



Ontario Centre of Excellence  
for Child and Youth  
Mental Health

Centre d'excellence de l'Ontario  
en santé mentale des  
enfants et des adolescents

**Bringing People and Knowledge Together to Strengthen Care.  
Rassembler les gens et les connaissances pour renforcer les soins.**

## Evidence In-Sight: Recreation therapy

Date:

December, 2012

The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the following question(s):

- According to the literature, is recreation therapy an evidence-informed practice for child and youth mental health services? What are the goals and objectives of recreation therapy?
- Are there children and youth that particularly benefit from recreation therapy? If so, are there established methods to determine an appropriate referral?

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at [evidenceinsight@cheo.on.ca](mailto:evidenceinsight@cheo.on.ca) or by phone at 613-737-2297.

## 1. Overview of inquiry

This report on recreation therapy was written for an agency that provides specialized multi-disciplinary services within residential and day treatment programs. The multi-disciplinary services include music therapy, art therapy, recreation therapy, a nurse therapist, a chaplain, and a transition worker.

Therapeutic services are provided for youth between the ages of 12-16 who are experiencing significant mental health, emotional and/or behavioural difficulties. Not all of the youth participate in the specialized services because only one staff member provides each specialized service leaving a minimal number of spots available. Referrals can be made by the youth themselves or by program staff, and youth can participate in no, one or multiple services, as well as in regular group and individual services.

The recreation therapy service involves a variety of programs including swimming, group sports, gym and exercise, running groups, and drop-in groups. Recreational outings (e.g., bowling, movies, shopping, festivals, a splash park, and a conservation park) are often awarded for good behaviour. The recreation therapist also supports youth by finding summer camps or extra-curricular activities of interest within the community. Any personal recreational goals that a youth would like to accomplish are also addressed by the recreation therapist.

The agency is in the midst of planning an evaluation and would like to begin by reviewing the literature on their individual specialized approaches to establish a baseline understanding of the current research support for these services and possibly how to strengthen the services being offered. Following the initial review and evaluation, they would like to look at the impact of the multi-disciplinary approach in general as an approach to service provision outside of typical individual and group therapy. For the purpose of this request, they specifically would like to look at the evidence and goals of recreation therapy as well as the youth who benefit most from the services.

Question statements:

- 1) *Is recreation therapy an evidence-informed practice for child and youth mental health services?*
- 2) *What are the stated goals and objectives of this approach (i.e. measurable outcomes)?*
- 3) *Are there children and youth who particularly benefit from these forms of service? If so, are there established methods to determine appropriate referral?*

## 2. Summary of findings

- Search tools used: University of Ottawa Library (PsychINFO, AMED- Allied and Complementary Medicine, Ovid MEDLINE®, Ovid MEDLINE® In-process & Other Non-Indexed Citations, PubMed, Scholars Portal), Google Scholar, EBSCO Host
- Search terms used: recreation therapy, recreational therapy, therapeutic recreation, leisure, youth, adolescents, children, emotional disorders, behavioural disorders, outcomes, evaluation, evidence-informed practice, evidence-based practice

### 3. Answer search strategy

- The quality of existing studies is poor due to small sample sizes, little longitudinal data, and unsophisticated use of current methods and analyses. This limits the generalizability of the findings.
- The literature suggests that recreation therapy in child and youth mental health is not currently an evidence-based practice, but there is reason to believe that it is a promising practice with need for outcome-based management for recreation therapy practices.
- Although recreational therapy does not have the depth of research support to call it evidence-based, there are several organizations and associations that specialize in recreation therapy and good practices that should be included in recreation therapy programming. Links are provided at the end of this report.
- Our search did not find standardized goals and objectives for recreation therapy in child and youth mental health services. However, common outcomes in healthcare recreation therapy settings apply to categories that include clinical status, well-being and quality of life, satisfaction, and cost/resources consumption.
- The use of resiliency and various combinations of associated protective factors, which are seen as measures of quality of life and well-being, are the most commonly used goals, objectives, and measureable outcomes found from our search of the literature.
- Existing literature on recreation therapy in child and youth mental health focuses on emotional and behavioural disorders, at-risk youth, and physical and developmental disabilities. Results are mixed and the literature has not defined those who particularly benefit from this service.
- Our search did not find established and validated methods for appropriate referral to recreation therapy practice in child and youth mental health. An example of a referral method used by a recreation therapy program is included in the report.

