Volume 16 | 2022

ISSN 2292-6232

Therapeutic Recreation: Practice & Research

The Journal of Therapeutic Recreation Ontario

The Journal of Therapeutic Recreation Ontario

trontario.org/education-research/trpr--journal-of-tro

Therapeutic Recreation: Practice & Research

The Journal of Therapeutic Recreation Ontario

Therapeutic Recreation: Practice and Research, Journal of Therapeutic Recreation Ontario

ISSN 2292-6225 (Print), Volume 16, 2022.

ISSN 2292-6232 (Online), Volume 16, 2022.

TRPR Journal of TRO (https://www.trontario.org/education-research/trpr-journal-of-tro/index) is a peer-reviewed journal published annually by the Department of Recreation and Leisure Studies at the University of Waterloo, 200 University Avenue West, Waterloo, Ontario, Canada, N2L 3G1.

Copyright © 2022 Therapeutic Recreation Ontario. All rights reserved. No part of this publication may be reproduced, store, transmitted, or disseminated, in any form, or by any means, without prior written permission from the Department of Recreation and Leisure Studies at the University of Waterloo, to whom all requests to reproduce copyright material should be directed, in writing.

Therapeutic Recreation Ontario and our publisher the Department of Recreation and Leisure Studies at the University of Waterloo make no effort to ensure the accuracy of all of the information (the "Content") contained in our publications. However, Therapeutic Recreation Ontario and our publisher the Department of Recreation and Leisure Studies at the University of Waterloo, our agents, and our licensers make no representations or warranties whatsoever as to the accuracy, completeness, or sustainability for any purpose of the Content. Any opinions and views expressed in this publication are opinions and views of the authors and are not the views of or endorsed by Therapeutic Recreation Ontario and our publisher the Department of Recreation and Leisure Studies at the University of Waterloo. The accuracy of the Content should not be relied on and should be independently verified with primary sources of information. Therapeutic Recreation Ontario and our publisher the Department of Recreation and Leisure Studies at the University of Waterloo shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario
Volume 16 | 2022

CONTENTS

Practice

Research

Call for Papers

Foreword

We are pleased to present the sixteenth volume of the *Therapeutic Recreation: Practice and Research (TRPR), Journal of TRO*. This resource is an opportunity for both practitioners and researchers to share practical experiences in addition to disseminating traditional research papers. Across the country, TR researchers, educators, and practitioners in Canada continue to work together to critically reflect on practices and engage in research to transform the field of TR. Alongside these shifts, TRO continues to work to make research available to practitioners, students, and people with whom we work. We hope to be able to reach practitioners across Canada and encourage all involved in TR to engage with research in our field.

Since 2003, the journal has involved collaboration between TRO and the department of Recreation and Leisure Studies at the University of Waterloo (uWaterloo). Founding editors consisted of Adrienne Gilbert, Sherry Dupuis, and Susan Arai. Previous volumes have also been led by doctoral students at uWaterloo including Shannon Hebblethwaite (now a faculty member at Concordia University in Montreal, Quebec) and Colleen Whyte (now a faculty member at Brock University in Ontario). In 2013, Dr. Kimberly Lopez and Carrie Briscoe, two doctoral students at the time in Recreation and Leisure Studies at the University of Waterloo, took the lead as the Co-Editors-in-Chief and engaged in a name changing process to truly represent the journal's purpose - to discuss therapeutic recreation practice and research happening in the TR profession in Ontario. They also collaborated with graphic designers to create our beautiful cover art. Dr. Kimberly Lopez (now a Faculty member at the University of Waterloo) has since become our Advisor of Journal Development. In 2017 Jaylyn Leighton (Co-Editor and PhD. Candidate at the University of Waterloo) joined the team as an Associate Editor and was involved in the publications of Volumes 12 and 13. In 2019 Jaylyn took over the role of Editor-in-Chief from the most recent Editor-in-Chief, Kimberly Lyons. We must specially recognize Kimberly Lyons for her contributing role in the growth of the journal. Jaylyn Leighton was the Editor-in-chief for Volume, 14 (2020) and the Special Edition: Reflections on COVID-19 (2020). Alexine (Allie) Serota (Co-Editor-in-Chief) also joined the team in 2017 as an Associate Editor and was involved in the publications of Volumes 12, 13, 14, and the Special Edition: Reflections on COVID-19. Jaylyn and Allie acted as Co-Editors-in-Chief for Volume 15 (2021), and the current Volume 16 (2022). It is with mixed emotions that we, Jaylyn and Allie, announce the completion of our terms as Co-Editors-in-Chief. We have both gained invaluable experiences and connections through our work with TRPR over the past six years and are thrilled to pass TRPR along to Hannah Mueller who will be stepping into the role of Editor for subsequent volumes. We are proud and honoured to have had the opportunity to serve as Co-Editors-in-Chief for the past few Volumes, as we feel this resource is integral and necessary for all TR practitioners and TRO members to learn and grow in their professional practices. We want to thank our readers, our authors, and TRO members for continuing to engage in meaningful care work beyond the pages of the TRPR journal.

The current issue consisted of a team of four Associate Editors including Sabrina Teles (joined 2019), Akua Kwarko-Fosu (joined 2019), Hannah Mueller (joined 2020), and Jasmine Nijjar (joined 2020). As Editors-in-Chief, we want to extend our deepest appreciation to each of these associate editors. Without their effort, time, and work ethic, this Volume, and all other TRPR-related work efforts, would not be possible. We also want to make a special acknowledgment to Crystal-Jade Cargill, a recent graduate of the Therapeutic Recreation program at the University of Waterloo for her invaluable work in the past year as the Special Projects Coordinator of TRPR. With Crystal-Jade taking the lead, we, the TRPR Journal, held a 3-part recorded webinar series (approved for 1 PCC point each) in Winter 2022. Topics relating to our ongoing work efforts at TRPR included: (1) conceptualizing a research and practice paper, (2) all about research ethics, and (3) attending to the research and writing process. These recorded webinars and transcripts are available for TRO members via the Thinkrific platform on TRO's webpage. Additionally, Crystal-Jade took the initiative on creating a 6-part podcast series that is being released bi-monthly through 2022 (via Anchor/Spotify platform).

The development and creation of our vision, mission, and objectives began in 2015. These statements evolved through several iterations with input from various committees—the TRO board, the TRPR steering committee, and the TRPR editorial team—before landing on the wording you see on page *vii*. The vision, mission, and objectives reflect the need to capture current collaborations and innovations in TR, while addressing the diverse aims individuals in TR have for a resource that discusses TR practice and research across Canada.

In working to expand the reach and scope of the TRPR Journal, this issue embodies perspectives from academics, students, and practitioners. The following edition of TRPR is divided into two sections: practice papers and research papers. The first practice paper by Fender and Ng-Gerritsen discusses the recently founded TRO Diversity and Inclusion Committee. As co-Chairs of the committee, the authors highlight ongoing initiatives aimed to develop a better understanding and awareness of key concepts related to diversity and inclusion and foster much-needed conversations in the field of TR. The second practice paper by Debus provides a detailed overview of a mindfulness program implemented within in-patient mental health recovery (specifically substance use disorders), and links to a digital mindfulness journal resource are available on the TRPR webpage.

The first research paper by Dupuis provides a timely account of the changing roles and responsibilities of recreation practitioners working in long-term care and retirement homes during the COVID-19 pandemic. The second research paper by Dwulit, Silijer, and Hopper provides an overview of a research study conducted to determine the cause and effect of varying job titles on the profession of TR within a Canadian context. In the third research paper, MacKillop, Campbell, McCartney, and Rodrigo discuss the role of therapeutic recreation in facilitating interprofessional therapeutic group programming in an acute inpatient psychiatric setting. The final paper in this volume by Diamond, Johnson, Faziluddin, and Jones highlights a research project that aimed to increase patients' engagement in recovery-based meaningful activities on a secure forensic unit by training staff in cognitive behaviour therapy skills.

Each of the papers in this volume provides a unique lens for viewing TR research and practice. The themes that emerge reinforce the importance of diversity, inclusion, creativity, interprofessional collaboration, and recovery-based programming. We feel that this work is even more meaningful to provide opportunities for connection as we return to TR and care work post-pandemic. The authors of the manuscripts in volume 16 encourage all of us – TR practitioners, scholars, researchers, and students – to find ways to bridge practice and research, by reflecting critically on our practice and the ways we evaluate the impact of TR programs, services, learning, perspectives, and research approaches. As the editorial team, we have the great pleasure and privilege of being a part of the growth and development of the TRPR Journal.

It is our hope that after reading this issue you take away new concepts, reflect on their importance, and perhaps even apply a different lens to your own practice. We are confident that you will benefit from reading this volume and will consider sharing examples of your own research or exemplary programs in the next volume of the TRPR Journal.

Sincerely,

Jaylyn Leighton & Alexine Serota
Co-Editors-in-Chief

Dr. Kimberly Lopez
Advisor of Journal Development

Sabrina Teles
Akua Kwarko-Fosu
Hannah Mueller
Jasmine Nijjar
Associate Editors

TRPR Journal Vision, Mission, and Objectives

Vision

The TRPR Journal will be the premiere therapeutic recreation (TR) journal in Canada aimed at inspiring innovations in knowledge, thought, and social justice.

Mission

The TRPR Journal is a resource that builds capacity, knowledge, and collaboration to inform practice, research, education, and advocacy in TR. The TRPR Journal actively promotes, supports, and encourages diverse theoretical frameworks, methodologies, and practices.

Objectives

In TR practice, research, and education, the TRPR Journal will:

- publish high quality, innovative papers for sharing TR knowledge;
- bridge diverse interests and perspectives across all stakeholders[1] of TR;
- inspire and embrace creative ways to critically reflect on, advance, and disseminate a multiplicity of TR perspectives; and
- stimulate continuous development of TR research to comply with TRO's Research Standard of Practice.

In partnership, the TRPR Journal Editorial Team, the TRPR Steering Committee, and Therapeutic Recreation Ontario strive to:

- encourage and support TR knowledge development, synthesis, translation, and dissemination;
- make this TR knowledge accessible to all stakeholders; and
- advocate and facilitate knowledge sharing and connection building among stakeholders in research, practice, and education within TR and beyond.

Contact Us

Department of Recreation & Leisure Studies | 200 University Avenue West | Waterloo, ON N2L 3G1
Email: TROjournal@uwaterloo.ca | facebook.com/TRPRJournalTRO | Twitter: @TRPRJournalTRO

About the Cover Art

For Volume 9 (2013), the TRPR Journal developed the graphic theme, **Trillium+Connecting Together**, in collaboration with graphic designers, Guia Gali and Robert Tu. Subsequent volumes, including Volume 14, also feature this graphic theme, described by our designers in more detail below.

The ***TRPR Journal Cover*** design draws on the bouncing ball theme (inspired by TRO) incorporating the old TRO logo with the new colours and design. Two individuals on the back cover are connected together with their hands overhead to accentuate their trillium petal-shaped bodies. Aiming to represent connection (one figure is incomplete without the other) and social engagement and collaboration within TR in Ontario. The ***wordmark*** is comprised of a mandala that wraps around TRPR lettering. This wordmark is composed of people holding hands, forming a trillium. Once again, the word mark alludes to the previous TRO logo, the trillium flower, with an added illustrative touch. The

[1] Stakeholders of TR being practitioners, researchers, educators, and partners in TR care

mandala reflects each person's search for completeness. The people are connecting through practice and research to make the "circle" complete.

About the Editorial Team

Co-Editors-in-Chief

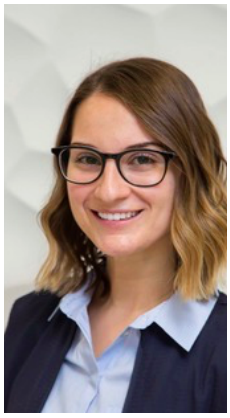
Jaylyn Leighton is a PhD Candidate in the Department of Recreation and Leisure Studies at the University of Waterloo in Ontario, Canada. Her research primarily focuses on critically examining the trajectories of healing for individuals who experience trauma through practices of care, leisure, and restoration. Jaylyn has been involved in the TRPR journal as an associate editor for three years before taking on the Editor-in-Chief position in September of 2019. This will be her fourth Volume as Editor-in-Chief.

Alexine (Allie) Serota is a Master of Arts graduate from the Department of Recreation and Leisure Studies at the University of Waterloo. Her Master's research focused on understanding the relationships persons living with dementia have with their companion animals, framed within social citizenship and relational perspectives. Allie has been an associate editor of the journal for the past four years and took on the Co-Editor-in-Chief role in September 2020. Currently, she works at the Schlegel-UW Research Institute for Aging as a Project Officer, Knowledge Mobilization.

Advisor of Journal Development

Kimberly J. Lopez works as an Assistant Professor in the Department of Recreation and Leisure Studies at the University of Waterloo in Ontario, Canada. She is interested in critically examining social structures and processes that reinforce difference and marginalization. As a community-engaged qualitative researcher, she values working collaboratively and creatively to amplify Othered meanings of identity, leisure, labour, care, aging, and well-being.

Associate Editors



Sabrina Teles graduated from the University of Toronto in 2018 with an Honours Bachelor of Arts degree with a Major in Linguistics, and a Double Minor in Sociology and Semiotics. Sabrina completed her Master of Arts degree in Recreation and Leisure Studies at the University of Waterloo in 2019 and is currently a Master of Science in Occupational Therapy candidate at the University of Toronto. Sabrina has been involved in a number of practices surrounding Therapeutic Recreation not only through her studies but through her previous experiences as a committee member for the Symposium on Aging Research, as a student representative for the Canadian Association on Gerontology, as a Recreation Assistant at a Retirement Residence and as the 2021-2022 Co-Executive Director of the Seniors Outreach Program at the University of Toronto.

Akua Kwarko-Fosu recently completed her Master of Arts degree under the supervision of Dr. Kimberly Lopez in Recreation and Leisure Studies at the University of Waterloo. She graduated from UW in 2019 with a Bachelor of Arts in Therapeutic Recreation and Psychology. Akua's primary research interests include using creative methodologies to examine connections between social structures, identity, well-being, and leisure for marginalized communities. She contributed to the creation and maintenance of the TRO research hub by collecting relevant articles of evidence-based practice and designing a toolkit to help TRs engaging in research.

Hannah Mueller is a third year PhD Candidate at the University of Waterloo. She completed her Master's of Science at the University of La Crosse (Wisconsin) in Recreation Management '18, and '14 graduate of the Therapeutic Recreation program (B.Sc.). Hannah has been a CTRS since 2014. She has been employed in the field of TR since 2012 working with various populations: SCI/TBI, geriatrics, mental health, and community-based programs. Her personal leisure hobbies include: knitting, traveling, and reading scholarly things. Hannah joined the editorial team in September, 2020. s

Jasmine Nijjar (she/her) is a second year PhD student in the Recreation and Leisure program at the University of Waterloo. Her education in Therapeutic Recreation provided her to work as a Therapeutic Recreationalist in long-term care before returning to the University of Waterloo to continue her studies. Her research interests are rooted in exploring the various relationships between individuals and leisure. She turns to considering colonial histories, multicultural and racial experiences, and unique intersectionalities to help understand experience of difference. Jasmine joined the editorial team in September, 2020.

TRPR Journal of TRO

©2022 Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario, Vol. 16, pp. 1-12

UNIVERSITY OF WATERLOO | FACULTY OF HEALTH Department of Recreation and Leisure Studies

Promoting Diversity and Inclusion within Therapeutic Recreation Ontario (TRO)

Practice Paper

Debbie-ann Fender and Yvonne Ng-Gerritsen

Abstract

As co-chairs of Therapeutic Recreation Ontario's (TRO) Diversity and Inclusion (D&I) Committee (founded 2021), we understand the importance of fostering diversity and inclusion within our association. We recognize current TRO members are of different genders, ages, ethnicities, racialized perspectives, abilities, sexual orientations, geographic locations, and have other lines of difference that all contribute to diversity. In this paper, we share strategies that will be passed to the TRO members, including the board of directors, in hopes that they will help us foster an environment where all members feel safe, and know that they belong. We will discuss the importance of developing awareness around concepts such as intersectionality, prejudice, stereotypes, discrimination, and microaggressions. We will also share some recommendations from participants of the 2021 TRO conference session, *The Journey to Unconscious Competency: An Exploration of Intersectionality*, and some upcoming initiatives from TRO's D&I Committee. Overall, the purpose of this paper is to begin a much-needed conversation about issues around D&I, as inspired by TRO members.

Keywords: Diversity, Inclusion, Intersectionality, Unconscious bias, Microaggressions, Recreation therapy

---

Debbie-ann Fender is the chair of the Diversity and Inclusion Committee at TRO. She is currently a faculty member in the Recreation Therapy program at Niagara College. She is passionate about teaching courses related to equity, diversity, and inclusion. Debbie-ann completed her Masters of Education in Adult Education at Yorkville University with a focus on inclusive adult educational practices.

Yvonne Ng-Gerritsen is the co-chair of TRO's Diversity and Inclusion Committee. She is a professor and program coordinator of Seneca's Honours Bachelor of Therapeutic Recreation program. She brings awareness to diversity and inclusion as evidenced in her masters research focused on The Role of Leisure for Chinese Immigrants Living in the GTA, which also addressed gaps in leisure research.

Contact: Debbie-ann Fender | Email : dfender@niagaracollege.ca

Promoting Diversity and Inclusion within Therapeutic Recreation Ontario (TRO)

Introduction: Diversity and Inclusion Committee (D&I Committee)

As a professional association, we, the authors of this paper, feel it is important for Therapeutic Recreation Ontario (TRO) to reflect on the past as a means to envision the future. TRO was originally created as a special interest group that was part of a larger association called Parks and Recreation Ontario (PRO). In 1999, TRO became an independent unit. By 2006 the association had 500 members (Gilbert, 2007) and has since increased to over 1900 members as of August 2021 (About TRO, 2021). This growth in membership has extended from therapeutic recreation (TR) professionals and Registered professionals (R/TRO, R/TRO DIP), to now include students-at-large through the educational institution membership (EIM) and associate members. Due to this rise in membership, TRO has formed an increasingly diverse community that continues to grow. In light of recent socio-political events, there are necessary conversations happening around the need for diversity, equity, and inclusion. In March 2021, TRO started the D&I working group to identify key gaps in diversity and inclusion within the organization so that *all* members can feel supported. What was then referred to as a working group was supposed to be term specific and was expected to promote diversity and inclusion (D&I) initiatives for a period of one to two years. However, based on feedback from our membership around the need to continue to engage in this work more permanently, we have now moved from a working group to a committee of the TRO board. As TRO seeks to promote a diverse and inclusive membership, we use the current paper to explore the concepts of intersectionality, unconscious bias, and microaggressions, which play a vital role and impact on broader organizational success. By creating opportunities for members to have a better understanding of these concepts, both personally and professionally, we hope all TRO members can feel safe and have a sense of belonging.

According to Bersin (2014), "organizations often define the diversity of their people according to unique and/or legally protected differences, such as race, gender, age, disability, sexual orientation, maternity status, and other "non-visible" qualities and backgrounds" (p.11). Bersin (2014) continues to note that inclusion looks at "creating an environment in which people feel involved, respected, valued, and connected—and to which individuals bring their authentic selves (their ideas, backgrounds, and perspectives) to their work with colleagues and customers" (p.12). As co-chairs of the D&I Committee, we understand the importance of fostering D&I within TRO. In current literature, organizations that promote diversity and inclusion have been demonstrated to be more productive (Dixon-Fyle et al., 2021). Productivity examines whether the activities of an organization are efficient and effective (Saxena, 2014). For TRO, productivity looks to current membership engagement to understand the diverse needs of all members. TRO's mission is to lead the TR profession through growth, advocacy, and innovation. In efforts for D&I to become a strategic organizational driver, TRO works to keep this mission in mind when

determining which aspects of diversity and inclusion to embrace, which to tackle, and how to implement appropriate synergies (Weaver, 2015).

The authors of this paper are both current educators in the field of therapeutic recreation (TR) and have each represented TR membership at the TRO board level. The D&I committee started in response to a gap identified by members and allies from diverse. TRO approached the authors of this paper to lead the D&I Committee and reflect on how TRO, as a larger governing body, is addressing issues around D&I. The expanded group now includes nine members from various positions and backgrounds. As a committee, we meet once a month to discuss important topics and brainstorm action-based ideas and initiatives to share broadly across TRO membership. On June 9, 2021, the authors of this paper presented at the TRO conference with the intention of providing education and raising awareness to the much-needed conversations around D&I. As part of this presentation, we felt it was necessary to outline a list of resources and action steps that need to be taken in efforts to ensure D&I within the TRO governing body and subsequent membership.

In this paper, we start by conceptually exploring the importance for TRO members to understand and embrace intersectionality. We discuss prevalent issues around unconscious bias, stereotypes, prejudice, discrimination, and microaggressions. Following this, we discuss how the D&I Committee hopes to promote D&I within TRO membership broadly by highlighting our future action-based initiatives that aim to promote D&I and support *all* TRO members.

Conceptual Exploration: Understanding Diversity and Inclusion

To begin this dialogue, we start by exploring concepts and terms related to D&I including intersectionality, unconscious bias, stereotypes, prejudice, discrimination, and microaggressions. We feel it is necessary to start by providing a basis of understanding and meaning of these terms before we shift toward discussions of future strategies and action steps.

Intersectionality

Here, we ask readers to stop and reflect on the many facets that make your own lived experiences unique in relation to their professions within the field of TR. As a large field of TR professionals, we all exist with varying identities that overlap. These overlaps refer to the concept of intersectionality, a term coined in 1989 by philosopher, professor, critical race theorist and advocate, Kimberlé Crenshaw. Intersectionality acknowledges that human lives cannot be reduced to single characteristics (Hankivsky et al., 2014). This is an important framework to understand individuals and to promote inclusion, social justice, and equity in any organization. As individuals, we identify with social concepts such as race, ethnicity, gender, class, sexuality, geography, age, religion, migration status and ability, among other factors. These terms are socially constructed and contextualized within connected systems such as laws, policies, media, and government (Hankivsky, et al., 2014). Depending on how societal structures are interpreted and approached, they can potentially create forms of privilege and disadvantage that lead to racism, homophobia, ableism, ageism, sexism, etc. For example, Gopaldes (2013) explained that

people's sexual orientation combined with a disability can affect their salaries and promotions, which in turn can affect their economic and social class, and their ability to access educational opportunities. Intersectionality encourages larger organizations to think critically about their practices and communication so that members from equity-deserving communities are included.

We feel it is important to take an intersectional approach to supporting TRO members because it allows us as an organization to focus on solutions for members that are informed by their voices and experiences. It also allows us to engage and activate members who are seeking a sense of belonging, and to connect with members in ways that resonate with their lived experiences and values. According to the Opportunity Agenda (2017):

> Intersectionality requires recognition of the voice of those most directly impacted, because they are frequently excluded from mainstream conversations. Valuing voice means lifting up, promoting, and supporting the leadership and storytelling of those most affected by policies and practices and centering their substantive suggestions and values into any given project and media advocacy. Impacted communities have direct experience that makes them thought leaders in the movement for social justice. Valuing voice allows those who are affected by policies to play a substantial role in building their own story.

