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TR Service Delivery and TR Outcome Models

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Throughout the last several decades, practice models have been used to describe the scope and nature of therapeutic recreation services. Changes in health and human services require updating our models to accurately reflect current practice. The TR Service Delivery and Outcome Models provide a comprehensive overview of contemporary professional therapeutic recreation practice. The components of the models are described and explained together with their theoretical foundations. A case study is used to make application to the field.

KEY WORDS: *Service Components, Leisure Experience, Intervention, Outcomes, Quality of Life, Wellness/Health Status, Functional Capacity*

Practice models provide a framework for visualizing, describing, and examining the interrelationship of the key components of professional practice. Although all models have their limitations, each is organized around underlying philosophies and belief systems which help to define and explain the nature and scope of the service, the nature of the client: therapist interaction, and the potential service outcomes. Since it is difficult to accurately describe all aspects of therapeutic recreation service in one practice model, this paper will present a description and rationale for two interrelated therapeutic recreation (TR) models. The TR Service Delivery Model provides an overview of the nature of service delivery and the TR Outcome Model focuses more specifically on service outcomes. Although presented as separate models, the Outcome Model should be viewed as an extension to the Service Delivery Model since it simply clarifies the service outcomes and shows the relationships among them.

Description of the Model Components

Service Delivery Model

The Service Delivery Model (see Figure 1) describes the scope of therapeutic recreation services, the nature of therapeutic recreation services, and the relationship between the therapeutic recreation specialist and the client. The *scope of service* refers to the ingredients or components of a therapeutic recreation service. In this model the components are organized vertically and include diagnosis/needs assessment, treatment/rehabilitation, education, and prevention/health promotion. On the horizontal plane, the *nature of service* describes the specialist as one who assists the client in achieving his or her goals and is a facilitator of leisure experiences. Through the complex, dynamic process of participating in the intervention and/or the leisure experience (*nature of the relationship*), the client is empowered to achieve her or his desired goals and optimally experience a sense of fulfillment, satisfaction, mastery, and well-being, which are the general, overriding outcomes of the model system. Thus, the nature of service begins to describe the underlying assumptions and philosophy of therapeutic recreation and its intended outcomes.

Scope of Service. The essential components for the delivery of health and human services are activities and strategies that contribute to (a) diagnosis or assessment of client needs, (b) treatment or rehabilitation, (c) client education, and (d) health promotion/prevention activities. According to Seibert (1991), viable participation in health care or human services requires that therapeutic recreation programs contribute to one or more of these service areas. *Diagnosis/needs assessment* refers to the use of standardized tests, field observations, or other techniques to determine clients' strengths and abilities or their potential limitations in achieving habilitation or rehabilitation goals. *Treatment/rehabilitation* involves providing assistance in restoring or stabilizing the health or abilities of an individual who has experienced loss or limitations in those abilities. Here, aquatic therapy might be used to maintain

