-CTRS, what level of education they have completed, what region they live in within Canada as well as how many years of experience have they been employed as a TR professional. This demographic information will be used to analyze the data.

Two open-ended questions will be added to the questionnaire to gain further information on competency expansion. They will be: "Please provide any additional items that may be relevant for competent Therapeutic Recreation practice in Canada" and "Rate those competencies on the same five-point scale". The second question of

importance will be “What do you see a being important issue(s) for competent Therapeutic Recreation practice in the next five years?” and “Rate those competencies on the same five-point scale”. The survey will be available in both French and English.

The researcher plans to make the instrument available to approximately 1100 professional Therapeutic Recreation members across Canada (Singleton et al., 2006) through the Dalhousie Opinio Survey Service, if all the professional organizations agree to participate in this study. Dillman’s four-wave reminder protocol will be used to enhance response rate.

Only the researcher and the supervisor will have access to the data generated from the survey and they will be stored on the premises of Dalhousie University, in the office of the supervisor. A statistician will have access to the data during the time it takes to complete data cleaning. Electronic survey material will be destroyed upon completion of data collection. Data will be kept securely at Dalhousie University for a period of five years post-publication.

The benefit of the research will occur in the area of understanding the skills and knowledge for competent Therapeutic Recreation practice in Canada. The findings of this national study will provide insights into the application of these job task statements and professional knowledge areas to members of Therapeutic Recreation professional organizations in Canada.

As an organization facilitating your membership participation in this study, you will be provided an executive summary of the results upon completion of the study and members of your organization may experience some degree of satisfaction by making a contribution to the identification of job task and knowledge areas of Therapeutic Recreation in Canada.

I am requesting that your organization to agree to forward the survey to your membership four times during the study period from October 2007 to November 2007 (see attached). I am also requesting that your organization identify a person who will distribute the survey who I can contact during the study who can keep me informed regarding the distribution of the survey and if any concerns arise during the study (see attached tasks and response sheet). Upon agreement from your organization, you will provide the researcher with the contact information the person who will be responsible to electronically deliver the survey to you membership (see Appendix D). The person identified is also requested to be a member of the pilot study to evaluate the web-based questionnaire for technical accessibility, readability and user-friendliness (see Appendix E, F and G). The organizational agreement letter and pilot study evaluation will be sent in both French and English to organizations and individuals.

I will be contacting you upon your identification of your participation interest or through a faxed or e-mailed a signed and returned consent form on behalf of yourself. I will be able to provide additional details regarding the study. If you have any questions, please do not hesitate to contact me at (506) 440-8275 or at Tanea.Goncalves@dal.ca. You can also contact Dr. Jerome Singleton (academic supervisor) at (902) 494-1166 or at Jerome@dal.ca

I would like to thank you very much for your consideration in participating in the study.

In the event that you have any difficulties with, or wish to voice concern about any aspect of your participation in the study, you may contact the Director, Office of Research Ethics Administration at Dalhousie University for assistance at (902) 494-1462.

Sincerely,

Tanea Goncalves

(Master of Arts candidate)

Jerome F. Singleton, Phd, CTRS

(Supervisor)

Appendix D

Therapeutic Recreation Professional Organization Consent Form

On behalf of the _____, I

Therapeutic Recreation Association Name

understand that participation in the study entitled For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Therapeutic Recreation Practice as the representative for our professional organization is entirely voluntary and that our organization may refuse to participate or may withdraw from the study at any time.

On behalf of our organization, I have read the attached letter and have retained a copy for our files. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I will fax or e-mail a completed copy of this consent form within two weeks of its receipt and have retained a copy for our organization's records.

- ☐ I agree to deliver a recruitment letter to our membership list of Therapeutic Recreational professionals in electronic form or by mail at the expense of the researcher.
- ☐ I am aware that a modified Dillman Tailored Design (2000) will be used to enhance response rate, meaning that our organization will deliver the survey request to our membership on four three occasions as specified by the researcher.
- ☐ The contact information for our organizations administrative individual responsible to deliver the recruitment letter is below.

☐ I understand that the administrative individuals will receive detailed instructions regarding the dates for the recruitment package with links to the survey as well as have to complete a tracking form for organizational participation in this study.