### 4. Findings

Recreation therapy is a practice that enables all individuals to achieve quality of life, and optimal health through meaningful experiences in recreation and leisure (Therapeutic Recreation Ontario, 2006). As a piece of the overall treatment plan, it provides service and advocates for individuals with physical, mental, social, behavioural and emotional limitations in various settings (e.g., hospitals, long-term care settings, day programs, community-based programs, mental health centres; Therapeutic Recreation Ontario, 2006).

The goals and objectives of recreation therapy center on resiliency (and associated protective factors), self-reliance, competency, independence, problem-solving/decision-making skills, communication, self-esteem, and self-efficacy. Therapeutic recreation activities have long been suggested as a way to address the needs of youth with a variety of mental disorders with particular focuses on emotional and behavioural disorders (Skalko, Williams, & Cooper, 2008). There has also been a focus on the use of recreation therapy to address the needs of at-risk youth, and youth with various disabilities (Skalko, Williams, & Cooper, 2008).

In general, the field lacks thorough and rigorous research on the effectiveness of recreation therapy. The research is fragmented with small sample sizes, virtually no longitudinal data, and single group designs with no control groups, which reduces the generalizability of findings (Stumbo & Pegg, 2010; Hill 2007; McGhee, Groff, & Russoniello, 2005; Lubans, Plotnikoff, & Lubans, 2012). Stumbo and Pegg (2010) pointed to problems with methodologies including the

unsophisticated use of up-to-date analysis of change methods, handling of missing data, power analysis, and mixed-methods approaches (Stumbo & Pegg, 2010). Recommendations have been made regarding the use of more sensitive instruments and techniques to identify individual and group changes (McGhee, Groff & Russoniello, 2005), and to use larger sample sizes, randomization, additional comparison groups isolating various aspects of a program, and documentation of confounding factors (Rothwell, Groff, & Russoniello, 2005). See **Appendix A** for a summary of the research evidence including the specific goals and objectives (i.e. measureable outcomes) as well as any referral methods mentioned in the articles.

Researchers have stressed the importance of evidence-based and evidence-informed practice in mental health services, including measuring client outcomes (Stumbo & Pegg, 2012; Van Andel, 1998). Despite the undeveloped state of the evidence, recreation therapy appears to be a promising practice for child and youth mental health services and at least has several common categories of outcomes related to healthcare.

#### **4.1 Recreation therapy and evidence-informed practice**

Most literature on recreation therapy focuses on elderly populations (Tabourne, 1991), particularly on elders with dementia (Buettner & Kolanowski, 2003). There is also a body of literature involving child and youth populations with cancer (Hancock, 2011), traumatic brain injuries (Andrews et al., 2010; Katz-Leurer, 2009), spinal cord injuries (Johnson & Klaas, 1997), and cerebral palsy (Dirienzo, Dirienzo & Baceski, 2007; Katz-Leurer, 2009). The literature highlights only a few examples of recreation therapy in the context of child and youth mental health, with autism being one area of interest (Garcia-Villamisar & Dattilo, 2010). Thus, it is not surprising that there is not any literature to date suggesting recreation therapy as an evidence-informed practice for child and youth mental health services.

Caldwell (2001) suggests that current conceptualizations of recreation therapy are inadequate for the needs of youth. The focus of the current conceptualization of recreation therapy is to provide services for individuals with disabilities, illness and other conditions. While these are important issues to address through recreation therapy, the reality is that these conditions do not necessarily reflect the needs of many youth in the community who could benefit from recreation therapy, including children or youth with substance use and/or mental health problems.

An article on the existing research on recreation therapy stated that evidence is required to build the best programs possible for clients (Stumbo & Pegg, 2010). As new data is accumulated from clients who are involved in recreation therapy programs, it can be used to demonstrate program effectiveness and inform program adjustments. The current reality is that recreation therapy is not well evaluated and there is a lack of practice-based evidence to inform program development as well as outcomes-oriented evaluation to demonstrate clinical effectiveness.

