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Use of Evidence-Based Practice in Recreational Therapy Programs for Schizophrenia Spectrum Disorder (SSD) Recovery: A Descriptive Study

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USE OF EVIDENCE- BASED PRACTICE IN RECREATIONAL THERAPY
PROGRAMS FOR SCHIZOPHRENIA SPECTRUM DISORDER (SSD) RECOVERY:
A DESCRIPTIVE STUDY

A Thesis
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science
Recreational Therapy

by
Natalie Montoya
May 2018

Accepted by:
Dr. Brent Hawkins, Committee Chair
Dr. Jasmine Townsend
Dr. Stephen Lewis

ABSTRACT

Schizophrenia Spectrum Disorder (SSD) is a mental illness that currently has no cure, however, with the use of pharmaceutical and psychosocial treatments, such as Recreational Therapy (RT), symptoms can be managed. RT provides services for individuals with SSD to improve their quality of life by incorporating leisure interests and individual needs into treatment. By utilizing evidence-based practices, such as the Mental Health Recovery Model and recommendations by the Schizophrenia Patient Outcome Research Team (PORT), RT treatment has the possibility to provide more efficient and beneficial treatment in various settings for individuals with SSD.

This research study utilized a cross-sectional survey to identify if Recreational Therapists are utilizing evidence-based practices, specifically the Mental Health Recovery Model principles and PORT recommendations, into treatment services for individuals with SSD. Data was collected, analyzed, and reported from 126 surveys completed by RTs that currently or have previously provided treatment for individuals with SSD. Quantitative data revealed that a majority of the participants utilize the Mental Health Recovery Model principles and PORT recommendations into RT treatment. Qualitative data supported the quantitative results by demonstrating how the principles and recommendations are utilized in practice through examples provided by participants.

DEDICATION

I dedicate this thesis project to my parents, Leslie and Will Montoya, who provided me with unconditional support and encouragement throughout this process. Their belief in my abilities to complete this project and degree provided me with the inspiration throughout this process, and I would not be where I am today without them.

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CHAPTER ONE

Introduction

According to the National Institute of Mental Health (NIMH, 2016), psychosis is a term that involves multiple psychotic disorders that effect the mind and sense of reality orientation. Psychotic disorders are defined by having at least one of the following symptoms: delusions, hallucinations, disorganized thoughts or speech, grossly disorganized behavior, and negative symptoms (American Psychiatric Association, 2013). One of the most common forms of psychotic disorders is Schizophrenia. Schizophrenia affects approximately 1.1% of the world population (National Institute of Mental Health, 2016). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), Schizophrenia is characterized by the following symptoms: delusions, hallucinations, disorganized speech such as incoherent sentences, grossly disorganized or catatonic behavior such as frigid or flexible stance or posture, and negative symptoms such as lack of expressive emotion. For a diagnosis of Schizophrenia, the symptoms listed must interfere with the occupational and social domains of an individual (American Psychiatric Association, 2013).

Schizophrenia is a mental illness that has no cure, however, recovery can improve quality of life. Broadly, mental health treatment often uses the Recovery Model to guide the recovery process (Jacob, 2015). The recovery process utilizes optimism, in addition to ten core principles to encourage individuals with mental illnesses to gain control of their life despite their mental illness (Warner, 2010). The combination of optimism or hope with appropriate treatment services can improve the recovery process of mental

illnesses, such as schizophrenia (Warner, 2010).

Treatment for schizophrenia consists of pharmaceutical, psychological, and psychosocial treatments, often used simultaneously for most effective treatment. Pharmaceutical treatments are the main form of treatment for Schizophrenia. Medications include antipsychotics to reduce symptoms, but side effects caused by these medications have physical consequences on patients. For example, fatigue and exhaustion are common side effects for antipsychotics, which contribute to a lack of participation in other forms of treatment, such as psychological therapies (Adams, Wilson, Gilbody, Bagnall, & Lewis, 2000). In addition, the reduction of symptoms as the result of taking antipsychotics often leads to individuals feeling that the medication is no longer needed for treatment. This common misconception of antipsychotics leads to relapse, in which schizophrenic symptoms return and additional treatment is required (Adams, Wilson, Gilbody, Bagnall, & Lewis, 2000). The National Collaborating Centre for Mental Health (2009) stated that about 50% of people diagnosed with Schizophrenia are non-compliant with their medication.

Psychological and psychosocial treatment for Schizophrenia consists of various forms of therapy designed to develop communication skills and coping strategies with the illness, increase independence, manage and reduce symptoms, enhance treatment adherence, and improve the overall quality of life for the patient (National Collaborating Centre for Mental Health, 2009). These goals are intended for long-term health management and to reduce the chance for relapse. Interventions designed to reduce symptoms, address the contextual influences of their condition, and promote health

management are integrated into the individual's individualized treatment plan. Examples of psychological and psychosocial treatments include adherence therapy, arts therapies, cognitive remediation, cognitive-behavioral therapy (CBT), counseling and supportive psychotherapy, family intervention, psychoanalysis and psychodynamic psychotherapy, psychoeducation, and social skills training (National Collaborating Centre for Mental Health, 2009). Limitations with psychological and psychosocial treatments for Schizophrenia include lack of evidence-based interventions, inability for therapists to adapt interventions to meet the needs of each individual, minimal training by therapists on applying skills taught in treatment to a community setting, and lack of attendance of people diagnosed in treatment interventions due to stigma and side effects of antipsychotics (Scott & Dixon, 1995).

One of the providers of treatment for Schizophrenia is Recreational Therapy (RT). RT services include psychological and psychosocial interventions. According to the American Therapeutic Recreation Association (ATRA), RT treatments provide structured recreation and leisure based interventions designed to assess the psychological health, physical health, and recovery needs of people with an illness or disability to improve their overall well-being (ATRA, 2017). The goal of RT is to improve the overall quality of life, which is obtained by developing skills for independence and increasing the level of functioning while reducing any limitations caused by the illness or disability (ATRA, 2017). Recreational activities have been demonstrated to have therapeutic benefits for a wide range of populations. For the mental health population, participation in recreation and leisure activities has been shown to develop self- identification, promote positive

emotions, improve social skills and relationships, teach coping skills, and improve overall health (Iwasaki, Coyle, & Shank, 2010). Though there is a limited amount of research pertaining to recreational based interventions and Schizophrenia, the contribution these interventions may have to psychiatric rehabilitation include developing social skills and relationships, assisting with community reintegration, and decreasing social isolation (Biancosino, Marmai, Marchesini, Bertasi, Targa, Bivi, et al., 2010). Recreational Therapists may contribute to the treatment of Schizophrenia by facilitating recreation based interventions that provide skills in coping and managing Schizophrenic symptoms. Through analysis of studies, the Schizophrenia Patient Outcomes Research Team (PORT) has identified six components that are recommended to be included in treatment for Schizophrenia: community re-integration training, vocational training, skills training, cognitive behavioral therapy, token economy intervention, and family based services (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010). Recreational therapy has the ability to provide these components recommended by PORT into treatment services for individuals with SSD.

The purpose of this study is to identify if recreational therapy programs within inpatient facilities, outpatient programs, or community based settings utilize evidence-based practices for patients diagnosed with SSD. Specifically, this study will explore if the principles of the Mental Health Recovery Model and recommendations provided by the Schizophrenia Patient Outcomes Research Team (PORT) are incorporated into the treatment services for adults with SSD. The objective is to determine if recreational therapists are using these practices with adults with SSD, and to what extent they are

being used. This study will utilize a cross-sectional survey that is designed based on the Recovery Model principles and recommendations made by PORT for schizophrenia treatment.

CHAPTER TWO

Literature Review

The literature presented in this chapter is related to research of recreational therapy programs within inpatient facilities, outpatient programs, and community-based settings for Schizophrenia treatment. For organizational purposes, the literature is presented under the following topics: (a) Mental Illness and the Diagnostic and Statistical Manual of Mental Disorders (DSM); (b) The Recovery Process for SSD; (c) Recreational Therapy for Schizophrenia Treatment; and (d) The Importance of Study.

Mental Illness and the Diagnostic and Statistical Manual of Mental Disorders (DSM)

In 2015, the United States had an estimated 9.8 million adults, 4% of the population, diagnosed with a severe mental illness (National Institute of Mental Health, 2015). According to the National Institute of Mental Health (NIMH), diagnosis of a severe mental illness includes a mental, behavioral, and emotional disorder, a diagnosis subsequent to the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, and serious functional impairment limiting life activities due to the diagnosis (NIMH, 2015).

The DSM was developed by the American Psychiatric Association (APA) to serve as a guideline for clinicians to assist in diagnosing mental disorders. The DSM defines a mental disorder as a syndrome that causes disturbance in the cognition, emotions, and behaviors of a person and shows dysfunction in biological, developmental and psychological processes of mental functioning (American Psychiatric Association,

2013). These disturbances result in distress and limitations in a person's participation in daily life activities.

Psychosis and Schizophrenia Spectrum Disorder. The DSM is separated into 20 sections of different types of psychological disorders. One of the sections is Schizophrenia Spectrum and Other Psychotic Disorders. According to the DSM, the diagnostic criteria for psychotic disorders and Schizophrenia Spectrum Disorder (SSD) requires having at least one of the following symptoms: delusions, hallucinations, disorganized speech, such as incoherent sentences, grossly disorganized or catatonic behavior, such as rigid or flexible stance or posture, and negative symptoms, such as lack of expressive emotion. Disorders categorized by SSD and Psychotic Disorders are differentiated by the length of time symptoms are experienced, and the number and types of symptoms present (American Psychiatric Association, 2013). Specifically, the diagnosis for Schizophrenia, a mental illness considered within SSD, is defined by the same symptoms as psychotic disorders and SSD but two or more of the symptoms must be experienced for a one-month period. In addition, the individual must have the occurrence of either hallucinations and/or delusions in addition to one of the 3 other symptoms listed. The symptoms must interfere and cause significant distress in the occupational and social domains of an individual to meet the criteria for Schizophrenia (American Psychiatric Association, 2013).

The Recovery Process and Treatment for SSD

The Recovery Model. Psychiatric treatment for mental illnesses, such as SSD and psychotic disorders, is defined by the perspective of the Recovery Model (Jacob,

2015; Warner, 2010). This model interprets recovery as maintaining control of one's life by using principles to highlight belief and hope, and that despite the symptoms, an individual diagnosed with a mental illness can obtain a purposeful life (Jacob, 2015). SSD is not a curable disorder, however, the Recovery Model utilizes the idea of optimism in that an individual can regain control of life and that symptoms can be managed. In addition to optimism, the recovery process for SSD should encompass empowerment and interpersonal support throughout recovery services, such as vocational rehabilitation (Warner, 2010). This model is seen as the foundation for the process of recovery for mental illnesses and has guided the development of various treatment options and services used in practice today (Jacobson & Greenley, 2001). In association to schizophrenia treatment, a study identified a correlation between the use of the Recovery Model in treatment with the quality of life with an individual with schizophrenia (Chiu, Ho, Lo, & Yiu, 2010).

According to the American Psychological Association and the Substance Abuse and Mental Health Services Administration (SAMHSA, 2012), there are 10 core principles that correspond with the recovery process. These core principles include the following: (1) *self-direction*, where the patient decides the recovery process; (2) *individualized and person-centered* therefore treatment is shaped by the patient's strengths, needs, and experiences; (3) *empowerment* so the patient has a say in all treatment options; (4) *holistic* recovery designed to encompass all aspects of the patient; (5) *nonlinear* rather than a step-by-step recovery process; (6) *strengths-based* where treatment is centered on working on the strengths of the patient; (7) *peer support* by

including caretakers and family in recovery; (8) *respect* in which the community and caretakers accept and appreciate the patient; patients have (9) *responsibility* of their recovery; and (10) *hope* for an improved quality of life (American Psychological Association, 2012). A combination of these principles and treatment services aim to increase the overall quality of life of individuals with a mental illness, such as schizophrenia (Jacob, 2015).

Treatment in practice. The most effective form of treatment for Schizophrenia consists of pharmaceutical, psychological, and psychosocial treatments (Adams, Wilson, Gilbody, Bagnall, & Lewis, 2000). Treatment heavily relies on pharmaceuticals to reduce symptoms. However, matching the appropriate medication and dosage with each person diagnosed is a difficult and time-occupying process, and medication is not sufficient enough to be the only form of treatment for Schizophrenia. For example, Lenroot, Bustillo, Lauriello, and Keith (2003) found that 14% to 40% of patients in studies that were treated exclusively with medication experienced relapses within one year. In addition, social and cognitive functioning remained impaired, despite the reduction of Schizophrenia symptoms (Lenroot, et al., 2003). Therefore, the importance and need of psychological treatment for Schizophrenia includes preventing relapse, improving the social and cognitive functioning, and managing the remaining residual symptoms (Bustillo, Lauriello, Horan, & Keith, 2001). The domains within psychological treatment include family therapy, community reintegration, social skills training, vocational rehabilitation, cognitive behavior therapy, and individual therapy (Bustillo, Lauriello, Horan, & Keith, 2001). These treatment services are commonly

provided in inpatient facilities, outpatient programs, or community-based settings. In addition, psychological treatment is most effective when provided simultaneously with pharmaceutical treatment (Bustillo, Lauriello, Horan, & Keith, 2001).