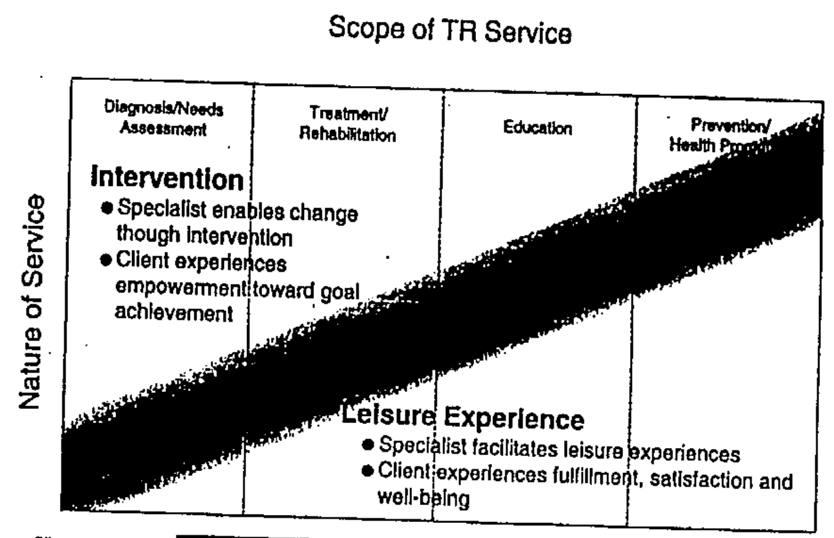

FIGURE 1. THERAPEUTIC RECREATION SERVICE MODEL

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has multiple sclerosis. *Educational* strategies develop the attitudes, values, and skills needed to function more effectively in society, to improve overall health, and/or to achieve a higher quality of life. Assertiveness training designed to develop the attitudes and skills needed to honestly communicate feelings and ideas is just one example of the many educational therapeutic recreation interventions. Others may include leisure education, cognitive retraining, reality orientation, and social skills training. *Prevention/health promotion* activities such as stress management and exercise programs develop attitudes and behaviors that protect or promote healthy lifestyles.

Although each of these components has been described as a separate construct, it is difficult to draw clear distinctions between them and several may function simultaneously. For example, swimming may be treatment/rehabilitation for a person recovering from the effects of a stroke but it could also serve as an opportunity to learn a new leisure skill (education) that may prevent further physical losses and promote a healthier lifestyle (prevention/health promotion). Therefore, the component is more descriptive of the specific short-term goals chosen for the activity. The vertical dashed lines separating the program components indicates the potential overlap between two or more in any given activity as described above.

A client may enter the service delivery system at any point on the continuum to receive the most appropriate mix of therapeutic services. Following the usual individualized assessment, a person might be included in a leisure education class as well as a community integration activity. Thus, the model is not intended to be a sequentially ordered continuum of service, but each individual uses the appropriate components as needed.

Although all therapeutic recreation programs include some form of initial and ongoing assessment, the use of other components may vary from setting to setting and agency and the goals of the program. In brief treatment settings, for example, the mission or purpose of the program may be to contribute to an accurate, comprehensive diagnostic work-up, while a community setting may emphasize educational and/or health promotion/prevention programs. Each is important for achieving the missions of the respective agencies and serving their respective constituencies.

Nature of Service. For most therapeutic recreation programs in community or clinical settings, the nature of the service involves an element of planned intervention, as well as a leisure experience dimension. However, some programs and/or settings may emphasize leisure experiences while others focus on intervention strategies to achieve client goals. Also, the nature of the experience may vary from individual to individual or even for the same individual over time. For example, for individuals who have not developed motor skills such as hand-eye coordination, playing basketball may be very frustrating, at least initially. On the other hand, it may help them achieve some personal therapeutic goals such as learning to play a game they could enjoy with their friends, increase their tolerance for frustration, improve coordination, or achieve a higher level of fitness. After several weeks of practice, however, the game may become easier and more enjoyable. Participation may facilitate a leisure experience while continuing to enhance the therapeutic goals. The key element in determining whether the activity is an intervention or a leisure experience is not the nature of the activity, rather the client's perception of the experience. Thus, interventions can be viewed as goal-oriented activities much like work which have the potential of becoming play depending on a variety of psychosocial factors, some of which are internal to the participant and some of which are part of the environment in which the activity takes place.

The heavy gray band that flows diago-

that area of interaction for the specialist and the client. Facilitation of a dynamic interrelationship between the goal-oriented intervention and the leisure experience contributes to restoring a sense of wholeness to the person and thus, enhances the potential outcome. A growing body of psychobehavioral research suggests that pleasurable leisure experiences that may stimulate laughter, for example, enhance the client's potential for achieving her or his desired therapeutic objectives by creating the internal environment that is conducive to the healing process (Cousins, 1989).

