Leisure Education III: More Goal-Oriented Activities

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Venture Publishing, Inc.

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Preface

Leisure Education III was developed in response to the very positive reception that was received from professionals for *Leisure Education I* and *Leisure Education II*. We appreciate the kind words, letters of encouragement and many requests we get for these volumes. Since it has been 12 years since the first volume and five years since the second volume was published, it was time to introduce new ideas to keep those creative juices flowing. We hope to continue to provide new and innovative activities that meet the needs of participants and specialists alike.

Feedback from practicing professionals has helped guide the development of this new manual. A few changes have been made in an attempt to keep abreast of the demands of practice and to make service delivery as easy as possible, yet meet the needs of participants. One of the most noticeable changes is that there are no leisure activity skills activities in this manual, as there are many activity books now available on the market. In their place a new section on Decision-Making Skills activities, a primary area of need for many of our participants, has been added. For similar reasons the number of Social Skills activities—again, a primary deficit for many participant groups—has nearly doubled. We hope these changes help specialists respond to these growing areas of concern for many types of clients.

Another difference is the beginning chapters. In *Leisure Education III*, the focus is on some basic conceptual foundations for service provision. One chapter highlights a conceptual framework that shows how the different elements of service provision, such as protocols, activity analysis, and quality improvement, are related. Another provides an examination of assessment issues and concerns that need to be addressed to meet increasing accountability demands. The third chapter reviews some problems and concerns with the use of activity interest inventories as a primary source of client assessment information. The combination of these three beginning chapters provides therapeutic recreation professionals with some food for thought about improving their service delivery to clients.

It is our hope that the entire manual assists professionals in improving practice in a time of increasing work demands and stresses. Please let us know if this hope has been realized.

NJS

Acknowledgments

Many individuals have touched this work and made it a better product. Four individuals helped tremendously in initial editing and inputting of submitted activities, and creating many of their own: Julie Keil, Nikki Colba Harder, Becky Klein and Theresa Connolly. Hopefully they learned as much as they gave. Terri was especially helpful in the final editing stages and her unflagging eye for detail was invaluable.

As with the *Leisure Education II* manual, an attempt was made to get as many professionals involved in submitting activities as possible, so that users would be assured of high quality and relevant activities. We were pleased that so many individuals responded, and their contributions clearly enhanced the utility and applicability of this manual. Also included are many Illinois State University student contributions, as they are very creative and innovative. The contributors are listed alphabetically here. A few activities with no author's name listed have been included—these appear to be "public domain" activities to which no one has claimed authorship. We included them because we thought they were worthwhile and unique. Thanks so much to all!

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Chapter One

A Proposed Intervention Model for Therapeutic Recreation Services

In a discussion of a personal, historical perspective of the field, Navar (1991) provided a longitudinal look at how the evolving profession of therapeutic recreation has defined accountability. Through the years, there has been a growing sophistication in the way therapeutic recreation specialists have defined and provided appropriate, quality services. Most recently, quality has been equated with the "degree of adherence to standards," according to Navar (1991, p. 5), while appropriateness has been defined as "providing the right patient with the right service [at] the right time in the right setting at the right intensity and for the right duration" (Navar, 1991, p. 5). In this way, quality and appropriateness have been linked with service accountability (Russoniello, 1991). "Healthcare professionals should appreciate that the cornerstone of accountability is evolution. Systems should develop over time to become more sophisticated approaches for monitoring and evaluating the quality and appropriateness of care" (Scalenghe, 1991, p. 30). These accountability systems, often proposed by external regulators, have moved the profession (and others) from beyond a more simplified approach of examining "structure" and "process" indicators to measuring "client outcomes" (Scalenghe, 1991, p. 33). The implication for therapeutic recreation is that the accountability focus shifts from designing and implementing quality intervention programs to also monitoring their cohesiveness and their success at producing client outcomes. While therapeutic recreation professionals continue to do a commendable job of designing and implementing quality programs, the task of developing and using "monitoring systems" (Riley, 1991a) to measure their cohesiveness and effectiveness has received less attention. One reason may be that the therapeutic recreation literature has not had adequate models to assist in conceptualizing and completing these systems.