While the social concepts of race, gender, sexuality, ability etc. may seem separate, these dynamic and multi-contextual factors intersect and make up an individual's life experiences and opportunities. For example, race as a comorbidity can touch on aspects of gender, class, ability, and health. Many of these factors can also be described as social determinants of health. Social determinants of health refer to social and economic factors that may contribute to certain health inequalities (Government of Canada, 2020). According to the World Health Organization (WHO) (2020), social determinants are the conditions in which people are born, grow, work, live, and age, as well as the wider set of forces and systems shaping the conditions of daily life.

By gaining a deeper understanding of intersectionality and social determinants of health, we can see the underlying impact that systems and/or organizations can have on an individual's well-being and level of inclusion. Further, by considering intersectionality when developing policies and frameworks within organizations, organizations can proactively eliminate any disadvantages and foster equality, diversity, and inclusion to the fullest. This is significant in the field of TR as our role, as TR professionals, is to help clients' reach their highest potential (through goals and objectives), and to improve their quality of life. By having a better understanding of potential areas of needs and strengths through an intersectional lens, we can advocate on our clients' behalf to ensure their right to leisure, health, and overall well-being.

Unconscious bias

At some point in our lives, we have relied on our instincts to make decisions. However, it is important to note that as TR professionals, we cannot solely rely on our instincts when making decisions about colleagues, patients, and communities that we work in because those instinctive

decisions may be clouded by unconscious bias. Unconscious bias refers to the assumptions and conclusions that are drawn about individuals without thinking (Moin & Nieuwerburgh, 2021). They are automatically activated and frequently operate outside conscious awareness and affect our everyday behaviour and decision making. Our unconscious biases are influenced by our background, culture, context, and personal experiences (Atewologun et al., 2018). Throughout our human development, our attitudes are shaped implicitly and explicitly by the cultural values we are exposed to. By engaging in conversations and activities, our unconscious brain is constantly processing information and looking for patterns. An example might be assuming that an older person walking with a child is their grandparent. Although the patterns identified may fit the predisposition to which the individual was exposed, that older individual could be a parent, a caregiver, a mentor, or just a friend. These assumptions made about others do not indicate hostility towards certain groups, rather, they reflect how the individual has been socialized. However, if such assumptions are left unchecked, they can easily lead to (at best) stereotypes and (at worst) prejudicial or discriminatory behaviours (Frith, 2015). As a D&I Committee, we want to encourage the TRO membership to avoid being complicit to any of these actions. To do this, we hope to support TRO in continuing to examine the practices of the organization, to ensure that strategies are put in place to prevent the negative impacts of unconscious bias which includes stereotypes, prejudice, discrimination, and micro aggressive practices towards members who belong to equity-deserving communities. We will share some strategies to address these issues throughout this paper.

Stereotypes, Prejudice, Discrimination, and Microaggressions

The D&I Committee strives to ensure that TRO members experience quality services and can thrive in TR practice. We aim to ensure that the principles and practices of D&I are embedded in TRO's internal operations, as well as in its corresponding TR programming. To do so, it is important to consider the concepts of stereotypes, prejudice, discrimination, and microaggressions as TRO members who have experienced such hurtful acts share that it can be mentally and physically exhausting.

Davidio and colleagues (2013) explained that stereotypes involve associating or attributing specific characteristics to a group. Stereotypes involve labeling people in different groups because of the way one group may *think* about another group (e.g., assuming that individuals with mental illnesses are dangerous) (Davidio et al., 2013). Prejudice examines the attitude that individuals have towards an evaluation of a group of people. Prejudices are a type of bias that ultimately devalues people because of their perceived membership to a social group and affects how *we feel* about them (e.g., agreeing with the stereotypes about individuals with mental illnesses thus developing feelings of fear, apprehension, or resentment towards them) (Corrigan & Watson, 2002). This often leads to discrimination, which involves biased behaviours towards, and treatment of, or *act* towards a group or its members due to stereotypes and prejudice (e.g., refusing to hire, work with, or acknowledge individuals who live with mental illnesses in the spaces that TRs work). Additionally, biased actions, inactions, and socialization practices put

people at risk of committing microaggressions (Williams, 2019). Microaggressions are the everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their marginalized group membership (Clark et al., 2014).

When these stereotypes, prejudice, discrimination, and microaggressions are present in a large organization such as TRO, they can result in reduced domain identification, job engagement, career aspirations, and receptivity to feedback. It can also affect areas of leadership, entrepreneurship, and competitiveness (Casad & Bryant, 2016). This often leaves a negative impact on the organization as a structure, as well as for the membership and their trust in the organization to protect their human rights. The concepts we discuss in this section directly affect how our TRO members function as a group, and if not addressed, can lead to low membership retention, lack of engagement, and lack of trust and cohesion within our membership.

2021 TRO Conference Presentation

During the 2021 TRO Conference, members of TRO's D&I Committee, and more specifically the authors of this paper, presented on the topic, *The Journey to Unconscious Competence: An Exploration of Intersectionality*. During the presentation, participants were asked to complete a poll related to common micro aggressive statements that they have heard and/or experienced that perpetuate stereotypes, prejudice, and discrimination. An example of a micro aggressive statement submitted by an audience member through the poll was: "Where are you from? I mean, where are you really from?" The person posing the question already has a preconceived answer based on their social perception of which groups are based geographically. Which is why, the verifying question of, "where are you really from?" is to confirm an unconscious bias, posing as a microaggression to the person who is asked. This question is inappropriate, and often harmful as it disregards the questionee's identity to match what the questioner expects. We have provided readers with a full list of statements that were shared with audience members during a mentimeter poll conducted at the 2021 TRO conference in Appendix A (these statements were adapted from resources provided in Sue (2010)). While microaggressions are most often unintentional, indirect, and oftentimes invisible to perpetrators, they can deeply affect the individuals they are perpetuated against. People who experience microaggressions may experience some of the following intrusive cognitions: "Did I interpret that correctly? Did she say what I think she said? What did he mean by that? Should I say something? Saying something may make it worse. They'll probably think I'm overreacting" (Banks, 2015, p. 11). Often, struggling with these internal dilemmas can lead to anxiety, depression, sleep difficulties, diminished confidence, helplessness, and loss of motivation (Banks, 2015). We therefore also feel that it is important for TRO to be able to tackle these issues so that inclusive and supportive environments can flourish.

Based on the discussions held during our presentation, some audience members shared that they have either thought, felt, or acted on the statements provided. Although these results reflect only a small portion of TRO members who were present, they represent the growing need

to address current understandings and practices of D&I issues within TRO membership. Therefore, as a committee, we feel that now is our chance to grow and strengthen our membership so that *everyone* feels a sense of safety and belonging.

Promoting Diversity and Inclusion within TRO

Now that we have examined some of the needs and concepts related to D&I, we want to connect this dialogue back to the organization of TRO by discussing how we work together to better promote D&I by identifying action-based needs and eliminating negative and harmful biases and discrimination. Some intervention strategies that have been field-tested and are easy to implement include: addressing environmental cues, valuing diversity, providing wise feedback, shifting organizational/cultural mindsets, reattributing training policies and protocols, reframing the task, valuing affirmations, belonging, communal goals, and interdependent world views, and teaching about stereotype threats (Casad & Bryant, 2016). We feel that by making intentional space for these conversations, organizations such as TRO can open up opportunities to gain valuable feedback from their members that are reflective of a broader cultural, organizational mindset. During our 2021 conference presentation, audience members were asked to engage in conversations around ways that TRO, as an organization, can foster D&I amongst its membership. The responses were gathered and documented and we plan to use these responses to make future plans around D&I for TRO in conjunction with the D&I Committee. For example, one TRO member suggested providing opportunities to amplify the voices and perspectives of TRs who identify as being a part of diverse communities (see Appendix B). Based on this recommendation, we plan to work closely with *TRPR: Journal of TRO* to develop a special issue and invite TRO members to share their lived experiences as they relate to D&I. We agree that successful organizational inclusion must go beyond diversity management, but also must promote greater inclusion of members by taking their views into account (Sabharwal, 2014). While diversity management is a good starting point to foster a positive and diverse environment, a more inclusive notion would be to hear from individuals of equity-deserving communities directly. Sabharwal (2014) shares how productive workplaces exist when employers are encouraged to get involved. Therefore, it is essential to lead an organization that is supportive of its members, creates space for individuals to feel empowered to express their opinions, and share in important decision-making for the future. This is why the recommendations outlined in Appendix B are invaluable as they come from TRO members directly. The D&I Committee understands that if we do not create safer spaces, we may inadvertently or intentionally leave out members from equity-deserving communities, hence having a continuous cycle of disadvantages. By embracing D&I, TRO can increase member engagement, build on TRO's brand externally, and enhance their ability to acquire new members.

D&I committee: Future Action-Initiatives for TRO

Dixon-Fyle et al. (2021) notes that if an organization wants to create a long-lasting, inclusive culture and promote inclusive behaviors, then *bold* actions must be taken. Our plan as a larger D&I Committee between 2021-2022, is to discuss and implement the following organizational approaches outlined by Nahm (2017) in efforts to bring positive, social justice-oriented changes in the following areas:

- Convert all job descriptions on the TRO website and online material to using gender-neutral language
- Develop resource packages to promote and support members who belong to BIPOC and LGBTQ+ communities
- Conduct a website audit to ensure accessibility for our TRO members with disabilities
- Develop a statement of commitment to building a diverse and inclusive culture
- Develop diversity-focused workshops and education sessions for all members to attend
- Develop an equity action plan that promotes fairness in access to educational opportunities offered by TRO
- Develop a survey to explicitly assess the experience of diverse members and allies, so that the right supports can be provided to members from these diverse communities

During the 2021 TRO conference session, we also asked participants for recommendations on how TRO can foster an environment where *all* members are valued. A summary of these recommendations is listed in Appendix B. Based on this summary, many members agreed that it is a good start by being transparent and having an open dialogue around diversity and inclusion issues. These recommendations will be used to guide the D&I Committee in its ongoing actions and initiatives. We hope to make space to empower TRO members by co-creating opportunities for individuals to share their own experiences. By engaging with TRO membership directly, we hope to instill a culture that promotes educating and learning from one another.

Conclusion and Future TR Considerations

As TR professionals, it is our responsibility to become pluralistic leaders that value diversity across *all* dimensions of life. As we follow a person-centred care approach, we need to understand the many areas of intersectionality and how they play a role in an individual's strengths and needs. We believe it is each of our responsibilities to educate ourselves about race, ethnicity, sexual orientation, inclusive language, truth and reconciliation, among other areas. As advocates, we need to reinforce respect and dignity for all, support social justice efforts, and be willing to call people out on prejudice. By fostering a diverse and inclusive environment within TRO, members can feel supported and competent to further explore these important issues.

As we keep these considerations in mind, we ask all of you, as members, students, instructors, and practitioners, to continue to reflect on this question: *How do diverse and inclusive practices allow you to grow as a recreation therapist?* It is our hope that you take opportunities to learn and grow in your own practices and increase efforts of self-awareness, diversity, and inclusion. We feel that by having a deeper understanding of our own

intersectionality and unconscious bias, not only can we help each other learn and grow, we can also address the needs and/or concerns of the individuals we work with on a daily basis.

Endnote

We would like to thank the current members of TRO's Diversity and Inclusion committee. These TR leaders have been working hard to bring about awareness and necessary change. The group will continue to work on a number of special projects, including a future TRPR special edition in which we will invite TRO members to share their stories and diverse perspectives in efforts of increasing and commitments to diversity and inclusion. This includes individuals who come from communities that have diverse and distinct identities, experiences, needs, and those who are allies. If you are interested in contributing to this special edition or have any questions for the D&I committee, please contact us at d-i@trontario.org for more information.

References

Atewologun, D., Cornish, T., & Thresh, F. (2018). *[PDF] Unconscious bias training: An assessment of the evidence for effectiveness | Semantic Scholar*. Equality Human Rights. Retrieved from https://www.semanticscholar.org/paper/Unconscious-bias-training-%3A-An-assessment-of-the-Atewologun-Tresh/509a580783bb5df10f3af42e8df720d8ad57dbd

Banks, B. (2015). *The impact of microaggressions – An introductory training*. Retrieved from https://cehs.unl.edu/images/EdPsych/nicpp/NICPP_microaggression_presentation_2015-06-02.pdf

Bersin, J. (2014). *Diversity and inclusion in Canada; the current state*. Retrieved from https://www2.deloitte.com/content/dam/Deloitte/ca/Documents/human-capital/ca-en-human-capital-diversity-andInclusion-in-canada.pdf

Casad, B.J., & Bryant, W.J. (2016). Addressing stereotype threat is critical to diversity and inclusion in organizational psychology. *Frontiers in Psychology, 7*(8), 1-18. DOI: 10.3389/psyg.2016.00008

Clark, D. A., Kleiman, S., Spanierman, L. B., Isaac, P., & Poolokasingham, G. (2014). "Do you live in a teepee?" Aboriginal students' experiences with racial microaggressions in Canada. *Journal of Diversity in Higher Education, 7*(2), 112–125. https://doi.org/10.1037/a0036573

Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics*. Chicago Unbound. Retrieved from https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8/?utm_source=chicagounbound.uchicago.edu%2Fuclf%2Fvol1989%2Fiss1%2F8&utm_medium=PDF&utm_campaign=PDFCoverPages

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry: Official Journal of the World Psychiatric Association (WPA)*, *1*(1), 16–20.

Dovidio, J. F., Hewstone, M., Glick, P., & Esses, V. M. (2013). *The SAGE handbook of prejudice, stereotyping and discrimination* (1st ed.). SAGE Publications Ltd.

Dixon-Fyle, S., Dolan, K., Hunt, V., & Prince, S. (2021, July 12). *Diversity wins: How inclusion matters*. McKinsey & Company. Retrieved from https://www.mckinsey.com/featured-insights/diversity-and-inclusion/diversity-wins-how-inclusion-matters

Frith, U. (2015). *Understanding unconscious bias*. The Royal Society. Retrieved from https://royalsociety.org/topics-policy/publications/2015/unconscious-bias/

Gilbert, A. (2007 September). *The history of Therapeutic Recreation Ontario.* Therapeutic Recreation Ontario. https://www.trontario.org/tr-history-ontario.html

Gopaldas, A. (2013). Intersectionality 101. *Journal of Public Policy & Marketing*, *32,* 90–94. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&AuthType=url,cookie,ip,uid&db=bth&AN=87372200

Government of Canada. (2020). *Social determinants of health and health inequalities.* Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/population-health/what-determines-health.html

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridkin, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity. *International Journal for Equity in Health, 13,* 119. https://doi.org/10.1186/s12939-014-0119-x

Frith, U. (2015). *Understanding unconscious bias*. The Royal Society. Retrieved from https://royalsociety.org/topics-policy/publications/2015/unconscious-bias/

Moin, F., & van Nieuwerburgh, C. (2021). 'The experience of positive psychology coaching following unconscious bias training: An interpretative phenomenological analysis', *International Journal of Evidence Based Coaching and Mentoring*, 19 (1), pp.74-89. DOI: 10.24384/n4hw-vz57 (Accessed: 28 September 2021).

Nahm, S. (2017). *The diversity and inclusion handbook*. Retrieved from https://ideas.wharton.upenn.edu/wp-content/uploads/2018/07/Leading-Diversity-in-Organizations_Lever-2017.pdf

Sabharwal, M. (2014). Is diversity management sufficient? Organizational inclusion to further performance. *Public Personnel Management, 43*(2), 197-217. DOI: 10.1177/0091026014522202

Saxena, Ankita. (2014). Workforce diversity: A key to improve productivity. *Procedia Economics and Finance. 11.* 76–85. 10.1016/S2212-5671(14)00178-6.

The Opportunity Agenda. (2017). *Ten tips for putting intersectionality into practice*. The Opportunity Agenda. Retrieved January 31, 2022, from https://www.opportunityagenda.org/explore/resources-publications/ten-tips-putting-intersectionality-practice

Therapeutic Recreation Ontario. (2021). *About TRO*. https://www.trontario.org/about/index.html

Williams, M. T. (2019). Microaggressions: Clarification, evidence, and impact. *Perspectives on Psychological Science*, *15*(1), 3–26. https://doi.org/10.1177/1745691619827499

World Health Organization. (2021). *Social determinants of health.* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Appendix A- Examples of Microaggressions

Adapted from (Sue, 2010)

1. "Where are you from? I mean, where are you really from?"
2. To someone who is Jewish, Sikh, Muslim- "why would you even wear that head covering, isn't it like 21st century?"
3. "As a woman, I know what you go through as a racial minority"
4. "Everyone can succeed in this society, if they just work hard enough."
5. "You people …"
6. "Do you live in a teepee?"
7. "Your name is so hard to pronounce, can I call you 'so and so' instead"
8. "Oh, you're gay? You should meet my friend Ann. She's gay, too!"
9. "My boss Jane is 'crazy'; it must be her time of the month or something"
10. "The way you've overcome your disability is so inspiring"
11. To an older person: "do you even know what Facebook is?"
12. To a person of color: "Is that your real hair?"

Appendix B- Summary of recommendations on how to foster an inclusive environment within TRO

Participants suggested the following:

- Being transparent and having open dialogue around D&I issues
- Offering mentorship opportunities to members from equity-deserving groups and developing ways to support needs
- Work closely with educators to get D&I embedded in TR curriculums
- Providing more education and training events around D&I
- Providing alternate payment options for members from diverse communities e.g., sliding scale membership
- Use promotional material where people from diverse backgrounds are represented
- Provide opportunities to amplify the voices and perspectives of TRs who identify as being a part of diverse communities
- Provide a space for members who continue to be affected by D&I to be able to share their stories
- Conducting more polls and surveys to continue to understand the needs of our members

TRPR Journal of TRO

©2022 Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario, Vol. 16, pp. 13-20

UNIVERSITY OF WATERLOO | FACULTY OF HEALTH Department of Recreation and Leisure Studies

Mindfulness Program Intervention Among Individuals Living with Substance Use Disorders

Practice Paper

Jenna Debus

Abstract

Recreation Therapists (RTs) working in mental health settings utilize a variety of therapeutic treatment modalities. Research has demonstrated practices of mindfulness to be beneficial when working with individuals recovering from an addiction and/or substance use disorders, as it alters the neurological structure of their brain and thought patterns. Mindfulness is one of many tools utilized in treatment contexts, however, it may be useful for practitioners and individuals living with substance use disorders to better understand mindfulness and the benefits of incorporating it into daily routines. Therefore, during my internship placement, I created a mindfulness program designed for individuals seeking treatment for substance use disorders. This program aims to not only educate participants on the benefits of mindfulness, but also create opportunity to expose participants to three different mindfulness interventions through practical application sessions. The intent of this program is to aid participants in understanding what mindfulness means to them and how it can be beneficial while in recovery. This program utilizes both educational and discussion-based techniques, as well as a practical application portion which allows participants to practice the mindfulness intervention then reflect on the benefits experienced during engagement. As a helpful resource for practitioners interested in implementing this type of program, I created a mindfulness journal that outlines each program session including mindfulness interventions (e.g., gratitude journaling, mindful nature walks and meditation), reflection prompts for participants, and additional literature and resources.

Key words: Mental health, Substance use disorders, Mindfulness, Therapeutic recreation

---

Jenna Debus graduated from Fanshawe College in 2018 with a diploma in Recreation and Leisure Services. She continued her education and graduated from the Therapeutic Recreation program at the University of Waterloo in 2021. Through various educational and employment opportunities, Jenna has developed a passion for supporting individuals with mental health and developmental challenges and enhancing individuals' quality of life through leisure.

Contact: Jenna Debus
Email: jenna.debus@gmail.com

TRPR Journal of TRO

Mindfulness Program Intervention Among Individuals Living with Substance Use Disorders

Introduction

To meet the requirements of my undergraduate program, I completed my therapeutic recreation (TR) internship placement at an in-patient treatment hospital in the addictions unit. Over the course of four months, I worked alongside a recreation therapist (RT) on the unit to provide leisure-based assessments, interventions, and programs to individuals seeking out in-patient treatment. The individuals seeking treatment in this space varied among age, gender, race, economic status, and occupation, making it clear that mental health can impact anyone. Throughout my internship I noticed individuals often discussed mindfulness during their treatment, however, through discussions and observations, it became apparent that many individuals did not understand the different forms and benefits of mindfulness practices. When discussing the concept of mindfulness in groups and one-to-one sessions, many individuals were able to identify what mindfulness is, and how it can be implemented in one's day-to-day routine. However, individuals also identified a lack of mindfulness in their own daily routine and had trouble identifying how mindfulness was relevant and beneficial towards their recovery. After engaging in discussions with both individuals and the RT on the unit, as well as observing the individuals during groups, I felt there was a need for a program that provided the opportunity to engage in mindful practices. As well as create space for individuals to reflect on whether the tools were beneficial to their recovery and something they would like to continue to pursue in their recovery following discharge.

While reviewing current literature, it became apparent that there is substantial evidence supporting mindfulness interventions for the treatment of mental health conditions (Carruthers & Hood, 2011; Emmons & Stern, 2013; Johnson, Mullen, Smith, & Wilson, 2016). However, there seemed to be a gap in knowledge detailing the practical application and implementation of mindfulness programming while supporting individuals with histories of substance abuse. Therefore, I developed a mindfulness program that can be implemented by RTs who are working with individuals living with substance use disorders, as well as other mental health challenges more broadly. The program I created and am highlighting in this manuscript highlights mindfulness interventions including gratitude journaling, mindful nature walks, and meditation as these therapeutic modalities remain accessible for both RTs as well as individuals to practice independently. Each intervention requires minimal resources, time, supplies and financial investment, therefore making it attainable in everyday implementation. The purpose of this program is to introduce individuals to mindfulness, and aid individuals in understanding how mindfulness can benefit their overall wellbeing, as well as aid in their on-going recovery from substance use disorders.

Literature Review

In this section, I discuss key concepts related to therapeutic mindfulness by drawing on leisure and TR based literature. Additionally, I present relevant literature identifying connections

between mindfulness modalities and substance use disorder treatment to provide a conceptual understanding and framework for the mindfulness program I am highlighting in this paper.