_____

Signature of President or Chair

Or Organizational Designate

_____

Position within the Organization

_____

Date Signed

If you have any questions, do not hesitate to contact Tanea Goncalves at 506-440-8275 or e-mail Tanea.Goncalves@dal.ca or my Academic Supervisor: Dr. Jerome Singleton at (902) 494-1166 or e-mail Jerome@dal.ca

Appendix E

Questionnaire for Pilot Study

Dear

To help ensure the success of this project, your feedback on completing the survey is requested and appreciated. Please provide any additional comments that will be useful in improving this survey:

Technical Accessibility:

Were you able to access the survey easily?

Please provide comments:

Were you able to access each page of the survey?

Please provide comments:

Were you able to complete survey?

Please provide comments:

Is there anything that you can suggest which can be used to improve the technical accessibility of the survey?

Readability:

Were there any questions that should be clarified within the survey?

Please provide comments:

Were sentences complete and easy to understand?

Please provide comments:

Were instructions clear?

Please provide comments:

Is there anything that you can suggest which can be used to improve the readability of the survey?

User-Friendliness

Are the correspondence and instructions friendly?

Please provide comments?

Is there anything that you can suggest which can be used to improve the friendliness of the survey?

If you have any questions, do not hesitate to contact Tanea Goncalves at 506-440-8275 or e-mail Tanea.Goncalves@dal.ca or my Academic Supervisor: Dr. Jerome Singleton at (902) 494-1166 or e-mail Jerome@dal.ca

Appendix F

Administrative Assistant/Individual Letter

Tanea Goncalves
c/o Dalhousie School of Health and Human Performance
Halifax, Nova Scotia
B3H 4H6
Telephone: (506) 440-8275
E-mail: Tanea.Goncalves@dal.ca
Date:

Dear

Your organization has agreed to participate in a research study as part of a graduate level thesis research project. The title of the study is called: For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Practice? The purpose of the study is to identify the skills and knowledge required for competent Therapeutic Recreation practice in Canada. Defined competencies of Therapeutic Recreation (TR) professional practice are the basis for standards of practice, educational programs, certification and licensure programs (O'Morrow & Reynolds, 1989). A competency study in Canada surveying all TR practitioners has never been conducted. This study will examine the skills and knowledge for TR practice in Canada. One strategy in defining competencies for TR is to ask the practitioners in the field what elements are important to competent practice to ensure protection for the public. Measuring the skills and knowledge necessary for TR practice in Canada will set the stage for further developments such as appropriate educational program needs, certification systems and standards of practice for the field of TR.

The principal investigator will be myself, and my role will be to ensure that the research proceeds in a manner agreed by your organization and that minimizes the risks and discomforts your members may experience. Therefore I will complete all data

collection via the Dalhousie Opinio Survey Service. A statistician from the Dalhousie Opinio Survey Service will assist with Data Cleaning.

You organization has identified you as the contact person for distributing the survey electronically to your organizations membership. I have attached documents that will assist you in this task (see attached).

I will be contacting you upon your identification of your participation interest or through a faxed or e-mailed a signed and returned consent form on behalf of yourself. I will be able to provide additional details regarding the study. If you have any questions, please do not hesitate to contact me at (506) 440-8275 or at Tanea.Goncalves@dal.ca. You can also contact Dr. Jerome Singleton (academic supervisor) at (902) 494-1166 or at Jerome@dal.ca

I would like to thank you very much for your consideration in participating in the study.

In the event that you have any difficulties with, or wish to voice concern about any aspect of your participation in the study, you may contact the Director, Office of Research Ethics Administration at Dalhousie University for assistance at (902) 494-1462.

Sincerely,

Tanea Goncalves
(Master of Arts candidate)

Appendix G

Administrative Assistant Tracking Form for Organizational Participation in Study

Tracking form for Study: For Therapeutic Recreation professionals in Canada, what are the skills and knowledge required for competent practice?