The diagonal dashed line reflects the differences among the service components. For example, diagnosis/needs assessment and treatment/rehabilitation, the first two categories in the scope of service, tend to be more structured, goal-directed activities which are less amenable to facilitating leisure experiences. Although some specialists may use play or leisure activities to assist in behavioral assessments, most rely on structured interviews, agency generated assessments, or standardized assessment tools such as the Leisure Diagnostic Battery (Witt & Ellis, 1985) to determine the individual's strengths and limitations. Similarly, activities and strategies used in treatment/rehabilitation are generally structured to achieve predetermined goals and as such, may limit or modify opportunities for facilitating a leisure experience. On the other hand, the latter two categories, education and prevention/health promotion, often lend themselves to greater personal freedom and thus greater opportunities for leisure experiences. For example, participation in a social dance may facilitate appropriate social or leisure skills, and after some initial anxiety the client may be able to enjoy a leisure experience.

The nature and philosophy of the agency and the TR specialist will also affect the relative emphasis on intervention or leisure experience. In some settings, such as long term care or community recreation programs for emphasize leisure experiences and structure activities which facilitate outcomes such as enjoyment, fulfillment, mastery, satisfaction, and a sense of well-being. In this context, the specialist could adapt the model to this setting by adjusting the diagonal dashed line upward to more accurately reflect the leisure experience philosophy and content of the program. Thus, the model allows for a broad continuum of service delivery philosophies, approaches, and settings represented in the therapeutic recreation field.

Nature of the TRS: Client Interaction. The nature of the ethical and professional relationship between the client or participant and the therapeutic recreation specialist involves an inherent respect for every person as a unique human being. A significant aspect of valuing the person is the recognition of the right to leisure experiences and the client's ability to make informed choices regarding his or her care (see NTRS Code of Ethics, 1990, section II. The Obligation of the Professional to the Individual). The model reflects these standards of professional practice by maintaining the focus on the client. That is, respect for clients involves informed consent and promotes independence and opportunities for self-determination. Many of these opportunities are realized in the context of play and leisure experiences which contribute to a sense of well-being and ultimately to what it means to be human (Sylvester, 1987).

The model also recognizes that there is a continuum of service delivery that requires professional judgment that will need to be shared with the client and/or her or his guardian to assist in making an informed decision regarding her or his care. More specifically, professional judgment involves choosing valid and reliable assessment tools to determine clients' strengths and limitations, and selecting appropriate intervention strategies to assist clients in achieving their treatment/rehabilitation, education, and/or prevention/health promotion goals. Wher-

ever possible, the client should be involved in the decisions regarding her or his care. The ultimate goal of any helping relationship is assisting the client to achieve her or his optimal level of independence. Therefore, the more competent the specialist is in humanizing the process by respecting the integrity of the individual as a rational human being, the better the outcome.

Theoretical Foundations of TR Service Model. The TR Service Delivery and Outcome Models attempt to show that the so called "recreation therapy" philosophy and the "leisure experience" philosophy may coexist. The key to accommodating these two views within one model is based on the theoretical interpretation of leisure proposed by Neulinger (1976; 1981). This theory approaches the nature of leisure from a psychological perspective which distinguishes between leisure and nonleisure experiences on the basis of one's state of mind (Neulinger, 1976). According to this theory, the higher the degree of choice one feels he or she has to determine personal action, the greater the perceived freedom, which most researchers recognize as the primary prerequisite for a leisure experience. Conversely, perceived constraint on personal choice would lead to a nonleisure or (work-related) experience. According to Neulinger (1976), the degree of internal motivation (doing something for its own sake) or external motivation (doing it for some pay-off or to avoid punishment) also helps to define the nature of the experience. He identifies several combinations of perceived freedom/constraint and intrinsic/extrinsic motivation which he uses to describe the complex nature of leisure and nonleisure experiences. Within this theoretical model, pure leisure involves total freedom from external control and the expectation of satisfying intrinsic rewards. Conversely, in the state of pure work (nonleisure state of mind) there is a sense of perceived constraint combined with extrinsic rewards.