One intent of this chapter is to introduce a conceptual model of accountability within therapeutic recreation service delivery. The Therapeutic Recreation Intervention Model (TRIM) highlights the various accountability and documentation procedures used by the therapeutic recreation specialist to monitor and make decisions about the delivery of services for producing client outcomes. The model

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Chapter One is adapted from Stumbo, N. J. (1996). A proposed accountability model for therapeutic recreation services. *Therapeutic Recreation Journal, 30*(4), 246–259.

synthesizes several concepts that are found usually singularly elsewhere in the literature (e.g., program planning, client assessment, or quality improvement) into a comprehensive system of accountable provision of intervention services. In this way, the contribution of this model to the literature is its ability to depict interrelationships between various decision or documentation points used by the specialist to provide and monitor appropriate, quality services. These logical linkages are crucial to providing clients with goal-oriented, outcome-based interventions. The need and logic behind outcome-oriented intervention will be discussed as the foundation for and prior to the introduction of TRIM.

Importance of Client Outcome-Oriented Intervention

"Outcomes are the observed changes in a client's status as a result of our interventions and interactions. . . . Outcomes can be attributed to the process of providing care, and this should enable us to determine if we are doing for our clients that which we purport to do" (Shank and Kinney, 1991, p. 76). "Determining what is effective therapeutic recreation intervention depends upon examining the relationships between various program/treatment protocols for a specific illness/diagnostic category and the associated outcomes of those treatments" (Riley, 1991a, p. 54). These statements emphasize that there must be a direct connection or match between the services provided and the expected client outcomes (Dunn, Sneegas and Carruthers, 1991; Navar, 1991; Shank and Kinney, 1991). In other words, the "right services" must be delivered to produce the "right outcomes" (Navar, 1991, p. 5).

According to Connolly (1984):

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

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

Outcome-Oriented Versus Non-Outcome-Oriented Programming

Dunn (1991) referred to non-outcome-oriented programs as *Type I* programs, while Stumbo (1992) labeled them *cafeteria-style.* Dunn (1991) expanded on this concept: "all the clients on the unit attend whatever has been planned for the day. There is no provision which matches his or her unique treatment goals. All clients are essentially seen as having the same treatment needs and thus receive the same services" (p. 3). Client assessment to collect essential baseline information, in this case, is minimal or nonexistent, resulting in a lack of or misdirected individualized treatment goals and action plans. The lack of client goals and directed involvement translates into programming (typically large group) that does not produce behavioral change nor measurable, useful client outcomes.

Intervention or outcome-oriented programs, labeled as *Type II* by Dunn (1991, p. 3), are designed to produce measurable, relevant and meaningful client outcomes. The process

begins with an assessment procedure that produces valid and reliable results. This information is interpreted into individualized goals and objectives (cf., Dunn, Sneegas and Carruthers, 1991) forming the basis for meaningful placement into appropriate programs that address the specific needs of the client. Client goals are worked on during these programs, and measurable client outcomes are likely to be produced. Programs that focus on individual client outcomes often are provided to small groups or on a one-to-one basis.

Intervention or outcome-based programs are very different in intent, content, and delivery from nonintervention programs. In order for therapeutic recreation programs to be considered intervention, they must possess the following characteristics:

a. be systematically designed prior to their implementation;
b. be a part of a larger system of programming;
c. be individualized, based on client needs;
d. have relevance to the clients;
e. have importance to the clients;
f. have timeliness to the clients; and
g. be able to produce desired results.

These seven factors will be discussed in three parts: (a) systematic program design, (b) client placement based on need, and (c) producing client outcomes.

Systematic Program Design

According to Peterson and Gunn (1984), a systems approach for designing therapeutic recreation programs implies that the designer must specify the intended outcomes as well as the process to accomplish the outcomes *prior* to the implementation of the program. That is, systems design assumes that there is a well-defined, goal-oriented *purpose* to the activity or program being provided. Enabling objectives, terminal performance or behavioral objectives, and performance measures help define where the program is going and how it is going to get there. There is a well-defined plan for getting the participant from point A to point B, through his or her participation in a program that has been specifically designed for that purpose (Peterson and Gunn, 1984). These linkages are one of the major factors that help systems-designed programs produce client change.