Mindfulness

Mindfulness is best described as, "the awareness that emerges through paying attention, purposefully and nonjudgmentally, to the unfolding of experience moment by moment" (Carruthers & Hood, 2011, p. 172). In recent years mindfulness interventions and relaxation training has become more prominent in spaces of care, specifically RTs providing therapeutic modalities. In practice, the implementation of mindfulness has been found to alleviate physiological distress (Jarukasemthawee & Pisitsungkagarn, 2021). According to Jarukasemthawee and Pisitsungkagarn (2021), when individuals engage in mindfulness practices there may be a reduction in the occurrence of ruminating thoughts and emotional dysregulation. As well, when negative thoughts or emotions do occur, individuals are better able to "reduce the intensity of their negative and repetitive thoughts and could be aware of and regulate their emotions" (Jarukasemthawee & Pisitsungkagarn, 2021, p. 7). In this light, when mindfulness is practiced, individuals may strengthen their ability to regulate emotions and focus on the present moment (Carruthers & Hood, 2011). Engaging in mindful exercises, such as yoga, meditation, or walking, enables individuals in withdrawing themselves from automatic thoughts, reactions, and behaviours, which promotes the ability to live in the present moment (Carruthers & Hood, 2011).

As the Leisure and Wellbeing Model suggests, "the outcome of TR services should be the enhanced well-being of clients" (Carruthers & Hood, 2011, p. 172). Research focused on wellbeing has identified two forms of wellbeing, hedonic (focused on happiness, pleasure, positive affect, and satisfaction) and eudaimonic (focused on self-actualization and a sense of purpose) (Ryan & Deci, 2001). Mindfulness interventions and practices have been found to positively correlate with individuals perceived sense of wellbeing, specifically enhancing individuals' sense of both hedonic and eudaimonic wellbeing (Carruthers & Hood, 2011).

Mindfulness and Substance Use Treatment

During active addiction, the brain experiences a vast amount of physical and chemical changes which can result in individuals responding impulsively, specifically in stressful situations (Crews & Boettiger, 2009; Li et al., 2017). Mindfulness interventions, such as meditation, can be a beneficial tool in relapse prevention (Johnson et al., 2016). Research has shown that mindfulness interventions can "modify brain and psychophysiological functions associations with addiction, and thereby reduce risk of relapse to substance misuse" (Li et al., 2017, p. 92). Mindfulness can be used to challenge negative thought patterns or substance-related urges and retrain the brain in a sense of intentionally slowing down and focusing on the present moment, feelings, or experience (Garland, 2014).

Mindfulness practices can also be used as coping strategies while in recovery, particularly while dealing with high-stress situations (Johnson et al., 2016). Experiencing stressful situations can increase the risk of relapse (Sinha, 2011). When individuals in recovery are exposed to stress, the body is conditioned to crave substances (such as drugs or alcohol)

(Sinha, 2011). Therefore, learning a variety of healthy coping skills to implement during stressful situations is imperative in addiction recovery and supporting long-term recovery.

When in recovery, individuals will often express feelings of guilt and shame as they reflect on past behaviours or responses. Mindfulness practices create space for individuals to identify and label their negative thoughts or feelings and the opportunity to accept, then let go of these thoughts or feelings, rather than dwelling on what they cannot change such as past experiences (Carruthers & Hood, 2011). While engaging in mindful practices, such as meditation or gratitude journaling, individuals can learn to cope with their feelings, ultimately contributing to their recovery. Mindfulness also has the potential to aid individuals in recovery from addictions by changing their relationship with their thoughts and emotions, as well as helping them focus on being in the present moment.

Program Design

As a helpful resource for practitioners interested in implementing this type of program, I created a mindfulness journal that outlines each program session including mindfulness interventions (e.g., gratitude journaling, mindful nature walks and meditation), reflection prompts for participants, and additional literature and resources. In this section, I speak to this mindful journal resource to provide information on how to best utilize this journal resource in practice. A digital copy of the mindfulness journal can be downloaded on TRO's TRPR webpage (https://www.trontario.org/education-research/trpr--journal-of-tro) for TR practitioners who may be interested in implementing mindfulness interventions in their own care practices. In this section, I begin by outlining the purpose, goals, and objectives of the mindfulness program, before providing a detailed overview of the program (including references to the use of the mindfulness journal resource). Following this, I speak to a useful program timeline, barriers and contradictions I experienced and considerations for practice, and a plan for evaluative measures. It is important to note here that this overview of the program is based on my own lived experiences creating and implementing the mindfulness program for individuals seeking out in-patient care for substance use disorders. As such, practitioners who utilize this type of program in their own workplace may need to adapt the program design as needed.

Program Purpose, Goals, and Objectives

The purpose of this program is to educate participants about mindfulness practices and the benefits of incorporating mindfulness into their recovery. This program will also offer opportunities for participants to identify and practice coping tools and grounding techniques through the use of various mindfulness interventions. The goals and objectives of this mindfulness program are as follows:

1. To understand how mindfulness can aid in recovery from addictions and substance use disorders.
2. To understand the link between mindfulness interventions and wellbeing.
3. Identify and utilize at least two mindfulness interventions.

4. To understand how to implement mindfulness interventions as a coping strategy.
5. To aid participants in focusing on the present and regulate their emotions.

Program Description

The mindfulness program described in this paper was designed for individuals who are in t recovery from a substance use disorder and are currently seeking in-patient treatment. This program may be adapted and implemented for different ages and mental health related disorders as needed. More specifically, this program is designed for individuals who may be unaware of the benefits of engaging in mindfulness practices or interventions or may have difficulty identifying how mindfulness can contribute to their recovery. Based on my experience of implementing this program, the suggested group size is four to six participants as having a small group may be beneficial as individuals feel more comfortable sharing their thoughts and experiences. The program consists of five one-hour sessions, with the first session focusing on education, and the following sessions focusing on the practical application of different mindfulness practices. The session length and number of sessions offered may be modified to best suit participants needs and abilities. Sessions will include the following interventions: (1) Introduction to mindfulness, (2) gratitude Journaling, (3) mindful nature walks, and (4) meditation. The final session consists of a debrief and discussion regarding the participant's experience throughout the program. During the first session, each participant will be provided with a reflective journal which consists of various written prompts and questions to encourage reflection on their experience in the group (see mindfulness journal, p. 2-12). This journal has been adapted from the Calm Journal (Slomka, 2018). After completing each practical application session, participants are asked to reflect on their experience, thoughts, and feelings before, during, and after the mindfulness intervention. Participants are encouraged to continue practicing each mindfulness intervention independently throughout the week and note how often they utilized the newly learned intervention (see mindfulness journal, p. 13-27).

Program Timeline

This program was implemented over the duration of five weeks. Each week there was a session (approx. one hour in length), during which a mindfulness intervention technique was discussed and practiced. The first session, *Introduction to Mindfulness*, was informational and knowledge-based, detailing how mindfulness is beneficial to recovery. The following sessions each focus on the practical application of different mindfulness interventions, including, gratitude journaling, mindful nature walks, and meditation. Between sessions, participants were encouraged to continue practicing the mindfulness intervention discussed and practiced for that specific weekly session and reflect in the provided journal whether they found it to be beneficial throughout the week. The final session consisted of a debrief and discussion regarding the overall experiences, thoughts, and feelings of participant's who engaged in the mindfulness program.

Participant Barriers/Contraindications and Considerations for Practice

While creating this program, it was important for me to consider the barriers and/or contraindications that participants may face. To ensure accessibility for the content of each session, I provided opportunity for both written and verbal reflections during each session. Taking into consideration individuals who live with substance use disorders, some may also have a co-morbid diagnosis, which may impact their ability to fully engage with the program. Another barrier I experiences with this population of individuals was their capacity to focus on the program sessions as individuals in early recovery often experience withdrawal symptoms (i.e., irritability, low energy, limited ability to focus or think clearly) (West & Gossop, 1994). Withdrawal symptoms may impact the ability to participate in a group session, therefore I would recommend that this program be facilitated as a closed session and for participants who have been in active recovery for a minimum of two weeks. I feel this will mitigate the likelihood of participants being unable to engage with the program content and opens up space for participants to reap the full benefits of the program. Additionally, it is important to consider participants who are receiving high doses of methadone maintenance therapy as they may not be appropriate for this group due to the side effects of the medication impacting their ability to experience or express emotions (Johnson et al., 2016). Further considerations include participants who attend a group under the influence of prohibited substances or participants experiencing significant mental health concerns or symptoms that would impact their ability to engage in this groups, or participants exhibiting inappropriate behaviour that would be disruptive to the group.

Evaluative Measures

As previously mentioned, participants received a copy of the mindfulness journal to provide space for them to record their weekly reflections. Participants were given this journal during the first session and asked to hand it back to the facilitator after completing the final session. Within the journal, participants were asked to reflect on whether they incorporated aspects of the program (e.g., knowledge and/or practices of mindfulness) into their weekly routine, and whether they felt these interventions impacted their thoughts, behaviours, and feelings while engaging in other aspects of active recovery. The intention of including the reflection questions in the mindfulness journal is to also be used as an evaluation tool to determine whether the program is effective (see mindfulness journal, p. 2-12).

Discussion

When considering the different TR modalities and/or programs to offer in in-patient settings, I wanted to educate individuals on useful and accessible mindfulness tools they could implement while in active recovery. Mindfulness interventions are inexpensive and inclusive for participants with varying backgrounds and abilities. I felt it was important to offer learning opportunities for individuals on mindfulness, and how mindful interventions (e.g., gratitude journaling, mindful nature walks, and meditation) can be informal and adapted to the needs of all individuals. I also felt it was important for individuals to recognize that mindfulness

interventions do not require high financial commitments, making this type of program also feasible to implement on a budget. Given the current circumstances of the on-going COVID-19 global pandemic and how it has impacted the field of TR, mindfulness is an intervention that can create space and opportunities for RTs to implement creative modalities of care for individuals in recovery of substance use disorder.

While creating and implementing this program, I had the opportunity to learn and practice developing a program from start to finish. Prior to my internship placement, I was involved in created new programs for TR practice, however, this was my first experience with implementing a program that I specifically created. This opportunity provided me with a better knowledge base for understanding what considerations need to be accounted for when creating and implementing a new program. This experience also created time for me to practice facilitation techniques (such as debrief practices), which are useful in group programming. As well, through this experience I learned more about the logistical aspects of creating and implementing a TR program in practice as what may seem to work in theory (i.e., explanations in a textbook), may not always be realistic in practice. While implementing this mindfulness program, I learned how to adapt or accommodate programming based on various circumstances so that I can ensure I am meeting both the individuals and collective needs of all participants. This required that I begin by identifying a need and/or gap in practice and intentionally develop a program to address those needs (e.g., the process of assessment and planning in the APIE process). While implementing this mindfulness program in practice, I was able to use the weekly reflections and discussions of program participants (detailed in the mindfulness journal) to assess whether or not the program met the intended goals and objectives outline above. Based on my experience with this program, the participants demonstrated that the program met the overall program goals and objectives as many participants reflected on a better understanding of mindfulness and how to implement mindfulness practices into their day-to-day routine while in active recovery.

Conclusion

In this paper, I have outlined the use of a mindfulness program for in-patient mental health recovery (specifically, substance use disorders). The purpose of the program was to educate participants about mindfulness and useful mindfulness practices, and the benefits of incorporating them into their active recovery of a substance use disorder. Over the duration of five sessions, the concept of mindfulness as it relates to recovery was explored, as well as three practical applications (including gratitude journaling, mindful nature walks, and meditation). Participants were provided with a reflective journal which consisted of written prompts and reflective questions to complete after each session and throughout the week. Based on my experience of creating and implementing this program, I feel mindfulness is a leisure-based intervention that can enhance one's overall wellbeing and mental health. It is my hope that this program description (and accompanying mindfulness journal resource) will be helpful for other

TR practitioners who may be interested in implementing a mindfulness program and/or intervention in their respective spaces.

References

Carruthers, C., & Hood, D. C. (2011). Mindfulness and well-being: Implications for TR Practice. *Therapeutic Recreation Journal, 45*(3), 171-189.

Crews, T. F., & Boettiger, A. C. (2009). Impulsivity, frontal lobes and risk for addiction. *Pharmacology Biochemistry and Behavior, 93*(3), 237-247. https://doi.org/10.1016/j.pbb.2009.04.018.

Emmons, A. R., & Stern, R. (2013). Gratitude as a psychotherapeutic intervention. *Journal of Clinical Psychology, 69*(8), 847-855. https://doi.org/10.1002/jclp.22020

Garland, E. L. (2014). Disrupting the downward spiral of chronic pain and opioid addiction with mindfulness-oriented recovery enhancement: A review of clinical outcomes and neurocognitive targets. *Journal of Pain & Palliative Care Pharmacotherapy, 28*(2), 122–129. http://dx.doi.org/10.3109/15360288.2014.911791.

Jarukasemthawee, S., & Pisitsungkagarn, K. (2021). Mindfulness and eudaimonic wellbeing: the mediating roles of rumination and emotion dysregulation. *International Journal of Adolescent Medicine and Health, 33*(6), 347-356. https://doi.org/10.1515/ijamh-2021-0009

Johnson, D., Mullen, D., Smith, D. I., Wilson, A. (2016). Mindfulness in addictions. *BJPsych Advances, 22*(6), 412-419. DOI: 10.1192/apt.bp.114.014142

Li, W., Howard, O. M., Garland, L. E., McGovern, P., & Lazar, M. (2017). Mindfulness treatment for substance misuse: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment, 75*, 62-96. http://dx.doi.org/10.1016/j.jsat.2017.01.008

Ryan, M. R., & Deci, L. E. (2001). On happiness and human potentials: a review of hedonic and eudaimonic wellbeing. *Annual Review of Clinical Psychology, 52*, 141-166. https://doi.org/10.1146/annurev.psych.52.1.141

Sinha, R. (2001). How does stress increase risk of drug abuse and relapse? *Psychopharmacology, 158*(4), 343-359. https://doi.org/10.1007/s002130100917

Slomka, C. (2018, October 22). Calm Mindfulness Journal. *Calm.* https://blog.calm.com/blog/calm-mindfulness-journal

West, R., & Gossop, M. (1994). Overview: a comparison of withdrawal symptoms from different drug classes. *Society for the Study of Addiction, 89*(11), 1483-1489. https://doi.org/10.1111/j.1360-0443.1994.tb03747.x

TRPR Journal of TRO

©2022 Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario, Vol. 16, pp. 21-32

UNIVERSITY OF WATERLOO | FACULTY OF HEALTH Department of Recreation and Leisure Studies

The Changing Role of Recreation Staff Working in Ontario Retirement and Long-term Care Homes during the COVID-19 Pandemic

Research Paper

Kate Dupuis

Abstract

During the COVID-19 pandemic, individuals working in therapeutic recreation (TR) roles in retirement and long-term care homes had to modify their practice in response to rapidly changing infection prevention and control regulations. The experiences of TR staff working in these settings in Ontario, Canada during the second wave of COVID-19 were investigated to better understand their challenges and share learnings for the future. A 20-item questionnaire was completed by 261 individuals (M = 35 years, range = 19-71, 95% female). Participants reported many common modifications to their roles, including a move to innovative one-on-one and small groups programming, and increased use of technology to facilitate activities and social interactions. Responses emphasize the resilience, creativity, and innovation of staff working within this space, and highlight the benefits of recreation for residents living in these homes. Finally, the results support a focus on the mental health recovery of recreation staff post-pandemic.

Keywords: Recreation Therapy, COVID-19 pandemic, Retirement Home, Long-term Care Home

---

Kate Dupuis is the Schlegel Innovation Leader in Arts and Aging at the Sheridan Centre for Elder Research and the Schlegel-UW Research Institute for Aging and is a registered Clinical Neuropsychologist. In her research, Kate explores barriers and facilitators to arts participation for older adults and their care partners.

Contact: Kate Dupuis
Email : kate.dupuis@sheridancollege.ca

The Changing Role of Recreation Staff Working in Ontario Retirement and Long-term Care Homes during the COVID-19 Pandemic

Introduction

The COVID-19 pandemic has been devastating for older adults. In particular, older adults living in communal care settings such as retirement and long-term care (LTC) homes have been at elevated risk of infection and death throughout the pandemic, with approximately 50% of Canadian COVID-19 deaths occurring in LTC residents (National Institute on Ageing, 2022).

From the very start of the pandemic, staff working in retirement and LTC homes were required to respond quickly to ever-changing restrictions, often while working short staffed and, especially in the earliest days, without adequate personal protective equipment (PPE). In order to shield older adults from danger, governmental policies restricted movement and social interaction both into and within retirement and LTC homes. Staff working in multiple locations in Ontario were required to choose one workplace to reduce the potential spread of COVID-19 between locations. This restriction of staff to one workplace may have contributed to the increases in critical staffing shortages seen in LTC homes and seniors' homes (e.g., retirement homes) during the pandemic (Clarke, 2021), as staff were no longer able to take on shifts in multiple locations. All of these modifications meant to protect residents required staff to develop new policies and strategies to better address the needs of those in their care.

Recreation staff working in retirement and LTC homes have a unique role in the care of residents; they are responsible for providing a daily suite of activities that reflect the needs and personal preferences of residents and create opportunities for meaningful and purposeful engagement that tap into multiple domains of well-being (e.g., social, physical, cognitive, emotional, spiritual). During the COVID-19 pandemic, much of the focus both within the media and the research literature has largely been on staff working in personal care roles (e.g., personal support work, nursing) within retirement and LTC settings. Recreation staff make up a small but crucial percentage of staffing within the sector (Ontario Ministry of Long-term Care, 2020), but have been largely overlooked during the pandemic (e.g., Genoe & Johnstone, 2021).

Current Work

The purpose of this project was to explore the pandemic experiences of health care professionals working in the recreation field in retirement and LTC homes in Ontario, Canada. Ontario was one of the hardest hit provinces in the country, with a 32% death rate for residents in LTC homes during the first wave of the pandemic (January 15 - August 2, 2020; Public Health Ontario, 2021). A survey was designed to examine how recreation staff modified best practice to serve those they care for, and how they coped with changes to their roles and to their lives during the pandemic. Based on anecdotal information from colleagues working in recreation, the author hypothesized that staff would have made rapid changes to their everyday best practices in response to ever-shifting regulations, including introducing virtual social opportunities for

residents, and increased reliance on technology/virtual programming. Collecting and sharing learnings from those working in the field could further enhance the offering of purposeful and meaningful recreation activities both during the pandemic and beyond.

Method

Participants

Participants were recruited by targeted email, social media, and through professional organizations such as Therapeutic Recreation Ontario. Individuals were eligible to participate if they were working in a recreation role in a retirement and/or long-term care home in Canada. Data were collected between December 10, 2020, and March 11, 2021. This timeframe was chosen to capture findings from the second wave of the pandemic in Ontario, Canada's most populous province, and to include February, which is Therapeutic Recreation month.

Questionnaire Development

A 20-item questionnaire was developed (see Appendix A), with questions divided into two sections: (1) Demographics (nine questions, e.g., age, gender, role, work setting, physical and emotional health), (2) Role changes during COVID-19 (11 questions, e.g., how has your role changed, how have you relied on technology, how has your job satisfaction changed).

Procedure

Participants accessed the questionnaire through a SurveyMonkey link provided by e-mail and listed on social media and were required to provide informed consent prior to beginning the questionnaire. There was no time limit, and a thank you message appeared upon completion. All research methods were approved by the Sheridan College Research Ethics Board.

Data Selection

Responses were collected from 399 respondents across Canada. For this paper, data were excluded from 120 participants from outside Ontario, and an additional two participants who did not respond to this question. Of the remaining 277 participants, 201 indicated they worked with residents in LTC, 51 indicated they worked with residents in a retirement home setting, and 19 indicated they worked with residents in both settings ($n = 271$). We excluded data from 10 individuals whose roles were either not indicated ($n = 7$) or not eligible for inclusion ($n = 1$ PSW, $n = 1$ volunteer, $n = 1$ dietary aide). Thus, 261 individuals were included in the final analysis.

Data Analysis

Data were analyzed using Microsoft Excel version 15.33 and SPSS version 26. Quantitative analysis of demographic data included means (e.g., age, length of time in role, resident population, self-reported health, job satisfaction) and frequencies (described gender, type of role). Quotes from participants were used throughout to further expand on quantitative

data (e.g., changes in job satisfaction, mental health). Qualitative thematic analysis allowed for the identification and grouping of specific modifications to practice, subjective experiences working in the recreation field during COVID-19, and learnings about self during the pandemic. Quotes from participants were also used to provide rich examples of these topics.

Results

Demographics

The majority of respondents identified as female (95%), mean age = 35.1 years (*SD* = 12, *range* = 19-71). Respondents had been working in their roles for an average of 4.5 years (*SD* = 5.5, *range* = 1 month-30 years) and the majority worked in LTC (75%) with a smaller number working in retirement (19%) and with residents of both retirement and LTC homes (6%). Respondents provided many different names for their roles, and these were divided into four categories: leadership (e.g., Supervisor, Manager, Lead, Director, Coordinator), 29% of responses, therapeutic recreation (e.g., Activationist, Lifestyle and Recreation, Life Enrichment Therapist, Recreation Programmer), 30% of responses, recreation aide/assistant (e.g., Activation Aide, Program Aide, Activity Aide), 40% of responses, and student, 1% of responses.

Self-reported Health

Participants were asked to rate their physical and emotional health separately on a 5-point Likert scale with 1 as "poor" and 5 as "excellent". Physical health rating was significantly higher ($m = 3.8$, $SD = 0.8$) than emotional health rating ($m = 3.0$, $SD = 1.0$), $t(260) = 11.35$, $p < .001$. There was no significant difference in physical health ($p = .9$) or emotional health ($p = .96$) based on the participant's role category. Similarly, time spent in role did not impact either physical ($p = .32$) or emotional health ($p = .95$), nor did the type of workplace (e.g., LTC, retirement, LTC and retirement) impact either physical ($p = .43$) or emotional health ($p = .37$).

Job Satisfaction

Participants were asked whether their job satisfaction had changed during the pandemic. The majority (56%) reported that job satisfaction had decreased, with participants indicating: "Each day has its ups and downs. Some days you feel you're in control and have made some great connections, other days you feel burnt out and defeated" (P104); "dramatic decrease" (P114); "Not enjoying my job like before. No communication with my team members and feel alone most of the time with no moral support..." (P139).

For a smaller number of participants (13%), job satisfaction had increased: "It's been tough and scary at times. But I love my job and will continue to support the seniors in my community" (P234) or stayed the same (11%). Twenty percent of the participants provided an "other" response. For some, they had just started working as the pandemic hit so had no frame of reference: "I've been learning the whole position through the pandemic" (P37), "have only worked during the pandemic in this setting- was quite difficult to get used to at first, but you …

just try to innovate adapted solutions" (P175). Other participants had more mixed feelings about working during the pandemic: "Each day has its ups and downs. Some days you feel you're in control and have made some great connections, other days you feel burnt out and defeated" (P15); "I would say the job has become more stressful and hectic however I find it just as rewarding if not more so than before the pandemic" (P338).

Modifications to Practice

Participants were asked to describe how their role had changed since the COVID-19 pandemic began. Responses were categorized into changes to programming, social interaction/visits, technology use, and safety/infection prevention and control (see Appendix B).