The TR Service Model recognizes that a leisure or nonleisure state of mind will be present in a participant at any given time. In the context of the TR process, *Intervention* reflects the perceived constraint state of mind where the client feels she or he is participating in a mandatory, externally controlled experience. *Leisure Experience* describes the perceived freedom or free choice experience. However, in either case the motivation for participating may be for intrinsic reasons, extrinsic reasons, or a combination of the two. For example, the specialist may encourage the client to participate in an exercise program with the goal of improving health and level of fitness. The client may feel constrained to participate (nonleisure state of mind), while at the same time realize that ultimately she will feel better about herself and be able to improve her level of function (intrinsic rewards) from this experience. Or, the client may really enjoy going for walks and may experience a sense of perceived freedom (leisure state of mind) from the selection of this activity and realize the sense of satisfaction and well-being of a leisure experience (intrinsic rewards). It should be noted however, that because of such psychosocial factors as social norms and expectations, personal experiences with a given activity or setting, and many other situational conditions, experiences are transitory and therefore can best be described as a process which is constantly changing. Thus, all experiences are dynamic interactions between perceived freedom and perceived constraint. Both interventions (perceived constraints) and leisure experiences (perceived freedom) contribute to outcomes which are described more fully in the Outcome Model.

Outcome Model

The current buzzword in health care and human services is "outcomes." Accreditation standards, continuous quality improvement programs, managed care organizations, and health and human service administrators are focusing on client outcomes such as the client's survival, health status, functional capacity, and quality of life, to determine the effectiveness and appropriateness of health care services (Seibert, 1991). Of these outcomes, therapeutic recreation services have been shown to impact clients' functional capacity, health status, and quality of life (Coyle, Kinney, Riley, & Shank, 1991; Shank, Coyle, Boyd, & Kinney, 1996). Since both health status and functional capacities/potentials are closely related to the quality of life outcomes, they serve as bookends for what may be viewed as the primary outcome for therapeutic recreation, a sense of well-being. Here, well-being refers to the satisfaction of health needs and social, physical, spiritual, aesthetic, and intellectual experiences and expressions (Sylvester, 1992). Thus, our unique contribution as a profession rests on our ability to facilitate integrative experiences, most frequently through play and recreation, which enhance the client's quality of life. Sylvester (1994/95) argues persuasively that, "therapeutic recreation outcomes . . . should be both functional and fulfilling, which means they should increase the capacity for living at the same time they foster meaning and value (quality) in the lives of individuals who are ill or disabled" (p. 120). Therefore, according to the TR Outcome Model, the functional capacity and health status outcomes are not intended to be isolated from the whole but are interrelated, organized around the central core of a person striving to achieve a sense of wholeness, a quality of life (see Figure 2).

As noted earlier, the Outcome Model identifies and extends our understanding of the specific outcomes that are inferred from the Service Delivery Model. For example, a leisure experience described in the Service Delivery Model will always affect the participants' quality of life and may also contribute to some improvement in functional capacity and/or health status as well. Thus, as we analyze the dynamic nature of the therapeutic recreation process, we begin to recognize various therapeutic outcomes that fit into one or more of the components of the Outcome Model.

Wellness/Health Status. In the traditional medical model, health status refers to clinical health indicators such as blood pressure, pulse rate, and related physiological measures. However, recent trends in health care have brought about a comprehensive definition that includes mental, spiritual, emotional, social and physiological health factors to define the client's relative health status or condition. The widespread use of biofeedback and meditation in the treatment of chronic pain is just one example of intervention strategies that recognize the dynamic interrelationship between the mind, body, and spirit and which contribute to a redefinition of health status. Thus, instead of being a unidimensional physiological description of a person's health, the new approach provides us with a more accurate composite, multidimensional picture often referred to as holistic health or wellness.

Health status or wellness is influenced by lifestyle behaviors and attitudes such as nutritional habits, self care, level of physical activity, stress management activities, safety practices, and use of alcohol or similar drugs. Active disease processes or disabling conditions such as high blood pressure, cancer or multiple sclerosis also affects one's level of wellness.

Quality of Life. Quality of life is a nebulous and somewhat confusing term which is often used interchangeably with well-being, and life satisfaction. Medical practitioners generally define quality of life in objective terms which describe the person's ability to engage in normal daily activities. Assessments may include changes in health status, social functioning, role functioning, physical functioning, energy levels, and current and general health perceptions (Ware & Sherbourne, 1992). The DSM-IV Axis V: Global Assessment of Functioning (GAF) scale (American Psychiatric Association, 1994) is an example of a tool that is frequently used to determine functional changes in the quality of life.