One barrier to moving recreation therapy forward as an evidence-informed practice is that the field lacks standardized assessment measures (Stumbo & Pegg, 2010). Existing measures are either broad, meaning applicable to multiple fields, or specific, meaning no single measure is suitable to all programs (Stumbo & Pegg, 2010). The Leisure Competence Measure (LCM) is one outcome measure of importance to recreation therapy, but it is not applicable to mental health use. The field is left with the option of using the LCM when/where appropriate, global or general outcome measures (e.g., functional independence or quality of life), or to develop new measures (Stumbo & Pegg, 2010).

Other barriers to moving recreation therapy forward include the lack of professional skills and training opportunities for practitioners and the lack of research specific to the practice environment (Stumbo & Pegg, 2010).

Despite these barriers, recreation therapy has some support as a promising practice for child and youth mental health. Ungar et al. (2005) found that despite the absence of well-designed research, and a field full of programs with varying lengths, characteristics, and little rationale for choices made, there is potential to influence participants in a positive manner due to the following positive, resilience-based outcomes found in the literature. Recreation therapy may potentially help youth via:

- Enhanced self-esteem, self-efficacy, coping, and competence
- Decreased delinquency, suicidality, and violence
- A greater tolerance for change
- Enhanced adaptability

Evidence for the effectiveness of programs continues to emerge and research is growing more sophisticated with researchers formulating their work in theory and modeling more complex behaviours that take into account multiple contextual factors (Ungar et al., 2005; Stumbo & Pegg, 2010).

#### **4.2 Goals, objectives, and measurable outcomes of recreation therapy**

##### *Recreation therapy in healthcare*

The literature does not provide any standardized goals, objectives, or measurable outcomes for recreation therapy in general, or as it applies to child and youth mental health services. In healthcare in general there are several common categories of outcomes: clinical status, functional status, well-being and quality of life, satisfaction, and costs and resource consumption (Stumbo, 2003b; Stumbo & Pegg, 2010). These can be more succinctly sorted into the following categories: cost and use, clinical outcomes, patient satisfaction, and quality of life (Stumbo & Pegg, 2010).

Stumbo and Pegg (2010) further suggest examples of questions that could aid in the identification and specification of outcomes for therapeutic recreation in general. Relevant questions include:

- To what extent do clients improve their ability to plan and conduct independent leisure involvement?
- To what extent do clients improve their ability to socially interact with family and friends?
- To what extent do clients improve their ability to locate and utilize leisure resources?
- To what extent is improvement sustained over time?
- Are there any demographics or factors that affect the success rate?
- To what extent are clients satisfied with the intervention and how do the interventions received affect patient satisfaction?

Van Andel (1998) suggests two different outcome models for recreation therapy settings. The *Service Delivery Model* intends to empower the client to achieve his or her desired goals and ultimately experience a sense of fulfillment, satisfaction, mastery and well-being. The *Outcome Model* attempts to impact clients' functional capacity, health status, and quality of life. The model argues that both health status and functional capacities/potentials (e.g., mental and cognitive function, physical function, psychological and emotional function, spiritual function, social function, and leisure

function) are closely linked to quality of life outcomes. As a result, these can be viewed as the primary outcome for recreation therapy, and as an overall sense of well-being.

### *Recreation therapy for children and youth*

Ellis and colleagues (2001) discuss recreation therapy in children and youth as outcome-based with the goal of developing self-reliant and competent individuals, and that there should be an emphasis on positive youth development intended to give participants the ability to function independently in social situations. They also discuss the importance of fostering resiliency as a key developmental outcome, and suggest the key to building resiliency may rest with the attainment of protective factors.

Protective factors include commitment to learning, positive values, social competency, positive identity, support, empowerment, boundaries and expectations, and constructive use of time. These are comparable to targeted outcomes of traditional recreation therapy interventions. The existing literature has in fact shown that many recreation therapy programs have met intended resilience-based outcomes (Ellis, Braff & Hutchinson, 2001). For example, Autry (2001) states that the goal of recreation therapy is for the client to become empowered and ultimately self-determined. Rothwell, Piatt, and Mattingly (2006) discuss social skills, a component of social competency, as a common goal in recreation therapy, and that social competency has been seen as a goal in recreation therapy for years.