Changes to Programming

Given the restrictions on entry both within and into homes, those working in recreation had to quickly pivot to providing programming that addressed regulations related to capacity limits/resident interaction: "social distancing is the hardest. We are in such a small home that its [sic] nearly impossible to do any programming with social distancing" (P35), "Large events and music groups that were well enjoyed are not possible with our space having to keep all physically distanced" (P53). They also had to provide additional programming in the absence of all the entertainers and volunteers who weren't allowed to come into the homes: "Lack of volunteers or outside help. Residents feel sad and unwilling to participate now" (P30).

Many respondents spoke about the move to small group or one-to-one programming, this was required for safety but did affect the number of residents they could connect with daily: "Keeping groups small and not being able to involve everyone" (P84). "Smaller groups, fewer programs, increased 1:1" (P82), and impacted how much programming was available: "Very few activities being offered" (P75). It was clear from their responses how those working in recreation were trying to modify programming in many different ways to better serve the unique needs of their residents: "Coming up with ways to engage with residents one to one" (P148), "We have tried to keep our residents [sic] emotional morale up by providing constant support and encouragement" (P142), "focusing our attentions on those we deem more 'at risk'" (P151).

Participants demonstrated a high degree of creativity when it came to modifying programming: "I have also enjoyed the challenge of having to be extra creative in coming up with … other programs" (P272). There were multiple mentions of travelling carts: "I have built myself a mobile recreation station" (P31), "Special carts have become a very popular thing (i.e., drink carts, snack carts, movie/book rentals)" (P37). Participants spoke about programs being offered in doorways/hallways/common spaces: "distance bingo (post 2 numbers per day in lobby)" (P37) and making up activity kits that could be dropped off for a resident to use independently in their room.

Participants reported that they were seconded to assist with mealtimes and other activities within the home, which took time away from recreation programming: "Involved in various areas of work now such as assisting personal support workers and dietary staff and occasionally

helping with stocking PPE" (P127), "assisting dietary when short" (P342), "More feeding" (P101). This shift away from time for programming was reflected in an overarching concern for not being able to provide enough activities, as well as concern for the residents in their care: "Recreation staff often get pulled off the floor away from residents to assist with administration tasks. These hours are not replaced and the residents suffer over time" (P370), "Only me plus one recreation staff to provide meaningful activities for 103 residents. Very challenging" (P23).

Social Interactions/Visits

Due to governmental restrictions, it became more difficult (and at times impossible) for residents to receive visitors indoors. Many homes moved to virtual and/or outdoor visits, with recreation staff often charged with the organization of these social opportunities for residents in their care. Organizing visits was high priority in order to maintain quality of life for residents: "We take advantage of every opportunity to connect the residents/patients with their loved ones" (P75), "The primary function of my role has been supported connections between resiidents [sic] and their loved ones through FaceTime/Window Visits and phone calls" (P206). Staff also reported liaising with residents' loved ones: "I spend a lot of time on phone and emails, returning calls regarding Family visitation" (P57), "Communication with families" (P64), "Providing families with the option to have virtual visits" (P337) to facilitate interactions.

Technology Use

Technology was widely used both to support modifications to programming and to provide social interaction opportunities for residents. Multiple forms of technology and social media, including tablets, email, Zoom, Whatsapp, Facetime, and Skype: "Absolutely on daily basis, a saving grace" (P2) were used. Programming was able to continue virtually thanks to technology: "It [technology] has also been a tool to facilitate spiritual care and entertainment where these programs needed to be stopped because non-essential visitors cannot enter the building" (359). In some cases, this pivot to new technologies did necessitate education: "Teaching our seniors how to use their tablets to use Zoom" (P20), "dealing with … the residents' lack of knowledge for using technology" (P87) and supervision of residents: "For the resident to play a game on their own or any hands on program using a tablet I have to supervise for it to be a success" (P366).

Safety/Infection Prevention and Control

Many respondents indicated that their roles had shifted to upholding infection prevention and control protocols, including reminding residents to socially distance, sanitize hands and wear PPE, and screening fellow staff and visitors: "I do more screening hrs then Rec hrs now" (P346), "Took on a screener role within the home" (P126), "…gowning, gloving, mask and shield with every patient interaction and changing all PPE after every interaction" (P380). During times when visitors were not allowed, participants also indicated that their roles involved trying to help

residents manage these restrictions: “Explaining to a person with dementia why there [sic] familiar [sic] are not allowed in anymore because of the covid virus” (P262).

Mental Health of Respondents

As reflected in the quantitative data discussed above, participants’ emotional health was negatively impacted by the pandemic. Numerous participants provided responses emphasizing the stress, strain, and burnout experienced in their roles: “I sometimes feel lost, alone, helpless there are days I dread coming into work especially Mondays I do not sleep well the night before I come back into work.” (P392), “The low morale at work comes home with me and has taken a toll on my mental health” (P353), “My work life has increased my stress with outbreaks” (P92), “Work stress and burnout leading to less emotional energy- pandemic stress and isolation leading to mental health struggles that can affect [sic] my work some days” (P273).

Participants reported purposely reducing socialization opportunities with friends and in some cases with family members in order to protect their loved ones: “The inability to have a ranged social life is causing extreme depression. Those factors and work create a vortex that cause elevated strain on my romantic relationship. All these stresses are carried with you at work even if you try not to let it show” (P31), “I go home and go to bed and cry. I have no home life. I cannot go near my loved ones because I do not want to expose them” (P355), “I don't see my friends or family (due to covid) I [sic] just go home and go to work” (P228).

Responses also underscored participants’ concerns that their profession was not being recognized or supported throughout the pandemic, both within their workplace and at a broader governmental and societal level: “Management undervalues my role but the residents appreciate the work I do and miss me” (P235), “Recreation is undervalued by Long Term Care and the general public. Staff are not paid in a way that reflects their education requirements or their responsibilities within the home” (P46), “The Recreation Department is very undervalued and unrecognized. It was very shocking that the Government recognizes and rewards PSW staff and not the recreation team members” (P57), “… the Recreation Team is a very overlooked support team in the general media, public and by the Government” (P64). Some participants reported that those working in recreation were seen by leadership and/or fellow staff as an easy target for being seconded into other roles: “When someone needs to stop their job to assist- it is likely going to be recreation. The whole role of recreation has been diminished” (P30), “Everytime [sic] I turn around we are given more tasks that don't pertain to activities. I didn't want to be a PSW that's why I took the Activation Course but feel myself doing more PSW work” (P170).

Searching for the Silver Lining

The last question asked of participants was: “What is the most important thing you have learned about your role and/or about yourself since the pandemic began?”. The responses to this question emphasized the incredible strength and resilience of the participants and demonstrated a dichotomy between pride in their own abilities to carry on helping others during the pandemic, and restrictions to their role that made everyday tasks much more difficult than ever before.

There were multiple responses emphasizing being flexible, creative, and adaptable: "Recreation has to be flexible and impromptu" (P6), "To be flexible, to try not to be upset by the almost constant change around me" (P116), "We can adapt and assimilate to anything" (P127). Participants also described the importance of recreation for the lives of residents and how other professions within their workplaces were taking note of how key recreation is in these settings: "We are so Important for residents especially In isolation" (P139), "We have taken the place for many loved ones who have been unable to enter the home to visit" (P144), "How important and blessfull [sic] role we perform as a recreation therapist" (P23), "How important TR is to our residents. We have had other employees who were redeployed to our area comment that they never realized how much TR did nor how valuable we were" (P151). This sense of validation was clearly seen in multiple responses, including the following: "It validated the importance of my role and our jobs at providing connection and love" (P227).

Participants were able to view themselves, their lives, and their own abilities differently: "How not to take anything for granted and how strong I am" (P204), "I am extremely adaptable and a real team player" (P113), "I don't give myself a enough credit, i'm really proud of how stronger of a profressional [sic] ive [sic] been" (P228), "I have learned that I have more patience and understanding than I realised" (P240), "I'm stronger than I know" (P23).

Finally, participants indicated a renewed appreciation for the connections they had formed, both with their fellow staff members and with the residents in their care, throughout the pandemic: "Sometimes amazing things come out of yourself, team members and residents during hectic times" (P112), "I am my residents [sic] advocate, I am a part of their family I am their connection to the world, I am their voice, their reason for joy and laughter, their constant when their families can't visit. I am their calm, their friend" (P272), "Use all your power and once they [the seniors] smile all pays off" (P69).

Discussion

The results from the current study provide insight into the experiences of retirement and LTC home staff working in recreation roles in Ontario, Canada, during the COVID-19 pandemic.

This work shows how recreation professionals made multiple modifications to everyday recreation offerings to better respond to resident needs, while also attempting to comply with ever-changing restrictions. These modifications took time, creativity, innovation, and extensive energy, and were made with the best interests of the residents in mind. There was a strong theme in the responses about the importance of recreation activities to resident well-being, and how difficult it was to witness (physical and/or mental) deterioration of residents, likely related to restrictions on meaningful and purposeful opportunities for participation. Many of the modifications described in the current data set appeared to have the aim of providing social connection opportunities with residents. This is particularly important given recent data indicating higher mortality rates of residents in LTC homes who had lower opportunities for personal contact with friends and family members (Savage et al., 2021). The importance of

ensuring that residents' cognitive, emotional, social, and spiritual domains of well-being, not only their physical health and safety, are being addressed, cannot be overstated.

Similar to research with other frontline workers (e.g., Brophy et al., 2021; Genoe, & Johnstone, 2021; Sritharan et al., 2020), mental health concerns and the impact of difficult working conditions on the professional and home lives of individuals working in recreation were apparent in these data. The final report released by the Ontario LTC COVID-19 Commission (2021) stated that "many [LTC staff] continue to be traumatized as a result of this experience and will require ongoing counselling and support" (p. 22). As such, mental health recovery for those working in retirement and LTC settings should be an immediate priority for operators and for the governmental bodies that regulate these homes. Recognition of the incredible dedication of recreation professionals, through increased wages and strong support by leadership and their peers may help to address and prevent future potential job loss within the field. Increased understanding of the importance of recreation within the retirement and LTC space may help to support the health and well-being of those working in this profession.

To this end, the author has provided guidance to Therapeutic Recreation Ontario (TRO) related to these data, with the specific aim of creating a dialogue about recreation's key role in communal care settings. In addition, the author has engaged in knowledge dissemination by presenting these data to a variety of audiences (including TRO's 2021 "TR: Push Through, Rise Above" conference). It is essential to share key learnings and help normalize the experiences of those working in recreation roles during the pandemic. It is often through finding commonalities with others that individuals can begin to heal from the trauma brought on by working through impossible situations in a time of great uncertainty. This paper can be used as a starting point to support recreation professionals as they share their own experiences with colleagues.

Practice Implications and Future Directions

The importance of recreation to the lives of residents may be poorly understood by the general public, and even by fellow staff working in different professions within the homes, but it cannot continue to be overlooked. The contribution of recreation to all domains of well-being and quality of life for residents of retirement and LTC homes must continue to be highlighted. One way to do so is to share these data with educators in the recreation field in order to better prepare students for the realities of their future workplaces, especially as we move slowly towards a post-pandemic world. It is the author's hope that this paper will be a catalyst for change and, to this end, she has presented these findings to students at both Sheridan and Mohawk Colleges who are training to work in recreation roles.

It is unlikely that this will be the last pandemic we see in our lifetime. Even during pre-pandemic times, LTC homes had outbreak protocols for flu and gastrointestinal viruses. The new best practices that have emerged in the recreation field in response to the global COVID-19 emergency can also be implemented to connect residents with their loved ones despite being geographically separated. These modifications to practice reflect the grounding of the therapeutic recreation field in person-centred and relational models of care (TRO, 2020). As we slowly

emerge from the COVID-19 pandemic, the importance of recreation for the overall health and well-being of both residents and the staff who care for them should take centre stage.

References

Brophy, J. T., Keith, M. M., Hurley, M., & McArthur, J. E. (2021). Sacrificed: Ontario healthcare workers in the time of COVID-19. *NEW SOLUTIONS: A Journal of Environmental and Occupational Health Policy*, *30*(4), 267-281. https://doi.org/10.1177/1048291120974358

Clarke, J. (2021). *Impacts of the COVID-19 pandemic in nursing and residential care facilities in Canada*. https://www150.statcan.gc.ca/n1/en/pub/45-28-0001/2021001/article/00025-eng.pdf?st=wIZwlN6N

Genoe, M. R., & Johnstone, J. L. (2021). The impact of COVID-19 on Therapeutic Recreation practice in long-term care homes across Canada. *World Leisure Journal*, *63*(3), 265-280. https://doi.org/10.1080/16078055.2021.1957011

Ontario's Long-term Care COVID-19 Commission. (2021). *Ontario's long-term care COVID-19 commission: Final report.*

Ontario Ministry of Long-term Care. (2020). *Long-term care staffing study*. https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

National Institute on Ageing. (2022). *NIA long-term care COVID-19 tracker.* https://ltc-covid19-tracker.ca/

Public Health Ontario, (2021). COVID-19 in long-term care homes in Ontario: January 15, 2020 to February 28, 2021.https://www.publichealthontario.ca/-/media/documents/ncov/epi/2020/06/covid-19-epi-ltch-residents.pdf?la=en

Savage, R. D., Rochon, P. A., Na, Y., Strauss, R., Brown, K. A., Costa, A. P., Gill, S., Johnstone, J., Tanuseputro, P., Stall, N. M., & Armstrong, P. (2021). Excess mortality in long-term care residents with and without personal contact with family or friends during the COVID-19 pandemic. *Journal of the American Medical Directors Association*. Advance online publication. https://doi.org/10.1016/j.jamda.2021.12.015

Sritharan, J., Jegathesan, T., Vimaleswaran, D., & Sritharan, A. (2020). Mental health concerns of frontline workers during the COVID-19 pandemic: A scoping review. *Global Journal of Health Science*, *12*(11), 89-105. 10.5539/gjhs.v12n11p89

Therapeutic Recreation Ontario. (2020). *Therapeutic Recreation Ontario: A blueprint to combat LTC residents' helplessness, loneliness and boredom.* https://www.trontario.org/files/Advocacy/TRO-LTC-Commission-Submission-Nov-2020.pdf

Appendix A- Survey Questions

Demographic Questions

1. What is your current age?
2. Which best describes your gender?
    a. Female
    b. Male
    c. Other
    d. Prefer not to say
3. Please choose the option that best describes your current physical health
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor
4. Please choose the option that best describes your current mental (emotional) health
    a. Excellent
    b. Very Good
    c. Good
    d. Fair
    e. Poor
5. In what province or territory do you work?
6. What population do you currently work with?
    a. Retirement home residents
    b. Long-term care home residents
    c. Residents of both retirement and long-term care homes
    d. Other (please describe)
7. Please provide the name of your operator (e.g., Schlegel Village, Chartwell, Revera etc.)
8. What is your current job title?
9. How long have you been in your current role?

Targeted Questions

10. Before the COVID-19 pandemic began in March 2020, what was the primary purpose of your role?
11. How has your role changed since the COVID-19 pandemic began?
12. What are challenges or obstacles to providing recreation during the COVID-19 pandemic?
13. How have you overcome (or attempted to overcome) these challenges or obstacles to providing recreation?
14. How have you made use of technology to perform your role during the COVID-19 pandemic?
15. How has your job satisfaction changed since the pandemic began?
    a. Increased
    b. Decreased
    c. No change
    d. Other (please specify)
16. What are your current sources of stress at work?
17. What are your current sources of satisfaction and/or joy at work?
18. How are demands and changes in your personal life impacting your work life or vice versa?
19. How will you help residents celebrate the winter holiday season this year?
20. What is the most important thing you have learned about your role and/or about yourself since the pandemic began?

Appendix B- Modifications to Practice Accommodating for COVID-19-related Restrictions

Major Changes to Role	Examples of Modifications
Programming	● More one-on-one and individual programs ● Travelling/rolling (themed) carts used to bring programs to individual rooms/suites (e.g., drinks carts, movie/book rentals) ● Running multiples of the same program on the same day to reach as many residents as possible ● Necessitated use of multiples of program materials and cleaning of items before they are shared between residents (e.g., individual manicure kits) ● Creative use of physical space (e.g., hallway/doorway programming, courtyard) ● Providing more dietary assistance compared to pre-pandemic (e.g., serving meals to resident rooms) which leaves less time to plan/lead recreation programs
Social interaction/visits	● Major focus of role had changed to booking and facilitating social opportunities for residents and family members/friends ● In-person visits: outdoors, through windows ● Virtual visits: Telephone, Skype, Facetime, Zoom, Google Duo, Facebook Messenger, Whatsapp, e-mail
Technology use	● Use of technology both for connecting residents with care partners outside of the homes (see above) and accessing programming ● Technology may be more challenging for older residents/residents living with dementia ● Livestreaming events for residents to "attend" ● Access to religious ceremonies ● Educating residents around the use of technology (e.g., email, Zoom) ● iPods for residents to access personal music libraries ● Using technology to work from home ● Accessing ideas on recreation programming during COVID-19 from around the world
Safety/Infection prevention and control (IPAC)	● Wearing PPE at work ● Supporting residents about wearing their PPE/sanitizing hands ● Rapid testing ● Supporting isolation period for new residents ● Managing outbreaks ● Taking on screening roles (e.g., rapid testing essential caregivers) ● Cleaning PPE (cloth masks for residents) ● Trying to social distance residents, made more challenging by lack of space, may even necessitate removing furniture (e.g., chairs)

©2022 Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario, Vol. 16, pp. 33-47

UNIVERSITY OF WATERLOO | FACULTY OF HEALTH Department of Recreation and Leisure Studies

The Impact of Varying Job Titles in Recreation Therapy

Research Paper

Mary Dwulit, Rachelle Silljer, and Tristan Hopper

Abstract

Despite accredited degree programs and a national association with standards of practice, entry-to-practice for Recreation Therapists is not yet regulated in Canada. The purpose of this study was to determine the cause and effects of varying job titles on the profession within a uniquely Canadian context. Qualitative and quantitative data was gathered via online survey using Qualtrics. Surveys were distributed via email and social media through a number of pathways across Canadian provinces and territories. Among the 255 participants, 50 different job titles among degree graduates currently working in recreation therapy (RecT) in Canada were identified. Despite participants having a set minimum level of education, (i.e., degree level education), data showed their job titles, pay, and scope of practice varied depending on where they worked. This research fills a gap in the RecT administrative literature and confirms that there are inconsistences between titles in RecT across Canada.

Key words: Allied Healthcare; Canada; Licensure; Recreation Therapy; Regulations; Therapeutic Recreation; Title Protection

---

Mary Dwulit, CTRS, is a Recreation Therapist with Fraser Health Authority in Burnaby, British Columbia, Canada.

Rachelle Silljer, Bkin, BSRS, is a graduate student at the University of Regina.

Tristan Hopper, CTRS, is an Assistant Professor in the Faculty of Kinesiology and Health Studies at the University of Regina in Regina, Saskatchewan, Canada.

Contact: Mary Dwulit
Email : Mary.dwulit@fraserhealth.ca

The Impact of Varying Job Titles in Recreation Therapy

Introduction

Canada is a large country with unique challenges and opportunities related to the professionalization of recreation therapy (RecT). In Canada, RecT has a long-standing history of triumphs and tribulations on the road to professionalization (Wozencroft et al., 2019). A noteworthy milestone is the establishment of the Canadian Therapeutic Recreation Association (CTRA) in 1996. The CTRA was developed to represent and advocate for RecT practitioners nationally (Reddick, n.d.). The majority of Canadian provinces have a provincial association or chapter in partnership with the CTRA (e.g., Therapeutic Recreation Ontario (TRO) or Alberta Therapeutic Recreation Association (ATRA). Chapters serve the same purpose as provincial associations but may be in less populated or conversely provincial associations with high membership like in Alberta. To date Prince Edward Island and the three territories do not have established associations or chapters with the CTRA. The CTRA formerly supported certification through a partnership with the National Council for Therapeutic Recreation Certification (NCTRC) shifting the country towards professionalization in May 2009 (CTRA, n.d.). Founded in 1981, the NCTRC's role is to protect the public by having practitioners meet standardized criteria for certification (NCTRC, n.d.). Canada currently has thirteen degree programs where graduates meet the requirements to be eligible for the Certified Therapeutic Recreation Specialist (CTRS) exam through the NCTRC (CTRA, n.d.; Sullivan, 2015). Despite degree programs and a national association with standards of practice, entry-to-practice for recreation therapists is not yet regulated in Canada. Being unregulated may be the leading contributor to varying titles in the profession as title protection is one of the many benefits that come along with regulation (Leslie et al., 2021). It is unknown what role a publicly funded health care system and universal coverage may play in regulating job titles, but it is worth considering this uniquely Canadian challenge. For example, since RecT is not regulated there is currently no insurance coverage for clients who may benefit from service but do not have access to it in Canada.

The purpose of the current study was to determine the cause and effects of varying job titles on the profession within the Canadian context. The question guiding the research was: What is the impact of varying job titles in recreation therapy across Canada?

Literature Review

RecT began to take shape in Canada during the early 1970's (Sullivan, 2015). Although the profession has existed for approximately 50 years in Canada, it has a documented history of disagreements associated with job titles, education, and scope of practice that continues today (Dieser, 2013; Reid et al., 2013; Sullivan, 2015; Wozencroft et al., 2009). Joining Nova Scotia, Eastern Health in Newfoundland now requires recreation therapists working at the provincial

health authority to hold credentials through the NCTRC (Sullivan, 2015). Credentialing remains a contested issue in many parts of Canada (Dieser, 2013).

RecT continues to see advancements towards professionalization, albeit a slow progression. Many of the challenges that are evident today have existed for decades and this includes being misunderstood by allied health professionals and clients (Bedini & White, 2018; Dwulit, 2017; Reid et al., 2013). Skalko and Smith (1989) conducted research in the United States that highlighted inconsistencies in the profession at that time. Research conducted by Genoe and colleagues (2019) confirmed that many of Skalko and Smith's (1989) findings still exist in Canada, including inconsistencies among titles, income discrepancies, and lack of entry-level to practice standards. Both Canada and the United States have been grappling with the same struggles (e.g., professional philosophy, terminology, titles etc.). In contrast, the United States has been engaged in these discussions for much longer than Canada and now has regulation through licensure in five states and reports of eight states that are "working towards licensure" (ATRA, 2020, p. 14). Licensure allows for regulation of job titles, scope of practice, and increased accountability of RecT professionals, which promotes client safety (Sullivan, 2015). Licensure of RecT has yet to be seen in Canada although the province of Nova Scotia has identified as being close to achieving that standard on their provincial association website as they are currently in communication with their provincial government (NSTRA, n.d.). We, the authors of this paper, feel that licensure will better align RecT with other allied professionals in Canada and resolve the negative impacts that go along with an unregulated profession in healthcare like misunderstanding amongst healthcare workers due to varying titles, entry-level qualifications and scope of practice.