A program that is designed and implemented to be an *intervention program* has as its outcome, some degree of client behavioral change (that is, behavioral change is the purpose of the program) (Riley, 1987a, 1991a; Shank and Kinney, 1991). This may mean an increase in knowledge, an increase in skill, a decrease in some behavior, an increase in functional ability, and so forth. To be accountable in being able to produce change, a program has to be well-designed and implemented according to a plan that addresses that specific participant change. On the other hand, programs that are not accountable often lack forethought into the content and process of delivery, or the intended outcomes.

In addition, designing and providing intervention programs assumes that each program is part of larger whole—a comprehensive set of programs that are designed to meet the diversity of needs of clients entering the program. This applies to the comprehensive series of therapeutic recreation programs as well as implying that departmental programs also need to align with the overall agency's system of services. Each program part should complement other programs within the department and agency.

Client Placement Based on Needs

A comprehensive set of programs designed and available to meet the range of incoming client needs is required so that each client may be placed into programs based on individual need (Peterson and Gunn, 1984). This depends on an assessment procedure that produces valid and reliable results. Other literature (Dunn, 1983, 1984, 1987, 1989, 1991; Stumbo, 1991, 1992, 1993/94, 1994/95, 1996) discusses the need for validity and reliability in any measurement procedure, specifically client assessment.

A major requirement to establish validity and reliability is the alignment between the content of the programs offered and the content of the assessment. The importance of this match cannot be overstated. When the match exists, the potential for the clients to receive the right services is maximized; when the match does not exist, the potential for clients receiving the wrong or unnecessary services is maximized. The alignment was highlighted by Navar (1991) in explaining the term *appropriateness* (as quoted in the first paragraph of this chapter). The right client cannot be placed into the right program unless the assessment contains the right information (valid) and is refined to the point that placement is accurate (reliable).

Figure 1.1 helps to explain the relationship between program placement and client needs. Quadrants I and IV indicate correct decisions—the match between the client needs (from assessment results) and their placement into programs is correct. Clients who need programs receive services, while clients with no need do not. In Quadrant II the assessment results indicate needed program involvement that is not realized—an incorrect decision. The end result is that clients involved with erroneous Quadrant II decisions do not receive the necessary services. Quadrant III also indicates faulty matches or decisions. In these cases, clients receive services that do not match their needs. Programs provided in Quadrant III are likely to be misdirected in that clients without need are involved in programs without clearly defined outcomes. Whether this is due to agency mandates, high staff to client ratios, client diversity or other reasons, the specialist often resorts to Type I (Dunn, 1991) programming, often with the intent of keeping clients busy. Producing meaningful and reliable client outcomes is less likely in situations where clients with widely varying characteristics and needs are placed into one program.

Clearly, Quadrant I contains the "right" programs in which the "right" clients are placed. As such, it has the greatest likelihood to be outcome-based intervention; that is to produce measurable, predetermined client outcomes. It requires the mix of an appropriate assessment procedure that is able to produce valid and reliable assessment results and appropriate programs that are designed based on common client needs. This match is essential for correct client placement decisions.

Producing Client Outcomes

The ability to produce client outcomes is contingent on well-designed and systematic programs in which clients are placed based on the needs shown from assessment results. The relationship or causal link (Riley, 1987a, 1991a) is a strong one. It assumed that client outcomes have relevance and importance and are attainable.

Relevance can be determined by judging which outcomes are most crucial to the client's future status. For some that translates into future independence post-discharge, for others it might mean living with dignity in their remaining years, and for still others it may mean being better able to cope with their current disability or illness. What knowledges, abilities, and skills are needed most frequently or are most likely to be used by the client in his or her home or other future environment? How generalizable or transferable are the skills being taught to settings to which the client will go or return? How relevant is the content of the program(s) to the future lifestyle of the client?

Importance is related to relevance in that the specialist is probably limited in the amount of time that can be spent with any given client. Therefore, client contact time must be spent in the most efficient and effective way possible. How can time be best spent with the client? What is the most productive use of the client's time? How can the client's treatment time be maximized to the fullest extent possible? What are the most important knowledges, abilities or skills for the client's independent leisure lifestyle?

The *attainment* of outcomes often depends on the logistics of the therapeutic recreation program. How often is the client expected to participate in the program? What is the

Figure 1.1. Relationship Between Client Placement Into Programs and Client Needs.