Inpatient psychiatric treatment. Treatment in inpatient psychiatric hospitals has decreased in numbers over the past four decades due to a movement toward outpatient treatment; however, this form of treatment is still prevalent for severe mental illness (Sharfstein, 2009). The most prevalent mental health or substance abuse disorders in inpatient psychiatric facilities include mood disorders, substance-related disorders, dementia, anxiety disorders, and schizophrenia (Owens, Myers, Elixhauser, & Brach, 2007). According to Sharfstein (2009), the most common reason for admission is the individual's need for crisis stabilization, as the person is a threat or harm to themselves or others due to their mental state. The treatment plan implemented for inpatient psychiatric hospital patients is formulated based off the reason for admittance, the life conditions of the patient, the resources and support available, and the diagnosis (Sharfstein, 2009). Inpatient hospitalization for mental illness overall provides the opportunity to have access to available treatment resources at all times and to prepare individuals for successful reintegration back into the community (Sharfstein, 2009).

Inpatient treatment for Schizophrenia has evolved over time. Through years of analyzing facilities and studies conducted in inpatient treatment settings, the Schizophrenia Patient Outcomes Research Team (PORT) has encouraged the following updates to improve inpatient treatment programs. PORT recommends that during the first initial stages of admission to an inpatient facility, patients should begin pharmaceutical

treatment to stabilize their mental state and control symptoms (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010). Once the appropriate type and dosage of medication is determined and the patient is stable, psychosocial treatment can be implemented while continuing medication. Psychosocial treatments are recommended to focus on community reintegration after discharge, support for obtaining and upholding employment, skills training for daily activities and independent living, cognitive behavioral therapy for managing and reducing symptoms, token economy interventions to learn acceptable behavioral skills, and family-based services to improve social support (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010).

Outpatient psychiatric treatment. The practice guidelines for the treatment of schizophrenia states that outpatient treatment can be an alternative option to inpatient treatment for two reasons: the individual has an acute psychotic episode or additional assistance for stabilization is needed after inpatient treatment. Outpatient treatment is referred to as day hospitalization or partial hospitalization. Facilities that provide this form of treatment are fully staffed and include family members or residence staff in treatment. Patient criteria incorporates that the individual cannot be a harm to themselves or others, must function at a level where they can participate in treatment services, have a caregiver and a network to resources for community treatment. This form of treatment has presented benefits such as decreasing symptoms in a short amount of time, reducing rehospitalization rate and cost, and is as effective as inpatient treatment if individual meets criteria (American Psychiatric Association, 2004). Included in Outpatient treatment is Day Treatment. Day Treatment is provided for individuals who are stable

and are living within the community. These types of programs provide structure, support, and services that work on improving social functioning and prevent relapse. Plans for treatment in this setting incorporate individual's needs and interests and focus employment opportunities and social skills training (American Psychiatric Association, 2004).

Community based settings. Community based programs, also referred to as crisis residential programs, are an acute form of treatment for severe mental illnesses that focuses on providing services that increase support for the individual (American Psychiatric Association, 2004). The practice guidelines for schizophrenia states that these facilities are based within the community, and therefore encourage integration by limited restriction in treatment. Criteria for individuals receiving treatment in this setting is that commitment is made on a volunteer basis, no unstable conditions or emergency medical assessments are needed, and substance detoxification is not necessary (American Psychiatric Association, 2004). Included in this type of treatment for severe mental illnesses is temporary care and crisis intervention within the community, full time staff available, and support during acute-care occurrence to maintain contact with caregivers and social networks.

Treatment in the community can continue in housing arrangements. For instance, if an individual with schizophrenia is unable to live with a caregiver or family member, group homes, therapeutic communities, and supported independent living are alternative living options. Care and continued treatment in housing encourages the individual to continue connections with psychiatric care while promoting independence in the

community. The main focus for continued treatment in this setting is maintaining stability and providing continued support to eliminate social isolation from the community (American Psychiatric Association, 2004).

Recreational Therapy for Schizophrenia Treatment

Within psychosocial treatment, recreational therapy (RT) uses recreational experiences and activities for treatment interventions to assist in reducing and managing the effects of an illness or disability (Sorensen, 1999). The goal of RT is to improve the overall quality of life of a person with an illness or disability through participation in recreational and leisure activities (Sorensen, 1999). Participating in these activities has the potential to improve social skills, cognitive skills, and life satisfaction for people diagnosed with mental illnesses through developing skills for independence, and increasing the level of functioning while reducing limitations (American Therapeutic Recreation Association, 2017; Snethen, McCormick, & Van Puymbroeck, 2012).

Unfortunately, there is limited research pertaining to RT interventions in inpatient psychiatric facilities for severe mental illnesses. However, what evidence there is suggests that recreation-based interventions used in inpatient psychiatric rehabilitation have been shown to develop social skills, build relationships, prepare for community reintegration, and reduces social isolation (Biancosino, Marmai, Marchesini, Bertasi, Targa, Bivi, et al., 2010), which fulfills PORT's recommendation to some degree (Kreyenbuhl, Buchanan, Dickerson, & Dixon, 2010).

Community re-integration treatment. RT utilizes community re-integration as a component of treatment for various populations, including SSD. Recreational

therapists can include community re-integration into treatment by providing recreational activities in real world settings, such as sporting events or malls (Hodges, Luken, & Zook, 2001). By providing RT interventions in the community, individuals gain the experience and skills necessary to interact in public settings independently (Hodges, Luken, & Zook, 2001). Community re-integration interventions for severe mental illnesses, including Schizophrenia, are designed to provide the resources and skills to successfully reintegrate into society after discharge from inpatient care (Smith, Hull, Mackain, Wallace, Rattenni, Goodman, et al., 1996). In addition, community re-integration treatment consists of making connections and socializing in society (Crosse, 2013), and interest-based activities within treatment has shown to increase social interactions and social networks for individuals with Schizophrenia as they develop the skills and competence to support independence in the community (Snethen, McCormick, & Van Puymbroeck, 2012). Lastly, integration into society reduces stigmatized views of Schizophrenia, resulting in an increase of self-confidence when in the community (Crosse, 2013).

Vocational training. Vocational training entails strengthening work functioning, or work skills, for a successful transition to employment after discharge (Cook & Razzano, 2000). Vocational programs offered in psychiatric treatment improve vocational activity, such as participation in jobs and increasing job skills (Lehman, 1995).

Skills training. Skills training is incorporated in treatment, as Schizophrenia symptoms cause a distress or impairment to the social domain of a person's life (American Psychiatric Association, 2013). Skills training consists of teaching and

applying skills for daily life and coping with a mental illness (Lieberman, Wallace, Blackwell, Kopelowicz, Vaccaro, & Mintz, 1998). Specifically, social skills training uses various techniques to improve communication skills required for living independently (Kopelowicz, Liberman, & Zarate (2006). Improving social and coping skills for a person diagnosed with Schizophrenia impacts how the person handles stress, reduces the chance of relapse, improves interpersonal supports, identifies societal placement, and improves quality of life (Kopelowicz, Liberman, & Zarate, 2006). RT commonly develops these skills for coping, such as problem solving, assertiveness training, cognitive restructuring, and stress management (Hood & Carruthers, 2002). Furthermore, RT can assist in developing the skills necessary for self-care, including managing leisure time, developing social connections, improving self-awareness, and increasing community participation for a psychiatric disorder (Hood & Carruthers, 2002).

Cognitive behavioral therapy (CBT). Cognitive behavior therapy (CBT) is a form of psychotherapy that uses various forms of interventions to influence the thinking process and emotions of a person (Addington & Lecomte, 2012). CBT has resulted in reducing relapse and command hallucinations, or hallucinations that order the person to perform tasks (Addington & Lecomte, 2012). In addition, there have been improvements on self- esteem, coping skills, and social support after participation in CBT interventions (Addington & Lecomte, 2012). In regard to RT, well-being is a central concept to the field (Carruthers & Hood, 2004). Carruthers and Hood (2004) explained wellbeing in RT as including the ideas of happiness, self-actualization, optimism, vitality, self-acceptance, purposeful centered life, highest level of functioning, and life satisfaction. RT

interventions designed to improve the well-being of individuals incorporate these aspects of well-being listed (Carruthers & Hood, 2004)

Token Economy Interventions. Token economy interventions are implemented to shape and condition behaviors and social learning (Dickerson, Tenhula, & Green-Paden, 2005). Interventions often include a token, or reinforcer, to influence the desired behavior. The token is viewed as an incentive throughout treatment to perform more targeted behaviors (Dickerson, Tenhula, & Green-Paden, 2005).

Family- Based Services. Family-based services within RT includes identifying and developing support for the individual by incorporating the family members in RT interventions to assist the individual achieve treatment goals (Heyne & Anderson, 2012). Additionally, RT can provide skill development for families of individuals with mental illnesses that encompasses how to improve family leisure activities. These skills include teaching how to facilitate new activities, creating an environment in the home for recreational activities, and making time for family leisure activities on a scheduled basis (Townsend & Zabriskie, 2010). For SSD, family-based services in treatment include providing education for families and support systems of the individual to assist in coping with mental illness (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2015). The family members and support systems of a person diagnosed with a mental illness experience high stress because of the impact the mental illness has on relationships and monetary resources. Therefore, the family is included in the treatment process to further expand knowledge about the mental illness and to receive therapeutic services. The services are

formatted as a psychoeducation, or educational sessions with a therapeutic component (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2015).

Importance of Study

Literature for the Recovery Model and the recommendations made by PORT has been published for professionals working with the mental health population. However, how many professionals, specifically recreational therapists, are using these evidence-based practices? This study explores this question by gathering information from recreational therapists who work with adults with SSD in a descriptive, quantitative study by using a cross-sectional survey. The objective of this study is to identify if recreational therapists are incorporating the principles of the Recovery Model and the recommendations made by PORT in recreational therapy programs for adults with SSD; and if so, how are they including these components in practice?

CHAPTER THREE

Methods

This chapter will outline the following information: (a) study design, (b) selection of subjects, (c) instrumentation, and (d) data collection procedures and analysis.

Study Design

This study utilized the methodological approach for a mixed methods, descriptive research study. The use of a cross-sectional survey explored if recreational therapists incorporate literature on the Recovery Model and recommendations from PORT into treatment services for adults with SSD.

Selection of Subjects

Participants for this study were Recreational Therapists that currently or had previously provided treatment for adults with SSD at an inpatient facility, outpatient program, or in a community-based setting. Data was collected over a one-month time period; from January 1, 2018 to January 26, 2018.

Recruitment for participants began post IRB approval. Participants recruited were recreational therapists that are members of The American Therapeutic Recreation Association (ATRA) affiliated with the Behavioral Health Section, and from various recreational therapy Facebook pages. The behavioral health section of ATRA consists of recreational therapists that work in the behavioral health settings, which includes but is not limited to the following settings: inpatient psychiatric hospitals-free standing; inpatient psychiatric units within larger healthcare facilities; day hospitals, partial hospitalization programs, and intensive outpatient treatment; co-occurring disorders

programs; addictions recovery centers; forensic facilities; public schools and alternative schools; community mental health centers; veterans hospitals; residential living facilities; long term care and skilled nursing facilities (The American Therapeutic Recreation Association, 2017). There were approximately 250 ATRA members in this section that received a link to the survey via email and had the opportunity to participate in the study on a volunteer basis.

In addition, the survey was posted on the following recreational therapy Facebook pages: Recreational Therapy Foundation Page, Recreational Therapy- Acute Psych In-Patient Setting, Recreational Therapy, Therapeutic Recreation, and the American Therapeutic Recreational Association page. A snowball sample of four recreational therapists was incorporated where recreational therapists were able to share the information about the study to other recreational therapists.

Instrumentation

The instrument used for this study was a survey (see Appendix A) designed specifically for this research. The program software Qualtrics was used to develop the survey since it provides templates for questions, can be sent via email, and generates a statistical analysis report of the responses. The survey consisted of open and closed ended questions designed to explore the use of the Recovery Model principles and the aspects of treatment advised by PORT in RT services for adults with SSD. The domains of the survey consisted of the following from the Recovery Model: self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, responsibility, and hope. In addition, the following

recommendations by PORT for schizophrenia treatment were included as well: community reintegration training, vocational training, skills training, cognitive behavioral therapy, token economy intervention, and family based services. For each of the principles and recommendations, a definition was provided for reference. See **Table 1** and **Table 2** for the list of definitions used on the survey.

Table 1. Mental Health Recovery Model Principle Definitions.	
Self- direction	The patient assists in deciding the recovery process.
Individualized and Person-Centered	Treatment is shaped by the patient’s strengths, needs, and experiences.
Empowerment	Individual has a say in all treatment options.
Holistic	Recovery is designed to encompass all aspects of the individual.
Nonlinear	Recovery process is gradual with ups and downs, not step-by-step.
Strengths-based	Treatment is centered on working on the strengths of the individual.
Peer Support	Family/friends/caretakers are involved in the recovery process.
Respect	The community/caretakers accept and appreciate the individual.
Responsibility	The individual has responsibility of their recovery process.
Hope	Individual has optimism that their quality of life will improve.
*Definitions from American Psychological Association (2012).	

Table 2. PORT Recommendations Definitions.	
Community Reintegration Training	Focus on community reintegration for individuals.

Vocational Training	Support for individuals obtaining and upholding employment.
Skills Training	Individuals learn/improve skills for daily activities and independent living.
Cognitive Behavioral Therapy	Individuals learn skills/techniques to manage and reduce symptoms.
Token Economy Intervention	Opportunity for individuals to receive non-monetary rewards for acceptable behavior.
Family Based Services	Family/caretakers are involved in treatment to improve social support.
*Definitions from Kreyenbuhl, Buchanan, Dickerson, & Dixon (2010).	