It is important to acknowledge how role discrepancies around the over-arching professional terminologies and definitions contribute to varying job titles. For example, recreation therapy and therapeutic recreation are often used interchangeably throughout academic literature (Reid et al., 2013). This discrepancy is evident amongst degree program titles in Canada and within provincial associations and chapter's websites. In a longitudinal educational study by Autry et al. (2020) trends show an increase in 2019 with a total of 67% of program titles incorporating, "therapeutic recreation …recreation or recreational therapy…" (p. 348). This is an increase of 51% since the 2010 study (Autry et al., 2010). This increase may be attributed to a combination of the number of programs participating, declining from 83 in 2010 to 58 in the 2020 study and because of the need for programs to meet NCTRC standards (Autry, 2010; Autry, 2020). An informal Facebook survey conducted by Wozencroft et al., (2009) demonstrated that almost half of the 47 participants (47%) preferred recreation therapy and 21% preferring therapeutic recreation with 21% choosing a combination of both. In contrast, the American Therapeutic Recreation Association (ATRA), which is the national association for the field of "therapeutic recreation" in the United States, attempts to provide clarity on their website referring to practitioners as "Recreational Therapists" and the practice as "Recreational Therapy" (ATRA, n.d.).

In a 2019 study conducted in Saskatchewan, almost 77% of respondents felt that "[i]nconsistent job titles and job descriptions [were] [b]arriers to development of TR in the province" (Genoe, et al., 2019, p. 29). This finding is pertinent to the current research and will be addressed. The subsequent study in 2021 by Genoe et al., analyzed perspectives of professionals which highlights variation in titles, personal definitions of the profession, and purpose. This data contributes to a current larger body of inconsistencies within terminology and philosophy.

The most recent NCTRC job analysis survey (2014) highlighted "Recreation Therapist" as the most prominent title at 44.5% and "Recreation Therapist/Supervisor" as the second most prominent title at 16.5% with the majority (32%) working in hospitals. A more recent study in 2019 by Roussel et al., compared job titles among CTRA members who are not certified and those who are; findings complement the 2014 NCTRC analysis illustrating Recreation Therapist being the most prominent job title amongst CTRA members. The relationship between the title Recreation Therapist and clinical work settings has also been evident in other studies (Reid et al., 2013; Wozencroft et al., 2009). A study conducted in the province of British Columbia by Reid et al., (2013) found that over 72.6% of practitioners preferred the title Recreation Therapist, despite what their current job title was. It was also determined in this study that language consistency could reduce confusion for clients and allied health colleagues.

One of the largest problems for RecT in Canada relates to the perceived legitimacy of the profession among other health professions (Reid et al., 2013). Several studies have reported the need to present a unified definition of RecT, which may be enhanced by coming to a consensus on the terms as well as job titles used in the field (Reid et al., 2013; Wozencroft et al., 2009). Reasons for varying titles in the profession are likely due to the dynamic and diverse responsibilities and settings in which practitioners work as well as being one of the few unregulated health professions (Reid et al., 2013). In relation to our allied health colleagues, standardization is vital for consistency not only for the recruitment process of new RecT positions, but also for service delivery and client outcomes (Roussel et al., 2019; Skalko & Smith, 1989). Bedini and White (2018) characterized RecT practitioners as being seen as "second class citizens in the health care arena" (p. 376). The authors also highlighted that not only did Occupational Therapists (OTs) see Recreation Therapists as less than them, but a surprising finding was that recreation therapy professionals agreed with their perception.

RecT specific evidence-based research has been identified as a way to combat misconceptions about the profession from other healthcare professionals (Dwulit, 2017; Paterson et al., 2013; Stumbo & Pegg, 2010). The current research responds to the historical and recent calls in the literature to further explore the impact of varying job titles in the field of RecT. The objective is not to provide an all-encompassing view of job titles in the field, rather to act as a starting point for Canadian provinces and territories to begin intentional discussions on establishing consistency.

Methodology

This study adopts a reciprocal and collaborative approach to research by utilizing qualitative questionnaires (Reid et al., 2017). Prior to data collection, ethical and operational approval was obtained through the University of Regina Research Ethics Board and the Saskatchewan Health Authority. By engaging in the questionnaire, participants gave informed consent after reading the invitational letter and participating in the study. The invitational letter outlined the purpose and any risks associated with the study. Participant criteria were also clearly stated and emphasized the voluntary nature of their participation, which could be terminated at any time prior to submitting. All steps were taken to ensure complete data anonymity and no respondents could be identified either by name or institutional affiliation.

Surveys were distributed electronically using Qualtrics and were delivered via email and social media through a number of pathways utilizing contacts at professional associations, educational institutions, and health authorities to best reach potential participants. Contact was made by the primary investigator and email blasts were then distributed through contacts. In addition to email blasts, organizations also publicized the survey on their social media platforms. These organizations were purposefully contacted as members, employees, and alumni would fit the participant criteria. Participation criteria included: (1) Currently working in the field of RecT, (2) graduated from a RecT degree program, and (3) currently working in Canada. A total of 290 individuals agreed to participate in the study. Of the 290 responses received, 255 met the participation criteria. Due to the high number of participants with related degrees in the field, the authors agreed to expand the second criterion to all degree graduates as degrees specific to RecT in some Canadian provinces and territories were or still are non-existent. Twelve participants who identified that they were diploma-level graduates were not kept in the study because they did not meet the criteria to maintain a set minimum education level in which to compare participants.

Data Analysis

Descriptive data were grouped into six categories using descriptive statistics function in Qualtrics: (1) Educators, (2) Management, (3) Therapist, (4) Activationalist/Specialist, (5) Assistant/Coordinator, and (6) Other. The groups created were based on professional judgement and through consultation with the research team. Groups were then filtered into tables using a descriptive statistics function in Qualtrics to analyze themes within and between groups. The three themes guiding data analysis included: (1) work environment, (2) documents/ documentation, and (3) professionalization. Sub-themes were organized for each main theme from the data to determine the impacts of varying job titles on the profession in Canada. The groups' answers were tallied and converted into percentages for ease of comparison. Little qualitative data was provided by participants and filtered using thematic analysis as outlined by Elo and Kyngäs (2008).

Regular discussions between the original Author 1 and Author 3 of this article took place until the end of the data collection phase at which time an Author 2 joined the research team and

provided regular feedback to all team members regarding all aspects of the study via email communication and virtual meetings. Additionally, the manuscript was shared with four practitioners working in different provinces in Canada who agree that the findings are accurate based upon their experience.

Findings

Participants represented most Canadian provinces and territories excluding Prince Edward Island, Northwest Territories, and Nunavut. The greatest participation was seen from the provinces of Alberta (41%), British Columbia (31%) and Nova Scotia (9%). Similarly, the majority of participant degrees came from Douglas College in Coquitlam (26%), University of Alberta in Edmonton (18%), and Dalhousie University in Halifax (11%). All participants had a minimum education level of degree in or related to RecT. Sixteen participants had a master's degree and one held a doctoral degree. A steady increase in numbers was evident in graduation years occurring after 2010 with the majority of participants (10%) graduating in 2019. The earliest graduating year identified was 1979 by one participant, however, that was also the earliest year available to choose on the survey. Inconsistencies among degree names were noted in the data, specifically among earlier degree graduates with degrees not including TR/RecT in the title. Examples of the earlier degree names include Bachelor of Arts (BA) in Physical Activity Studies – Adapted, BA in Recreation Administration specializing in special populations and Allied Human Service Degree with a TR Diploma. 96% of participants identified as being a woman.

Among the 255 participants in this study there were 50 different job titles among degree graduates currently working in RecT in Canada (see Table 1). After organizing these job titles into groups, the "Other" group had the highest percentages of job title variances and the lowest percentage of working in a health authority. A surprising finding was that Assistant/Coordinator and Other groups were the only to identify as having multiple job titles within the same group. Interestingly, "Therapist" was the only group that had 100% consistency in job title and also had the highest percentage of participants (70%).

Excluding "Educator", all other categories identified having "Recreation Therapist" as one of their job titles. For instance, "Management" (n = 10), "Activationalist/Specialist" (n = 3, "Assistant/Coordinator" (n = 7), and Other (n = 4). Moreover, 80% of total degree graduates felt that their title accurately represented their position with highest percentages in Educator (100%), Therapist (92%), and Management (72%). Some participants felt their title did not accurately represent their current position. For example, participants said things like: "Would like to use CTRS," "While the role does have aspects of therapeutic recreation the majority of the role relates more to Child Life Specialist," "There should be more recreation in it," and "It is quite vague and doesn't show my clients or coworkers that I have the ability to assess and implement individualized recreation with a purpose…" Other answers included wanting recreation in their title or how their title serves the purpose of meeting a pay classification.

To better understand the impact of varying job titles in the context of the work environment, four areas were compared amongst groups including: (1) sector, (2) setting, (3) focus area, and (4) population served. The majority of participants (65%) work in a health authority with the two highest settings identified as “Residential” (42%) and “Community” (43%). The top three areas of focus identified were long-term care (43%), mental health and addictions (28%), and rehabilitation (24%). Across all groups except for Educator and Assistant/Coordinator, older adults ranked highest in population served with an average of 53% among all participants. The Assistant/Coordinator group indicated children and youth as the highest population served at 65%, while older adults ranked second for them at 35%.

Table 1
Variety of Job Titles among RecT Degree Graduates

Group:	Titles:	Totals:
Educator	Professor	1
	Faculty	1
	Total Participants	**2/2**
Management	Recreation Manager	9
	Director of Recreation	6
	Practice Lead	3
	Clinical Lead	2
	RecT Team Lead	1
	Interim Professional Lead RecT	1
	Clinical Lead for RecT or RecT Level 2	1
	Manager of RecT and Volunteer Services	1
	Recreation and Volunteer Manager	1
	Lifestyles and Program Manager	1
	Wellness Manager	1
	Manager of Community Development and Engagement	1
	Manager of Adult Services	1
	Executive Director	1
	Director of Health and Wellness	2
	Director of Resident Programs	1
	Senior Program Coordinator	2
	Professional Coordinator of Recreation and Music Therapy	1
	Regional Coordinator	1
	RecT Supervisor	1
	Senior RecT	1
	Total Participants	**36/39**

Table 1 (continued)
Variety of Job Titles among RecT Degree Graduates'

Therapist	Recreation Therapist	179
	Total Participants	**179/179**
Activationist/Specialist	Recreation Specialist	6
	Life Enrichment Specialist	2
	Recreationalist	1
	Recreation Development Specialist	1
	Community Integration and Meaningful Occupation Specialist	1
	Inclusion and Accessibility Specialist	1
	Behaviorist	1
	Total Participants	**14/16**
Assistant/Coordinator	Recreation and Volunteer Coordinator	5
	Recreation and Wellness Coordinator	1
	Rehabilitation Assistant	1
	Therapeutic Assistant	5
	Recreation Coordinator	10
	Program Coordinator	7
	Community Coordinator	1
	Community Inclusion Coordinator	1
	Recreation Assistant	7
	Total Participants	**38/34**
Other	Recreation Worker	1
	Recreation Technician	1
	Program Facilitator	1
	Recreation Staff	1
	Activity Aide	4
	Recreation Aide	3
	Wellness Mentor	1
	Activity Worker	2
	Community Support Worker and Workshop Facilitator	1
	Recreation Programmer	2
	Total Participants	**15/15**

All groups except for Educator indicated that they manage or supervise staff or volunteers in their job responsibilities. The lowest numbers of this trend was seen in Assistant/Coordinator (29%) and the highest in Management (95%). Interestingly, 79% of total degree graduates answered yes to the responsibility of supervising. On average, only 51% of total degree graduates are responsible for managing a budget with the highest number again in Management (74%), and the lowest in Other (33%). Furthermore, 44% of participants indicated they needed their Class 4 commercial driver's license (or equivalent) to transport clients. The Educator group had the lowest percentage at 0% and while Other had the second lowest percentage at 13%. Activationalist/Specialist had the highest (50%) with Management close behind (49%); Therapist and Assistant/Coordinator were close at 31% and 29% respectively.

There was an overt descending trend in hourly wage from the Management group to other. No data was available from Educator. The most common wages per hour for each group were as follows: Management ($37-$43), Therapist ($37-$43), Activationalist/Specialist ($31-$36), Assistant/Coordinator ($25-$30), and Other ($19-$24).

When looking at the impact of varying job titles in documentation among the groups, Therapist indicated the highest percentage of documenting progress notes (93%), discharge notes/summaries (60%), and care plans (74%) surpassing the total average among all groups**.** Management and Assistant/Coordinator scored highest in documenting program plans at 77% and 94% respectively. A total of 89% percent of total degree participants indicated they document where other allied health can access. As well, 90% of total degree graduates indicated they document individual assessments with the highest scores in Activationalist/Specialist (100%), Therapist (96%), and Management (85%). Combinations of both standardized and non-standardized assessment tools were the most popular among total degree graduates (51%) and only 7% of participants said they did not use any assessment tools. Therapist data indicated assessment tool use most often; with only 3% indicating they do not use them. Ninety-three percent of total degree graduates indicated that they participate in client-centered interdisciplinary collaboration either "sometimes", "often", or "always". The highest percentage of participants that indicated they do not participate (i.e., lowest participation) appeared in Other (13%), Assistant/Coordinator (12%), and Management (10%).

Although only 13% of participants said it was mandatory for them to be a CTRS for their job, 53% of participants identified as certified. A total of 28% of total degree graduates said being a CTRS was encouraged for their job. Similarly, 28% of total degree graduates were encouraged to be certified for their job with the highest number in Therapist (33%). A surprising finding was that 1% of total degree graduates indicated they were certified but are no longer with the highest numbers seen Therapist and Assistant/Coordinator (3%).

Data shows that 87% of total degree graduates are members of a professional association related to RecT with the highest numbers seen in Educator (100%), Therapist (92%), and Activationalist/Specialist (88%). Additionally, 23% of total degree graduates currently sit on a board or committee, again, with the highest numbers in Educator (50%), Activationalist/Specialist (38%), and Therapist (23%). When reviewing the data on mentorship, a

total of 255 participants have completed a CTRS internship with 64 (25%) of the total degree graduates. In order of highest to lowest groups that have hosted a CTRS internship are Activationalist/Specialist (63%), Educator (50%), Management (31%), Therapist (30%), Other (13%) and Assistant/Coordinator (12%).

When looking at professional development among varying job titles, most participants participate through work (93%) with the lowest participation seen in Other category (73%). The remaining groups scored in the high 80th percentile, with Educator reporting 100%. Only 85% of professional development is through a national or provincial association or chapter, again with Educator scoring 100%. The majority of total degree graduates indicated that "sometimes" they participate in professional development on their own time (71%), while 9% "only participate during work hours." Alternatively, 18% of total degree graduates said they "always" participate in professional development during their personal time.

Participation in research is consistently small among all groups with Educator demonstrating the highest involvement. Twenty percent of total degree graduates indicate they have worked on research for publication and 9% of total degree graduates have had their research published in an academic journal. Educator scored the highest in achieving publication in an academic journal (50%) with Activationalist/Specialist coming in second (13%). Management (8%), Therapist (8%), Other (7%), and Assistant/Coordinator (3%) reported the lowest scores on publication.

Discussion

The study conducted by Genoe and others (2019) in Saskatchewan identified that inconsistencies in job titles and job descriptions are a significant barrier to professionalization. Data from this current study supports the existing literature by highlighting the impact of varying job titles in many aspects of RecT (Reid et al., 2013; Wozencroft et al., 2009; Sullivan, 2015). Of the 255 participants, 50 different job titles emerged that illustrated varying work settings, wages, and levels of engagement in professionalization of the field. Themes and patterns were evident when analyzing data and comparing groups. The first four groups, (i.e., Educator, Management, Therapist, and Activationalist/Specialist), often scored higher in wages, involvement in documentation, assessments, research, and student mentorship. Furthermore, research emphasizes that responsibilities in RecT depend on where practitioners work and with whom (Roussel et al., 2019).

Findings correlate with the 2014 NCTRC Job Analysis, with Recreation Therapists being the predominant title represented in this study (70%) while predominately working in Long-Term-Care (40%). The Other top focus areas for Recreation Therapists were mental health and addictions (32%) and rehabilitation (27%). These areas were similar amongst total degree graduates, not surprisingly, due to the high percentage of Recreation Therapist's amongst overall participants.

Evidence-based research was highlighted in studies (Paterson et al., 2013; Steffen & Reid, 2017; Stumbo & Pegg, 2010) as lacking in RecT but also needed to provide legitimacy. Although research is outlined by the CTRA as being one of the profession's standards of practice

(CTRA, n.d.), data shows that only 20% of participants identify as participating in conducting research in the field, with 9% having their research published in an academic journal. Educator was identified as being most involved in publication (50%) with Activationalist/Specialist being second at 13%; Management and Therapist fell behind at 8%. Data also cited a lack of opportunities for CTRS internship as being a challenge for students graduating (Sullivan, 2015). This was reflected in the findings with only 25% of participants having hosted a CTRS internship student. In fact, Other (13%) and Assistant/Coordinator (12%) were among the lowest percentages in these findings.

Stumbo (1990) provided an overview of pathways to credentialing in the United States and based on these findings, Canada has all the building blocks to move towards licensure. Although the study was published over three decades ago, regulation has yet to be seen in Canada. There are currently 13 degree programs in Canada where graduates are eligible to sit for certification and there are opportunities for registration with national and provincial associations and chapters (CTRA, n.d.). Although it is not required by most jobs noted in the current data, over half of participants are certified under the NCTRC. Furthermore, although it is not enforced by law in Canada, 87% of participants identified as being a member (i.e., registered) with a national or provincial association or chapter. Licensure is the benchmark towards regulating the profession in Canada, like our neighbours to the south and at least three provinces have made it public of their efforts to pursue (ATRA, n.d.; BCTRA, n.d.; NSTRA, n.d.). We, the authors, understand low professional membership numbers and funding to be known barriers that could potentially be resolved if professional membership was mandatory to practice. Research supports a national entry to practice providing consistency of titles, service delivery, better client outcomes, and safety (Roussel et al., 2019).

Limitations

One of the main limitations in this study was the specific RecT degrees offered could be fairly new or non-existent in few parts of Canada, for example, the territories are without any degree programs. In turn, this resulted in the curriculum and content learned amongst participants to vary. Additionally, the earliest graduation year participants could choose was 1979. It was later discovered that, "…the University of Waterloo offered a TR area of concentration in 1972…" (Sullivan, 2015, p. 27). This oversight may have resulted in some participants leaving that question blank.

The number of participants amongst groups were not consistent and it should also be noted that participant numbers in certain groups, such as Group 1: Educator which had two participants are too small to reflect Educators on a national scale in RecT. It is evident that some participants had more than one title or job and findings in wage differences or responsibilities like documentation may be skewed as a result. The study also did not take into account that practitioners who indicated that they are not currently working in the field may be on a temporary leave and returning to the field. However, these individuals were removed from the study for not meeting eligibility requirements. Finally, data in this study was subjective and

without standardized job descriptions implemented by employers in Canada, it is impossible to decipher the scope of practice expected within each group.

Recommendations

It is recommended that the CTRA engages members on discussions around regulation and standardization of job titles to add legitimacy to the field of RecT in Canada. This shift can only occur if professionals agree on a unified definition, purpose, and terminology of RecT. Educational institutions in Canada should continue to promote research in the field to contribute to academic literature. In addition, academic institutions must also consider creating curriculum to support learning about policy change and pathways to licensure to better inform future practitioners about the importance of title protection across the Canadian provinces and territories.

It is also recommended that more research be conducted on the topic of RecT job titles across Canada. More specifically, it is recommended that a comprehensive national comparison among job postings in RecT be conducted to explore the varying titles, wages, responsibilities, and qualifications requested by employers. This would provide a greater understanding and create awareness and discussions about regulation across Canada.

Conclusion

As demonstrated in the findings, there are many causes of varying titles in RecT. Despite participants having a set minimum level of education, data show their job titles, wage, and scope of practice varied depending on where they worked. These findings confirm that there are inconsistencies between job titles in RecT in Canada. Findings also support existing literature and raise concerns around the legitimacy of RecT in relation to allied colleagues within healthcare. Wozencroft et al., (2019) study exploring preferred terminology concluded that if practitioners in RecT, "…conduct their programs and services without being cognizant of the turmoil in which multiple professional titles causes; not only to our profession as a whole but also for those trying to understand the profession" (p. 15). Furthermore, Stumbo and Pegg (2010), emphasized, "How each specialist 'practices'… matters a great deal… [i]f not now, when; if not you, who?" (pp. 19-20). It is imperative for practitioners to change the collective narrative and to take tangible steps towards legitimizing RecT within healthcare across Canada. This can start with a singular job title and entry-level to practice based on standardized qualifications that should be determined by the CTRA and adopted by employers.

References

Alberta Therapeutic Recreation Association. (n.d.). *Regulation*. https://www.alberta-tr.ca/employers/regulation/

American Therapeutic Recreation Association. (n.d.). *FAQ About Recreational Therapy (RT)*. https://www.atra-online.com/page/faq?&terms=%22faq%22

American Therapeutic Recreation Association. (2020). *Summer 2020 Newsletter*. *36*(2), 1-18.
Autry, C. E., Anderson, S. C., & Sklar, S. L. (2010). Therapeutic recreation education: 2009 Survey. *Therapeutic Recreation Journal, 44*(3), 161-181. https://js.sagamorepub.com/trj/article/view/914
Autry, C. E., Anderson, S. C., & Sklar, S. L. (2020). The 2019 Therapeutic Recreation Education Survey: A 50-Year Comparison. *Therapeutic Recreation Journal*, *54*(4), 339-365. https://doi.org/10.18666/TRJ-2020-V54-I4-10420
British Columbia Therapeutic Recreation Association. (n.d.). *Certification and Regulation*. https://bctra.org/certification-regulation/
Bedini, L. A., & White, A. L. (2018). We need more than another keychain: An analysis of marketing needs of CTRSs. *Therapeutic Recreation Journal, 52*(4), 374-389. 10.18666/trj-2018-v52-i4-8791
Canadian Therapeutic Recreation Association. (n.d.). *Standards of Practice.* https://canadian-tr.org/wp-content/uploads/2015/02/Standards_of_Practice_2006-English.pdf
Canadian Therapeutic Recreation Association. (n.d.). *Educational institutions.* https://canadian-tr.org/about-recreation-therapy/educational-institutions/
Dieser, R. (2013). Special issues: Global therapeutic recreation: Should the United States therapeutic recreation profession and the United States National Council for Therapeutic Recreation Certification (NCTRC) be replicated in other nations. *World Leisure Journal, 55*(4), 307-319. 10.1080/04419057.2013.843305
Dwulit, M. P. (2017). Student perceptions of therapeutic recreation: An exploratory study. *Therapeutic Recreation Journal, 51*(3), 193-205. 10.18666/trj-2017-v51-i3-8076
Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 61*(1), 107-115.
Genoe, R., Cripps, D., Nelson, S., Park, K., Ostryzniuk, L., Boser, D., & Azizi, Z. (2019). Therapeutic recreation in Saskatchewan: Executive summary. https://therapeuticrecsk.wixsite.com/website
Genoe, M. R., Cripps, D., Park, K., Nelson, S., Ostryzniuk, L., & Boser, D. (2021). Meanings of therapeutic recreation: Professionals' perspectives. *Leisure/Loisir*, *45*(1), 35–51. https://doi.org/10.1080/14927713.2021.1872411
Leslie, K., Moore, J., Robertson, C., Bilton, D., Hirschkorn, K., Langelier, M. H., & Bourgeault, I. L. (2021). Regulating health professional scopes of practice: Comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. *Human Resources for Health*, *19*, Article 15. https://doi.org/10.1186/s12960-020-00550-3
National Council for Therapeutic Recreation Certification. (2014). *2014 Job analysis report: NCTRC report on the international job analysis of certified therapeutic recreation specialists*. https://www.nctrc.org/wp-content/uploads/2019/05/JobAnalysisReport.pdf
National Council for Therapeutic Recreation Certification. (n.d.). *Licensure.* https://www.nctrc.org/about-ncrtc/
Nova Scotia Therapeutic Recreation Association. (n.d.). *Why is licensure important to our practice in Nova Scotia.* https://www.nstra.info/licensure-faq-1
Paterson, G., Rachfall, T., & Reid, C. (2013). Building a culture of research: using undergraduate research to advance the TR profession, build research capacity, and foster collaborative relationships. *Therapeutic Recreation Journal, 47*(4), 259-275.
Reddick, P. J. (n.d.). History of the Canadian therapeutic recreation association. https://canadian-tr.org/wp-content/uploads/2015/02/TR-History-Reddick.pdf

Reid, C. J., Landy, A., & Leon, P. (2013). Using community-based research to explore common language and shared identity in the therapeutic recreation profession in British Columbia, Canada. *Therapeutic Recreation Journal, 47*(2), 69–88.