Name of Therapeutic Recreation Professional Association:					
First Wave:					
Scheduled Date to be Sent as designated by researcher:					
Date Sent	Number of Professional Members in Organization	Number of Professionals Members e-mailed for Study	Number of Professional members mailed for Study	Number of Returned e-mails from study	Number of Returned mail envelopes from study
☐ Blind copy of e-mail send to researcher **Date:**_____					

Second Wave:					
Scheduled Date to be Sent as designated by researcher:					
Date Sent	Number of Professional Members in Organization	Number of Professionals Members e-mailed for Study	Number of Professionals members mailed for Study	Number of Returned e-mails from study	Number of Returned mail envelopes from study
☐ Blind copy of e-mail send to researcher **Date:**_____					

Third Wave:					
Scheduled Date to be Sent as designated by researcher:					
Date Sent	Number of Professional Members in Organization	Number of Professionals members e-mailed for Study	Number of Professional members mailed for Study	Number of Returned e-mails from study	Number of Returned mail envelopes from study
☐ Blind copy of e-mail send to researcher **Date:**_____					

Fourth Wave:					
Scheduled Date to be Sent as designated by researcher:					
Date Sent	Number of Professional Members in Organization	Number of Professionals members e-mailed for Study	Number of Professional members mailed for Study	Number of Returned e-mails from study	Number of Returned mail envelopes from study
☐ Blind copy of e-mail send to researcher **Date:**_____					

_____ _____

Completed By Date

If you have any questions, do not hesitate to contact Tanea Goncalves at 506-440-8275 or e-mail Tanea.Goncalves@dal.ca or my Academic Supervisor: Dr. Jerome Singleton at (902) 494-1166 or e-mail Jerome@dal.ca

Appendix H

Administrative Assistant/Individual Consent Form

On behalf of the _____, I

Therapeutic Recreation Association Name

understand that my participation in the study entitled For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Therapeutic Recreation Practice as the administrative assistant/individual for our organization is entirely voluntary and that I may refuse to participate or may withdraw from the study at any time.

I have read the attached letter and have retained a copy for my files. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I will fax or e-mail a completed copy of this consent form within two weeks of its receipt and have retained a copy for my records.

- ☐ I agree to deliver a recruitment letter to our membership list of Therapeutic Recreational professionals in electronic form or by mail at the expense of the researcher.
- ☐ I am aware that the Dillman Tailored Design (2000) will be used to enhance response rate, meaning that our organization will deliver the survey request to our membership on four occasions as specified by the researcher.
- ☐ I understand that as the designated administrative assistant/individual for our organization I will be responsible to deliver the recruitment letter to our membership via electronic or mail-out means.
- ☐ I understand that as the designated administrative assistant/individual I will send out the recruitment package along with links to the survey as well as complete a

tracking form for organizational participation in this study on the following three dates:

☐ I will send the first wave of Participant Recruitment Packages our professional organizational membership on _____

Date

and complete tracking form for the study.

☐ I will send the second wave of Participant Recruitment Packages our professional organizational membership on _____ and complete

Date

tracking form for the study.

☐ I will send the third wave of Participant Recruitment Packages our professional organizational membership on _____ and complete

Date

tracking form for the study.

☐ I will send the fourth wave of Participant Recruitment Packages our professional organizational membership on _____ and complete

Date

tracking form for the study.

☐ I will send blind copies of electronic recruitment package to researcher during each wave.

☐ I will forward tracking for to the researcher via e-mail, fax or by mail after the fourth wave of Participant Recruitment Packages.

☐ I understand that as the administrative individual for our organization will be asked to be a member of the pilot study.

☐ I understand that being a member of the pilot study, prohibits me from being involved as a participant in the research study.

_____ _____

Signature of Designated Administrative Assistant/Individual

Date Signed

If you have any questions, do not hesitate to contact Tanea Goncalves at 506-440-8275 or e-mail Tanea.Goncalves@dal.caor my Academic Supervisor: Dr. Jerome Singleton at (902) 494-1166 or e-mail Jerome@dal.ca

Appendix I

Participant Consent Form Letter

Tanea Goncalves
c/o Dalhousie School of Health and Human Performance
Halifax, Nova Scotia
B3H 4H6
Telephone: (506) 440-8275
E-mail: Tanea.Goncalves@dal.ca
Date:

Dear Therapeutic Recreation Professional,

I am, Tanea Goncalves, a M.A. graduate student in Leisure Studies at Dalhousie University. The title of my study is: For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Practice? The purpose of the study is to identify the skills and knowledge required for competent Therapeutic Recreation practice in Canada. Defined competencies of Therapeutic Recreation (TR) professional practice are the basis for standards of practice, educational programs, certification and licensure programs (O'Morrow & Reynolds, 1989).