Outdoor programs, including adventure therapy and wilderness therapy, are extensions of recreation therapy and include their own body of literature surrounding goals, objectives, and measurable outcomes. These appear to be similar to other recreation therapy programs for children and youth. Wilderness therapy programs have two goals: (1) change inappropriate behaviour through experiential learning that is based on a physically challenging experience, and (2) group cohesion (Hill, 2007). The therapeutic goal of these programs is to promote feelings of empowerment, responsibility, confidence, and group cohesiveness, and they implement various activities throughout the experience to achieve the goals of improved communication, increased problem solving, and increased decision making skills (Hill, 2007).

Unger et al. (2005) also suggest that there are many potential positive outcomes associated with outdoor programming and that researchers in this area have focused on enhanced self-esteem, self-efficacy, coping, competence, and decreased delinquency, suicidality, and violence. However, there is no rigorous research to confirm these effects or any underlying mechanisms.

Achieving good outcomes in any program, particularly an outdoor/wilderness recreation program, depends on multiple contributing factors beyond just the therapeutic approach. Caldwell (2001) mentions that important contributing variables include who is running the program, who is participating, and program format. Contributing factors specific to the youth client include independence, confidence, self-efficacy, self-understanding, assertiveness, internal locus of control and decision making. These might be important considerations for which youth are prepared to be involved in a group wilderness therapy program, although specific research on inclusion and exclusion criteria for participation is likely recommended.

### *Examples of goals and objectives in specific mental health-related programs*

McGhee, Groff, and Russoniello (2005) examined the *We Care Too* program for youth (7-11 years old) with emotional and behavioural disorders and included the following goals:

- Develop ability to engage in recreational activities,
- Increase self-esteem,
- Develop ability to follow directions,
- Increase social interaction with adults and peers,
- Develop anger management skills, and
- Improve use of manners with peers.

Skalko, Williams and Cooper (2008) evaluated the effectiveness of the *ECU Horizons Day Treatment* program for children and youth (8-16 years old) with emotional and behavioural disorders with the following primary goals:

- Development of age appropriate social skills,
- Development of skills/knowledge for healthier lifestyles and habits,
- Facilitate cognitive development,
- Enhance interpersonal skills, communication, and relationship building,
- Enhance self-concept and self-esteem, and
- Promote physical development.

Unger et al. (2005) examined a case example of the *Choices Adolescent Drug Treatment* program for at-risk youth (13-19 years old) with the following resilience-based objectives:

- Demonstrate alternative lifestyle choices,
- Promote responsible thinking,
- Increase self-awareness and confidence,
- Increase awareness of our connection to natural world,
- Teach/practice teamwork,
- Challenge excuse making,
- Promote accountability,
- Enhance decision-making and problem solving, and
- Create a positive/supportive environment.

Sklar, Anderson, and Autry (2007) conducted a case study of the *Adventure Challenge Experience* for at-risk youth (13-15 years old) with the goal of self-determination and flow within the context of participants' lives ultimately supporting positive growth and development.

### 4.3 Groups that may benefit from recreation therapy

Therapeutic recreation activities have long been suggested as a way to address the needs of youth with a variety of disorders (Skalko, Williams and Cooper, 2008). However, the literature has not identified particular characteristics of children and youth that benefit most from recreation therapy services. In fact, Ungar et al. (2005) found a lack of research to reliably link recreation interventions and certain youth or populations. Nevertheless, research has focused some attention on particular target populations including emotional and behavioural disorders, at risk youth, and physical and developmental disabilities.

### *Emotional and Behavioural Disorders*

Emotional and behavioral disorders (EBD) is a wide-ranging term that includes various internalizing and externalizing conditions. McGhee, Groff and Russoniello (2005) evaluated the effectiveness of the *We Care Too* program on youth with EBD using the Kid-KINDL measure pre- and post- treatment and found that the overall scores were not conclusive in terms of the program's impact on participants' quality of life. However, positive changes were noted in emotional well-being and family subdomains.