The survey consisted of 16 domains: ten principles from the Mental Health Recovery Model and six from the PORT recommendations for Schizophrenia treatment. Two questions were asked about each domain with a Likert-type response options. The first question was, “Is this principle/recommendation used in your practice?” (yes, no, I don’t know), and the follow-up question, “If yes, to what extent do you use it?” (a lot, sometimes, rarely, and not at all). Following the Likert-type response questions, participants were encouraged to answer an open-ended response to explain how the principle or recommendation was used in their RT practice. The survey took approximately 10-15 minutes to complete, and contained 9 demographic questions and 16 Likert style questions. The instrument was pilot tested with 3 recreational therapists prior to being distributed for the study to ensure that the questions were understandable to participants and valid pertaining to the purpose of the study.

Data Collection Procedures and Analysis

The survey was distributed to members of the behavioral health section via email. Emails were attained through the member directory on the ATRA website. Participants received a description and purpose for the study, in addition to instructions for how to complete the survey. It was stated in the email that participation in the study is voluntary, and by completing the survey participants consent that the information they provide will be used in the study (Consent form included in the survey- see Appendix A). All information provided by the participants was used only for the purpose of this study. In addition, a link to the survey with a brief informative paragraph about the qualifications for participants and overview of the study were posted on various Recreational Therapy Facebook pages.

Surveys were sent to participants January 1, 2018 and were closed on January 26, 2018. During this time, the researcher used the modified Dillman technique to achieve a high response rate (Babbie, 2013). First, recipients received an initial email containing the link to the survey and a cover letter describing the study. Ten days after sending the initial email, the researcher provided a follow up email to participants that had not completed the email, or a thank you to participants who have completed the survey. Once this had occurred, a final contact to participants was sent. This entailed a final thank you to all participants, whether they completed the survey or not, and a notice that the study had been concluded.

Data from the surveys was analyzed through descriptive statistics analysis using SPSS and Excel. The researcher and committee an. For the qualitative data, a deductive

content analysis was used to analyze the data. The process of the deductive content analysis consisted of the following steps. First, all the principles and recommendations were separated with their corresponding responses from the survey in a Word Document. Next, an unconstrained categorization matrix (See Appendix B) was developed based on reoccurring phrases or themes, organized as codes, supporting the specific domain (Elo & Kyngäs, 2008). Each response was reviewed and grouped with other similar responses that correlated with the principle and recommendation. Responses that did not support the principle or recommendation were removed from the analysis. From these groups of responses, a code was created that encompassed the theme of the group to support the principle and recommendation. Last, supporting phrases for each code were organized and counted to identify which code was most prevalent for each specific domain.

CHAPTER FOUR

Results

Sample Description

A total of 208 surveys were completed via Qualtrics by Recreational Therapists that currently or had previously worked with individuals with SSD between January 1, 2018 to January 26, 2018. Approximately 80 responses were removed from the overall data prior to analysis due to incomplete responses following the demographic questions. The final sample size for the study was 126 responses.

Table 3 presents the demographic information of the sample in detail. The majority of participants (80.2%) currently provide or have previously provided (94.5%) RT services to individuals with SSD. One to three years of experience working with individuals with SSD was the most prevalent among respondents (30.2%). A majority of respondents had a Bachelor's degree in Recreational Therapy or Therapeutic Recreation (82.5%) and worked in an inpatient setting (74.5%).

Table 3. Demographics of Participants.		
Currently provide RT services to individuals with SSD.		
Yes	101/126	80.2%
No	25/126	19.8%
Provided RT services to individuals with SSD in the past.		
Yes	119/126	94.5%
No	7/126	5.5%
Years of experience working with individuals with SSD.		
Less than 1 year	11/126	8.7%
1 to 3 years	38/126	30.2%

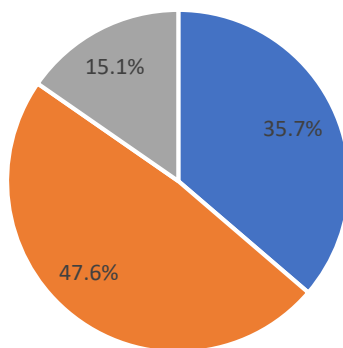
3 to 5 years	28/126	22.2%
5 to 10 years	24/126	19%
More than 10 years	25/126	19.8%
Have a certification (CTRS) to practice RT.		
Yes	121/125	96.8%
No	4/125	3.2%
Have a license (LRT) to practice RT.		
Yes	20/126	15.9%
No	106/126	84.1%
Highest level of education completed.		
Bachelor's Degree	88/126	69.8%
Master's Degree	36/126	28.6%
Doctoral Degree	2/126	1.6%
Other	0/126	0%
Degree obtained in RT/TR (selected all that applied)		
Bachelor's Degree	104/126	82.5%
Master's Degree	14/126	11.1%
Doctoral Degree	6/126	4.8%
Master's Degree/ None of the above	1/126	<1%
None of the above	1/126	<1%
RT work setting (selected all that applied)		
Inpatient facility	94/123	76.4%
Outpatient facility	7/123	5.6%
Community based	9/123	7.3%
Inpatient/outpatient	8/123	6.5%
Inpatient/outpatient/community based	3/123	2.4%

Quantitative Survey Results

Participants were asked their familiarity level with the Mental Health Recovery Model and the Schizophrenia Patient Outcomes Research Team (PORT) recommendations for treatment. The provided range of responses were *very familiar*, *somewhat familiar*, and *not at all*, respectively. **Figure 1** shows the responses regarding the Mental Health Recovery Model and recommendations from PORT. A majority of the participants responded that they were somewhat familiar with the Recovery Model (47.6%), and not at all familiar (69.8%) with the PORT recommendations. In addition, the crosstabs correlation analysis presents that there is a positive correlation coefficient of $r = .408$, indicating that participants that are familiar with either the Recovery Model or PORT recommendations, and have a familiar understanding of the other.

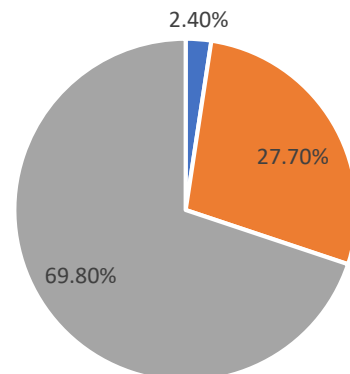
Figure 1. Familiarity with the Recovery Model and PORT Recommendations.

Familiarity with the Mental Health Recovery Model



■ Very Familiar ■ Somewhat Familiar ■ Not at all

Familiarity with the PORT recommendations.



■ Very Familiar ■ Somewhat Familiar ■ Not at all

Domains- Mental Health Recovery Model Principles and PORT

Recommendations. To breakdown the responses regarding the question, “*Is this principle/recommendation used in practice?*”, percentages were calculated for each individual response (*Yes, No, and I don’t know*). To measure what extent it is used in practice, a mean score for each principle and recommendation was calculated for easy comparison. The mean was formulated from the range of not at all, rarely, sometimes, to a lot; each response corresponded with a numerical value from 1-4, respectively. Listed from the most used principle to the least used are reported as the following based on the mean score: individualized/person centered (3.62), responsibility (3.56), strengths based (3.55), respect (3.49), holistic (3.48), hope (3.44), nonlinear (3.39), self-direction (3.37), empowerment (3.33), peer support (3.04). The mean for each of the principles were between a score of 3.0 and 4.0, which corresponds with the responses of “sometimes” and “a lot”, indicating that each principle is used sometimes or a lot in practice.

Listed from the most used recommendation to the least used are reported as the following based on mean scores: cognitive behavioral training (3.61), skills training (3.40), community reintegration training (3.01), family-based services (2.91), token economy (2.53), vocational training (2.38). Family based services, token economy, and vocational training each had a mean score between 2.0 and 3.0, which corresponds with using the recommendation between rarely and sometimes in practice. CBT, skills training, and community reintegration are used in practice sometimes or a lot, since the mean score for these recommendations are between 3.0 and 4.0. See **Table 4** and **Table 5** for the percentages and mean scores.

Table 4. Quantitative Results for the Mental Health Recovery Model principles.				
Principle	Is the principle used in practice?			If yes, to what extent is it used? <i>mean score- not at all (1) to a lot (4)</i>
Self- Direction	Yes No I don't know	75.2% 16.8% 8%	94/125 21/125 10/125	3.37
Individualized/ Person Centered	Yes No I don't know	92.8% 6.4% .8%	116/125 8/125 1/125	3.62
Empowerment	Yes No I don't know	79.8% 15.3% 4.8%	99/124 19/124 6/124	3.33
Holistic	Yes No I don't know	84.7% 11.3% 4%	105/124 14/124 5/124	3.48
Nonlinear	Yes No I don't know	73% 13.1% 13.9%	89/122 16/122 17/122	3.39
Strengths Based	Yes No I don't know	86.2% 10.6% 3.3%	106/123 13/123 4/123	3.55
Peer Support	Yes No I don't know	74% 22% 4.1%	91/123 27/123 5/123	3.04
Respect	Yes No I don't know	81.3% 8.9% 9.8%	100/123 11/123 12/123	3.49
Responsibility	Yes No I don't know	94.4% 4% 1.6%	117/124 5/124 2/124	3.56
Hope	Yes No I don't know	85.4% 8.1% 6.5%	105/123 10/123 8/123	3.44

Table 5. Quantitative Results for the PORT Recommendations				
Recommendation	Is this recommendation used in your practice?			If yes, to what extent do you use it? <i>mean score- not at all (1) to a lot (4)</i>
Community Reintegration Training	Yes	58.1%	68/117	3.01
	No	37.6%	44/117	
	I don't know	4.3%	5/117	
Vocational Training	Yes	33.3%	39/117	2.38
	No	59.8%	70/117	
	I don't know	6.8%	8/117	
Skills Training	Yes	72.6%	85/117	3.40
	No	22.2%	26/117	
	I don't know	5.1%	6/117	
Cognitive Behavioral Training (CBT)	Yes	89%	105/118	3.61
	No	7.6%	9/118	
	I don't know	3.4%	4/118	
Token Economy	Yes	47.4%	55/116	2.53
	No	48.3%	56/116	
	I don't know	4.3%	5/116	
Family Based Services	Yes	63.2%	74/117	2.91
	No	32.5%	38/117	
	I don't know	4.3%	5/117	

Qualitative Results

The use of a deductive content analysis was used to derive the ways in which the Mental Health Recovery Model principles and PORT recommendations are being used in RT practice (Elo & Kyngäs, 2008). The content analysis yielded various codes that were categorized according to the responses associated with the principles and recommendations. Refer to **Table 6** and **Table 7** for the deductive content analysis.

Table 6. *Content Analysis for the Mental Health Recovery Model Principles.*

Principle	Codes (# of code occurrences)	Supporting Quotes
Self- Direction	<ul style="list-style-type: none"> • Input on treatment plan: treatment, discharge, safety (15) • Autonomy in choosing leisure activities/interests (14) • Goal setting (10) • Participation in treatment groups (7) • Part of assessment process (5) • Utilizing skills at the facility (4) • Decide type of medications (3) • Patient’s advocating for themselves (1) 	<p>“They are part of the assessment and treatment planning process. They have a say in everything including medications, length of stay, etc. While they may not always get a chance to “choose”, they can at least voice their opinions.”</p> <p>“Our patients are encouraged to choose what suits them best for their treatment in terms of groups they attend and advocating for themselves to move through the program.”</p>
Individualized and Person-centered	<ul style="list-style-type: none"> • Assessment results identify individual information used for treatment (10) • Personalized treatment plans (8) • Group activities planned based off patient needs and interests (7) • Treatment groups based on individual’s strengths (5) • Participation in developing individualized treatment plan (5) • Goal setting specific to the individual’s needs (5) • Patient has a choice of groups (3) • 1:1 treatment sessions (3) 	<p>“Assessments administered pinpoints individual’s strengths, needs, and experiences. This helps to better match individuals with appropriate interventions.”</p> <p>“We complete group therapy sessions and always try to plan our groups around the patient/group dynamics and abilities.”</p>