	Client Placed Into Program	Client Not Placed Into Program
Client Needs Program	**I. Correct Decision** Client receives necessary services—likely to be intervention	**II. Incorrect Decision** Client does not receive necessary services—no or unnecessary program involvement
Client Does Not Need Program	**III. Incorrect Decision** Client receives unnecessary services—not likely to be intervention	**IV. Correct Decision** Client does not receive services—program involvement not necessary

frequency, duration and intensity of client participation? When are outcomes to be measured? How are the individual characteristics (variations) of the clients accommodated within the programs? How will the outcome data be collected? How reliable is this process?

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

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

a. the efficiency and effectiveness of demonstrating client change;
b. a reasonable expectation or relationship between the services provided and the expected outcome;
c. the connection between occurrence of the outcome and the timing of data collection;
d. the relevance to the client and society;
e. the goals and intent of the program;
f. an appropriate level of specification, but not reduced to trivial detail;
g. individual client variation within any given program;
h. both long-term and short-term goals and objectives;
i. the social and home environment to which the client will return; and
j. behaviors that are generalizable and transferable to a variety of settings and situations.

Client outcomes are vital to survival in today's healthcare arena. The ability to produce client outcomes is largely a factor of providing well-designed, systematic programs that are part of a comprehensive whole. It is important for specialists to be able to visualize and understand how individual components fit into the comprehensive whole. One of the major intentions of the Therapeutic Recreation Intervention Model is to provide this comprehensive perspective to design, implement and justify programs.

Components of the Therapeutic Recreation Intervention Model

The Therapeutic Recreation Intervention Model (TRIM) was created to help specialists visualize the interactive nature of documentation and decision points involved in the delivery, implementation and evaluation of accountable programs. Expanding on the models and concepts documented by Peterson and Gunn (1984) and Carter, Van Andel and Robb (1995), the TRIM attempts to depict the relationship between program input factors (such as activity analysis and assessment) and output factors (such as program outcomes and client outcomes).

The Therapeutic Recreation Intervention Model is presented in Figure 1.2. Each component of the model will be discussed separately, beginning with Comprehensive Program Design. The reader should note that, in practice, these elements are highly interactive. Interactive arrows virtually could be drawn between all components of the TRIM Model; those with the strongest relationships are provided.

Comprehensive Program Design

Program design involves establishing the direction of the therapeutic recreation department, unit or agency (Peterson and Gunn, 1984). This process entails gathering data about those factors (such as the community, agency and/or department, clients and profession) that impact the program and its clients, and prioritizing and selecting those programs that best meet client needs. Implementation and evaluation plans are created to ensure that the right programs will be delivered and reviewed systematically. Details about carrying out this process are provided through the Peterson and Gunn (1984) and Carter, Van Andel and Robb (1995) therapeutic recreation program planning models. The direction taken by the therapeutic recreation department at this point is crucial to the success of its remaining operations.