Skalko, Williams and Cooper (2008) looked at the effect of the *ECU Horizons Day Treatment* program on youth with EBD using behavioural observation sheets (BOS) as their primary assessment tool. Substantial effect could not be determined from the BOS, although the mean of all behavioural areas (e.g., emotional control, group cooperation, character, and interpersonal relationships) did demonstrate a trend suggesting improvement towards the end of treatment. In addition to the behavioural improvements noted by the parents, participants stated that they made new friends, and most stated that they learned new skills to manage anger, improved interaction skills, and found new activities for positive time use. Previous surveys examining program effectiveness demonstrated improved time-management skills, increased feelings of social competence, enhanced leadership skills, and shifting toward an internal locus of control.

Flom and Johnson (2011) reviewed the literature on school and community-based use of outdoor programming on EBD. They found that children with behavioural issues, particularly attention-deficit hyperactivity disorder, demonstrated decreases in symptoms, and teens with behavioural issues demonstrated improved social behaviours and greater self-efficacy. Furthermore, most youth demonstrated significant reductions in behavioural and emotional symptoms after participating in outdoor-based programs with symptoms falling within normal ranges.

Other studies have focused on either behavioural or emotional disorders alone. For example, Rothwell, Piatt and Mattingly (2006) looked at behavioural disorders only. They evaluated the effectiveness of their recreation therapy program designed to enhance participants' social skills using the School Social Behaviour Scales (SSBS) composed of the Social Competency Scale and the Antisocial Behaviour Scale. The overall consensus was that the program had a positive impact on social skills of participants with significant scores on the Social Competence Scale, particularly within the Interpersonal Subscale. A recreation therapy program involving basketball scrimmages for adolescent males with disruptive behaviour disorders was evaluated for effectiveness (McKenney & Dattilo, 2001). Results from this evaluation suggested an intervention within a sport context on prosocial behaviour might have a limited effect on pro-social behaviour. Although some prosocial behaviours improved (e.g., encouraging and helping), the effect was not maintained through to follow-up and overall positive effects were not observed. Dieser and Ruddell (2002) focused on adolescents with major depression and looked at the effects of attribution retraining on attributions and explanatory style during therapeutic recreation using the Causal Dimension Scale II and the Attribution Style Questionnaire. The results of this study were unclear, but suggest that attribution retraining in a therapeutic recreation setting can have a significant effect on stability and personal control.

### *At-Risk Youth*

At-risk youth is another population that appears frequently in research involving recreation therapy in children and youth mental health settings with multiple programs shown to be successful for at-risk youth (Everett, Chadwell &

McChesney, 2002). Ungar et al. (2005) looked at the *Choices Adolescent Drug Treatment* program with a recreation therapy based wilderness adventure component for youth harmfully involved with drugs, alcohol and/or gambling. Effectiveness of the program was evident from client observations as there was an overall sense of accomplishment and pride as well as a greater willingness to engage in individual counseling. There were also many themes associated with resilience that emerged as positive outcomes, and there was opportunity for development of new competencies, problem-solving, autonomy and helpfulness.

Autry (2001) examined the effects of an adventure therapy program on at-risk adolescent girls. Issues facing the girls when entering the program included aggressiveness, depression, truancy, probation violation, detention, substance abuse, sexual abuse, eating disorders and/or suicidal ideation or attempts. The girls appeared to construct individual and group meanings that led to the development of a more positive sense of self and meaning with four major themes: awareness and existence of trust in oneself and others, sense of empowerment, improved teamwork, and enhanced positive personal values.

Sklar, Anderson and Autry's (2007) evaluation of the *Adventure Challenge Experience (ACE)* intervention for youth at-risk of problematic transition to high school was based on participant interviews. The major themes that emerged from interviews included: (1) participants fostered personal growth, social growth, helping and positive development, (2) participants fostered an environment of interdependence and reciprocity where youth gained satisfaction, trust, social support, and friendship, (3) participants formed bonds between staff and youth.

A recent review was conducted on the use of physical activity programs for at-risk youth suggesting potential to improve social and emotional well-being (Lubans, Plotnikoff & Lubans, 2012). Five of the studies on outdoor adventure programs demonstrated significant improvements in social and emotional well-being in terms of self-worth, self-concept, resilience, perceptions of alienation, and self-control. However, two of the studies did not show improvements. Six studies evaluated the effectiveness of sport and skill-based programs. The empirical evidence supporting the utility of these programs is limited. Some of the few examples of program effectiveness included: improved self-esteem in children and adolescents of the *Singapore Sports Challenge* program, and improved temperament in children with social cognitive disruptive behaviours involved in a karate program. The review included only two physical fitness programs, and findings showed significant improvements in self-concept after participating in the *First Choice Fitness* leaders program for at-risk youth, but not for children with behavioural disorders. Findings also suggest that intensive aerobic exercise programs have the potential to induce improvements in self-esteem and depression.