Reid, C., Greaves, L., & Kirby, S. (2017). Experience, Research, Social Change: Critical Methods, 3rd Edition. Toronto: University of Toronto Press.

Roussel, H., Ouellette, P., Singleton, J., & Hopper, T. (2019). A survey of professional responsibilities and job satisfaction among Canadian therapeutic recreation practitioners. *Therapeutic Recreation Journal, 53*(3), 210-223. 10.18666/trj-2019-v53-i3-9675

Skalko, T. K., & McQuagge Smith, M. (1989). The status of therapeutic recreation in state personnel systems: A national survey. *Therapeutic Recreation Journal, 3(2)* 41-47.

Steffen, S. A., & Reid, C. J. (2017). Evidence-based practice in therapeutic recreation: An examination of clinical decision-making in mental health. *Therapeutic Recreation Journal, 51*(1), 18-34. 10.18666/TRJ-2017-V51-I1-7578

Stumbo, N. J. (1990). Overview of state credentialing concerns: A focus on licensure. *Therapeutic Recreation Journal, 24(2)* 40-59. https://js.sagamorepub.com/trj/article/view/4490

Stumbo, N., & Pegg, S. (2010). Outcomes and evidence-based practice: Moving forward. *Annual in Therapeutic Recreation, 18,* 12-23.

Stumbo, N. J., Wilder, A., Zahl, M., Devries, D., Pegg, S., Greenwood, J., & Ross, J. (2015). Community integration- Showcasing the evidence for therapeutic recreation services. *Therapeutic Recreation Journal, XLIX*(1), 35-60.https://js.sagamorepub.com/trj/article/view/5913

Sullivan, A. (2015). Credentialing of therapeutic recreation in Newfoundland and Labrador, Canada. *World Leisure Journal, 57*(1), 25-33. 10.1080/16078055.2014.1001174

Wozencroft, A. J., Kennedy, E. J., & Pihera, A. N. (2009). What's in a name? Exploring the preferred terminology of professionals in the field of recreation therapy. *American Journal of Recreation Therapy, 8*(2), 7-16. 10.5055/ajrt.2009.0009

Wozencroft, A. J., Scott, J. L., & Waller, S. N. (2019). Professional quality of life in recreation therapists. *Therapeutic Recreation Journal, 53*(1), 22-36. 10.18666/TRJ-2Q19-V53-I1-9Q98

©2022 Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario, Vol. 16, pp. 48-60

UNIVERSITY OF WATERLOO | FACULTY OF HEALTH Department of Recreation and Leisure Studies

Examining Positive Outcomes of Therapeutic Interventions in Acute Inpatient Psychiatry with Recreation Therapy as Linchpin to Interprofessional Collaboration

Research Paper

Emily MacKillop, Megan D. Campbell, Karen McCartney, & Achala H. Rodrigo

---

Abstract

The present study sought to emphasize the important role of Therapeutic Recreation in facilitating interprofessional therapeutic group programming in acute inpatient psychiatry. During a six-month timeframe in 2019, information on therapeutic programming and outcomes, group facilitators, types of groups offered, and unit participation was collected on two inpatient acute mental health inpatient units at a large academic hospital. Patient experiences when participating in therapeutic programming were also examined as outcome measures through anonymous patient surveys. The purposes of the study were, 1) to provide data that introduces a framework for and strengthens the role of recreation therapists as core treatment facilitators in acute inpatient settings, 2) to gain insight into the experiences of the individuals on the units who participate in therapeutic programming to determine efficacy, and 3) to provide pilot and feasibility data examining the novel collaboration between recreation therapy and psychology in the development and implementation of group Cognitive Behavioural Therapy (CBT) psychotherapeutic programming. Findings revealed patients were highly satisfied with therapeutic recreation programming as well as the new psychotherapeutic group interventions and attributed both as being important to their mental health treatment. This research highlights the value and need for investigative clinical research examining the utility of recreation therapists' roles in developing novel intervention programming, facilitating interdisciplinary collaboration, and enhancing patient experiences during acute psychiatry inpatient admissions.

Keywords: Acute Inpatient Psychiatry, Interprofessional Collaboration, Recreation Therapy, Group Cognitive Behavioural Therapy, G-CBT

Emily J. A. Mackillop, PhD, CPsych, ABPP, is an Assistant Professor (PT) in the Department of Psychiatry and Behavioural Neurosciences at McMaster University and a clinical psychologist and board-certified neuropsychologist at St. Joseph's Healthcare Hamilton. She actively considers medical, neurological, psychological, and behavioural factors in treatment and assessment as collectively impacting individual wellness. Her research focuses on this perspective in applied clinical contexts.

Megan D. Campbell is a Recreation and Leisure Services graduate with a specialization in Therapeutic Recreation. Megan is a Recreation Therapist at St. Joseph's Healthcare Hamilton in the Acute Mental Health program. Megan was the inaugurate co-lead of the TRO Mental Health Community of Practice. She has presented at TRO and CTRA conferences on a positive psychology program called Growing Gratitude.

Karen McCartney, CTRS, R/TRO, holds a Bachelor of Recreation and Leisure Studies with Major in Inclusive and Therapeutic Recreation from Brock University. Karen is a Recreation Therapist at St. Joseph's Healthcare Hamilton. Karen was the inaugurate co-lead of the TRO Mental Health Community of Practice. She has presented at TRO conferences on various topics, with various co-presenters.

Achala H. Rodrigo, PhD, is a Postdoctoral Fellow in Clinical Neuropsychology at St. Joseph's Healthcare Hamilton. Prior to joining SJHH, Dr. Rodrigo completed his doctoral training in clinical psychology at the University of Toronto Scarborough and his pre-doctoral residency in clinical neuropsychology at the London Clinical Psychology Residency Consortium.

Contact: Megan Campbell,
Email: mecampbe@stjosham.on.ca

Examining Positive Outcomes of Therapeutic Interventions in Acute Inpatient Psychiatry with Recreation Therapy as Linchpin to Interprofessional Collaboration

Background

According to data from the Canadian Institute for Health Information (2020), mental health and addictions conditions are among the most common causes for hospitalization across Canada, with average stays in acute settings being between 5.7-14.4 days. Thus, individuals experiencing acute psychiatric illness are often admitted to an inpatient mental health unit for a short period of time (i.e., less than one month). When an individual is admitted into acute inpatient care, the standard approach to treatment is focused on stabilization of psychiatric symptoms. This commonly includes medication management and psychosocial support to address possible environmental contributing factors (e.g., financial distress, homelessness, or interpersonal difficulties) (Bowers et al., 2005). Once stabilized, patients are discharged to outpatient settings or transferred to tertiary inpatient settings, which includes specialized treatments that are often diagnosis specific, from specialty healthcare professionals with expertise in a given area (Wasylenki et al., 2000). Such specialized and targeted therapeutic interventions that are commonly available in outpatient or tertiary setting are not typically available during acute inpatient admissions. Despite the well-recognized benefits of therapeutic recreation and psychological interventions, these interventions arguably represent an afterthought in acute inpatient settings rather than key components that constitute the treatment approach. We posit that this is a missed opportunity for treatment that could be significantly beneficial for patients.

In addition, due to the nature and structure of inpatient units, high quality therapeutic interventions can only be accomplished through interprofessional collaboration. The advantages of collaboration in healthcare are well-recognized and produce better outcomes with enhanced patient experiences (Bennett et al., 2017). Within this context, the potential value of the Therapeutic Recreation discipline in facilitating interprofessional collaboration, particularly within their roles in inpatient psychiatric settings, needs to be elucidated. Therefore, the current study sought to examine the potential impact of interprofessional programming within an acute inpatient psychiatric setting, with a particular emphasis on a novel collaboration between Therapeutic Recreation and Psychology.

Therapeutic Recreation in Acute Inpatient Psychiatry

According to an infographic published by Therapeutic Recreation Ontario (2018), Therapeutic Recreation is a purposeful process by which recreation and leisure assessment, planning, intervention, and evaluation are used to achieve individual goals and promote, restore and/or maintain quality of life and wellbeing. It is also noted that Therapeutic Recreation takes a strength-based approach while addressing physical, cognitive, social, emotional, and spiritual needs through different group and 1:1 interventions. While the benefits of community-based recreation therapy are well-established (Fenton et al., 2016, 2017), little is documented about

how such benefits can be translated into inpatient settings. Within an acute mental health inpatient setting, structured leisure activities with clear goals and opportunities provide meaning and a sense of wellbeing. Research has demonstrated that participating in meaningful leisure can elicit positive emotions and lead to a sense of accomplishment for patients in ways that other treatments cannot (Kolanowski et al., 2011). According to Therapeutic Recreation Ontario (2018), meaningful leisure can provide opportunities for enhanced quality of life for individuals with serious mental illness which can be steppingstones for positive relationships and improved wellbeing. In addition, they suggest that skill-based programming provides patients an opportunity to gain further insight and understanding into their mental health and play an active role in their recovery (Therapeutic Recreation Ontario, 2018). Perhaps a lesser known, but valuable, role of recreation therapists in acute inpatient settings is their stable presence on the unit. While other professionals (e.g., social workers, psychologists, occupational therapists) may interact with patients primarily on a referral-basis to address identified needs, recreation therapists tend to be more accessible as they are located principally on the unit. They provide open-access opportunities to all patients through impromptu interactions and drop-in programs. In this regard, Therapeutic Recreation as a discipline is uniquely situated as the therapeutic center of the acute inpatient unit.

Collaborative Care in Inpatient Psychiatry: Therapeutic Recreation and Psychology

There is expansive literature on the benefits of psychological intervention programming on inpatient psychiatry units based on cognitive behavioural therapy (CBT) (Clarke & Wilson, 2009). Nonetheless, in inpatient settings, patients are often presumed to be too unwell, or unstable to engage in this type of treatment effectively, or other interventions beyond medication management and supportive coping (Bowles, 2000). In this vein, many inpatient psychiatry units lack empirically established psychological treatment programs and reliable access to programming delivered by registered mental health providers.

It is important to recognize the many types of allied health professions present on any given acute unit (e.g., nurses, occupational and recreation therapists, psychologists, social workers), and none are wholly sufficient to independently meet the complex intervention needs of such a diverse patient population. Many barriers exist to engaging in interdisciplinary collaborations (Bowers et al., 2005; Mullen, 2009), this study is unique as it examines the positive impact from the collaboration between Therapeutic Recreation, Psychology and other allied health disciplines. Although disciplines differ, they share common underlying therapeutic goals (e.g., enhancing the mental health well-being; providing skills to assist managing emotional crises; focus on lifestyle factors as contributing to mental health), which we have found to be highly complementary. Despite these shared perspectives and goals, the authors were unable to identify any health outcomes research involving psychologists and recreation therapists working collaboratively. The present study reveals the importance of drawing from the resources of providers from many disciplines collectively to meet the patient needs as part of a complete approach to mental health treatment. We argue not only are recreation therapists particularly

well-suited to engage in interprofessional collaboration, but they also serve as the linchpin to coordinating and co-facilitating interprofessional programming in inpatient psychiatry units.

Present Study

The present study sought to examine the utility of interprofessional collaboration and patient experience while admitted on an acute inpatient mental health unit through three primary goals: 1) provide data that introduces a framework for and strengthens the role of recreation therapists as core treatment facilitators in acute inpatient settings, 2) to gain insight into the experiences of the individuals on the units who participate in group programming to determine efficacy, and 3) provide pilot and feasibility data examining the novel collaboration between recreation therapy and psychology in the development and implementation of group CBT psychotherapeutic programming.

Method

Participants

The present study consisted of 1) observational tracking participation and 2) collecting voluntary survey data on recreation and psychotherapeutic intervention programming from individuals who were undergoing psychiatric inpatient care across two acute mental health units located within a large academic hospital during a six-month time frame in 2019. A total of 452 patients were admitted and 1447 participant contacts were documented in group programming during the study time frame. Fifty (11.1%) of the 452 patients from two acute mental health units completed program evaluation forms anonymously and voluntarily[1]. Patients were assured of their right to participate in any group programming and could withdraw and rejoin without prejudice. Many individuals on the acute care inpatient units involved in this study had multiple psychiatric diagnoses, and the most common diagnoses during this time-period include depression, anxiety, substance abuse, and borderline personality disorder (Cheng et al., 2020). In addition to group programs, patients received treatment as usual care within the inpatient unit.

Programming and Engagement

Types of programming offered were based on availability of personnel, popularity, and inclusiveness of the activity to meet diverse patient needs. During the study period, 20 unique programs were offered multiple times during the six-month study period (physical activity programs consisted of four variations). Unless physical, cognitive, or severe psychiatric symptoms prevented engagement, programs were open to all individuals except one referral-based program "Managing Emotions." For data analytic purposes, the 20 programs were conceptualized under three core thematic areas: 1) broad range therapeutic (e.g., life skills) 2) psychotherapy intervention focused (e.g., CBT, Dialectical Behavioural Therapy (DBT)), and 3)

[1] Two surveys were excluded from analyses due to apparent inconsistent responding.

physical activity focused (e.g., walking). Additional information regarding these programs is presented in Table 1 (see Appendix A).

Facilitators

All groups were held in the Therapeutic Recreation room directly on the two inpatient psychiatry units. The recreation therapists played a primary role in facilitating all programming. Most groups were facilitated (9) or co-facilitated (10) by recreation therapy and other individuals or registered health care providers. One group was facilitated by the occupational therapist only.

Procedure

Program evaluation forms (see Appendix B) were placed in the Recreation Therapy room and were available to all patients to complete during their admission. The form instructed patients to rate the available inpatient programming in the Therapeutic Recreation room regarding their level of interest and perceived helpfulness relating to their health, including well-being, mood, and attitude. In addition, they were asked to specifically share their reflections concerning a novel CBT-based psychotherapy group, which was a new group designed by psychology and co-facilitated by Therapeutic Recreation and Psychology (MacKillop & McCabe, in press). Participants were also asked to identify their favorite programs, and comment on aspects of programming they liked the most and aspects that could be improved. Out of the 50 patients who completed the survey data, 44 of the patients indicated their preferences for the available programming (i.e., the programs that each patient preferred the most)[2].

Data Analysis

The program evaluation ratings were provided on a scale ranging from 1 (lowest) to 10 (highest), which were converted to percentages for the descriptive statistics provided below. The associations between key variables of interest were evaluated using linear regression.

Results

Patients reported a high level of overall interest in the therapeutic programming offered during their course of admission (M = 84.3%, SD = 14.2), and rated overall programming was helpful to their mental health (M = 83.0%, SD = 13.3). Patient level of interest in programing was positively associated with the reported level of helpfulness of these programs for their mental health (b = .48, $p < .001$).

For those who attended the CBT-based psychotherapy group, the patient-rated level of interest was high (M = 85.8%, SD = 17.8), and so was the perceived level of its helpfulness in facilitating patients' understanding of their mental health (M = 85.2%, SD = 1.56). In line with the trend seen regarding overall programming, patients' level of interest in the CBT-based

[2] Some patients indicated more than one favourite program.

psychotherapy group was also positively associated with the reported usefulness of this group for understanding their mental health ($b = .55$, $p < .001$).

Of the 44 patients who indicated a group preference on the evaluation form, 59.1% favoured programing within the broad range therapeutic category, 54.5% indicated a preference for psychotherapy intervention focused groups, and 18.2% indicated a preference for programs that focused on physical activity. There were many individuals who rated more than one program as their preferred program, which contributed to the tally of greater than 100%.

Discussion

Current findings reveal support for positive patient outcomes because of interprofessional collaboration, highlighting the unique role of recreation therapists as facilitators to therapeutic programming on acute inpatient psychiatry units. Multiple benefits for the patients as well as the healthcare professionals were observed. Not only did the collaboration between TR and other disciplines contribute to programming patients found helpful and interesting, but it also provided opportunities for more diverse therapy programming offerings. It is also important to note that the level of patient interest in the programs offered was a significant predictor of the perceived usefulness of the programs that they attended. The present study emphasizes the potential wide-ranging impacts of evaluating programming, interprofessional collaboration, and health outcomes in acute inpatient psychiatry. Additional research examining the effects and benefits of combining professional resources to provide care on inpatient psychiatry units is clearly needed. The Therapeutic Recreation room served as the hub from which professional collaborations were developed and implemented on the units. Advocacy is needed to advance the professional role of Therapeutic Recreation as a discipline to be included in collaborations within healthcare systems models (Bennett et al., 2017; Hutchinson & Lauckner, 2020). This can be accomplished by investigative research examining benefits of TR within acute inpatient psychiatric units, such as in this study, but also in research assessing the efficacy of tools for patient assessments and feedback (Jacob et al., 2017), and via research that promotes the development of interprofessional team collaboration (Orchard et al., 2012).

Further, our study demonstrated that patients were highly interested in the psychotherapy-based intervention programming (i.e., CBT- and Dialectical Behavioural Therapy (DBT)-type) and the interest was as high as other types of group programming offered. The individuals rated psychotherapy-based programming to be useful for understanding their mental health. These findings help to dispel the stigmatizing belief that individuals on acute inpatient units may be too unwell to recognize the benefits of psychotherapeutic intervention. More research in this area is needed.

During the study period, there were a total of 1447 group session contacts with individuals who were admitted during this time frame. While the average is approximately three groups attended per individual, many individuals attended more than three, while some individuals were too unwell to attend any programming (e.g., dementia, active psychosis). Since no identifying

information was collected during the study period, we were not able to further evaluate this information, which represents an avenue for additional investigation. Nonetheless, our data suggest individuals attend group programming when it is available and that it is integral to their care on inpatient psychiatry units.

Future directions of this research include exploring how therapeutic recreation interventions can be improved on inpatient psychiatry units by investigating types of groups offered, patient satisfaction, and self-selected engagement. Our findings should encourage recreation therapists to engage in treatment opportunities in inpatient settings by developing and facilitating interventions with other allied healthcare professionals. Implications include removing low-value programming (inherently reducing provider burden and improving care) and targeting specific needs for certain groups (inherently improving individualized care). For example, findings from the current study revealed a preference for psychotherapy-based, broad-based therapeutic focused groups more than physical activity programming, which is intriguing given the overwhelming focus on the benefits of physical activity programming in the recreation therapy literature. This surprising finding may directly relate to the level of mental health needs and the stage of change patients are in during an acute admission. While the benefits of physical interventions are indisputable and well documented in the TR literature (e.g., Fenton et al., 2016, 2017; Kolanowski et al., 2011), inpatients in certain settings may be more willing to self-engage in other types of programs, particularly when physical space is limited. Our study provides evidence for the efficacy of alternative therapeutic programming for recreation therapists who are working in confined settings or those without access to larger recreation facilities.

Finally, the comments on the survey forms collected as a supplementary part of the present study were perhaps the most interesting. While not quantitatively analyzed, anecdotal themes of comfort and humanity emerged in the comment section of the survey. The comments revealed that, overall, recreation therapy-facilitated programming was regarded positively on the unit and integral to their care. Within the hospital setting, individuals found comfort in the humanized interactions they had with the recreation therapists, allied health professionals, and other individuals who are going through similar struggles in the group room. Far too few individuals with severe mental health concerns are asked about their experiences during their hospitalization and/or are given a platform to provide feedback to directly influence therapeutic programming. Patient feedback is crucial to developing, adjusting, and improving medical healthcare, and our data revealed its value when it was also part of the delivery of therapeutic interventions.

Limitations and Future Directions

The current study was observational and involved voluntary participation in surveys. The questionnaires were available to all individuals who participated in the programming; however, there is a self-selection bias as to who availed themselves to complete them. The study consisted of a sample of approximately 11% of the total number of patients who were admitted during the study period, and there is not much known about the other individuals on the unit at that time. Since the study was designed to be anonymous to facilitate response candor and uptake, there

was no demographic or patient-specific information collected. This study provides preliminary data to direct the focus of future studies, towards a better understanding the characteristics of individuals who attend the programming (e.g., gender, age, education, diagnosis(es)) and potentially post-admission outcomes. In addition, it may be helpful to better understand which individuals benefit from different types of programming to direct patients to programming, or to empirically inform recreation and collaborative program development and offerings in inpatient psychiatry.

In conclusion, this study is unique and innovative in its function and has wide ranging applications and implications for enhancing the role of Therapeutic Recreation in acute inpatient settings. Recreation therapists serving as core programming facilitators in an interdisciplinary setting is an unexplored area of outcomes research, despite their critical role in facilitating frontline therapeutic programming.

Acknowledgments

This project was supported by grant funding from the Professional Advisory Committee at St. Joseph's Healthcare Hamilton.

References

Bennett, J., Piatt, J., Townsend, J., & Taylor, J. (2017). If you don't measure it, you won't improve it: The advancement of recreation therapy through collaborative research. *American Journal of Recreation Therapy, 16*(3) 7. doi:10.5055/ajrt.2017.0136.

Bowers, L., Simpson, A., Alexander, J., Hackney, D., Nijman, H., Grange, A., & Warren, J. (2005) The nature and purpose of acute psychiatric wards: The Tompkins acute ward study, *Journal of Mental Health, 14(*6), 625-635.