Activity Analysis, Selection and Modification

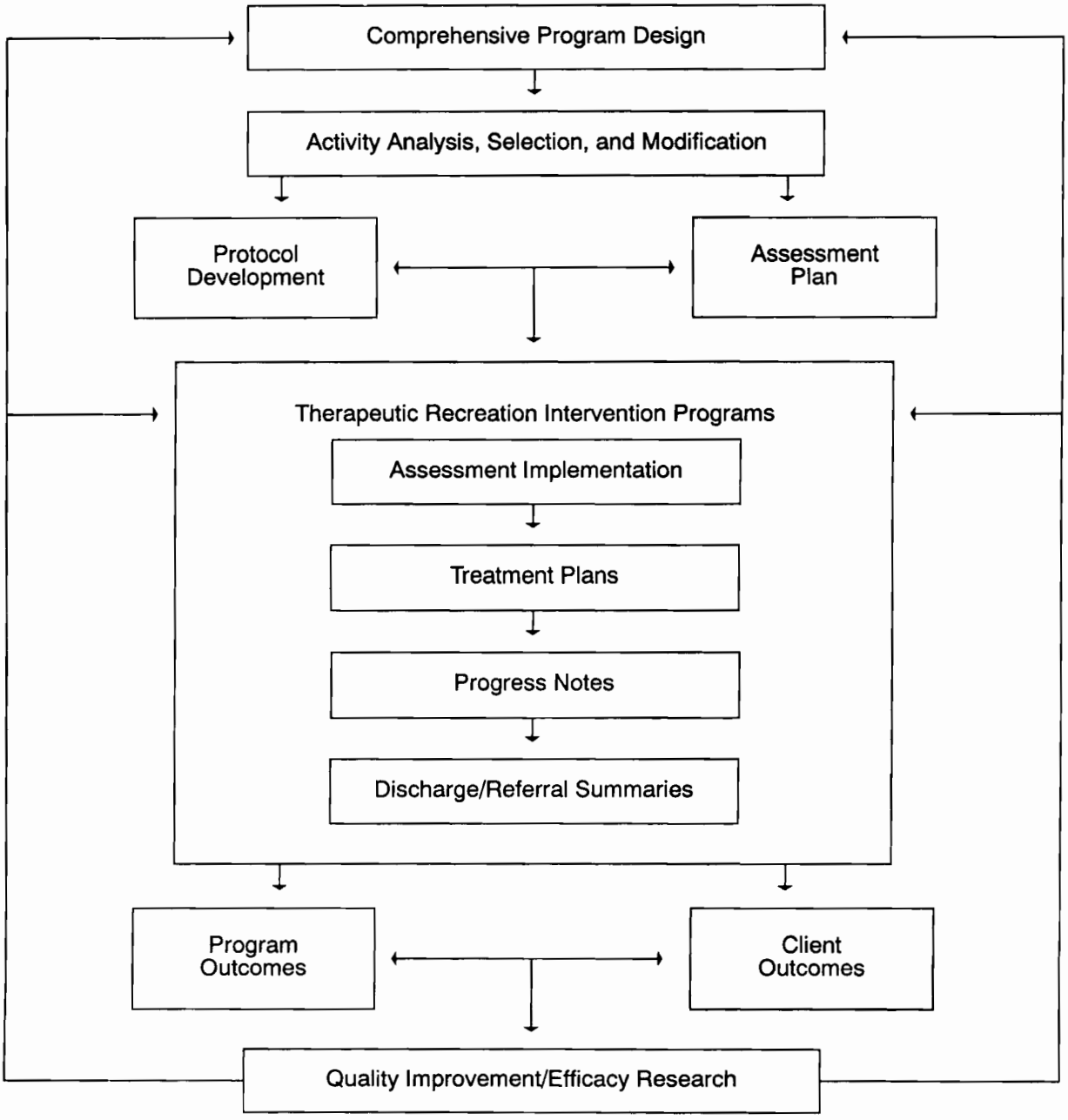
To make sure that the participation requirements of each planned activity are understood fully, an activity analysis is conducted. This helps planners understand, for example, that softball, volleyball and bingo are not primarily social activities; that there is little in the rules of these activities that teaches and/or requires social interaction, and therefore, social interaction skills. An activity analysis helps the programmer select specific activities that are more likely to be delivered as intervention, simply because the planner has had to look at the activity's requirements systematically through this process (Peterson and Gunn, 1984). "Through the processes of activity and task analyses, the [Therapeutic Recreation Specialist] selects and sequences potential content so the desired client changes will result from participation" (Carter, Van Andel and Robb, 1995, p. 127). The professional should "understand the activity and its potential contributions to behavioral outcomes" (Peterson and Gunn, 1984, p. 180). An activity analysis helps the programmer determine if any modifications need to be made to the selected activity in order that clients will benefit most fully. Thorough activity analysis is a critical link to program planning because it helps ensure that the specialist is providing programs that meet client needs and abilities. Activity analysis is an additional accountability factor that helps the specialist know that the "right service" or intervention is being delivered.

Peterson and Gunn (1984) have developed a system for completing an activity analysis and determining what modifications might be needed. This system complements the efforts taken by the specialist within comprehensive program design, protocol development, and assessment.

Protocols

Protocols are meant to aid in the "standardization of interventions" (Knight and Johnson, 1991, p. 137). Protocols are "a group of

Figure 1.2. The Therapeutic Recreation Intervention Model.



strategies or actions initiated in response to a problem, an issue, or a symptom of a client. They are not programs or program descriptions . . . but are approaches or techniques that will lead to expected treatment outcomes" (Knight and Johnson, 1991, p. 137). Protocols are meant to provide a blueprint of treatment for a specific diagnosis or client problem, and when validated through professional use and consensus, allow for program benchmarks to be set. They are useful methods of increasing the standardization of intervention programs within various service delivery agencies and departments across the country, primarily because they help define the input, process and projected outcomes of well-designed intervention

procedures. Connolly and Keogh-Hoss (1991) and Knight and Johnson (1991) asserted that protocols are a link between standards of practice and both efficacy research and quality improvement activities.