#### *Physical and Developmental Disabilities*

One study focusing on physical and developmental disabilities looked at the effectiveness of recreational therapy programs at the *Division of Therapeutic Recreation and Teen Centers* for youth 12-18 years old (Ellis, Braff & Hutchinson, 2001). The study provided evidence for effectiveness in this particular population including a greater sense of self-efficacy through which participants attained a sense of voice and improved confidence. Leisure independence was also an outcome, which the author suggested facilitates the acquisition of other protective factors. Furthermore, this program provided opportunities for youth direction through which the teen centers attempted to foster self-determination and empowerment.

### *Methods for Referral*

We did not find established or validated methods to determine an appropriate referral to recreation therapy services in the field of child and youth mental health. However, we found one program that discussed their method of referral. *ECU Horizons Day Treatment* program made referrals based on a formal assessment process that included input from the child, family, mental health service professionals, schools, juvenile justice system, and related agencies. The criteria included a documented need for day treatment services, the youths' ability to attend the majority of sessions, the physical and cognitive abilities to engage in program services, the desire to participate, and the potential benefit from the program's services. Elements of this referral method have been echoed in other programs. For example, the idea of selecting those who would benefit most from the program was a referral criteria used in the *We Care Too Program* (McGhee, Groff & Rusoniello, 2005), and the idea of expressed interest from the client was used in referrals to a basketball scrimmage recreation program (McKenney & Dattilo, 2001) and in the *Choices Adolescent Drug Treatment* program (Unger et al., 2005). Also, children and youth who are seen as particularly disruptive are often referred to recreation therapy programs (Rothwell, Piatt & Mattingly, 2006; McKenney & Dattilo, 2001; McGhee, Groff & Rusoniello, 2005) as well as those who are able to participate physically and cognitively (Unger et al., 2005).

### **5. Next steps and other resources**

Associations and organizations that exist regionally, nationally, and internationally have expertise and experience in recreational therapy. Some of these organizations provide recreation therapy as part of a multi-disciplinary service. The following is a list of various relevant resources. The Centre has not contacted any of these organizations to obtain further information or ask for the opportunity to discuss their experiences, but we may be able to make connections if that would help to inform evaluation and program planning.

#### **Local and Provincial**

Centre for Addiction and Mental Health (CAMH)

[http://www.camh.ca/en/hospital/careers\\_and\\_volunteers/student\\_placements/CAMH\\_care\\_providers\\_overview/Pages/careproviders\\_recreation\\_therapy.aspx](http://www.camh.ca/en/hospital/careers_and_volunteers/student_placements/CAMH_care_providers_overview/Pages/careproviders_recreation_therapy.aspx)

Health Workforce Information Centre

<http://www.hwic.org/experts/browse/xc131>

IWK Health Centre

<http://www.iwk.nshealth.ca/index.cfm?objectid=7D7C1E4D-B12C-7E9B-598F83080DEA49E2>

Ottawa Children's Treatment Centre

<http://www.octc.ca/staff.php>

Pathways

<http://www.pathwayscentre.org/program-service/therapeutic-recreation>

Therapeutic Recreation Ontario

<http://www.trontario.org/>

### **National**

Canadian Therapeutic Recreation Association

<http://www.canadian-tr.org/>

Leisure Information Network

<http://lin.ca/>

National Recreation and Parks Association

<http://www.nrpa.org/>

### **International**

American Therapeutic Recreation Association

<http://atra-online.com/>

Therapeutic Recreation Directory

<http://www.recreationtherapy.com/trorg.htm>

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive “drivers” related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement.

For more information, visit:

<http://www.excellenceforchildandyouth.ca/what-we-do> or check out the Centre’s resource hub at

<http://www.excellenceforchildandyouth.ca/resource-hub>.

For general mental health information, including links to resources for families:

<http://www.ementalhealth.ca>

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