	<ul style="list-style-type: none"> • Progress evaluations for patient (2) 	
Empowerment	<ul style="list-style-type: none"> • Patient has the right to choose, refuse, voice opinions (20) • Patient assists in deciding treatment plans and discharge plans (11) • Patient participates in treatment team meetings (5) • Patient can decide medications (2) • Patients give feedback on groups (1) 	<p>“The person can voice his or her opinion.”</p> <p>“Though participation in treatment is strongly encouraged, patients have say in what they choose to participate in.”</p>
Holistic	<ul style="list-style-type: none"> • Groups designed to improve overall well-being of the person (13) • Teach healthy lifestyles, leisure activities, and coping skills-focus not only on symptoms (6) • Various integrative therapies; interdisciplinary approach (5) • Treatment and discharge plans (3) • Education about holistic approach to patient; further education (3) • Family group events/outings (2) • Holistic models used (1) 	<p>“The Rec therapy department is instrumental in offering programs based on social, emotional, physical, creative, intellectual, and spiritual needs of patients.”</p> <p>“We do not just focus on the schizophrenia symptoms the patients may be dealing with, we work on all aspects of mental, emotional, and physical health.”</p>
Nonlinear	<ul style="list-style-type: none"> • Meet patients at their level of functioning (8) • Addressing patient progress and areas for improvement (6) • Patient cycles on progress (4) • Educate patients on nonlinear treatment (2) 	<p>“Treatment is always based on where a patient is at in their process today.”</p> <p>“Staff are aware of possible cycles of symptoms and monitor patients for changes in behavior. We discuss the findings with patients regularly.”</p> <p>“Patients need to understand that life is based on successes and</p>

		challenges on a daily basis.”
Strengths- based	<ul style="list-style-type: none"> • Building on positives, increasing self-esteem, confidence, and skills (9) • Groups and interventions designed around strengths (8) • Discuss strengths with patient; address strengths in assessment to use for treatment plan (5) • Encourage patients to use coping skills and talents (3) • Programming is strengths based (2) 	<p>“Attempt to provide groups that focus on patient’s strengths to provide encouragement and opportunities for success.”</p> <p>“We try to encourage the patients to use their skills/strengths to relate to others, to reach goals, to develop those skills more, etc.”</p>
Peer Support	<ul style="list-style-type: none"> • Family involved in various family based services (treatment team meetings, family therapy, family consultations, family education groups) (16) • Patient community passes with family; family calls, luncheons, and visitations (6) • Other disciplines address peer support (6) • Promote and/or encourage peer support daily for patients (4) • Peer support specialists and support groups (3) 	<p>“It’s a team approach. We include as many people as they want in the treatment process, so they will have support upon discharge. This improves the level of understanding and knowledge of loved ones so that they fully understand how to help, not enable, the client.”</p> <p>“Groups are designed to be peer support.”</p> <p>“The Rec Therapy Department promotes peer support and encouragement daily.”</p>
Respect	<ul style="list-style-type: none"> • Facility’s actions of respect toward patients (7) • Supportive atmosphere (4) • Recommendations and providing choices for patients (3) • Interactions with patients (3) 	<p>“A supportive, family atmosphere was promoted. Social activities and fostering an atmosphere of taking healthy risks and not being afraid to make mistakes was a critical part of the program.”</p>

	<ul style="list-style-type: none"> • Patient councils, community meetings, and suggestion boxes (2) • RTs are advocates for patients (2) 	<p>“Respecting the patient and their choices...”</p> <p>“The Rec Therapy department advocates for each and every patient regardless of their circumstance.”</p>
Responsibility	<ul style="list-style-type: none"> • Patients choose to go to group and their level of participation (8) • Patient autonomy in treatment process (6) • Patient sets and designs goals (3) • Participants in treatment planning; review progress at treatment team meetings (3) • Responsibility included in group discussions and therapy sessions (2) • Encouragement by RTs to be responsible (2) • Take patients on outings to teach responsibility and life skills (1) • Use of models that include responsibility in RT program (1) • Taking medications (1) • Patient rights (1) 	<p>“Group discussion often focus on accepting responsibility instead of blaming.”</p> <p>“Progress towards goals is patient driven.”</p> <p>“The decisions and actions of the individuals determine their progress or lack there of.”</p>
Hope	<ul style="list-style-type: none"> • Support patients by nurturing growth (5) • Positive attitudes (5) • Interventions focused on hope and positive emotions (4) • Peer support (4) • Focus on goals and successes (4) • Identifying skills and techniques to adapt to living with a mental illness (3) • Provided rewards for progress (1) • Philosophy of hope in RT department (1) 	<p>“Providing examples of successful recovery, plentiful peer support, and messages of hope helped create a vision of full rehabilitation and recovery, or as close to it as possible.”</p> <p>“The staff often has to hold a patient’s hope until the patient is ready to take it back.”</p>

		“Give them hope by making long-term goals and breaking down how to accomplish them.”
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Table 7. Content Analysis for the PORT Recommendations.

Recommendation	Code (# of code occurrences)	Supporting Quotes
Community Reintegration Training	<ul style="list-style-type: none"> • Education and guidance for community resources; community supports (8) • Community outings, passes, therapeutic home visits with family; facility tours (8) • Community re-entry and leisure education groups (7) • Other disciplines address community reintegration (1) • Off-grounds privilege (1) • Volunteers come in from the community (1) 	<p>“We provide outings to give our patients the chance to identify resources in the community.”</p> <p>“Through Leisure Education groups, offer patients information of community resources that may be accessed upon discharge.”</p>
Vocational Training	<ul style="list-style-type: none"> • Vocational Training Program (10) • Employment resources (3) • Life skills and leisure groups (3) • Exploration of values, beliefs, and ideals to find employment (1) 	<p>“...on site work program for patients.”</p> <p>“Referral to vocational rehabilitation and provide information on programs that work with people with mental illnesses.”</p>
Skills Training	<ul style="list-style-type: none"> • Groups designed to develop various skills (18) • Education and resources (3) • Co-treatments to develop skills (2) • Community outings (1) 	<p>“RT provided social skills training, stress reduction techniques, and leisure skills training, and physical fitness.”</p> <p>“Maintaining a schedule, organization, work/life balance.”</p>
Cognitive Behavioral Therapy (CBT)	<ul style="list-style-type: none"> • Groups focus on CBT (22) • Education (5) 	<p>“Communication, anger management, coping and various other skills are introduced and worked on</p>

	<ul style="list-style-type: none"> • Co-treat with other disciplines for CBT (4) • 1:1 sessions (1) 	<p>in order to manage and reduce symptoms.”</p> <p>“RT worked in conjunction with the psychology department and individual therapist to teach and reinforce CBT principles, and practice using principles in social situations, or situations with higher amount of stimuli.”</p>
Token Economy	<ul style="list-style-type: none"> • Reinforcements (15) • Prizes for group activities (2) • Privileges for appropriate behaviors (2) • Peer and professional support available for verbal rewards, feedback, and reassurance (1) 	<p>“Patients earned points for groups attended and were able to earn privileges...”</p> <p>“We use a token system to encourage group participation, ADLs, and meetings.”</p>
Family Based Services	<ul style="list-style-type: none"> • Family sessions and therapy (7) • Informed about treatment and participation in treatment team meetings (6) • Visitations (2) • Support gatherings (1) 	<p>“They are involved in the steps taken to care for individual.”</p> <p>“Family is encouraged to be an active participant in the recovery of each individual.”</p>

Mental Health Recovery Model principles: qualitative results. Principles of the Mental Health Recovery Model, though presented individually, were often interrelated. Therefore, some codes for one principle overlapped with another principle. Codes were placed in the category that best represented the code. In addition, various restrictions arose in responses that depicted challenges to incorporating the principle into practice.

Self- direction. The most common response was that self- direction is present in practice through the patient's autonomy in choosing leisure activities and interests. Self- direction is also present in practice by participation and decision making in various aspects of treatment and utilizing the skill sets unique to the individual at the facility.

Individualized and person centered. Individualized and person centered is mostly used in practice by using assessments to identify information about the individual for their treatment. In addition, this principle is used in practice by personalizing the overall treatment process for individuals, incorporating a person's strengths into treatment, and providing individualized feedback for individual's receiving treatment.

Empowerment. According to the survey, empowerment is used in practice by providing the opportunity for individuals to have the right to choose, refuse, and voice their opinions. Empowerment is also prevalent in treatment through participation and decision making in the overall treatment process.

Holistic. According to the responses on the survey, this is used primarily in designing groups to improve the social, mental, and physical well-being of a person. In practice, holistic is also applied by providing treatment that will best improve an individual's quality of life and incorporating various forms of therapies and opportunities in treatment.

Several restrictions were mentioned in the responses regarding the inclusion of the holistic approach into practice. These included that there is too heavy of a focus on pharmacological interventions, lack of staffing and resources, setting of treatment

restricts patient's rights and time, and this approach is only used if the client indicates an interest.

Nonlinear. In treatment, nonlinear is displayed as meeting patients at their current level of functioning, according to the responses from the survey. A nonlinear approach is also present in practice by awareness of the natural cycle of symptoms for an individual and continuing to address areas of improvement throughout the treatment process. A restriction discussed in the responses include that some RT programs continue to utilize a step-by-step process for treatment based off the model that the program is designed around.

Strengths based. The most common way strengths based is used in practice is building on positives, increasing self-esteem, confidence, and skills of an individual. Strengths based approach in practice is also incorporated by including strengths into programming, interventions, and treatment plans.

Peer Support. Based on the results of the survey, the most prevalent way of including peer support in treatment is by involving the family in various family-based services. These include treatment team meetings, family therapy sessions, family consultation sessions, and family education groups. Peer support is also used in practice through other disciplines and groups outside of RT, and encouragement from RTs. Some restrictions that arose in the responses on the survey include that family is often not involved in the individual's life or do not want to be involved in their treatment. Patients also have the ability to choose the level of involvement of family or friends in their treatment.

Respect. According to the responses from the survey, respect is most often used in practice by the facility treating individuals with dignity and respect. Respect towards patients is also displayed in practice by opportunities for individuals receiving treatment to voice opinions, positive interactions between individuals and therapists, and creating a supportive atmosphere in treatment.

Responsibility. Responsibility is most included in treatment, based off the responses from the participants that completed the survey, through individuals choosing to go to group and determining their level of participation. Responsibility is also displayed in practice by autonomy in various aspects of the treatment process and opportunities for individuals to take responsibility within their treatment.

Hope. Hope is most commonly used in practice by RTs supporting patients by nurturing growth as an individual and in treatment and incorporating positive attitudes in treatment. Other ways hope is utilized in practice include focusing on positive emotions and successes for the individual, and involving peers for support throughout the treatment process.

Restrictions that were acknowledged about hope, based on participant responses, include: short hospitalizations which do not allow enough time to instill hope in the individual; settings for treatment can make hope difficult to find; and the concept of hope is subjective and can be difficult to identify effectiveness. Also, presence of hope depends on the person and their diagnosis. In addition, when a person stabilizes, they can become depressed over the crime they committed when they were in a psychotic state. Also, individuals with mental illnesses often create unrealistic goals for themselves with

no specific plans to achieve them, which can reduce hope in the person. Lastly, going through court sentences can hinder the confidence of individuals.

Schizophrenia PORT recommendations: qualitative results. Similar to the Mental Health Recovery Model principles, the PORT recommendations can be integrated to supplement one another. As a result, specific codes can be used to explain how various recommendations are used in practice. In addition, restrictions were also presented in responses for some of the recommendations, which are included in the following results.

Community reintegration training. Community reintegration training is most commonly incorporated in practice, based off the survey, by providing education and guidance for community resources and supports available for individuals. Other descriptions of how community reintegration training is included in practice having opportunities for individuals to integrate in the community during treatment and education about community integration in different components of treatment.

Restrictions to community reintegration training to be involved in practice include acute settings or short hospitalizations that limit the amount of time the individual can have in treatment and/or limited staffing, so community reintegration is not a focus. Specific settings, such as prison or lockdown facilities, that do not allow patients to leave the facility until discharge. Lastly, the nature of the client's mental state can determine if they can participate in outings into the community.

Vocational training. In practice, based off the survey, vocational training is most commonly implemented by participation in the vocational training program at the facility.

Other examples of vocational training used in practice include educating and teaching skills necessary for employment through resources and group interventions. Restrictions for vocational training in practice include treatment settings, like an acute care setting, that provide limited time to focus on this or do not allow individuals to leave on their own account (e.g. lockdown facilities).

Skills training. The most prevalent way skills training is incorporated in practice, based off responses from the survey, is designing groups to develop various skills. Skills training is also incorporated in the following areas of practice by addressing skill training in other disciplines outside of RT during treatment, educating individuals about different skill sets, and providing opportunities for individuals to practice skills in treatment.

Cognitive behavioral therapy (CBT). The responses from the survey indicated that CBT is most often incorporated in treatment by facilitating groups that focus on CBT. In addition, CBT is incorporated in practice by providing education on coping skills and the benefits of recreation on symptom management, co-treating with other disciplines to implement CBT, and facilitating 1:1 sessions to work on CBT. The main restrictions that apply to CBT in practice are that other disciplines, such as psychology or counselors, provide CBT and that some Recreational Therapists are not trained in CBT.

Token economy. According to the survey, token economy was most commonly done by providing reinforcements to individuals for performing acceptable behavior. In addition to reinforcements, token economy includes providing prizes for participating in group activities and games and earning privileges for appropriate behaviors.

Family Based Services. Responses from the survey indicate that family-based services are used in practice most commonly by facilitating family sessions and family therapy. Family based services also include informing families and caretakers about treatment, having them participate in treatment team meetings, allowing visitations with the individual, and offering support gatherings for individuals and their families. Restrictions for family-based services include that family is not often involved or available, therapy sessions for families are not offered, some patients do not have a support system, and policy, procedures, or setting may prevent family-based services.

CHAPTER FIVE

Discussion

Overview of Study

This descriptive study utilized a cross-sectional survey to identify if recreational therapists are incorporating the Mental Health Recovery Model principles and the PORT recommendations into practice when providing treatment for adults with SSD. Four main research questions were developed to guide the study. These included:

Question 1: *To what extent do RTs have knowledge about the Mental Health Recovery Model and/or the PORT recommendations?*

This study found that 83.3% of participants were either somewhat familiar or very familiar with the Mental Health Recovery Model, and only 15.1% were not at all familiar with the model. These results supported that the majority of participants who completed the surveys did have some level of knowledge about the model.