Behavioral scientists have generally

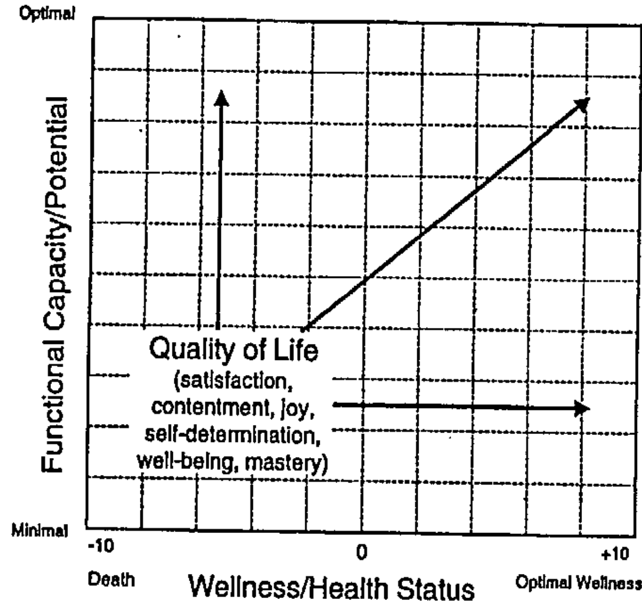

FIGURE 2. THERAPEUTIC RECREATION SERVICE OUTCOME MODEL

taken a slightly more psychological or subjective perspective and have emphasized the importance of need satisfaction, an ability to tolerate stress, independence (self-determination), manifest joy, meaningful interpersonal interactions, a sense of personal competence (mastery), a sense of contentment and well-being, and the meaningful use of time as indicators of life quality (Bigelow, McFarland, & Olson, 1991; Rosenfield, 1992; Iso-Ahola, 1980). Given the complex nature of the quality of life, researchers suggest that both objective and subjective measures should be used to assess this construct (Compton, 1994).

However we choose to define it, quality of life and its relationship to leisure experiences is an important aspect of being human. Sylvester (1992) argues that the related constructs of well-being, quality of life, happiness, and self-actualization are conditions and opportunities required to live a full, meaningful, worthwhile, and satisfying life that emanate from moral principles which define humanity. Human rights, according to Sylvester, are an "entitlement considered vital for living a life of worth and dignity" and include conditions that contribute to life, liberty, security, and opportunities for vital experiences such as play, work, and friendship (p. 11). In this context, he argues that leisure is a core value, a prerequisite to achieving happiness and fulfillment as a person. Given this rationale, quality of life becomes the central, integrating construct of a person-centered outcome model.

Functional Capacity/Potential. The ability to function mentally or cognitively, physically, spiritually, socially, and emotionally is essential for optimal health. These domains which are located along the left axis of the outcome model are defined as follows:

- *mental/cognitive function*—the ability to learn and use mental capacities.
- *physical function*—the ability of all body systems to function efficiently and effectively during work or play.
- *psychological/emotional function*—the ability to deal comfortably and appropriately with emotions.
- *spiritual function*—the ability to find meaning and purpose in life.
- *social function*—the ability to enjoy meaningful relationships with other people in one's environment.
- (*leisure function*)—the ability to participate in and enjoy leisure experiences.

Although we often refer to these domains as distinct categories and even use specific assessment tools to evaluate them, it is good to remember that in reality they are each part of one organism which cannot and should not be reduced to individual segments or parts. In fact, leisure function, the most important functional component in most therapeutic recreation programs, has been listed in parentheses because it represents a complex interaction of all the domains working together. Similarly, spiritual function is both elementistic, viewed as one of the domains, and an integrative and overarching concept found within each of the dimensions of our humanity (Heintzman, 1997). Since therapeutic recreation practice seeks to address the needs of the whole person and spirituality has been identified as an important aspect of one's health and well-being (Greenberg & Dintman, 1992), it has been included in the model. Thus, although we do not want to minimize our understanding of the unique contribution of each functional domain, our goal is to assist the client in achieving the highest possible level of health and well-being through leisure and nonleisure experiences.