Cheung J., Wong Gonzalez, D., Amarioarei, A., Campbell, M., McCartney, K., MacKillop, J., Amlung, J., & MacKillop, E. (2020). Targeting trauma: Identification and intervention in acute mental health inpatient settings. Poster presented at the McMaster University Research Day.

Bowles, A. (2000). Therapeutic nursing care in acute psychiatric wards: Engagement over control. *Journal of Psychiatric and Mental Health Nursing (Commentary)*, *7,* 179– 184.

Clarke, I. & Wilson, H. (2009). *Cognitive behavioral therapy for acute inpatient mental health units.* New York: Routledge.

Fenton, L., White, C., Gallant, K., Hutchinson, S., & Hamilton-Hinch, B. (2016). Recreation for mental health recovery. *Leisure/Loisir, 40*(3), 345-365.

Fenton, L., White, C., Gallant, K., Gilbert, R., Hutchinson, S., Hamilton-Hinch, B., & Lauckner, H. (2017). The benefits of recreation for the recovery and social inclusion of individuals with mental illness: An integrative review. *Leisure Sciences, 39*(1)*,* 1-19.

Hutchinson, S., & Lauckner, H. (2020). Recreation and collaboration within the Expanded Chronic Care Model: Working towards social transformation. *Health Promotion International, 35*(6)*,* 1531-1542.

Jacob, J., Boshoff, K., Stanley, R., Stewart, H., & Wiles, L. (2017). Interprofessional collaboration within teams comprised of health and other professionals: A systematic review of measurement tools and their psychometric properties. *The Internet Journal of Allied Health Sciences and Practice, 15*(2), 1-12.

Kolanowski A., Litaker, M., Buettner, L., Moeller, J., & Costa, P.T. (2011). A randomized clinical trial of theory-based activities for the behavioral symptoms of dementia in nursing home residents. *Journal of the American Geriatrics Society, 59*(6), 1032-41.

MacKillop, E. & McCabe, R.E. (in press). Structuring and delivering group CBT in acute inpatient settings. In P. J. Bieling, R. E. McCabe, & M. M. Antony, (Eds.), *Cognitive Behavioral Therapy in Groups* (2nd edition). New York, NY: Guilford Publications.

Mullen, A. (2009). Mental health nurses establishing psychosocial interventions within acute s inpatient settings. *International Journal of mental health nursing, 18*(2), 83-90.

Orchard, C., King, G., Khalili, H., & Bezzina, M. (2012). Assessment of interprofessional team collaboration scale (AITCS): Development and testing of the instrument. *Journal of Continuing Education in the Health Professions, 32*(1), 58-67. doi: 10.1002/chp.21123

The Canadian Institute for Health Information. (2020). *Inpatient hospitalization, surgery, and newborn statistics, 2019-2020*. https://www.cihi.ca/en/quick-stats

Therapeutic Recreation Ontario. (2018). *Therapeutic Recreation, 2018.* TR-and-Mental-Health-Infographic-May-29-2018.pdf

Wasylenki, D., Goering, P., Cochrane, J., Durbin, J., Rogers, J., & Prendergast, P. (2000). Tertiary mental health services: I. Key concepts. *Canadian Journal of Psychiatry Revue, Canadienne de Psychiatrie. 45,* 179-84.

Appendix A

Table 1.

List of Group Programs, Description, Facilitator, and Total Attendance and Offerings

Group	Brief Description	Offerings	Attendance	Facilitator
Coffee/Tea	Aimed to increase activation and socialization	8	48	TR
Cognitive Behavioral Therapy (CBT)	Introduction to CBT Skills	33	153	TR, PY
Community Meeting	Unit supportive program to provide patients updates and allow feedback	5	19	TR
Coping Skills 101	Introduction to coping skills	1	4	TR
Creative Expressions	Guided art project	4	27	TR
Dialectical Behavioral Therapy[a] (DBT)	Referral-based, DBT skills	35	96	TR, SW, NR
Growing Gratitude	4 module positive psychology program	6	33	TR
Helping Hands	Community-promotion program involving working together on a Project to benefit others	2	14	TR
Life Skills	Basic life skills (e.g., sleep, budget)	19	112	OT
Medication Group	Education on medication and non-medication strategies for mental health	16	87	TR, PH
Mindfulness	Skill development applying mindfulness	28	95	TR, OT
Motivation Monday	Activation and goal setting group	10	52	TR, OT
Music Appreciation	Music related activities	19	105	TR, OT
Open Leisure	Low barrier recreation programming	25	170	TR
Pet Therapy	Therapy dog visit with patients	8	89	TR, V
Pottery[b]	Clay, paint, and glazing ceramics	16	78	TR,

Physical Activities (4 programs)	Seated stretching/chair exercises, outdoor and indoor walking, workout video	24	92	CV TR
Self-Care	3-step hand care regime program	9	55	TR, CV
Special Event	Holiday/Seasonal events	5	50	TR
Spirituality	Non-denominational discussion group	15	68	TR, SC

Note. TR = Therapeutic Recreation; PY = Psychology; SW = Social Work; NR = Nursing; OT = Occupational Therapy; PH = Pharmacy; CV = Community Volunteer; SC = Spiritual *Care*

[a]Closed group/referral required.

[b]Attendance in each session was limited to 10 participants

Appendix B- Therapeutic Feedback Survey

Therapeutic Interventions Survey

Take a few moments to complete this form about **programming attended in the Recreation Therapy Room**. Your answers are confidential and we ask that you do not put your name on the form. We appreciate your thoughts and opinions! Your participation is completely voluntary.

1. On a scale from 0 to 10 how would you rank your interest in the programs that are being offered?
   (with 0 = no interest at all to 10 = the most interesting thing you did/are doing while here)

   0------1------2------3------4------5------6------7------8------9------10

2. How much do you think that the programming is helping with your health (such as your well-being, mood, attitude) during your admission?
   (with 0 = Not at all to 10 = the Most important Contribution)

   0------1------2------3------4------5------6------7------8------9------10

3. If you attended the CBT for Anxiety group, how useful were the techniques being taught?
   (with 0 = Not at all Useful to 10 = Extremely Useful)

   0------1------2------3------4------5------6------7------8------9------10

   _____I did not attend CBT for Anxiety Group

4. If you attended the CBT for Anxiety group, how helpful was it to understanding your mental health?

   0----------1----------2----------3----------4----------5----------6----------7---------8---------9---------10
   Much Worse A little Worse About the Same A little Better Much Better

   _____ I did not attend the CBT Anxiety Group

5. What was your favourite program to attend? _____

   What did you like about it? _____

   _____

6. Do you have any thoughts about how we could improve programming? _____

   _____

©2022 Therapeutic Recreation: Practice and Research
Journal of Therapeutic Recreation Ontario, Vol. 16, pp. 61-75

UNIVERSITY OF WATERLOO | FACULTY OF HEALTH Department of Recreation and Leisure Studies

Increasing Recovery-Based Activities for Patients on a Secure Forensic Unit Through Staff Training in Cognitive Behavior Therapy Skills and the Use of Microsoft Access

Research Paper

Jessica Diamond, Heather Johnston, Suraya Faziluddin, and Roland Jones

---

Abstract

The forensic mental health system in Ontario is a partnership between the criminal justice system and the mental health system for people who have committed offenses and been found not criminally responsible on account of mental illness or unfit to stand trial. Individuals can be detained for the purposes of public safety in an environment that focusses on collaborating with patients (patient-centered care) in the management of their symptoms and overall recovery. Participation in structured and purposeful daily activities has been found to contribute to the well-being and recovery of forensic patients and plays a role in reducing the risk of recidivism and aggressive behavior (Rani & Mulholland, 2013; Meehan & Bergen, 2006). Strengthening patient engagement also helps to improve experiences of care in forensic hospitals (Livingston, et al. 2013). To encourage an increase in the participation of patients in meaningful activities, staff members of a secure forensic unit at the Centre for Addiction and Mental Health (CAMH) were trained in Cognitive Behaviour Therapy (CBT) Skills to be used in 1:1 interventions with patients on a daily basis. Focus was placed on behavioral activation (encouraging patients to partake in both mastery and pleasurable activities) and relaxation exercises. Microsoft Access was also used as a way to track participation and present the weekly participation numbers to patients and staff. This article will describe our project rationale and process, as well as highlight our findings regarding patients' participation in meaningful activities which led to an overall increase in engagement in recovery-based programs.

Keywords: Cognitive Behavior Therapy Skills, Forensic Mental Health, Meaningful Activity, Microsoft Access, Motivation, Therapeutic Engagement

---

Jessica Diamond, BRLS, GCertTR, R/TRO, is a Recreation Therapist at the Centre for Addiction and Mental Health, working on a secure forensic unit and a R/TRO member since 2009. Mental health recovery has been the focus of her career. With continued education, she followed up her Georgian College TR graduate certificate with degree in Recreation and Leisure Studies from Brock University.

Heather Johnston, HonsBA, R/TRO, has been working in the field of Recreation Therapy since before completing an Honors Bachelor of Arts in Therapeutic Recreation at the University of Waterloo (1998). Heather has a rewarding career in adult mental health (inpatient/outpatient populations) and is currently a Recreation Therapist on a secure unit in the forensic program at the Centre for Addiction and Mental Health.

Suraya Faziluddin, MSW, RSW, is an Advanced Practice Clinical Leader - Forensic Division, with the Centre for Addiction and Mental Health.

Dr. Roland Jones, PhD, MSc., MB. ChB, BSc., MRCPsych, is a Forensic Psychiatrist & Clinician Scientist, the Centre for Addiction and Mental Health. Dr. Jones is an Associate Professor, University of Toronto.

Contact: Jessica Diamond, Centre for Addition and Mental Health
Email: jessica.diamond@camh.ca

Increasing Recovery-Based Activities for Patients on a Secure Forensic Unit Through Staff Training in Cognitive Behavior Therapy Skills and the Use of Microsoft Access

Introduction

Patients in the forensic mental health system reside in a hospital setting five times longer than general psychiatry patients (Andreasson et al., 2014). The length of stay is impacted particularly so for individuals with more complex mental illnesses and severe index offences (Gosek et al., 2020). It's also significant that patients in the forensic mental health system across Canada are subject to more restrictions than general psychiatry patients. In Ontario, patients' length of stay in the forensic system are overseen by the Ontario Review Board (ORB). This legal body issues disposition orders to direct where a patient is to be detained (in the hospital or in the community), and under what conditions and supervision requirements. The elements of a patient's recovery considered by the ORB are the assessed risk of violence and the recovery and rehabilitation progress over the course of a year (Barbaree & Bettridge, 2004). These patients are individuals who have either committed a crime for which they are found to be not criminally responsible for on account of mental illness or have been found unfit to stand trial. Forensic patients who are subject to compulsory detention often have a high level of complexity due to co-morbid personality disorders, substance misuse, trauma, and criminal offending behaviour (Williams et al., 2014). Individuals in this system often require specialized care plans and programs to meet the complex needs in their recovery.

Forensic rehabilitation has been changing with the emergence of evidence-based care in recovery, which supports positive therapeutic engagement and provides opportunities for meaningful participation in rehabilitation programs; a critical part of the recovery process (Bjorkedal et al., 2020). Rani and Mulholland (2013) noted that this is a systemic change shifting the focus of approach from one that is punitive to rehabilitative, contributing to an increase in availability of structured programs to support rehabilitation. It becomes the responsibility of the care team (doctors, nurses, and allied health practitioners) to develop/implement rehabilitation and recovery programs, while providing opportunities for patients to participate in meaningful activities.

Further considerations and barriers for therapeutic programming in a forensic rehabilitation program relate to risk management, safety, time, and resources. According to Rani and Mulholland (2013): "With higher levels of security come greater obstacles to engaging in meaningful occupation or activities" (p. 386). Studies identify an optimal amount of time in which patients should engage in meaningful activities to support recovery and wellbeing (p. 385). Despite this, acute care units may have difficulty meeting these goals due to [individual and systemic] challenges relating to engagement in structured activities and programs (Rani & Mulholland, 2013). Therefore, it is imperative to use all tools available to reduce barriers, increase motivation to attend and provide increased opportunities for engagement in therapeutic programming.

Literature Review

Additional stressors for patients in institutional environments identify issues and variables with the conditions in which the individual lives. Meehan and Bergen (2006) highlight that congregate settings have a variety of triggering situations, noting that a lack of engagement in meaningful activities and living in a challenging and restrictive environment increases risk and opportunity for aggression. In conjunction with the impact of a complex mental illness, these factors can lead to feelings of boredom, hopelessness, and depression. Unsurprisingly, individuals with psychiatric illnesses participate less and meaningful engagement is decreased (Bjorkedal et al., 2020). Alternatively, Bjorkedal et al. (2020) note that engagement in more activities can support a reduction in symptoms and have a positive impact on cognition, reasoning, self-esteem, and empowerment. Participating in purposeful daily activities contributes to the well-being and recovery of forensic patients and plays a role in reducing the risk of recidivism and aggressive behavior (Meehan & Bergen, 2006; Rani & Mulholland, 2013). Strengthening patient engagement also helps to improve the patient's experiences of care in forensic hospitals (Livingston et al., 2013).

Motivation for participation

Individuals with complex mental illness often experience reduced motivation for engaging in meaningful activities; affected by boredom, their use of time and engagement level (Farnworth, 1998). Those residing within the forensic system have increased restrictions of liberties which contributes to decreased motivation and often requires individualized supports to encourage participation and develop intrinsic motivation levels. Communication with the patient's care team can help identify the individual's motivation for participation leading to increased insight into one's wants/ needs and support therapeutic engagement. This communication guides the directions for which clinicians can encourage participation and increase motivation.

Meaningful Activities

Meaningful activities are things individuals do to occupy their time (Eklund & Brunt, 2017). These activities are positive as they help to create connections and increase one's quality of life. Bjorkedal et al. (2020) identify that meaningful engagement is an important part of the recovery process for individuals with mental illness. It is often these very activities that help support wellbeing and enjoyment, reducing boredom and other maladaptive behaviours. Evidence shows that activities that are meaningful and consistent "can reduce the need for containment strategies, incidents of self-harm, violence and absconding" (Baker et al., 2014, p. 20). When an individual experiences environments that are controlled or limited, as in extended hospitalization, these meaningful activities can make a positive difference in their recovery.

Therapeutic Engagement

In recovery, the establishment of a strong therapeutic rapport is an important factor in creating positive opportunities for engagement. Livingston et al. (2013), suggested that patient engagement refers to being actively involved in a variety of activities that have meaning to the individual as well as making decisions regarding their recovery. Livingston et al. (2013) identified that patient engagement supports self-determination, providing choices and understanding the values of lived (mental health) experiences, as well as create meaning in one's life. Pereira and Woolaston (2007) noted that environments with positive therapeutic engagement allowed the patient to feel supported and willing to participate in their own recovery. Additionally, Baker et al. (2014) note patient engagement is aided by quality interactions between staff and patients. Thus, the role of therapeutic engagement is important as there is a correlation to supportive, positive connections with staff that help foster a therapeutic rapport. It is this therapeutic engagement that increases a patient's propensity for being actively involved in their care and recovery. Livingston et al. (2013) recommend benefits of investing resources to train frontline clinicians how to effectively provide person-centered care, and recovery related care to achieve improve engagement with patients.

Cognitive Behaviour Therapy Skills

Longstanding research has provided evidence that Cognitive Behaviour Therapy (CBT) is effective in treating some mental illnesses, in conjunction with "traditional psychiatric care interventions" (Tarrier, 2005, p. 136). Additionally, "CBT includes an emphasis on scheduling pleasant and mastery activities" (McCauley et al., 2015, p. 292). There are benefits in utilizing the related skills and similar concepts to help support recovery. Of the factors that can influence the therapeutic engagement process, using CBT skills can be supportive in strengthening therapeutic relationships and rapport (Baker et al., 2014). When patients feel supported and comfortable it leads to an increase in their willingness to work cooperatively with the care team.

The use of CBT skills with individuals with mental illnesses can have encouraging effects. CBT skills practice allows the individual to "discover the connections between their thoughts, feelings and behaviours and to realize that by altering thoughts and/or behaviours, their feelings can be changed for the better" (Baker et al., 2014, p. 22). Furthermore, Baker et al. (2014) endorses that this understanding strengthens learned self-help skills and the development of better coping strategies. This positive engagement strengthens opportunities for holistic healing, promoting hopefulness and encourages an active participation in one's life (Durrant et al., 2007). Williams et al., (2014) identify that engagement may support a reduction of negative symptoms. In addition, practicing CBT skills such as breathing and grounding techniques may help reduce negative symptoms, and positive changes can come from patients confronting their thoughts and challenging the "perceptions of their own limited resources and help them to invest in activities by changing their outcome expectancies" (Williams et al., 2014, p. 72). This comes with changing one's mindset to seeing how practicing a variety of CBT skills can lead to beneficial outcomes through practical learning and development of these supportive skills.

CBT informed skills can be delivered effectively by mental health professionals from different disciplines (Durrant et al., 2007; Gratzer & Goldbloom, 2016). There is also evidence of the effectiveness of CBT skills for patients with schizophrenia in secure forensic mental health settings (Williams et al., 2014). Several studies have begun to connect the rehabilitative functions of increased engagement with staff and participation in meaningful activities with patients' recovery and wellbeing. For example, Bjorkedal et al.'s (2020) study addresses rehabilitation interventions on recovery and activity engagement. Rani and Mulholland (2014) examine hours of activity engagement in a forensic setting and Durrant et al. (2007) as well as Williams et al. (2014) explore the use of CBT in both inpatient and forensic settings. These studies have researched optimal amounts of patient activities and have identified the use of CBT skills as an effective treatment modality and supports patient engagement.

Objective

This study attempted to connect the use of CBT skills with increasing motivation for participation in meaningful activities. The authors utilized an approach known to have positive results and applied it to support a further understanding of therapeutic engagement, in addition to monitoring hours of activity participation to identify how it supported the participants' mental health recovery.

This study seeks to identify that participation in recovery-based activities increase through the use of CBT skills. To do this, the author's used Microsoft Access as a data collection tool and form of motivational support. We attempted to motivate patients to engage in meaningful activity for a minimum of 25 hours a week, based on recommendations from the Quality Network of Mental Health Services (QNMHS) located in London, UK.

Our hypothesis was that by engaging patients in daily CBT skill related exercises, their overall motivation to engage in, and participate in activities would increase. We also anticipated that by supporting patient cohesion and a feeling of safety and security there would be improvements in overall unit atmosphere.

This research will contribute to new knowledge and understanding about the connection between CBT skills and increased activity participation, as well as promote engagement in meaningful activities as a part of recovery. Moreover, this study demonstrates that an increase in participation can result from a concerted effort in recovery-based care across all disciplines. It is within this work that the patient strives toward therapeutic treatment goals with a positive awareness of self, increased recovery skills, and support for the development/ accomplishment of meaningful goals through recovery and rehabilitative supports.

Methods

This study was implemented on an all-male, adult unit in the secure forensic rehabilitation program at the Centre for Addiction and Mental Health (CAMH) in Toronto, Ontario. A convenience sample of 14 patients participated throughout the duration of the study.

CBT Staff Training

An interdisciplinary care team consisting of a psychiatrist, psychologists, nurses, recreation therapists, occupational therapist, social worker, behaviour therapist, senior methodologist and members of the leadership team met to develop the CBT skills training program for staff and patients. The next step involved assessing baseline levels of staff familiarity with CBT skills and current levels of engagement with patients. Participating staff attended a seven and a half hour, in person CBT skills training session, in which the goal was to increase their comfort in assisting clients to learn the skills and collaboratively practice applying them on an ongoing basis. Additionally, 37 staff members completed a pre training assessment evaluating staff confidence in facilitating CBT skills and 22 staff members completed the post training measure.

Over an eight-week period following the initial training session, staff received weekly 30-minute continuing education sessions on CBT skills. Unit staff also had the opportunity to review the skills daily with a qualified clinician trained in CBT. There was also an opportunity to debrief experiences using CBT skills with patients and reflect on clinical cases, receiving feedback and support.

Data Collection

Unit staff were trained in and began using a tracking system created in the Microsoft Access program to track hours of patient engagement. Data entry became part of the standard work for all clinical staff. Baseline activity levels were established through consulting clinical documentation and therapeutic program attendance records. The use of time data collection allowed the staff to start tracking and monitoring activity participation on the unit. A data recording program must make reporting simple and accessible for staff to use and needs to easily capture patients in activities accurately while allowing for easy review of data. The hours of participation results were reviewed after five months, as well as the data of pre/post confidence measure of staff using CBT skills.

EssenCES

Patients completed the EssenCES assessment, which is a survey designed to evaluate the unit's (ward's) social climate. The areas assessed identified three dimensions, looking at the patients' experiences relating to the areas of therapeutic rapport, the patient cohesions and mutual support among others, and supporting a safe environment (Schalast et al., 2008).

Data Analysis

Quantitative statistical analysis was used with statistical software. T-tests were used to compare changes in total hours of engagement, staff confidence in using CBT skills and changes in unit atmosphere.

Results

The QNMHS has identified that 25 hours was the optimal amount of time for patients to engage in activity each week to support recovery. There are benefits for clinicians and patients who use technology to track participation in activities. The hospital offers a wide range of recovery and evidence-based programs for inpatients, but despite the variety of program opportunities it was noted that overall baseline participation on the unit can be low. Results indicate that patient participation and engagement levels increased as a result of the support given by staff through the practice of CBT skills.

Engagement and Participation

The data collected in Microsoft Access was reviewed with each patient bi-weekly during team review discussions. Patients were able to visualize their ongoing levels of activity by reviewing a graph that depicted hours of activity per week (see Appendix A). This data was also tabulated into monthly line graphs that were reviewed individually with each patient to track progress towards their identified goals. Reviewing these graphs with patients facilitated discussions around motivation levels, reasons for choosing to or not to participate and the therapeutic value of engaging in meaningful activity, such as recovery programming, recreation therapy programming, and activities of daily living (ADL's).

Total Hours of Engagement in Activities

Over the five months of the study, there was an increase in over 300 hours of engagement in meaningful activities. With the baseline of 200 hours of engagement, the participation hours increased to just over 500 hours. These numbers rose significantly in the last two months of the study, once staff education, support and supervision were complete. By months four and five, staff were fully engaged with supporting and promoting the patient's engagement in meaningful activities (see Appendix B).

Increase in Activity Level of Patients

Of the 14 patients involved in the study, we found a significant increase in the amount of time patients engaged in therapeutic activities from a mean of 14.65 hours per month per patient to 36.49 hours per month per patient ($t = -4.5$, $p < .001$). The increase in patient engagement in therapeutic activities (previously enjoyed and new initiatives) more than doubled from baseline measures. Although there is a variability in the hours, they are noted to be trending upward (see Appendix C).