For RTs not involved in research or not using research to inform their practice, they may not be aware of the PORT recommendations and Mental Health Recovery Model. Like the Recovery Model, participants were also asked on the survey their familiarity level with the PORT recommendations. The responses demonstrated that 30.1% of the participants were either somewhat familiar or very familiar with the recommendations, and 69.8% were not at all familiar. A majority of the participants in this study had no familiarity at all, therefore they have little or no knowledge about the recommendations. This finding indicates support for the idea that more RTs have

knowledge about the Mental Health Recovery Model than the PORT recommendations, which leads into the next research question for this study.

Question 2: *To what extent do RTs incorporate principles of the Mental Health Recovery Model and/or recommendations from PORT in to RT programs for individuals with SSD?*

In regard to the Recovery Model principles, at least 73% of the participants responded that they use at least one of the principles in practice. For the recommendations, at least 33% of participants responded that they use each recommendation in practice, individually. Like the principles, some of the recommendations are used in practice. This does not clarify if the complete Recovery Model and PORT recommendations are used as a whole in practice. Since there were “No” and “I don’t know” responses for each recommendation and principle, this infers that some principles and recommendations are not used in practice. It cannot be determined based off this study if the study sample utilizes the entire Recovery Model and all recommendations into practice. Further research would need to be done.

Question 3: *How frequently do RTs utilize these principles and recommendations in practice?*

Now this brings up the concept of how frequently they are used in practice. For analysis purposes to make clearer comparisons between frequencies for each principle and recommendation, the mean score was calculated for all responses. Based off the mean scores, all of the principles of the Recovery Model were at least used sometimes in

practice. For the PORT recommendations, half of the recommendations fell between rarely and sometimes, and the remaining recommendations were used at least sometimes in practice. These results indicate that all the Recovery Model principles are used frequently, either sometimes or a lot, in practice. On the other hand, not all of the PORT recommendations are used frequently in practice because half of them were indicated to be used rarely or sometimes.

Based on the results, some principles and recommendations are more frequently used individually, while others are not. This indicates that the model and recommendations are not implemented as a whole. Overall, there is room to improve the usage of the Mental Health Recovery Model and PORT Recommendations in RT practice. Once again, further research will be necessary to indicate if and how frequently RTs are using the whole Recovery Model and all PORT recommendations in practice.

Question 4: *What are examples of how these principles and recommendations are used in RT practices?*

To acquire the best description of how the Recovery Model principles and PORT recommendations are used in practice, a qualitative component was included in the study. By providing an open-ended response to this question, participants were able to describe how the specific principle or recommendation is incorporated into their practices. Specific examples were provided, and responses were organized to find common types of treatment approaches. During this process, it was identified that there were overlapping themes among principles and recommendations. This supports the concept that the

Recovery Model is an integrated model in which the principles involved can intersect and complement one another. The reoccurring code of an individual's autonomy was used as an example to explain how the principles of self-direction, responsibility, individualized and person centered, and empowerment are used in practice. In addition, the incorporation of the principle itself in group therapy sessions was mentioned for self-direction, individualized and person centered, peer support, hope, holistic, and strengths based. For the PORT recommendations, reoccurring codes also were noted, however not as frequently as for the Recovery Model principles. The PORT recommendations were created based off research conducted to guide what treatment for Schizophrenia should include. Therefore, the recommendations are not designed to be integrated, but used in a way to make sure all the skill sets and knowledge is delivered to each individual with Schizophrenia receiving treatment.

Overall, the following concepts were the general findings from this study. The Mental Health Recovery Model and the principles that make it up are more known among RTs, than the recommendations made by PORT. Therefore, the principles are used in practice more frequently and to a greater extent than the PORT recommendations. From the examples provided by participants present the idea that the Recovery Model integrates the principles, and the PORT recommendations are implemented to complement one another in which individuals receiving treatment can obtain skills necessary to live independently with Schizophrenia.

Contribution to Existing Literature

The overall objective of this study is to identify if RTs are utilizing evidence-based practices in RT programs through the use of the Mental Health Recovery Model and recommendations from PORT. Both the Recovery Model and PORT recommendations have a foundation of literature to support their benefits for the mental health population. There are concepts from this study that can be applied to existing literature in regard to the Mental Health Recovery Model, PORT recommendations, treatment for SSD, and RT practice.

Recovery model. With the use of 10 principles, the Recovery Model aims to guide an individual in treatment to take control over their life (Jacob, 2015). Through this study, the Recovery Model was broken down by each principle to gain insight to if and how it is utilized by Recreational Therapists to provide treatment for individuals with SSD. Jacob (2015) states that a combination of the Recovery Model principles and treatment services has the possibility to increase the overall quality of life for individuals with a mental illness. Many of the examples for some of the principles, specifically peer support and a holistic approach, have similar codes and involve other disciplines to implement the principle in treatment. According to Jacob (2015), these two principles would then have a higher possibility to increase an individual's quality of life because there are integrative components between principles and other treatment services are involved.

Authors have also identified that the recovery process for SSD should include empowerment and interpersonal support throughout treatment (Warner, 2010). The

Recovery Model consists of an empowerment principle and a peer support principle. The responses from the study showed that both empowerment and peer support are being used in RT treatment for SSD. Examples of empowerment consisted of autonomy and participation in aspects of the treatment process. For peer support, this included support from family, other group therapy members, and the therapists themselves.

PORT recommendations. The majority of the participants in this study stated on the survey that they were not familiar at all with the PORT recommendations. Therefore, the recommendations are not implemented in RT practice as much as the Recovery Model principles. Results from the survey support the need for increased use of the PORT recommendations in RT treatment for SSD. The following recommendations demonstrate areas for improved practice of the PORT recommendations in RT services.

Community reintegration for individuals with severe mental illnesses is designed to provide appropriate resources and skills to assist individuals receiving treatment to successfully reintegrate into society post inpatient care (Smith, Hull, Mackain, Wallace, Goodman, et al., 1996). Results indicated that community reintegration treatment was included in practice, primarily, through providing education and guidance for community resources and supports, and allowing community outings in treatment for individuals to apply the skills they have learned in group sessions to the community setting. In addition, participants indicated that RTs designed groups to improve skills such as stress and symptom management, social skills (communication), balancing life responsibilities, and self-care. According to the literature, it is important for individuals with SSD to learn

social and coping skills to manage stress, reduce their chance of relapse, build social relationships and personal identity, and improve overall quality of life (Kopelowicz, Liberman, & Zarate, 2006).

However, regarding the CBT recommendation, there is a lack of literature that pertains directly to RT facilitating CBT groups in treatment for individuals with SSD or any severe mental illness. Evidence has indicated that RT utilizes CBT techniques into practice. A restriction that arose in the responses for this study showed that CBT was implemented in treatment by other disciplines, such as psychologists, counselors, or individual therapists. Some participants reported that as an RT, they were not trained specifically in CBT and therefore, did not implement it into practice. It would be beneficial to provide RTs more education and training in CBT so CBT can be implemented into practice more frequently.

Lastly, literature focused on family support for individuals with mental illnesses indicate that there is high stress due to monetary factors and the overall impact mental illnesses have on the relationships (Pitschel-Walz, Leucht, Bauml, Kissling, & Engel, 2015). A main concern for implementing family-based services into treatment for individuals with SSD, based off responses from the survey, was that family was often not available or involved because relationships had been strained or family acts as enablers for the individuals with SSD. This can be a result of the monetary stress, stress from the mental illness, or other causes related to mental illnesses. Therefore, as literature suggests and results from the survey have shown, RTs have implemented family therapy sessions, meetings, or educational groups to inform and teach families about mental

illnesses, how to cope and handle the symptoms of a mental illness, and receive therapeutic services.

Treatment limitations. Many restrictions arose in the qualitative results of the survey which are deemed important when analyzing RT treatment options for SSD. It is important to address the limitations noted in the literature related to psychological and psychosocial treatments for Schizophrenia. The first limitation is an inability for therapists to adapt interventions to meet the needs of each individual (Scott & Dixon, 1995). With the use of the individualized and person-centered principle in the Mental Health Recovery Model, examples showed that there is effort to individualize aspects of treatment through incorporating individual's strengths, setting personalized goals, and creating individualized treatment plans. However, this study's results indicated that only group sessions are provided in some facilities which can make it difficult to implement interventions that are directed to each individual's needs. Second, minimal training for individuals by therapists for how to apply skills learned in treatment to the community setting (Scott & Dixon, 1995). The PORT recommendation, community reintegration, demonstrated that RTs were facilitating groups to teach skills necessary to be successful in a community setting, and provided opportunities, such as outings, for individuals to practice their skills in the community. On the other hand, some facilities were acute care settings or lockdown facilities where there was not enough time to focus on community integration or individuals could not leave the facility. The last limitation identified in the literature was the lack of attendance of people diagnosed in treatment interventions (Scott & Dixon, 1995). Token economy, one of the PORT recommendations, is implemented to

reward and encourage specific behaviors, including group attendance. This study shows that some RTs are implementing some type of token economy intervention to work specifically on maintaining or increasing attendance in groups.

The use of these recreational and leisure activities for individuals with mental illnesses have the potential to improve social and cognitive skills, and life satisfaction through skill development and increasing levels of functioning (American Therapeutic Recreation Association, 2017; Snethen, McCormick, & Van Puymbroeck, 2012). Through the analysis and discussion of this study, it has been indicated that through the use of various Recovery Model principles and PORT recommendations, that these outcomes can prevail in treatment for individuals with SSD. The following section will address possible future recommendations for RT practices for treatment for individuals with SSD based off the results of this study.

Implications for RT Practice

This study has some direct implications for RTs serving individuals with SSD in various mental health settings. Specifically, this includes implementation of the Mental Health Recovery Model and PORT recommendations, implications for inclusion of evidence-based practice in education, and resolving restrictions.

Implementation of the Recovery Model and PORT recommendations. A majority of participants in the study sample utilizes principles from the Recovery Model and recommendations from PORT in practice. However, there is still a percentage of participants who do not utilize these principles and recommendations in practice or were not sure if they were using them. This finding displays that treatment for Schizophrenia

varies from program to program, and based on literature, this model and recommendations have research support for the outcomes regarding individuals with SSD and successful treatments. Therefore, aspects of the model and recommendations, if not the entirety of both, should be included in treatment to best benefit individuals with SSD. Various types of models are used as a foundation to guide the dynamics of RT programs. Knowledge about these types of models can be obtained through coursework required in an undergraduate degree for RT, other RT programs, or education by organizations such as the American Therapeutic Recreation Association (ATRA). For a program to utilize a model, there must be prior knowledge of the model and an idea of how the model can benefit not only the program, but how it will provide the best opportunities for treatment for the specific population. In order to address if RT programs are utilizing the Mental Health Recovery Model and recommendations for treatment created by PORT, the RTs level of knowledge about both needed to be assessed and improved.

The results of this study indicate that the Mental Health Recovery Model is an integrative model in which the principles involved can overlap and complement one another. There is evidence from the responses that RTs are incorporating each principle individually, however, it cannot be determined if the model as a whole, is being implemented. For best treatment results, it would be encouraged that in the development of RT programs, the Recovery Model is utilized as a baseline for the program components. This concept can be applied to the PORT recommendations as well, since the recommendations combined teach all skill sets necessary for individuals with SSD to successfully live in the community with Schizophrenia.

Implication for education. The field of RT is encouraging the use of evidence-based practice in treatment services. This study attempts to identify if RTs are incorporating the Mental Health Recovery Model and PORT recommendations, which are evidence based, into services for individuals with SSD. Results from this study indicate that there is a need for more education and knowledge of evidence-based practices. Models, such as the Mental Health Recovery Model, are discussed in the curriculum for RT. However, research, such as the PORT recommendations, are not as discussed or well-known among the RT practitioners. Therefore, the inclusion of these evidence-based models and studies can assist in moving the field towards utilizing evidence-based practices. In addition, can provide a deeper support for the interventions used in RT not only with individuals with SSD, but also other disabilities and illnesses.

Resolving restrictions. There should be a focus on the restrictions that arose from this study to why some of the principles and recommendations could not be implemented into RT practice. The restrictions could be topics for future research to identify solutions for how they can be resolved in the RT field.

Facility restrictions. Many concerns were mentioned in responses regarding implementing the principles and recommendations applied to restrictions from the facility. For example, limited staffing and resources impacted the ability to implement vocational programs and community outings. In addition, depending on the type of facility, there is a limited amount of time to work with individuals before they are discharged. When this occurs the focus for treatment is on pharmaceutical remedies and

stability. Lastly, lockdown facilities do not allow individuals to leave buildings or the facility.

Community reintegration and vocational training can be beneficial in teaching skills for job employment and community integration after discharge, and if not included in treatment, individuals are not improving or learning these skills which can result in relapse or homelessness. The question is then brought up, how can RTs practicing in facilities with these limitations successfully adapt and incorporate these aspects into treatment for individuals with SSD? Further research needs to be conducted to identify solutions.

Family involvement. Family involvement in treatment for individuals with SSD cannot always be incorporated. Circumstances within families between the individual with SSD and other members, can inhibit family involvement from occurring. By providing opportunities to try and rebuild relationships with family members or solve any issues, such as monetary problems, for families can help recover and improve support. If family involvement is not an option for families due to the standing circumstances in which RT cannot intervene or impact, it is important for an RT to identify a caretaker or build peer support among individuals receiving treatment, so that the individual can have a person to support them and be involved in treatment. In addition, the RT themselves can provide professional support for the individual through treatment if limited personal support is available.