A competency study in Canada surveying all TR practitioners has never been conducted. This study will examine the skills and knowledge for TR practice in Canada. One strategy in defining competencies for TR is to ask the practitioners in the field what elements are important to competent practice to ensure protection for the public. Measuring the skills and knowledge necessary for TR practice in Canada will set the stage for further developments such as appropriate educational program needs, certification systems and standards of practice for the field of TR.

Taking part in this study is completely voluntary. You may withdraw from the study at anytime. Only the researcher and the supervisor will have access to the data

generated from the survey and they will be stored on the premises of Dalhousie University, in the office of my supervisor.

The benefit of the research will occur in the area of understanding the skills and knowledge for competent Therapeutic Recreation practice in Canada. The findings of this national study will provide insights into the application of these job task statements and professional knowledge areas to members of Therapeutic Recreation professional organizations in Canada.

If you have any questions, please do not hesitate to contact me at (506) 440-8275 or at Tanea.Goncalves@dal.ca. You can also contact Dr. Jerome Singleton (academic supervisor) at (902) 494-1166 or at Jerome@dal.ca

I would like to thank you very much for your consideration in participating in the study.

In the event that you have any difficulties with, or wish to voice concern about any aspect of your participation in the study, you may contact the Director, Office of Research Ethics Administration at Dalhousie University for assistance at (902) 494-1462.

Sincerely,

Tanea Goncalves
(Master of Arts candidate)

Jerome F. Singleton, Phd, CTRS
(Supervisor)

[Link to study in English]

[Link to study in French]

[Link for those who do not wish to complete the questionnaire]

Appendix J

Informed Consent for Participant

I understand that my participation in the study entitled For Therapeutic Recreation Professionals in Canada, What are the Skills and Knowledge Required for Competent Therapeutic Recreation Practice is entirely voluntary and that I may refuse to participate or may withdraw from the study at any time.

I have read the attached letter and have retained a copy for my files. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I understand that by completing the questionnaire, informed consent is assumed.

☐ Check off Box if you consent to participate in the study.

If you have any questions, do not hesitate to contact Tanea Goncalves at 506-440-8275 or e-mail Tanea.Goncalves@dal.ca or my Academic Supervisor: Dr. Jerome Singleton at (902) 494-1166 or e-mail Jerome@dal.ca

Appendix K

Mean and Standard Deviation for Knowledge and Skill Areas & Top and Bottom Knowledge and Skill Statements

Standard 1: Assessment					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. Leisure theories, models, and principles to address issues such as the client's functional ability, leisure awareness and leisure interests	4.45	.689	1. Select and implement assessment instruments based on the individual client and in accordance with organizational policies	4.46	.652
2. Assessment processes, procedures and instruments specific to individual clients	4.68	.535	2. Inform the client and/or caregiver(s) of the assessment process and procedure when suitable	4.39	.706
3. Assessment techniques which may include observation, interview, or other means	4.74	.469	3. Determine the client's physical, social, cognitive, emotional, spiritual and cultural needs and/or values	4.82	.417
4. The clients medical condition, social history, legal status and ethnic values	4.59	.593	4. Gather information from caregiver(s) or significant others as required	4.47	.633
			5. Educate the clients and/or caregiver(s) about recreation therapy services that are offered and the funding available for these services	4.45	.705
			6. Communicate assessment results to the client, caregiver(s), recreation therapy assistant and health care team members	4.68	.557
			7. Coordinate and update intervention or service waiting lists with other service providers for timely access	4.13	.819
			8. Schedule re-assessments when necessary	4.19	.755

Standard 2: Intervention Plan Development					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. Recreation Therapy models and organizational procedures as they relate to creating an intervention plan	4.24	.744	1. Apply recreation therapy models in the development of the intervention plan	4.21	.748
2. The effects of the client's medical condition, social history and ethnic values and how this will impact his or her participation	4.71	.490	2. Develop specific program protocols and procedures which are specific to the needs of the client	4.53	.644
3. The client's needs based on analysis and interpretation of the assessment results with input from the clients and his or her caregiver(s)	4.67	.546	3. Apply information from the assessment to synthesize short-term and long-term goals and objectives that are measureable and achievable	4.62	.609
4. The leisure experiences that would best facilitate achievement of the client's goals and objectives	4.66	.548	4. Communicate the intervention plan to the client, caregiver(s), recreation therapy assistant and healthcare team when necessary	4.63	.593
5. Adaptations and/interventions that can be used to enable, minimize or mitigate constraints	4.62	.595	5. Review and modify interventions or services to ensure that client goals and objectives are met	4.62	.586
6. Social attitudes (ex. Stereotypes) which exist	4.21	.681	6. Create discharge plans and provide follow-up services when necessary	4.31	.910
7. Principles of behaviour and how they relate to individual clients	4.34	.646	7. Perform task analysis	3.99	.830
8. A client's right to inclusion within the community and how to incorporate inclusive practices	4.52	.592	8. Develop partnerships with a variety of service providers in the community	4.30	.758
9. The principles of accessibility	4.46	.618	9. Determine inclusive community leisure opportunities	4.28	.786
10. The mission and operations of all facilities in the community which are accessible for persons with disabilities	4.02	.856	10. Educate the client and caregiver(s), if necessary, about ways to become involved in the community	4.39	.787
11. Advocacy techniques and methods to build	4.18	.825			