Increase in Staff Confidence in Using CBT Skills

Thirty-seven staff completed the questionnaire prior to training in CBT. The pre training mean score was 2.65, rating staff confidence in using CBT skills. In total, 22 staff completed a post training measure, with a mean score of 3.14, showing an improvement in the confidence level of staff post training ($t = 1.99$, $p = .05$). In addition, developed CBT skills were evident as patients were actively utilizing these skills.

Improvement in Ward Atmosphere - EssenCES Scoring Results

The EssenCES assessment was administered to patients to measure unit atmosphere; specifically: Patient cohesion (mutual support), therapeutic hold, and safety. These elements help create a positive environment for recovery. Seventeen clients completed the EssenCES pre-CBT skill training and 15 completed the post training measure. We found a significant improvement in patient cohesion (mean of 8.71 compared with mean of 10.22, $t = -2.30$, $p = .03$). While there were improvements in the measures of therapeutic hold and experiences safety, these differences did not reach statistical significance.

Implications for Therapeutic Recreation Practice

One of the biggest challenges faced by recreation therapists in mental health settings is the lack of patient motivation to attend programming. This is compounded by a variety of factors, such as (but not limited to) negative symptoms of schizophrenia or the sedating effects of medication, leading to an overall decrease in participation. Observations noted throughout this study indicate that with more effort focused on practicing CBT skills and engaging in meaningful activity, there was an increase of participation in a variety of programs offered on the unit. There was a marked increase in patient engagement in both recreational activities and recovery-based programs.

Improved communication allowed for opportunities to discuss with patient's their weekly hours of activity. The care team noticed patients taking an interest in engaging more, noting that patients were motivated to increase their number of hours from the previous week. By developing an understanding for the increase of activities, and through the staff facilitation of CBT skills, the 1:1 engagement with patients became more meaningful and supported the development of skills that facilitate recovery. This resulted in an increase in patients' intrinsic motivation to participate, as well as building an interest in their overall well- being and commitment to recovery.

The staff also noted an improvement in communication about programming and engagement. With the opportunity for informal interest assessment and evaluation, patients were openly providing feedback. This included feedback about the availability and type of programs offered as well as more openly sharing thoughts and ideas about what helps their recovery process, resulting in changes to the program schedule. Baker et al. (2014), highlighted the

importance of collecting client feedback and using tools that provide clinicians with a reliable means of evaluation.

Some of the recovery-based groups utilized the data from Microsoft Access as a motivational tool to positively reinforce program attendance and would discuss the connection between increased participation and feelings of overall well-being. The data was also used as a conversation starter between staff and patients regarding individual participation levels. Patients expressed a value in seeing their participation efforts portrayed visually. Also positively supported, was the opportunity for patients to work with staff to develop their own monthly schedule and to encourage attendance in groups available, thus increasing a sense of empowerment in their own rehabilitation. Overall, there has been an increase in quality of care on the unit, involving a more collaborative, yet individualized planning approach that resulted in an increase in motivation and thus therapeutic engagement and participation in meaningful activities.

Additional Considerations

Post-study, variables affecting program participation related to staff training and facilitation of the CBT skills, seasonal changes, program structure changes, and the onset of the COVID-19 pandemic. Other areas to consider for this study are the development of staff supports and sustainability efforts, as well as troubleshooting technological issues. As with any study/project, initially the frequency of staff supervision and reinforcement of learning required a lot of resources such as daily staff CBT skills practice and weekly supervision. Over time, this decreased to more informal check-ins with staff and continued with patient reviews in their bi-weekly case conferences. To foster ongoing engagement, we continue to utilize opportunities for reflective practice and provide additional support to staff as needed.

Limitations

Some of the limitations identified in this study are related to staff, patient, and technological issues. It was noted that there were consistency issues with staff inputting accurate data, resulting in differences between observations of what someone was doing, and what the data indicates. Sometimes staff did not capture patient participation, particularly if the activity was done independently, which would have led to an underestimation in the hours of activity. Fluctuations in a patient's mental status can affect participation levels, as well as reduced/loss of off-unit passes can impact hours of onsite engagement.

Issues relating to technology emerged when using Microsoft Access. At times, the database showed signs of instability, such as freezing or not loading properly. This resulted in the need for regular database maintenance, and on occasion required more complex IT support to retrieve the data. Although this study utilized Microsoft Access 2010 to track activity data and graph the results; the concept could be supported by using other data collection tools available.

Future Actions

The next step of this study is to support the facilitation of ongoing administration of the EssenCES assessment, reviewing staff's confidence in using CBT skills with patients, and training newer staff in CBT skills and data collection in Microsoft Access. Further assessments could measure patients' mood and anxiety levels, as well as explore participation using other participatory and motivational assessments. Engagement modalities could also involve support from a wider group, including patients' family members and peer group, in addition to the care team. Lastly, there is hope to integrate the data collection of meaningful activity hours in other clinical programs within CAMH and to embed the data collection of participation hours into clinical documentation systems.

Conclusion

Positive outcomes from this study are the enhanced therapeutic relationships and improved communication between staff and patients. This is a by-product of using the CBT skills and the overarching increase in patient participation. In understanding the relationship between increases in participation and the use of CBT skills, we were able to continue to support patient engagement and participation in recovery-based care. Continuing to track and review patient participation assists with developing a greater understanding of how patients meaningfully spend their time and increases intrinsic motivation to engage in a variety of activities.

Acknowledgments

This project would not have been possible without the dedicated team of staff who supported this project with their hard work and commitment to patient engagement. We would like to thank Shawnna Balasingham (MSW, RSW), who was the Secure Unit Manager and Talitha Dykstra, (M.ADS, BCBA), who was the unit Behaviour Therapist that facilitated the implementation of this project and the analysis of this data. We would also like to acknowledge the support of Tania Saccoccio, Forensic Program Outpatient Clinical Director, Faraaz Khan, RN Team Lead and the unit nurses and allied health staff of the Secure Forensic Unit.

References

Andreasson, H., Nyman, M., Krona, H., Meyer, L., Anckarsäter, H., Nilsson, T., & Hofvander, B. (2014). Predictors of length of stay in forensic psychiatry: The influence of perceived risk of violence. *International Journal of Law and Psychiatry*, *37*(6), 635-642.

Baker, J., Sanderson, A., Challen, K., & Price, O. (2014). Acute inpatient care in the UK. Part 1: Recovery-oriented wards. *Mental Health Practice*, *17*(10), 18-24.

Barbaree, H., & Bettridge, S. (2012). The forensic mental health system in Ontario: An information guide. CAMH Publication.

Bjorkedal, S., Bejerholm, U., Eplov, L, Moller, T. (2020). Meaningful Activities and Recovery: The effect of a novel rehabilitation intervention among persons with psychiatric disabilities on activity engagement – study protocol for a randomized controlled trial. Trials, *21*(789), 1-11.

Durrant, C., Clarke, I., Tolland, A. & Wilson, H. (2007). Designing a CBT Service for an Acute Inpatient Setting: A Pilot Evaluation Study. *Clinical Psychology and Psychotherapy*, *14*, 117-125.

Eklund, M., & Brunt, D. (2017). Measuring Opportunities for Engaging in Meaningful Home-Based Activities in Housing Services for People with Psychiatric Disabilities: Development of the Perceived Meaning of Activity in Housing (PMA-H). *Evaluation & the Health Professions*, *42*(2), 131-147.

Farnworth, L. (1998). Doing, Being, and Boredom. *Journal of Occupational Science*, *5*(3), 140-146.

Gosek, P., Kotowska, J., Rowińska-Garbień, E., Bartczak, D., & Heitzman, J. (2020). Factors Influencing Length of Stay of Forensic Patients: Impact of Clinical and Psychosocial Variables in Medium Secure Setting. *Frontiers in Psychiatry*, *11, 1-9.*

Gratzer, D., & Goldbloom, D. (2016). Making Evidence-Based Psychotherapy More Accessible in Canada. *Canadian Journal of Psychiatry*, *61*(10), 618-623.

Livingston, J.D., Nijdam-Jones, A., Lapsley, S., Calderwood, C., & Brink, J. (2013). Supporting Recovery by Improving Patient Engagement in a Forensic Mental Health Hospital: Results from a Demonstration Project. *Journal of the American Psychiatric Nurses Association*, *19*(3), 132-145.

McCauley, E., Gudmundsen, G., Schloredt, K., Martell, C., Rhew, I., Hubley, S., & Dimidjian, S. (2015). The Adolescent Behavioral Activation Program: Adapting Behavioral Activation as a Treatment for Depression in Adolescence. *Journal of Clinical Child & Adolescent Psychology*, *45*(3), 291-304.

Meehan, T., & Bergen, H. (2006). Aggressive behaviour in the high-secure forensic setting: the perceptions of patients. *Journal of Psychiatric and Mental Health Nursing*, *13*(1), 19-25.

Pereira, S., & Woollaston, K. (2007). Therapeutic engagement in acute psychiatric inpatient services. *Journal of Psychiatric Intensive Care*, *3*(01), 3-11.

Rani, S., & Mulholland, F. (2013). An appraisal of service users' structured activity requirements in an Irish forensic setting. *Journal of Psychiatric and Mental Health Nursing*, *21*(5), 383-390.

Tarrier, N. (2005). Cognitive Behaviour Therapy for Schizophrenia – A Review of Development, Evidence, and Implementation. *Psychotherapy and Psychosomatics*, *74*(3), 136-144.

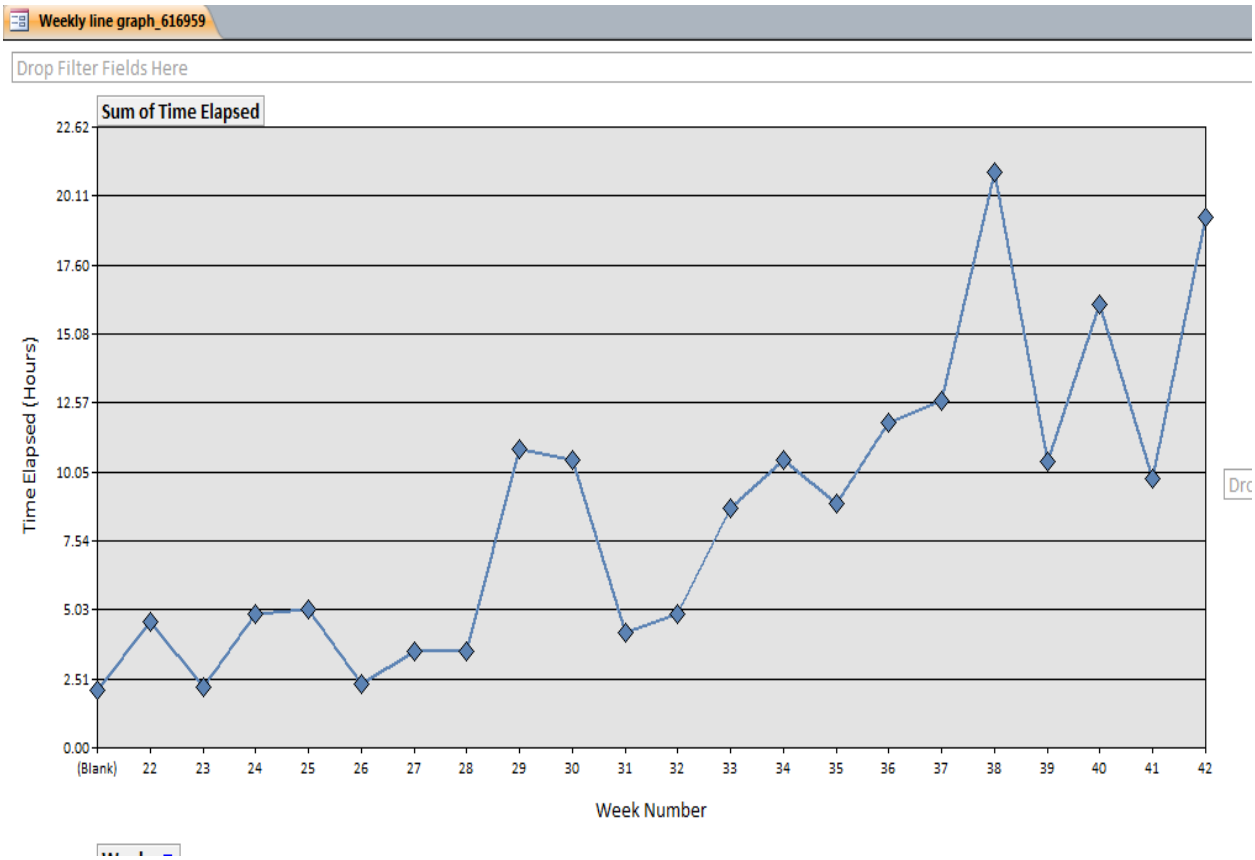
Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health, 18*(1), 49-58.

Williams, E., Ferrito, M., & Tapp, J. (2014). Cognitive-behavioural therapy for schizophrenia in a forensic mental health setting. *Journal of Forensic Practice*, *16*(1), 68-77.

Appendix A

Figure 1

Depiction from Microsoft Access, an example of a patient's weekly hours of activity

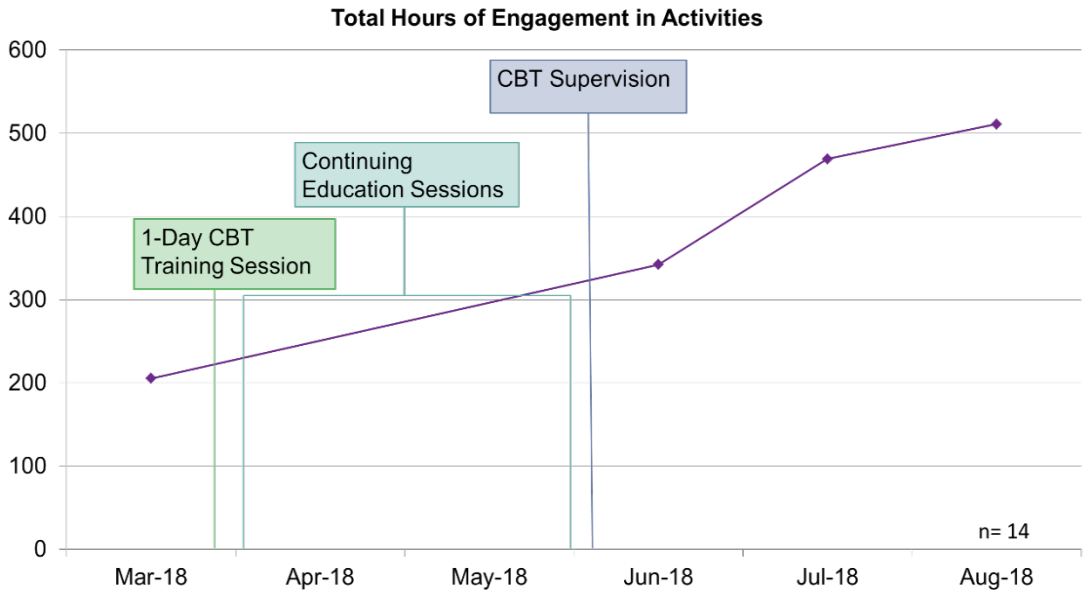


Note. An example of the data that was presented to patients at their team review discussions, as well as during 1:1 sessions with staff.

Appendix B

Figure 2

Depiction of the total hours of engagement in activities across the study

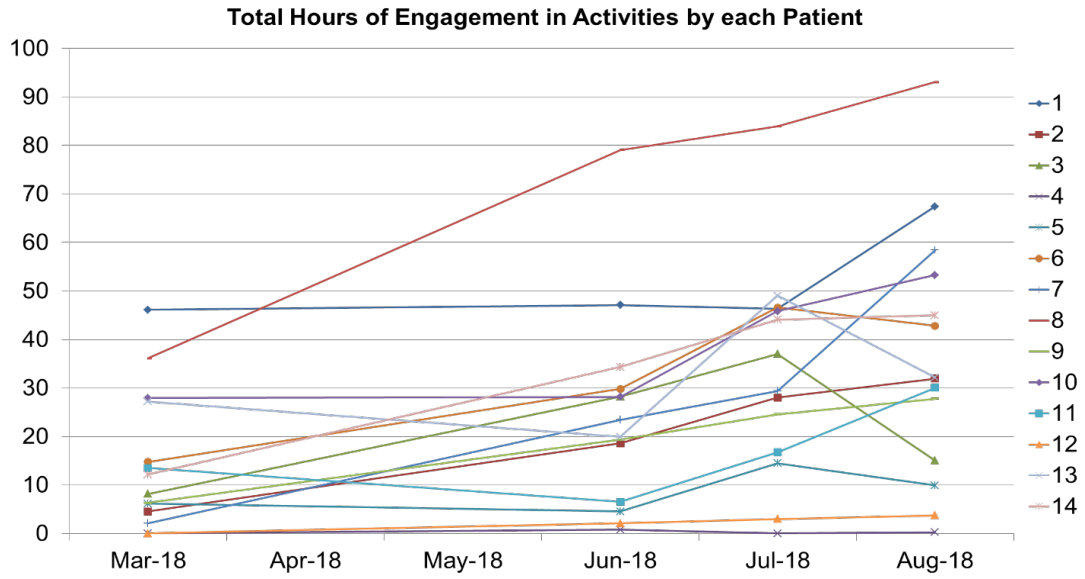


Note. Significant increase was found in the total amount of hours patients engaged in therapeutic activities.

Appendix C

Figure 3

Depiciton of total hours of activity engagement per client involved in the study



Note. There were 14 patients on the unit throughout the duration of the CBT training initiative. We found a significant increase in the amount of time patients engaged in therapeutic activities from a mean of 14.65 hours per month per patient to 36.49 hours per month per patient ($t=-4.5$, $p<0.001$).

CALL FOR PROFESSIONAL PRACTICE PAPERS (Volume 17, 2023)

We invite practitioners, students, and researchers to write about issues, experiences, and examples of innovative programs, interventions, or practices in TR service delivery. While manuscripts are accepted based on the judgment of our editors and associate editors, we make significant effort to work with authors to move their visions and insights into publication. No payment is made for articles published in the *TRPR Journal of Therapeutic Recreation Ontario.*

Manuscript Guidelines for Professional Practice Papers

Papers highlighting a program, practice, or intervention you have developed or are in the process of developing:

• ***Introduce your reader to the program, practice, or intervention:*** describe and also provide a clear rationale (e.g., why this program is needed for a particular client group).

• ***Provide a detailed program description:*** include the program purpose, goals/outcomes, client group, exclusion/inclusion criteria for referral to the program), and outline program procedures or content (i.e., techniques used, program modules). Discuss key literature (including citations) used to develop your program, intervention, or practice.

• ***Further discuss***: topics such as experiences of participants; outcomes related to participation; challenges of implementing your program, intervention, or practice; and methods of evaluation you use.

• ***Recommend and discuss implications***: discuss how to advance the program, practice or intervention and implications for TR practice.

Papers exploring specific TR issues or topics of TR conversation (e.g., ethics, credentialing, insight into supporting a specific population, new treatment models, etc.):

• ***Introduce your reader to the issue***: describe the purpose of the paper, and provide a rationale for the paper (i.e., why this issue is important to the development and growth of TR practice).

• ***Describe and develop the issue***: in your own voice describe the issue and include citations from practice and academic literature that inform your insights into this issue.

• ***Provide specific stories or examples*** (where appropriate): describe how this issue arises in your TR practice, and in your specific setting.

• ***Outline the implications of the issue for the TR profession***: recommend how we might advance conversations about this issue, further develop knowledge and insight into this issue, or other practices we need to develop to advance the profession in relation to this issue.

All manuscripts should include the following:

- **Title page:** Include the title of your manuscript plus all author names, titles, institutional affiliations, and current contact information
- **Biography:** Maximum 60 words per contributor.
- **Abstract:** Maximum 250 words. Also include 5-6 keywords that best describe content of your article.
- **Length of manuscript:** Normally, the maximum number of pages including references is 15.
- **Formatting**: Type manuscripts in *Microsoft Word,* Times New Roman (font size of 12), double-spaced, with 1-inch margins on all four sides. Tables must be original (created in your WORD document, or able to be edited in WORD), figures must be of high quality (i.e., jpg file, high dpi).
- **Citations and Referencing:** Please follow the guidelines laid out in the *Publication Manual of the American Psychological Association*, 7th edition guidelines for the text, labeling tables and figures, citations, and references.

CALL FOR RESEARCH PAPERS (Volume 17, 2023)

To support engagement in the spirit of research, the *TRPR Journal of Therapeutic Recreation Ontario* invites authors to submit empirical and conceptual research papers with relevance to the field of TR. Research papers are written to communicate information about research studies being conducted and encourages further initiatives in research. While manuscripts are accepted based on the judgment of our editors and associate editors, we make significant effort to work with authors to move their visions and insights into publication. No payment is made for articles published in the *TRPR Journal of Therapeutic Recreation Ontario.*

Manuscript Guidelines for Research Papers

Research-oriented manuscripts should contain:

- A ***rationale for the study:*** include a clear purpose statement and/or research questions addressed in the paper, and a brief review of related literature including key citations.
- A ***methodology*** section: include a description of the following: your sample size, how the sample was selected and recruited, the methodology, data collection strategies used, and data analysis procedures
- ***Findings:*** highlight the key findings of the study making sure to address the study purpose and all research questions. Include any tables, graphs, and figures that help summarize the findings.
- A ***discussion of implications for TR practice:*** describe contributions the study makes to therapeutic recreation practice, and provide specific recommendations for practice.

All manuscripts should include the following:

- **Title page:** Include the title of your manuscript plus all author names, titles, institutional affiliations, and current contact information.
- **Biography:** Maximum 60 words per contributor.
- **Abstract:** Approx. 250 words. Also include 5-6 keywords that best describe content of your article.
- **Length of manuscript:** Normally, the maximum number of pages including references is 15.
- **Formatting**: Type manuscripts in *Microsoft Word,* Times New Roman (font size of 12), double-spaced, with 1-inch margins on all four sides. Tables must be original (created in your WORD document, or able to be edited in WORD), figures must be of high quality (i.e., jpg file, high dpi).
- **Citations and Referencing:** Please follow the guidelines laid out in the *Publication Manual of the American Psychological Association*, 7th edition guidelines for the text, labeling tables and figures, citations, and references.
- For more details, please refer to www.trontario.org/trpr-journal-of-tro

Submit your manuscript via the Scholastica platform (https://app.scholasticahq.com/login) to the TRPR- Journal of TRO. As a new author you will need to create a profile. If you have any questions regarding Scholastica or submission please email: trojourn@uwaterloo.ca Deadline for Submission for Volume 17 – *September 30, 2022* ***Please note the Volume will be released in **June 2023

Therapeutic Recreation: Practice & Research

Volume 16 | 2022

Practice Papers

Research Papers

TRPR

The Journal of Therapeutic Recreation Ontario

trojournal@uwaterloo.ca

THERAPEUTIC RECREATION ONTARIO
Believe · Belong · Become

info@trontario.org