RT and other disciplines. Another restriction discovered throughout the results of the study was that other disciplines were responsible to implementing a principle or

recommendation, and it was out of the scope of the RT practice. It is important for RTs to understand the role and responsibilities of other therapeutic disciplines and understand how to complement other therapies in the interdisciplinary team. For RTs to incorporate these principles and recommendations that were noted to be the responsibility of another discipline, a couple solutions can be available. The opportunity to co-treat with other specialties allows both to work together to implement the principle or recommendation. Specialized training is another option. Facilities can offer trainings for RTs to learn the skills necessary to implement these principles or recommendations, such as CBT, and they will feel confident about teaching that specific skill and more likely include it into practice.

Future Research

In regard to future research, more research needs to be conducted to identify why RTs are not utilizing principles from the Recovery Model and/or PORT recommendations. However, a possible consideration includes the lack of awareness and education of the Mental Health Recovery Model and the Schizophrenia PORT recommendations. However, there is a push for RTs to incorporate evidence-based interventions into practice. With searching for evidence-based interventions, there is the possibility to come across the Mental Health Recovery Model and PORT recommendations. With more RTs implementing and searching for evidence-based interventions, hopefully more awareness of this model and recommendations will be a result within the RT field.

Study Limitations

Limitations that arose in this study included the following. Approximately 80 responses, or 38% of the total surveys, were not included in the study because participants opened the survey and did not answer any questions, did not consent to participate, or did not provide responses after the demographic questions. In addition, the majority of the sample of participants were RTs that worked in the inpatient setting. This can imply that the sample is not representative of RTs that work with this population, or that RTs work with this population mostly in an inpatient setting. This topic can influence further research. Also, the sample is generalized by RTs that are engaged or connected in the Recreational Therapy field. Since the main form of survey distribution was through RT Facebook pages and the organization, ATRA, participants include RTs that are actively affiliated on social media and in the organization. RTs that are not members of the organization or of the Facebook pages may not have access to the survey even if they qualify to participate in the study.

Conclusion

This study demonstrates if and how RTs are providing treatment for SSD and incorporating the Mental Health Recovery Model and recommendations from PORT into treatment services for individuals with SSD. Overall, a majority of participants include the principles and recommendations into practice, but it is unclear if programs are developed around the model or recommendations. The Recovery Model is more prominently used in RT practices than the PORT recommendations. Restrictions

developed from the responses which can influence further research for RT practices for treatment with SSD. As mentioned, there is no cure for SSD, however, by providing treatment that can assist individuals diagnosed with SSD to manage and reduce symptoms and live independently within the community, then their quality of life can improve. By incorporating the Mental Health Recovery Model and PORT recommendations in RT services for SSD treatment, RT has the possibility to improve the quality of life and promote mental health recovery for individuals diagnosed with SSD.

APPENDICES

Appendix A

Survey

Survey

SURVEY INSTRUCTION

The following survey is designed to identify if Recreational Therapists are incorporating evidence-based practice into their services for adults with Schizophrenia Spectrum Disorder. As a recreational therapist, you are in an ideal position to give valuable first-hand information from your services and experiences.

The purpose of the study is to identify if recreational therapy programs within inpatient facilities, outpatient programs, or community based settings utilize the Recovery Model and recommendations from the Schizophrenia Patient Outcomes Research Team (PORT) in treatment services for patients diagnosed with Schizophrenia Spectrum Disorder. This survey will assist in identifying if recreational therapists are using these practices with this population, and to what extent they are being used.

The survey will take around 10-15 minutes to complete. Your responses will be anonymous, and the information will be kept confidential and will only be used for the study.

If you are a recreational therapist that works with individuals with Schizophrenia Spectrum Disorder and would like to participate in this study, please complete the following survey.

Thank you in advance for your time and participation!

Informed Consent

Welcome to the research study!

Information about Being in a Research Study

Clemson University

Use of Evidence-Based Practice in Recreational Therapy Programs for Schizophrenia Spectrum Disorder (SSD) Recovery: A Descriptive Study.

Description of the Study and Your Part in It

Brent Hawkins and Natalie Montoya are inviting you to take part in a research study. Brent Hawkins is an Assistant Professor of Recreational Therapy at Clemson University. Natalie Montoya is a student at Clemson University, running this study with the help of Brent Hawkins. The purpose of this research is to identify if recreational therapy programs within inpatient facilities, outpatient programs, or community based settings utilize evidence-based practices for patients diagnosed with Schizophrenia Spectrum Disorder. Specifically, this study will explore if the principles of the recovery model and recommendations provided by the Schizophrenia Patient Outcomes Research Team are incorporated into treatment services for adults with Schizophrenia Spectrum Disorder. The objective is to determine if recreational therapists are using these practices with adults with Schizophrenia Spectrum Disorder, and to what extent they are being used. Your part in the study will be to complete this survey regarding the use of evidence-based practice in Recreational Therapy services for individuals with Schizophrenia Spectrum Disorder. It will take you about 10-15 minutes to be in this study.

Risks and Discomforts

We do not know of any risks or discomforts to you in this research study.

Possible Benefits

You will receive no direct benefits from participating in this research study. However, possible benefits from this study may include awareness or education for Recreational Therapists in the following areas: what treatment for Schizophrenia Spectrum Disorder is recommended to entail; awareness of the Recovery Model and the principles involved; awareness of the recommendations for Schizophrenia treatment by the Schizophrenia

Patient Outcomes Research Team for treatment. In addition, this study can address if recreational therapists are utilizing these practices into their services.

Protection of Privacy and Confidentiality

All surveys will be anonymous, and information gathered is saved in Qualtrics. The researchers are the only personnel who will have access to the information saved in Qualtrics. The results of this study may be published in scientific journals, professional publications, or educational presentations; however, no individual participant will be identified. We might be required to share the information we collect from you with the Clemson University Office of Research Compliance and the federal Office for Human Research Protections. If this happens, the information would only be used to find out if we ran this study properly and protected your rights in the study.

Choosing to Be in the Study

You may choose not to take part and you may choose to stop taking part at any time. You will not be punished in any way if you decide not to be in the study or to stop taking part in the study. If you choose to stop taking part in this study, the information you have already provided will be used in a confidential manner.

Contact Information

If you have any questions or concerns about your rights in this research study, please contact the Clemson University Office of Research Compliance (ORC) at 864-656-0636 or irb@clemson.edu. If you are outside of the Upstate South Carolina area, please use the ORC's toll-free number, 866-297-3071. The Clemson IRB is a group of people who independently review research. The Clemson IRB will not be able to answer some study-specific questions. However, you may contact the Clemson IRB if the research staff cannot be reached or if you wish to speak with someone other than the research staff. If you have any study related questions or if any problems arise, please contact Natalie Montoya at Clemson University at nmontoy@g.clemson.edu

Consent

By participating in the study, you indicate that you have read the information written above, are at least 18 years of age, been allowed to ask any questions, and are voluntarily choosing to take part in this research. You do not give up any legal

rights by taking part in this research study.

Please note that this survey will be best displayed on a laptop or desktop computer. Some features may be less compatible for use on a mobile device.

- I consent, begin the study
- I do not consent, I do not wish to participate

Skip To: End of Survey If Q1 = I do not consent, I do not wish to participate

Do you currently provide recreational therapy services to individuals with Schizophrenia Spectrum Disorder (SSD)?

- Yes
- No

If you do not currently provide RT services to individuals with Schizophrenia Spectrum Disorder (SSD), have you ever provided RT services to this population in the past?

- Yes
 - No
-

How many years of experience do you have working with individuals with Schizophrenia Spectrum Disorder?

- Less than 1 year
 - 1 to 3 years
 - 3 to 5 years
 - 5 to 10 years
 - 10 or more years
-

Do you have a certification (CTRS) to practice recreational therapy?

- Yes
 - No
-

Do you have a license (LRT) to practice recreational therapy?

- Yes
 - No
-

What is the highest level of education you have completed?

- Bachelor's Degree
- Master's Degree
- Doctoral Degree
- Other: _____

What degree did you obtain in Recreational Therapy/Therapeutic Recreation? Please select all that apply.

- Bachelor's Degree
- Master's Degree
- Doctoral Degree
- None of the above.

Which describes the setting you work in? Please select all that apply.

- Inpatient facility (examples: long-term hospitalization, state hospital, forensic facilities, etc.)
 - Outpatient facility (examples: day treatments, day hospitalization, partial hospitalization, etc.)
 - Community-based (examples: crisis residential programs, group homes, therapeutic communities, supported independent living, etc.)
-

How familiar are you with the mental health recovery model?

- I am very familiar.
- I am somewhat familiar.
- Not familiar at all.

How familiar are you with the Schizophrenia Patient Outcomes Research Team (PORT) recommendations for treatment?

- I am very familiar.
 - I am somewhat familiar.
 - Not familiar at all.
-

Recovery Model Principles:

The following items are principles of the Recovery Model used in behavioral health care. Which of these principles do you use in RT/TR practice and to what extent?

Is this principle used in your practice?	<u>If Yes</u> , to what extent do you use it?	Please describe how this principle is used in your practice.
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Yes	No	I don't know	A lot	Sometimes	Rarely	Not at all	Open Ended Question _____
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<p>Self- Direction (the patient assists in deciding the recovery process) (Self-Direction)</p>	○	○	○	○	○	○	○	○
<p>Individualized and person-centered (treatment is shaped by the individual's strengths, needs, and experiences) (Individualized and person-centered)</p>	○	○	○	○	○	○	○	○
<p>Empowerment (individual has a say in all treatment options) (Empowerment)</p>	○	○	○	○	○	○	○	○

<p>Holistic (recovery is designed to encompass all aspects of the individual) (Holistic)</p>	○	○	○	○	○	○	○	
<p>Nonlinear (recovery process is gradual with ups and downs, not step-by-step) (Nonlinear)</p>	○	○	○	○	○	○	○	
<p>Strengths-based (treatment is centered on working on the strengths of the individual) (Strengths-based)</p>	○	○	○	○	○	○	○	
<p>Peer support (family/ friends/ caretakers are involved in the recovery process) (Peer support)</p>	○	○	○	○	○	○	○	

<p>Respect (the community/ caretakers accept and appreciate the individual) (Respect)</p>	○	○	○	○	○	○	○	○
<p>Responsibility (the individual has responsibility of their recovery process) (Responsibility)</p>	○	○	○	○	○	○	○	○
<p>Hope (individual has optimism that their quality of life will improve) (Hope)</p>	○	○	○	○	○	○	○	○

Schizophrenia Patient Outcomes Research Team (PORT) Recommendations:

The following items are treatment recommendations from PORT to use with individuals

with SSD. Which of these recommendations do you use in RT/TR practice and to what extent?

Is this recommendation used in your practice?			<u>If Yes</u> , to what extent do you use it?				Please describe how this recommendation is used in your practice.
Yes	No	I don't know	A lot	Sometimes	Rarely	Not at all	
							Open Ended Question _____

<p>Community Reintegration Training (focus on community reintegration for individuals) (Community Reintegration Training)</p>	○	○	○	○	○	○	○	○	
<p>Vocational Training (support for individuals obtaining and upholding employment) (Vocational Training)</p>	○	○	○	○	○	○	○	○	
<p>Skills Training (individuals learn/improve skills for daily activities and independent living) (Skills Training)</p>	○	○	○	○	○	○	○	○	

<p>Cognitive Behavioral Therapy (individuals learn skills/techniques to manage and reduce symptoms) (Cognitive Behavioral Therapy)</p>	○	○	○	○	○	○	○	○		
<p>Token Economy Intervention (opportunity for individuals to receive non-monetary rewards for acceptable behavior) (Token Economy Intervention)</p>	○	○	○	○	○	○	○	○	○	
<p>Family Based Services (family/caretakers are involved in treatment to improve social support) (Family Based Services)</p>	○	○	○	○	○	○	○	○	○	

Appendix B
Categorization Matrix

Self-Direction

- Assessments: choosing leisure activities/interests (20)
 - Recreational therapy assessment
 - Have choices
 - Axs, check in and processing
 - Assessments- identify problem areas
 - Support individual to be self-directed with their leisure interests
 - Autonomy to choose
 - Providing leisure activities based on interests
 - Give input on group/outing ideas
 - Choose what groups they feel will benefit them
 - Choose what classes to take
 - Can give input in what they want to do for that session
 - Chooses interventions based on goals
 - Programming based off patient choice
 - Selecting therapeutic interventions to meet goals and interests
 - Freedom to pick categories
 - Part of assessment process
 - Assessments
 - Encouraged to choose which groups with suit them best
 - Choosing leisure activities
 - Have a say in some of the groups they would like to attend
- Input on planning: tx/discharge/safety; say in tx team (20)
 - Decide how to follow up with tx
 - Input on tx
 - Creating tx plan
 - In tx/discharge planning
 - Part of tx meetings
 - Say in length of stay in the program (x2)
 - Choose their therapists
 - Engage in every aspect of tx
 - Ask clients input regarding tx plan every 30 days; can inform wishes through their stay at the program
 - Choices about tx
 - Tx team meetings with pts. And their case workers- pt. decides on plan of action following their stay
 - Active part of tx team
 - Pt. guides aspects of tx through face to face meetings
 - Tx and safety plans
 - Take part in developing tx plan