Theoretical Foundations of TR Outcome Model. Living life involves experiences and actions which contribute to learning and personal development. Who we are as unique human beings is the product of a variety of experiences, not the least of which are leisure or play experiences that provide continuity, purpose, and meaning throughout life. "The play of childhood, the exploration of adolescence, the intimacy building of young adulthood, the competence and personal expression of the middle years, and the social integration of later life are central themes of developmental perspective on leisure" (Kelly, 1990, p. 423). As developing human beings, we use nonleisure and leisure experiences to understand and reinforce who we are and to become all that we can be. It is this developmental process of "becoming" that produces the outcomes described in the TR Outcome Model. Since illnesses and disabilities may serve as barriers to human development, therapeutic recreation programs frequently provide individuals with alternatives that contribute to normal developmental experiences.

Additional support for the outcome model emerges from a review of the rehabilitative sciences empirical research (Shank, Coyle, Boyd, & Kinney, 1996). Shank et al. identify numerous studies that support improvements in physical functioning (Buettner, 1988; Green, 1989; Rothe, Kohl, & Mansfield, 1990), psychological functioning (Searle, Mahon, Iso-Ahola, Sdrolias, & van Dyck, 1995; Mactavish & Searle, 1992; Coyle & Santiago, 1995; Chakravorty, Trunnell, & Ellis, 1995), cognitive functioning (Hutzler, 1992; Dattilo & Barnett, 1985; Mahon, 1994; Mahon & Bullock, 1992), and in social functioning (Schleien, Kiernan, & Wehman, 1981; Rancourt, 1991; Bullock & Howe, 1991) when therapeutic recreation activities and interventions are used in therapeutic programs that focus on functional capacity/potential.

The relationship of leisure experiences to health and quality of life has been extensively reviewed (Compton & Iso-Ahola, 1994; Iso-Ahola, 1994; Ragheb, 1993). Iso-Ahola (1994) notes that, "theoretically leisure affects health in three interrelated ways: (1) leisure becomes a tool by means of which

health is pursued and obtained, that is, leisure provides the time and environment in which health behaviors are practiced; (2) leisure is a way of life, that is, it is a cognitive orientation toward life and a lifestyle that promotes and is conducive to health; and (3) leisure has some inherent qualities and characteristics that are germane to health." (p. 43)

Although discussions on the relationship of spirituality and leisure experiences are still somewhat speculative, McDonald and Schreyer (1991) also identified possible spiritual benefits of leisure participation. Hawks et al. (1995) also suggested that observed physical and emotional health outcomes were related to the use of spiritual program components such as meditation, yoga, and imagery. These researchers suggest that spirituality plays a role in our functional capacity, health status/wellness and quality of life. Because of these and other findings, Heintzman (1997) concludes that human service professionals, including those in recreation and therapeutic recreation, need to pay closer attention to the spiritual dimension in programming.

The Model in Practice

The Case of Ms. Z: A Community-based Approach. A particularly intriguing case reported by Negley (1994) provides an excellent example of how the TR Service and Outcome Models guide practice. Ms. Z., a 25-year-old mother of two, was initially hospitalized for problems which restricted her ability to ambulate and speak. Following an extensive neurological workup the client was diagnosed with a conversion disorder and referred to the in-patient neuro-psych unit. The psychiatric evaluation included a therapeutic recreation assessment designed to determine her self-esteem and leisure functioning, including her perspective of herself and her family, her internal validation (negative and positive), and her ability to express personal feelings. In cooperation with the staff psychiatrist, an intensive outpatient treatment plan was designed to address two short term therapeutic recreation goals: (a) to develop trust in the therapeutic relationship and (b) to increase Ms. Z's willingness to communicate. The long term goals were to: (a) increase her ability to identify personal feelings, (b) increase her ability to communicate feelings without self harm, (c) re-establish leisure functioning, and (d) increase tolerance for social functioning.