Kelland (1995) provided examples of 25 protocols, such as fitness, community living, and leisure education. The seven-part format used was adapted from Ferguson (1992) and includes categories of (a) general program purpose, (b) program description, (c) deficits the program might address, (d) facilitation techniques, (e) staff responsibilities and requirements, (f) expected program outcomes, and (g) appendices (samples). Connolly and Keogh-Hoss (1991) and Knight and Johnson (1991) also provided several examples of completed protocols.

Assessment Plan

Client assessment is the process used to place clients into therapeutic recreation programs based on their individual needs, strengths and limitations. Without a valid and reliable assessment, a program has little chance of being intervention and a client has little chance of attaining outcomes. That is, when clients are not assessed individually for their strengths, weaknesses and program needs, and all participants are encouraged or invited to come to all programs, this is a major signal of Type I (Dunn, 1991) programming.

In this phase of the model, a plan for developing or selecting, and implementing an assessment procedure is formed. Decisions about assessment content and implementation procedures are made.

Figure 1.1, introduced earlier in this chapter (page 5), helps explain the necessary relationship between assessment results and program placement, and points to key factors in assessment selection or development. At least four major concepts are important to understanding this relationship:

a. the content of the assessment must reflect the content of the programs that have been selected for delivery to clients;
b. the match between the assessment content and the program content implies that the assessment must be valid for its intended use, primarily for placing clients into the most appropriate programs to address their needs;
c. the assessment process must be able to deliver reliable results, indicating that specialists need to have standardized procedures and tools; and
d. client assessments play an important role in determining the baseline of client needs, abilities and limitations, and this baseline is crucial to proving outcomes during or after the process of intervention.

Client assessment, conducted in a systematic and meaningful manner, is a major foundation for providing outcome-based programs as it helps determine what types of behavioral change(s) are needed by the participant. Several pieces of literature have discussed the need for quality assessment procedures and tools, and their relationship to intervention programming (cf., Dunn, 1983, 1984, 1987, 1989, 1991; Stumbo, 1991, 1992, 1993/94, 1994/95, 1997).

Intervention Programs

Therapeutic recreation intervention programs are provided to clients based on need. It is common practice to group participants in programs based on their disability and/or illness characteristics that imply similar needs. For example, individuals with traumatic brain injury may demonstrate similar needs to develop impulse control. Planning for intervention programs relies heavily on the programmer's knowledge of the disability and/or illness characteristics of the participant group.

Shank and Kinney (1987) imply that the intervention process is one that requires careful and directed planning. "The clinical or

therapeutic use of activity implies a careful selection and manipulation of the activities in a prescriptive sense" (Shank and Kinney, 1987, p. 70). This means that intervention programs must have the specific intention of modifying client behavior and be presented in a manner most likely to systematically produce these changes.

The likelihood of program success is improved by the forethought given during planning. As mentioned previously, well-designed and systematic programs that include processes such as protocol development and activity analysis are much more likely to be planned as intervention and produce client behavioral changes.

The baseline for intervention is documented in a client assessment. Problems, strengths, limitations and the like are documented in order to determine the client's needs for services. As services are delivered, additional client documentation includes the client's individualized treatment or program plan, a periodic progress note(s), and a discharge and/or referral summary of services. The treatment plan outlines the goals and specific plan of action to be taken with a client (sometimes coplanned by the client). Progress notes are used to monitor progression toward or regression from the goals established in the treatment plan and to modify, if necessary, the original plan of action. Discharge and referral summaries are a compilation of the services received by the client, his or her reaction to the plan of action, as well as any future recommendations for leisure service involvement.

The focus of these action plans and summaries is on the expected or planned behavioral change (outcomes) within the client as a result of receiving appropriate and quality services. These pieces of documentation flow from the efforts taken within the program design, activity analysis phases, protocol development, and assessment. As a result of quality documentation, the specialist is better able to prove client outcomes and program effectiveness.