community capacity for clients					
12. How various service interest groups and legislation acts (ex. For individuals with disabilities or seniors) can offer support to a client	4.04	.810			

Standard 3: Intervention Plan Implementation					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. The effects of a client's medical condition, social history and ethnic values and how this will impact his or her participation	4.68	.548	1. Develop and utilize a variety of intervention protocols to facilitate desired change in clients	4.42	.627
2. How to implement interventions that will meet the needs of a client considering his or her strengths and abilities	4.74	.543	2. Direct client interventions relating to leisure education, functional intervention and/or recreation participation and/or supervise recreation therapy assistants and volunteers as they direct client interventions relating to recreation participation	4.56	.622
3. How to supervise and manage leisure programs within clients capabilities, resources, agencies and/or community resources	4.53	.632	3. Coordinate facilities, funding, and intervention logistics	3.90	.859
4. Facilitation techniques	4.54	.652	4. Encourage clients, caregiver(s) and significant others to participate	4.45	.699
			5. Review the progress of the client and in collaboration with the client and/ or caregiver(s) modify goals and objectives when necessary	4.57	.594
			6. Facilitate participation in community facilities that are accessible for persons with disabilities	4.28	.801

Standard 4 - Documentation					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. Methods of documentation used by the organization	4.63	.598	1. Complete documentation in accordance with the organization's standards in an accurate and professional manner, using agency specific terminology	4.62	.587
2. Organization documentation policies and procedures	4.52	.639	2. Complete a summary of recreation therapy services provided for each client and when appropriate a discharge summary	4.37	.753
3. Accountability that results from completing documentation	4.64	.611	3. Include the frequency, duration, intervention, facilitation, and nature of client participation in the document	4.44	.727
			4. Periodically review and update documents in accordance with the organization's standards	4.30	.703
			5. Document fund allocation and expense records	3.87	.925
			6. Complete workload measurement in accordance with the organization's standards	4.20	.818

Standard 5 - Evaluation					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. Objective outcome measurement instruments and methods	4.35	.764	1. Interpret and analyze a client's level of engagement and whether the intervention goals and objectives are achieved based on outcome oriented measures	4.58	.634
2. Formal evaluation techniques and procedures in accordance with the organization's policies	4.31	.745	2. Determine whether to maintain, amend or discontinue intervention goals and objectives based on the evaluation results	4.59	.647
			3. Formalize the input from a client, caregiver and significant others in the evaluation process and/or in	4.43	.726

			preparation for the transition or end of services and communicate these findings to relevant other professionals		
			4. Prepare the client and caregiver(s) for transition, end of service or follow-up	4.37	.849

Standard 6 – Interdisciplinary Collaboration					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery	4.72	.557	1. Communicate in such a way to avoid presenting inaccurate or misleading information	4.73	.473
2. Importance of other professionals and their unique contributions to a client's medical, social, psychological, emotional, physical and spiritual needs, etc	4.69	.524	2. Address conflict in a professional and respectful manner in order to promote positive working relations	4.68	.494
			3. Collaborate with other professions when appropriate, including assessments, creating individual intervention plans, implementing program plans, creating documentation, and writing evaluations	4.72	.485
			4. Promote the importance of recreation therapy to other disciplines	4.74	.516
			5. Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of a client	4.74	.447
			6. Refer clients to other disciplines if necessary	4.64	.537