- Tells tx team their preferences
- Part of tx planning process
- Input on discharge plans, work daily with tx team
- Work alongside tx team to come up with a plan that will work best for them
- Goal setting (10)
 - Set goals and how they plan to achieve them
 - RT assists in developing tx goals
 - Makes own goals
 - Self-directed goals
 - Identify tx personal goals with tx team
 - Determine short and long term goals
 - Choose their goals
 - Ask patient goals every 30 days
 - Chooses own goals for hospitalization
 - Identify needs and specific TR goal
- Utilizing skills at facility (4)
 - Use skills at the recovery mall
 - Use what they learn
 - Teaching independent leisure skills
 - Let them work on decision making, problem solving, then provide feedback and allow them to reevaluate
- Participation in tx groups (7)
 - Take leadership in groups
 - Allowed to opt in or out of tx
 - Group participation
 - Right to attend tx or not
 - Treatment is optional
 - Choice to come to groups
 - May refuse groups
- Motivational interviewing (1)
 - Use when interacting
- Say in medications (3)
 - Medication options- oral vs. long acting shot
 - Medication selections
 - Say in medications
- Advocate (1)
 - Encourage them to advocate for themselves to move through the program

Individualized/person-centered

- Group activities planned based off needs/interests (8)
 - Group activities are individual based on dx
 - Groups provided with broad topics to benefit all pts. And cover most goals
 - Client's needs dictate the group topic of the day
 - Group discussion and processing tailored as individually as we can
 - Interventions are based on results of assessment
 - Activities are formulated based off interest of individual
 - Used in day to day activities according to interest
 - Provided a schedule formulated to help address their needs
- 1:1 sessions (3)
 - 1:1 sessions if requested or recommended by tx team leader
 - 1:1 leisure counseling
 - 1:1 interventions
- Personalized tx plans based on assessments (18)
 - Personalized tx plans created for each pt
 - Interviewed upon admission to determine demographic info, reason for admission, interests, leisure barriers, special precautions
 - During initial assessment
 - Individual assessments focusing on pt. strengths and needs
 - Using an Initial RT Screening to place pt in appropriate group programs
 - Care plan based off strengths and weaknesses
 - Plan is tailored to pt needs
 - Individual Recovery Plan (IRP) used as a road map for guiding individuals towards their goals
 - Focus is around strengths, weaknesses, and goals
 - Individualized recovery plans
 - Assessments pinpoint strengths, needs, and experiences to match with appropriate interventions
 - Individualized tx plan created by tx team based off assessments
 - Through assessments, chart review, and face to face discussion with pt. they identify direction they would like to pursue
 - Tx based off needs pulled from assessment
 - Assessments completed to determine strengths, needs, and experiences- tx goals created by these experiences.
 - Assessments
 - Assessments completed to see what leisure works for them
 - Suggested tx based on assessments
- Strength-based tx groups (5)
 - Groups are strength-based
 - Groups are split by pts. Cognitive level and strengths

- Activities formulated to enhance strengths
- Incorporate strengths and experiences
- Plan groups based off dynamics and abilities
- Say in developing tx plan (5)
 - Choose their tx based on needs and what they would like to do
 - Input in tx
 - Involved in developing tx plan
 - Tx is individualized based on a collaborative effort
 - Involved in individualized plan of care
- Goal setting (5)
 - Goal setting
 - Decide on their own goals
 - Identifies tx goals
 - Personalized goals
 - Makes own goals
- Choice of groups (3)
 - Encouraged to attend all groups
 - Pts. Chose what groups to attend based on interests and needs
 - Group selection
- Progress evaluations (3)
 - Receive prompts and encouragement when needed
 - Every 30 days ask strengths, goals, and areas they want to work on and incorporate it in tx
 - Follow up throughout tx on progress towards TR goals

Empowerment

- pts. Give feedback on groups (1)
 - give feedback on programs
- participate in tx team meetings (5)
 - express what they would like with tx team
 - participate in weekly tx team meeting with family
 - tx team shares what they discussed with pt.
 - tx team meetings
 - part of tx team
- tx plans/discharge planning/goal setting (12)
 - tx and program planning
 - assessments help determine what individual needs to work on
 - have input on tx options
 - has a say in all tx options
 - choose their goals

- tx with pt. input determine safety plans
- recovery plan is discussed with pt to make sure they agree
- incorporate their input into goals
- care plan
- choose tx options
- work with therapist to come up with a discharge plan
- decide course of tx
- right to choose, refuse, voice opinions (20)
 - opportunity to choose which tx modality is best for them
 - opportunity to deny tx options
 - try to provide choices for pts.
 - Right to choose their level of participation and can refuse tx
 - Pts. Can make a decision to participate or not
 - provide rec and leisure opportunities and is encouraged to participate but can decline at any time
 - options are presented
 - options are available to what they may participate in
 - clients decide which sessions benefit them the best
 - group votes between 2 therapeutic group options
 - can request to adjust scheduled groups
 - participation in tx is optional
 - pt decides tx groups to attend
 - choose length of stay, therapists
 - they can refuse groups
 - has ability to choose groups they attend
 - can select the group they want to do that day
 - group selection
 - can voice their opinion
 - chooses to be a part of group therapy session
- decide medications (2)
 - opportunity to deny any medicine
 - 3 days to decide oral or long acting shot

Holistic

- groups designed to improve social, mental, physical well being of person (whole person, mind, body, spirit); self-care focus (11)
 - group activities based on the well-being of the individual
 - RT groups allow to dig into each of the 6 domains
 - Attempt to treat the whole person, mind, body, and spirit
 - Focus on social, physical, mental well-being

- Need to treat the whole person- offer programs based on social, emotional, physical, creative, intellectual, and spiritual needs
- Interventions provided to aid with mind, body, spirit
- Self-care focused
- Programming schedule: offers aspects of wellness and health
- Work on all aspects of mental, emotional, and physical health
- Groups address all aspects of the individual
- Making sure you see the person for who they are and enhance strengths and identify barriers
- teach healthy lifestyles, leisure activities, and coping skills (focus not only on symptoms) (8)
 - focus on healthy lifestyle, healthy leisure activities, healthy coping skills, relaxation
 - includes coping skills for mental health and symptom management, health self-care
 - group sessions: dx education, coping skills, leisure education, social skills
 - interventions focus on leisure skills, emotion regulation, cognitive recovery, social skill building, overall engagement
 - work on life skills, finances, leisure, ECT
 - provide sessions to assist in all areas of functioning
 - relaxation skills, yoga, yaog nigra, mindfulness
 - variety of groups to touch on all levels of holistic theory
- tx/discharge plans (3)
 - tx plan process
 - discharge planning: least restrictive living arrangements with med supervision
 - all pts. Provided with group therapy, individual therapy, RT, nursing care, and psych care
- models (1)
 - PERMA, bio-psycho-social-spiritual
- various integrative therapies; interdisciplinary approach (5)
 - different areas
 - IDT treatment sessions
 - Interdisciplinary approach
 - Various integrative therapies
 - Groups, therapist, and daily routine have to do with several adjustive therapies
- family group events/outings (2)
 - community outings designed to benefit the whole person
 - can attend family group events within the hospital and outings

- education about holistic approach to pt; further education (3)
 - explain medication is one aspect of tx and other is participation in groups/individual sessions
 - options for further education and/or experience
 - education on holistic approach and how all aspects of individuality influence progress and tx
- LIMITATIONS (4)
 - Too heavy focus on pharmacological interventions
 - Lack of staffing and resources at times
 - Forensic psych- had little rights and time was structured, holistic practices not implemented well
 - Only used if client indicates an interest

Nonlinear

- RESTRICTIONS: (4)
 - RT program is a step-by-step process following the RT model for addicted persons
 - Company model stuck in old ways of steps
 - This is often skipped
 - Individual based- cannot be answered broadly
- Meet pts. Where they are at/level of functioning (8)
 - How the pt is doing on a day to day basis- can decline meds before they get better
 - Work where the client is at, at that time
 - Meet each pt. where they are in the process
 - Modification to group sessions or leisure opportunities to meet the client where they are at
 - Tx based on where a pt. is at in their process today
 - There will be setbacks or bumps in the road- meet the pt. where they are at
 - Pt driven with meeting them where they are in their process
 - Privileges depend on their current level of functioning
- Pt. Cycles (4)
 - Identifying needs and learn to communicate needs during cycles
 - Working through cycles- both tx and pt. cycles
 - Some participants relapsed
 - Some days are better than others
- Addressing pt. progress and areas for improvement (6)
 - Discharge is dependent on progress/lack of progress toward discharge criteria
 - RT interventions addressing progress and areas of improvement

- Monitor for changes in behavior → discuss with pt.
- Care plan updates
- Discussed realistic goal setting for recovery/healing at least 2x weekly
- Discuss baby steps and how to work on problems
- Educate pts. On nonlinear (2)
 - Pt needs to understand life is based on successes and challenges on a daily basis- encouraged to take risks based on what is best for them knowing that some choices will be successful, and some may not.
 - Education that living with a mental illness will have its ups and downs

Strengths based

- Goals created based on what needs improvement; work on weaknesses (2)
 - Problem sheet and goals are set by working to improve a pt. problem
 - Use strengths and abilities to make goals and objectives
- Groups/interventions designed around strengths (8)
 - Focus of my groups
 - Provide groups that focus on pts. Strengths to provide encouragement and opportunities for success
 - Interventions based on strengths identified in assessments
 - Tailoring group therapy topics and intervention selections to build off pt strengths
 - Group sessions/ 1:1 with pts.
 - Activities modified to the strengths of the pt
 - Groups focus on strengths of individual
 - Activities offered that the pt. can do
- Encourage pts. To use coping skills/talents (3)
 - Pts. Encouraged to use their coping skills and talents when able
 - One of the goals of the RT department is to offer pts. Opportunities to showcase their talents and strengths
 - Encourage to use skills/strengths to relate to others and reach goals
- Building on positives, increasing self-esteem, confidence, and skills(9)
 - Building confidence and esteem, pt. more able to then dealing with areas in which they need to work toward
 - Tx is to build on the positives in a client
 - Focus on what the pt. can do well and use that as a bridge to make connections for improvements
 - Tx curriculum is very skill development per dx based
 - Use previous interests/participation patterns
 - Tx based on stabilizing and getting back in community
 - Identify how strengths can balance out liabilities

- Incorporate internal strengths for clients who experience a lack of control in their lives
- Building on strengths and improving weaknesses
- Discuss strengths with pt./address in assessment → create plan (5)
 - strengths charted, updated, and played a central role in programming
 - strengths and virtues a major component of assessments with descriptions on examples and plans to build on those strengths
 - RT designated to discuss strengths with pts.
 - Recovery tx plan
 - assessments
- Programming (2)
 - Tailor programming based on strengths or needs
 - Adapt programming to embrace each pts. strengths

Peer support

- RESTRICTIONS: (13)
 - Family rarely involved because they do not want to be, but caretakers are
 - Rarely interacted with family members or visitors
 - family often enablers for pts.
 - Weak, could be better
 - Pt. may or may not have support
 - Families rarely engaged
 - Really bad in prison
 - Not all family wants to be involved. Have to be aware of enablers.
 - Often families are not involved in pt. life
 - Due to forensic nature, sometimes family/friends are not/cannot be involved
 - In most cases, family is not involved in pt. life
 - Takes cues from clients about family/friend involvement- can contribute to enabling behaviors which is counterproductive
 - Many have state guardians which are overworked and provide little involvement; many families don't have anything to do with the pt.
- Family attends tx team meetings, family therapy, setting goals, family consultations, family education group (16)
 - Family kept in loop with tx and participate in family therapy and tx teams
 - Family/friends involved in aspects outside of RT
 - Team approach- include as many people as they want in the tx process; teaches loved ones to understand how to help, not enable, the client
 - Family meetings
 - Involved in tx team meetings, goal setting (with permission from pt.)