Initially the client was resistant to participate in therapeutic recreation but she agreed to attend sessions on a nine-week trial basis. Building a relationship and developing trust proved difficult but the therapist reported more positive responses during outdoor activities such as walks in the woods where she "appeared to feel safe and less guarded" (Negley, 1994, p. 37). Many board games and paper/pencil exercises as well as a variety of media activities such as drawing, collages, clay and music were used to assist Ms. Z in identifying and communicating personal feelings. Legos and Tinker Toys were also used to symbolize the rebuilding of her life and horticulture activities simulated the slow process of growth taking place. A structured, seven step self-esteem program based on Project IBIM-I Believe in Me (Radmall & Negley, 1989), was used to develop Ms. Z's assertion skills and ability to exercise more control over her environment. As the client began to express her repressed rage and anger, more physically active activities such as racquetball and volleyball became appropriate outlets of release. Negley (1994) reported that as therapy continued the walks in the foothills increased, becoming an important diagnostic tool. It was in this open space where she "felt safe" that the therapist was able to "monitor Ms. Z's increased understanding of her feelings, and her increased ability to express those feelings" (p. 38).

Following nearly two years of intensive out-patient therapy, Ms. Z "recognized the value of leisure as a coping skill, as well as its role in enhancing her overall quality of life. She became active in women's volleyball and basketball leagues, was able to tolerate shopping alone, could play and interact with her two children in recreation activities, and even began to consider returning to college for further education" (Negley, 1994, p. 40). Although the process of social and community reintegration happened slowly, the study shows the effective use of therapeutic recreation in the treatment of difficult mental health issues.

Application to the Therapeutic Recreation Models. This case describes the full scope of services outlined in the TR Service Delivery Model. Social and leisure functioning and self-esteem constructs were assessed and short-term and long-term goals were developed. Treatment/Rehabilitation interventions were varied and extensive, including the use of expressive media, athletic activities, and walks in the woods. Educational interventions involved the use of the IBIM materials which helped to develop appropriate skills to control her environment and various recreational sport activities served to reinforce appropriate forms of aggression and self-expression. These activities played an important role in promoting healthy behaviors and preventing regression to previous dysfunctional behaviors.

The walks also serve as a good example of the overlap and integration of a therapeutic intervention with the leisure experience (the dotted diagonal band on the model). The open space was important in creating a free, unencumbered leisure environment that contributed to the client's self-disclosure and expression of feelings. It was this environment that provided the forum for diagnostic assessments (diagnosis/needs assessment), as well as opportunities for the safe expression of feeling (treatment/rehabilitation). This same interactive relationship between intervention (nonleisure) and leisure experience can be seen in many of the interventions used in this case, including the music and sports activities. At times they may have been purely a leisure experience, while at other times the client may have experienced these activities as work or nonleisure, depending on her attitude and the context of the activity experience. For example, the degree of perceived control or freedom given to the client varied from therapy session to therapy session and even within a given session. Re-searchers indicate that the perception of free-dom is a key element in experiencing leisur (Neulinger, 1981; Csikszentmihalyi, 1975) Therefore, the nature of the TRS:client inter action is an important variable in achievin optimal leisure experiences and/or interven tion relationships.

This case also exemplifies the viability o the TR Outcome Model. Functional outcome included improved social and leisure func tioning, and an ability to deal comfortabl with feelings (emotional function). In addi tion, improved quality of life and improve health status were all reported as client ou comes. Ms. Z's improved ability to functio more appropriately in several areas of life an her improved self care and increased physica activity (health status) seemed to contribut substantially to her overall quality of life. Th relationship between leisure satisfaction an wellness (Coleman & Iso-Ahola, 1993; Iso Ahola & Weissinger, 1984; Ragheb, 199 and the correlation of an active leisure lif style and psychological well-being (Caldwel Smith, & Weissinger, 1992; Flanagan, 197 support the value of play and leisure exper ences for all people, but especially for tho who experience barriers to self-directed le sure opportunities.