Navar (1984) outlined guidelines for producing quality client documentation and provided several examples of these forms within her chapter on Documentation in the Peterson and Gunn text (1984). These guidelines and examples can help the specialist improve the quality of his or her written documentation, and ensure alignment with other professional accountability activities.

Program Evaluation and Program Outcomes

In specific program evaluation, the specialist must gather and analyze selected data in a systematic and logical manner, for the purpose of determining the quality, effectiveness and/or outcomes of a program. It makes sense that the plan for program evaluation closely follows the plan for program implementation (Peterson and Gunn, 1984). For example, program factors such as facilities, equipment, staff, budget, advertisement and promotion, and the like can be evaluated as a function separately from individual client outcomes. Although they are undoubtedly interrelated, program documentation and evaluation focuses on program outcomes and client documentation and evaluation focuses on client outcomes.

Program evaluation questions might include the following: Were there adequate staff to implement the program and supervise clients? Was the facility adequate for the purpose of the program—enough space? accessible? Was the equipment functioning properly? How effective and efficient was the program format in assisting the clients in achieving their outcomes?

One such specific program evaluation procedure was developed by Connolly (1981, 1984). This procedure has been validated on a variety of programs and leads to useful evaluative data for the purpose of program review and revision. The procedure focuses on both the process and content of program delivery. As such, it is helpful in refining the focus of intervention programs, and in measuring client outcomes.

Client Evaluation and Client Outcomes

Client evaluation implies that the focus will be on whether the client outcomes targeted in the initial treatment plan have been accomplished. The focus will be on the end result of the intervention designed on behalf of the client, and is one part of patient care monitoring (Sheehan, 1992). For the most part, client evaluations will be conducted on an individual basis (for example, as progress notes or discharge and referral summaries), although these individual evaluations may be synthesized later into grouped data that addresses larger program evaluation concerns. Again, the achievement of client outcomes may be highly interrelated to the achievement of program outcomes.

The targeted client outcomes will vary based on the different client needs and varied purposes of the programs. In non-outcome-based programs, the focus of client evaluation may be the number of times the client attended a program or the level of client enjoyment. While these are sometimes important, when therapeutic recreation services are delivered as planned interventions, different client outcomes usually are expected. In intervention programs, the focus of service provision is client behavior or functional change as a direct, proven result of the program, and the focus of client evaluations becomes one of measuring and documenting those changes. "Outcome measurements become especially important if we view TR [therapeutic recreation] as an agent of change, as a means to modify behavior, attitudes or skills. This is important because the outcome measurements that we specify . . . will indicate what the client is expected to achieve during treatment" (Sheehan, 1992, p. 178). That is, specialists must target goals for client change that are expected to come about as a result of a well-planned and well-designed program. Typical questions concerning client outcomes include: Did the client achieve the targeted outcome within the planned program? If not, what prevented the client from achieving this end? Did the client learn a skill? change a behavior? change an attitude? Other specific questions may exist according to the treatment plan established for and with the client.

Client outcomes are dependent on well-designed programs in which clients are placed systematically, and in which interventions are delivered for a specific purpose. In essence, client outcomes, like program outcomes, rely on all previous parts of the Intervention Model being in place and being conceptually cohesive. Several sources (cf., Dunn, Sneegas and Carruthers, 1991; Shank and Kinney, 1991; Sheehan, 1992) supply examples and methods for measuring client outcomes.

Quality Improvement and Efficacy Research

The most common method of evaluating therapeutic recreation services at the comprehensive program level is through quality assurance or quality improvement mechanisms (Huston, 1987; Wright, 1987). A parallel activity, that may or may not be a separate function, is efficacy research (Shank, Kinney and Coyle, 1993). Both of these activities are intended to provide useful data to document and improve the standard of care delivered to clients.

Quality assurance (now termed quality improvement or continuous quality improvement) is defined as a "wide spectrum of activities ranging from determining an appropriate definition of care to establishment of actual standards of practice, that, if implemented, will result in acceptable levels of service" (Riley, 1991a, p. 54). Quality assessment is defined as a systematic process of collecting targeted data, analyzing and comparing data against predetermined standards, taking appropriate action if necessitated, and optimally managing the entire quality review operation (Riley, 1991a, p. 54; Wright, 1987, p. 56). Both of these functions focus on the quality and appropriateness of service delivery (Navar, 1991).