Standard 7 – Professional Development					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. The recreation therapy standards of practice and related agency practices and theories	4.50	.626	1. Follow guidelines addressed in the recreation therapy standards of practice	4.48	.671
2. Recreation therapy organizations which exist locally, provincially, nationally and internationally	4.15	.755	2. Conduct self-assessment and/or performance appraisals to identify and improve knowledge, skills and abilities necessary to perform job responsibilities	4.34	.706
			3. Plan and participate in in-service training and staff development sessions	4.56	.623
			4. Seek out and pursue educational opportunities	4.55	.576
			5. Complete certifications required by the national and/or provincial professional association(s) and organization of employment and renew when necessary	4.42	.827
			6. Share new knowledge and skills with colleagues, students and volunteers	4.46	.598
			7. Supervise and support future therapists (students)	4.53	.639

Standard 8 – Research					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. Methods to access applicable research relevant to recreation therapy	4.11	.761	1. Retrieve and critically analyze the content of academic based research through literature reviews	3.86	.859

2. Outcome oriented and evidence based research practices	4.19	.811	2. Apply evidence based research to professional practice	4.22	.828
3. Research methods and protocols used by the organization, the scientific community and/or the government	3.85	.842	3. Support, assist or participate in research related to recreation therapy	4.07	.837
4. Ethical guidelines for involving human subjects	4.27	.837	4. Access required resources through funding proposals, when engaging in a research study	3.74	.965
5. Relevant research agencies that may be accessed for support and assistance	3.94	.853	5. Develop relationships with relevant research agencies	3.64	.933
			6. Follow requirements stated in the ethical guidelines for involving human subjects (ex. by obtaining the approval and consent of research participant(s), ensuring his/her confidentiality and respecting his/her right to withdraw from the study)	4.35	.876
			7. Evaluate, analyze and interpret research results before announcing the findings to the public	4.30	.894

Standard 9 - Ethics					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. The CTRA code of ethics as well as the organization's policies regarding ethical conduct	4.60	.644	1. Comply with the CTRA ethical codes of conduct	4.62	.621
			2. Ensure that a client's confidentiality, dignity, and autonomy are respected and upheld	4.95	.218
			3. Report unethical incidences to the appropriate personnel within the organization	4.79	.447

Standard 10 – Sensitivity to Diversity					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. Principles of equity, fairness and social justice	4.52	.606	1. Value and respect each client for his/her inherent worth	4.88	.343
2. What diversity means and how to access resources which will enhance appreciation of the concept	4.43	.643	2. Alter verbal and non-verbal communication depending on the client	4.75	.515
3. His/her own personal biases and how to turn these biases into understanding	4.52	.652	3. Advocate for equal treatment of all clients	4.77	.533
4. The Canadian Charter of Rights and Freedoms	4.13	.732	4. Be sensitive to a client's values and how they affect his/her decision making	4.83	.410
5. The Universal Declaration of Human Rights	4.11	.743	5. Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship	4.80	.440
			6. Recognize calendar events which are relevant to specific cultures	4.47	.638
			7. Maintain an environment which is sensitive to diversity	4.66	.525

Standard 11 – Risk Management					
Knowledge Areas	**Mean**	**SD**	**Skills Areas**	**Mean**	**SD**
1. The potential risks that exist within the organization and the client's community and how to prevent them from causing harm	4.59	.556	1. Review and update policies that relate to risk prevention procedures annually	4.16	.764
2. The potential risks of various leisure experiences	4.69	.514	2. Develop a risk management plan which identifies likelihood and severity of risk, assesses the environment and plans a course of action	4.22	.773
3. The organization's policies, practices, and procedures in regards to risk management incidences	4.61	.559	3. Communicate potential risks to clients and recreation therapy assistants	4.64	.568

4. Emergency procedures for environmental, situational, or behavioral crisis	4.69	.513	4. Ensure that recreation areas are clean, safe, and properly maintained in keeping with health, fire, and safety codes	4.72	.516
5. Infection control, hazards, fire safety and prevention	4.63	.557	5. Respond to emergency situations while maintaining composure	4.75	.487
6. Pertinent national, provincial or territorial laws related to health and safety	4.30	.744	6. Document any risk management issues or incidents in accordance with organizational policy	4.66	.540
			7. Perform cardiopulmonary resuscitation (CPR) and first aid procedures in the event that medical staff are inaccessible	4.47	.854
			8. Apply do not resuscitate codes (DNRs) depending on the client and/or caregiver's wishes	4.54	.752