Strengths and Limitations of the Models

Because both models reflect current pra tice, they provide consumers, employer practitioners, legislators, and others, with clear understanding of the scope and natu of therapeutic recreation services, as well expected outcomes. For example, it is cle from the TR Outcome Model that therape tic recreation seeks to address functional c pacities, health status or wellness, and t

quality of life as therapeutic goals. The model shows quite clearly that these are not three independent components of a person's health but are interrelated and interdependent parts of a total person linked around the concept of quality of life or well-being. This is especially important for those in the profession who are concerned with an overdependence on the medical model which tends to focus on "fixing broken parts" while ignoring the unique nature of the whole person. Indeed, the outcome model seeks to represent both "functional and fulfilling" aspects of the individual.

Although the focus of the models is to describe service delivery and outcome measures, they were derived from and are supported by developmental and leisure theory, research from the rehabilitation literature, and from our professional standards of practice and codes of ethics. The models creatively integrate a variety of concepts and philosophies that contribute to a better understanding of the profession and its unique role in health and human services. For example, the TR Service Model incorporates components of both the traditional medical or disease model (therapy) and health/wellness (leisure experience) perspective to health care. Terms such as diagnosis, treatment/rehabilitation, and intervention are used to communicate to health care practitioners who operate under the medical model, while needs assessment, education, prevention/health promotion, and leisure experience suggest an orientation toward human services oriented toward leisure experiences and wellness.

While accommodating both therapy and leisure orientations, the overall emphasis of both models is on the holistic nature of the person. This is seen through the emphasis on the integrative nature of the client experience in the Service Model, (i.e. intervention and leisure experience) and the centrality of the quality of life within the interrelated components of the TR Outcome Model. As previously stated, the intent is to avoid a reductionist view of the client by focusing on the disease or impairment of the human organism at the expense of treating the person as a unique, complex human being.

The flexibility of the models contributes to their use across a wide range of human service and health care settings. Community recreation agencies that serve persons with disabilities, as well as acute care medical or rehabilitation hospitals, can adapt the model to reflect their respective therapeutic recreation service philosophies by adjusting the degree to which they emphasize therapeutic intervention or leisure experience while focusing on outcomes unique and appropriate to each setting. As noted earlier, this is done by simply raising or lowering the diagonal line/band which divides intervention and leisure experience on the service model. Thus, it reflects and supports the wide continuum of services provided by therapeutic recreation personnel in human service and health care agencies.

All models have their limitations and these are no exception. First, further study is needed to determine the nature of the relationships among the components of the model system. For example, what is the relationship between an intervention and a leisure experience? What is the relationship between the service components, such as treatment and education, and the various outcomes? What is the relationship between functional capacities and quality of life and/or health status/wellness and quality of life?

Another possible limitation is that at present some of the terms used to describe various components are not clearly defined. Lack of clarity may lead to confusion and misinterpretation. Therefore, continued refinement is needed in the development of these models to accurately describe the true nature of this profession.

Future and Continued Development

Professional practice must be built on a strong theoretical and philosophical foundation. Although the TR Service Delivery and Outcome Models seem to meet these criteria, further work needs to be done to strengthen these assumptions. Just as professional practice is not static, practice models cannot be static. The effectiveness of the models lies in their ability to reflect changes that will take place in professional practice, such as new service delivery systems which are developing in the health and human service arenas (Pew Health Professions Commission, 1995). Leisure experiences may also be recognized as a more valuable dimension of life in a society of retired baby boomers and will therefore, play a more prominent role in the delivery of health and human services. Likewise, we are seeing a resurgence in spirituality and support for its role in the healing process (Larson & Larson, 1992; Van Andel & Heintzman, 1996; Heintzman, 1997). Some of these changes in health care will likely reinforce existing constructs in the models while others will suggest a need for modifications.

Practice models can be effective tools for introducing and explaining what we do, how we do it, and the intended results. Given the variety of therapeutic recreation settings and programs, it is difficult to represent all the nuances of our profession in any set of models. However, continued development of our models is imperative since they assist practitioners and educators in their efforts to describe our profession to consumers, administrators, students, and the public.

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