Quality improvement tends to focus on four areas: "good professional performance, efficient use of resources, reduction of risk, and patient/family satisfaction" (Navar, 1991, p. 6).

These four areas can help the specialist to focus evaluative efforts and provide direction in defining the purpose of data collection. That is, they help establish the "content focus" of the evaluation process.

The quality improvement process, as outlined by the Joint Commission on Accreditation of Healthcare Organizations, involves 10 steps that are to be used by all healthcare providers in delivering and evaluating quality and appropriate services. These steps help provide the "process" to be used in improving quality service delivery. The reader should be aware that other sources are available that explain in greater detail the application of quality improvement activities to therapeutic recreation services (cf., Riley, 1987b, 1991b; Winslow and Halberg, 1992).

In a similar vein, efficacy research also focuses on the outcomes, benefits or results of service delivery (Shank, Kinney and Coyle, 1993). It involves systematic data collection and analysis, with an aim of documenting service effectiveness, specifically client-based outcomes, for a particular group or groups of clients. While it does have distinct purposes and actions separate from quality improvement, it also shares some similar goals and professional benefits. In addition, it can be accomplished only through a careful and systematic analysis of program delivery factors. A particularly useful resource for more information about efficacy research is Shank, Kinney and Coyle (1993).

Key Points to the Intervention Model

The purpose of the Therapeutic Recreation Intervention Model is to show the interrelationships between different tasks of providing intervention programs to clients. As such, several concepts are worth mentioning.

1. **In order to provide intervention, therapeutic recreation specialists must be aware of and competent in each task or type of documentation depicted in the Therapeutic Recreation Intervention Model.**

It is the responsibility of every therapeutic recreation professional to become well-versed in the various aspects of providing therapeutic recreation intervention. This means increasing competencies in all accountability activities, such as protocols, client assessments, and quality improvement activities. The therapeutic recreation literature and conference offerings are becoming richer with resources to help specialists increase understanding of and competencies in improving program accountability. It is each specialist's responsibility to make sure he or she understands and can apply these concepts to practice.

2. **In order to produce client outcomes, therapeutic recreation specialists must conceptualize the interrelationships between program design, delivery and evaluation.**

In the past, it was acceptable to be satisfied with providing Type I programs. In the vast majority of healthcare settings, this is no longer the case. Providing quality programs is not enough; we must be able to produce client outcomes—especially those that make a difference in the lives of clients and are valued by other healthcare providers. We can only address this change in service provision through recognizing that all parts of program delivery and documentation must align with one another. It is no longer acceptable to, for example, have a client assessment that gathers useless information (and dust!). We now acknowledge that all parts of the accountability system must match and follow a logical, interconnected pattern.

3. **The connection between components must be clear and logical.**

Again, the purpose of this Model is to provide a visual context that allows the specialist to view the entirety of service provision. Descriptors, such as systematic, interrelated, alignment,

and connections, are crucial to ensuring that service provision be outcome-based. Literally every component box on the Model could be connected with every other box, because one action or decision affects all other actions or decisions. If one part of the Model, for example, client assessment, is not in alignment with other components, then being able to provide intervention is highly unlikely. The connections must be clear and logical.

4. **We need to take the guesswork out of "providing the right patient with the right service [at] the right time in the right setting at the right intensity and for the right duration" (Navar, 1991, p. 5).**

One aim of the Model is to help specialists become more systematic in delivering programs to clients. Therapists need to discover and document what works and what does not. We need better, more comprehensive "systems" for service provision. Each piece of the Model plays a vital part in conceptualizing and improving the accountability of therapeutic recreation programs. Systematic research and data collection will improve our ability to predict and deliver consistent client outcomes.

Summary

For nearly a decade, the profession of therapeutic recreation has focused on the production of client outcomes. Following mandates established by external accreditation bodies, health insurance companies, and other professions, the profession has made strides in upgrading the quality and appropriateness of service delivery.

The Therapeutic Recreation Intervention Model (TRIM) is provided as one avenue for describing the process used to design, implement, and evaluate quality intervention programs. It is intended that practicing professionals use it as a diagnostic tool in evaluating their program operations and that preservice professionals use it as a conceptual learning aid. It is offered with the intention of helping us design and provide quality programs that make a difference in the lives of clients.

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