- Family consultations
- Work with families to assess the safety of pts. And inform them of their tx plan
- Provide family sessions
- Family education group offered once per week
- Parents extremely involved
- Family invited to tx plan meetings
- Involved in family therapy and safe discharge planning
- Family meetings
- Family meetings
- ROI for family members
- Family encouraged to participate in tx
- Other disciplines address peer support (6)
 - Social workers and doctors reach out to family/friends
 - Under supervision of nursing staff or counselors
 - Provided by social workers
 - Social worker or physician may contact the family
 - Social workers set this up
 - Family sessions with their primary staff psychotherapist
- Promote/encourage this daily for pts. (4)
 - RT department promotes peer support and encouragement daily
 - Groups designed to be peer support
 - Family/friend involvement is encouraged- more support, the smoother the process
 - Group therapies
- Peer support specialists/support groups (3)
 - Work with peer support specialist (individuals who have been hospitalized and offer unique support to those pts.)
 - Staff who are peer support specialists; I am a certified WRAP instructor
 - Circle of Support Gatherings- provide information, education and support to families
- Pt. community passes, family calls, family luncheons, visitations (6)
 - Have opportunities to meet with family/friends/caretakers as desired to discuss tx
 - Allowed for visits, but only involved in tx if care provider
 - Visitations
 - Allow pt. community passes with family, call family with status changes and updates, have a family luncheons in the summer and for Christmas
 - Visitation every day
 - visitations

Respect

- Recommendations/providing choices; requests are honored (4)
 - Requests are honored provided they do not violate policy or safety protocols
 - Recommendations provided to each individual based on their needs
 - Respecting the pt. and their choices
 - Give choices
- Patient council, community meetings, suggestion boxes (2)
 - Pt council assists with decisions made throughout the hospital
 - Community meetings, suggestion boxes
- RTs are advocates for pts. (2)
 - RT advocates for each and every pt regardless of their circumstance
 - Advocate for safe discharge into a supportive environment
- Interactions; person 1st language; (3)
 - Interactions use an appreciative framework with person-first language
 - Open communication between therapist and pt
 - Talk to them, not at them
- Supportive atmosphere (4)
 - Supportive, family atmosphere promoted- social activities and fostering an atmosphere of taking healthy risks and not being afraid to make mistakes
 - Hospital staff encouraging
 - we go on community group outings we call ourselves "Outdoor Recreation Club" an adult special needs group to protect patient privacy.
 - Employees required to remove badges when out in the community to respect the privacy of the individuals
- Facility actions toward pts. (&)
 - Pt treated with respect
 - Mission stresses respect
 - All pts. Treated with dignity and respect
 - Treatment providers respect the pts.
 - Discuss respect regularly
 - Respect is in my everyday rapport building with my pts.
 - Staff treat with dignity and respect

Responsibility

- Choose to go to group/level of participation (8)
 - Choose if they want to come to group
 - Pt decides to what level they want to participate
 - Given responsibility for the way they engage in groups and apply coping mechanisms during groups

- The amount they participate is up to the client
- Has option to go to all groups
- May refuse groups
- Responsibility to engage in therapy on unit and post discharge
- Participation in groups allows pt to earn spending tokens and privileges
- Autonomy in tx process (6)
 - Pt has full responsibility over their recovery process
 - RT department is a nurturing department with intentions of assisting pts. To be the best they can be, but also openly discusses with pts. How they can help themselves move forward
 - Have recovery journals to keep track of their own progress and efforts made towards reaching their goals
 - Option to have responsibility in tx
 - Responsibility in therapy process
 - Decisions and actions of the individuals determine their progress
- Take pts. On outings to teach responsibility and life skills (2)
 - Take pt. out in the community and focus on teaching responsibility and life skills to return to the community
 - Med management classes, stress management, coping skills, life skills
- Pt. sets and designs goals (3)
 - Encouraging pts. To set goals that they have control over
 - Design their goals
 - Progress towards goals is pt driven
- Models (1)
 - Recovery and WRAP model
- Group discussions/therapy sessions (2)
 - Group discussion often focus on accepting responsibility, instead of blaming
 - Sessions focus on aspects of recovery that are within the persons control
- Planning/ Review progress at tx team (3)
 - Weekly tx plan review with the multi-disciplinary team to assess and evaluate each pt. progress- then meet with each pt. to review progress.
 - Care plan
 - Takes part in tx planning
- Taking medications (1)
 - Responsibility to take their meds
- Education/encouragement (4)
 - Encourage them to make good choices

- Explain that therapists provide tools, but they ultimately make a commitment to their tx by accepting them; provide community resources for them to utilize upon discharge
- Always encouraging personal responsibility
- education
- Pt. rights (1)
 - Have to be mindful of pt. rights

Hope

- Provided rewards for progress/stabilization (2)
 - When stabilized they are reminded that they will go to a lower level of care that does not have as strict rules, they will have more outings, more freedom such as having shoe strings, belts, even though it is not healthy they can use tobacco products which is important to many of the patients. We still teach they will have other benefits such as better health and having more money.
 - Individuals create or diminish hope based on their actions/decisions
- Philosophy of hope in RT department (1)
 - The Rec Therapy Department instills a philosophy of hope. All people, no matter what the circumstances must look optimistically to their future, identifying goals and plans for way to achieve their goals. As a Rec Therapy Department, we support patients by planting seeds and nurturing growth.
- Support pts. By nurturing growth (5)
 - The staff often has to hold a pts. Hope until the pt is ready to take it back
 - Examples given of ways QOL has improved with past pts.
 - Provide examples of successful recovery
 - Message of hope help create a vision of full rehab and recovery
 - Encourage pts. To find something that gives them hope
- Positive attitudes (5)
 - Hope to continue with tx to help life get better
 - 90% of groups are focused on positivity
 - Provide programming on positive attitudes
 - Positivity in all aspects
 - Programming is optimistic
- Interventions focused on hope/positive emotions (4)
 - RT interventions focus on experiencing hope and other positive emotions and processed that this is possible after discharge
 - RT provides positive activities and process how they can help pts. Cope past discharge

- Group therapy
- Group therapy
- Peer support (4)
 - Family and children make pt. optimistic
 - Therapist stress hope everyday
 - Plentiful peer support
 - Encourage pts to find someone that gives them hope
- Goals and successes (4)
 - Focus is put on defining and meeting the steps needed to help pts. Be their version of successful
 - Pts. Reminded daily of their goals and review daily goals per tx plan
 - Making long term goals and breaking down how to accomplish them
 - Discharge planning
- Identifying skills/techniques to adapt to living with MI (3)
 - Group coping skills provided include self-compassion, including self-forgiveness, letting go and moving on, small steps are celebrated and expectation of relapse, but getting back on the program.
 - Identifying skills/techniques to adapt to living with a mental illness, instead of allowing the mental illness to dictate their life.
 - Leisure interests
- RESTRICTIONS: (10)
 - Depending on where an individual is stationed and what other dx are involved can be the deciding factor
 - Short hospitalizations and interacting with pt fresh out of a crisis made this difficult to measure
 - Depends on the person
 - Hard to find and support in prison
 - When pt stabilizes, they get depressed over crime
 - Unclear at times how effective it is
 - This message is always instilled and pts voice this preference but as time and tx options fail, they do get discouraged because that community component for constructive coping/leisure offerings is usually missing due to funds, transportation and no one/rec therapist to carry out
 - Often unrealistic goals with no specific plans
 - Subjective
 - Going through court sentences hinders spirits

Community reintegration training

- RESTRICTIONS: (9)
 - Not enough time to focus on individualized community reintegration plans
 - Stay at hospital is too short
 - Acute setting that is locked and no pts. Are allowed off the unit
 - Prison so they cannot leave
 - Most pts. Are incarcerated with no upcoming out date
 - A gap in our services due to limited staffing
 - Difficult to implement the way current mental health facilities are run- do not allow community outings
 - Nature of client's mental state when we receive them requires extensive time and tx
 - Lockdown facility- do not go in the community before discharge
- Community re-entry/leisure education groups (7)
 - Community re-entry groups
 - Leisure education groups
 - Groups in budgeting, social interaction, etc transitioning into off-campus groups practicing navigating social situations, basics of transactions (i.e. payment, tipping, shopping)
 - Leisure planning program when pts. Are close to discharge during leisure education group or 1:1 leisure counseling
 - Leisure counseling
 - RT groups focus on QOL
 - CR groups to assist in smooth transition post discharge
- Community outings, passes, therapeutic home visits with family; facility tours (8)
 - Community outings, passes and therapeutic home visits with family outside the facility
 - Community outings once a month
 - At least once a week pts. Engage in outings into the community
 - Plan leisure trips into community
 - Community outings/facility tours
 - Group outing once a month
 - Provide outings to give pts. Chance to identify resources in the community
 - Multiple outings led every month
- Off-grounds privilege (1)
 - Pt. can earn off-grounds privilege
- Volunteers come in from the community (1)

- At least once a week volunteers from the community come in and provided an activity
- Education and guidance for community resources; community supports (8)
 - Resource Research project is a group activity completed in each treatment cycle. Provides individuals the opportunity to identify resources in community of command station or next duty station.
 - Discuss community resources
 - Offer pts. Info of community resources that may be accessed upon discharge
 - Discuss community supports in group programs
 - Ride boards: participants can meet up to ride with other participates to engage in various community outings
 - Work with pts. Daily to help them get acclimated into society
 - Community leisure resources group
 - Offer PHP and IOP program after discharge
- Other disciplines (1)
 - Social workers

Vocational Training

- Vocational training program (10)
 - Vocational program
 - Have a job at the site
 - Vocational training program
 - On site work program
 - Work therapy at the tx mall
 - 3 work programs
 - Vocational training
 - Work training program on campus
 - Work opportunities
 - Employment provided based on assessments and qualifications
- Exploration of values, beliefs, ideals to find employment (1)
 - Exploration of people's values, beliefs, ideals, and ideas offered participants with finding meaningful employment
- Resources (3)
 - Ongoing ORS provided to counsel people to build upon their strengths, interests, and resources to meet their employment goals
 - Referral to vocational rehabilitation and provide info on programs that work with people with MI
 - Info and/or resources provided
- Life skills/leisure groups; 1:1 sessions (3)

- Leisure education session: how to apply and create a resume
- Groups encompass life skill components
- 1:1 therapy
- RESTRICTIONS: (2)
 - Acute care- little time available
 - Acute setting that is locked

Skills Training

- Groups designed to various skills: (18)
 - Life skills training
 - Teach skills in all RT groups
 - Cooking, communication, money management
 - Focus on teaching life skills
 - Skills training during some groups
 - Coping skill strategies
 - Groups on communication, stress/symptoms management, self-care
 - Leisure education group: leisure skills and ADL skills
 - Social skills
 - Skill building workshops
 - In RT groups
 - Maintaining a schedule, organization, work/life balance
 - Help pts learn and improve life skills
 - Group activities
 - Teach coping skills, stress management
 - Groups
 - Groups
 - Basic life skills
- Community outings (1)
 - Community outings
- Education and resources (3)
 - Healthy leisure participation, leisure education
 - Go over hygiene importance in jobs and relationships
 - Through education, time management resources
- Co-treatment (2)
 - Occupational therapists provided training for personal hygiene while RT provided social skills training, stress reduction techniques, and leisure skills training, and physical fitness
 - Co treat with OT and work on ADL skills

CBT

- Groups focus on CBT (22)
 - Communication, anger management, coping and various other skills are introduced and worked on in order to manage and reduce symptoms.
 - Part of groups
 - Groups that offer CBT
 - Engaged in and/or reminded of techniques that can assist them in managing their challenges
 - Coping skills
 - Self-awareness and trigger identification
 - Coping skills strategies
 - Coping skills and CBT
 - Relaxation and coping skills group program
 - CBT and DBT
 - Coping and social skills
 - CBT applications available in groups and individual therapies
 - Learn to manage emotions and behaviors
 - Daily CBT and CBT for psychosis groups
 - CBT based interventions
 - Used in all group sessions
 - Session that teach positive and healthy coping outlets
 - Gear activities around ways to implement skills identified
 - Teach coping skills
 - Managing and reducing symptoms groups
 - CBT groups
 - Medication management, anger management
- 1:1 sessions (1)
 - 1:1 therapy
- Co-treat with other disciplines to teach (4)
 - RT, nursing, doctors and social work all focus on these through relaxation/coping skills groups
 - Team approach
 - RT worked in conjunction with the psychology department and individual therapist to teach and reinforce CBT principles, and practice using principles in social situations, or situation with higher amount of stimuli
 - Offered by all therapists/RTs and social workers
- Education (5)
 - Taught how they can improve/reduce disease by having recreation in life
 - Medication education and outpatient set up
 - Reminding pts of the skills they have learned that are available to them
 - Gear education around ways to implement skills identified

- Coping skills education
- RESTRICTIONS: (6)
 - Psychologist or other departments taught this
 - Psychology department
 - Individual therapists use this
 - Not trained in CBT
 - Team of clinicians (not RT) providing CBT
 - Led by a counselor every quarter

Token Economy

- Reinforcements (15)
 - Attendance parties
 - Points earned on a daily basis with opportunities to redeem earned points in a points store
 - Points earned for attending groups
 - Monthly activities
 - Snacks, positive notes, outside time, early release
 - Coupon system- coupons for attending groups that they can turn in for items (hygiene supplies, candy, puzzle books, stuffed animals)
 - Coupon system
 - Candy and verbal praise
 - Leisure group, free art
 - Continued sessions
 - Weekly participation card signed for attending groups, participating in hygiene, and earn \$1 in tokens for each signature
 - Special snacks
 - Token system to encourage group participation, ADLs and meetings
 - Earn points daily to purchase goods or tickets to special events through our therapeutic Incentive program (TIP)
 - Incentive program- can earn a radio and then a tv
- Prizes (2)
 - Prizes given out for coping bingo- questions must be answered first
 - Winning prizes during leisure education games
- privileges (2)
 - Privileges given if behavior is acceptable
 - Privileges- trips to vending machines/cafeteria, off campus visits with family
- Peer and professional support available for verbal rewards, feedback, and reassurance (1)

Family based services

- RESTRICTIONS: (13)
 - Family not involved that much
 - Not in the RT setting
 - Family members not always available
 - Other disciplines work with family, RT does not
 - Provided by social services
 - Facility/unit policy prevents me from interacting with family members
 - Not reasonable due to prison setting
 - Family therapy not available
 - Often not involved
 - Depends on client level of interest for family involvement
 - If they have a support system
 - Many have state guardians
 - Social workers
- Informed about tx/ treatment team meetings (6)
 - Through tx team meetings
 - Assist pts. In having a successful discharge
 - Family involved in tx
 - Involved in steps taken to care for individual
 - Pt. can sign a release of information and social worker will send families updates on progress
 - Offered by social worker/LCSW
- Visitations (2)
 - Family can visit
 - visitations
- Support gatherings (1)
 - Circle of Support gatherings and meetings became a critical aspect of recovery by providing information, education, and support to people who are important to the affected individual
- Family sessions/therapy; tx groups (7)
 - Invited to be involved in education programs and meetings
 - Complete family sessions with pts. families and loved ones
 - Family sessions and speak with families frequently
 - Family sessions offered
 - Family therapy
 - Family meetings
 - Encouraged to be an active participant in the recovery

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