Top Knowledge Statements

Standard	Knowledge Statement	Mean
Assessment	V23 – Assessment techniques which may include observation, interview, or other means	4.74
Intervention Plan Implementation	V56 – How to implement interventions that will meet the needs of a client considering his or her strengths and abilities	4.74
Interdisciplinary Collaboration	V80 – The roles of the recreation therapist and recreation therapy assistant as part of an interdisciplinary team within service delivery	4.72
Intervention Plan Development	V34 – The effects of the client's medical condition, social history and ethnic values and how this will impact his or her participation	4.71
Risk Management	V128 - Emergency procedures for environmental, situational, or behavioral crisis	4.69
Risk Management	V126 - The potential risks of various leisure experiences	4.69
Interdisciplinary Collaboration	V81 – The importance of other professionals and their unique contributions to a client's medical, social, psychological, emotional, physical and spiritual needs	4.69
Intervention Plan Implementation	V55 – The effects of the client's medical condition, social history and ethnic values and how this will impact his or her participation	4.68
Assessment	V22 – Assessment processes, procedures and instruments specific to individual clients	4.68
Intervention Plan Development	V35 – The client's needs based on analysis and interpretation of the assessment results with input from the client and his or her caregiver(s)	4.67

Top Skill Statements

Standard	Skill Statement	Mean
Ethics	V111 – Ensure that a client's confidentiality, dignity, and autonomy are respected and upheld	4.95
Sensitivity to Diversity	V118 – Value and respect each client for his/her inherent worth	4.88
Sensitivity to Diversity	V121 – Be sensitive to a client's values and how they affect his/her decision making	4.83
Assessment	V27 – Determine the client's physical, social, cognitive, emotional, spiritual and cultural needs and/or values	4.82
Sensitivity to Diversity	V122 – Recognize the vulnerability of a client and treat him/her in such a way to sustain the recreation therapy relationship	4.80
Ethics	V112 – Report unethical incidences to the appropriate personnel within the organization	4.79

Sensitivity to Diversity	V120 – Advocate for the treatment of all clients	4.77
Risk Management	V135 – Respond to emergency situations while maintaining composure	4.75
Sensitivity to Diversity	V119 – Alter verbal and non-verbal communication depending on the client	4.75
Interdisciplinary Collaboration	V85 – Promote the importance of recreation therapy to other disciplines	4.74
Interdisciplinary Collaboration	V86 – Respect the ideas and abilities of each professional discipline, staff member and/or volunteer involved in the care of the client	4.74

Bottom Knowledge Statements

Standard	Knowledge Statement	Mean
Research	V99 – Research methods and protocols used by the organization, the scientific community and/or the government	3.85
Research	V101 – Relevant research agencies that may be accessed for support and assistance	3.94
Intervention Plan Development	V42 – The mission and operations of all facilities in the community which are accessible for persons with disabilities	4.02
Intervention Plan Development	V44 – How various services interest groups and legislation acts (ex. For individuals with disabilities or seniors) can offer support to a client	4.04
Sensitivity to Diversity	V117 – The Universal Declaration of Human Rights	4.11
Research	V97 – Methods to access applicable research relevant to recreation therapy	4.11
Sensitivity to Diversity	V116 – The Canadian Charter of Rights and Freedoms	4.13
Professional Development	V89 – Recreation therapy organizations which exist locally, provincially, nationally and internationally	4.15
Intervention Plan Development	V43 – Advocacy techniques and methods to build community capacity for clients	4.18
Research	V98 – Outcome oriented and evidence based research practices	4.19

Bottom Skill Statements

Standard	Skill Statement	Mean
Research	V106 – Develop relationships with relevant research agencies	3.64
Research	V105 – Access required resources through funding proposals, when engaging in a research study	3.74
Research	V102 – Retrieve and critically analyze the content of academic based research through literature reviews	3.86
Documentation	V72 – Document fund allocation and expense records	3.87
Intervention Plan Implementation	V61 – Coordinate facilities, funding, and intervention logistics	3.90
Intervention Plan Development	V51 – Perform task analysis	3.99
Research	V104 – Support, assist or participate in research related to recreation therapy	4.07
Assessment	V31 – Coordinate and update intervention or services waiting lists with other service providers for timely access	4.13
Risk Management	V131 – Review and update policies that relate to risk prevention procedures annually	4.16
Assessment	V32 – Schedule re-assessments when necessary	4.19