AN EVALUATION OF THERAPEUTIC RECREATION SERVICES
PROVIDED FOR PSYCHIATRIC CLIENTS
IN THE STATE OF TEXAS

THESIS

Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements

For the Degree of

MASTER OF SCIENCE

by

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Denton, Texas
December, 1977
The problem with which this study is concerned is the delineation of current practices in therapeutic recreation in psychiatric treatment centers in Texas. The programs of the forty-two hospitals responding to the survey questionnaire were evaluated in terms of the National Therapeutic Recreation Society's "Standards for Therapeutic Recreation in Psychiatric Facilities."

It was determined that, while the use of recreation in psychiatric rehabilitation is widespread, many programs are not administratively independent. A close association between recreation and occupational therapy was found. Extensive recreation facilities and activities were reported. Use of community resources was widespread, but follow-up and leisure counseling services were rare. Most personnel had no recreation training. The evaluation showed limited compliance with the standards.
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CHAPTER I

INTRODUCTION

An essential feature of a dynamic and developing profession is a complete body of knowledge concerning the current status and practices of that profession. Unfortunately, therapeutic recreation does not appear to have this comprehensive overview so needed for development of new programming techniques and theories for adaptation to and maximum exploitation of the recent changes in psychiatric rehabilitation.

Recreation as a therapeutic modality for the treatment of illness, particularly mental illness, has attained widespread acceptance in the past few decades. Dr. Robert Felix, former director of the National Institute of Mental Health, has stated:

The greatest value of recreation is that it can be prescribed as a definitive therapeutic treatment. Particularly in the field of psychiatry... recreation plays a positive role in the care and treatment of the mentally ill (2, p. 3).

The American Medical Association has also accepted the importance of recreation in maintaining physical and mental health. In 1971, they stated:

Recreation contributes to the promotion of health; the prevention of illness or further disability; the treatment of illness and the rehabilitation of persons with physical, emotional and mental disabilities (13, p. 98).
The fact that it is now estimated that one in ten persons in the United States suffers from, or will suffer from, a mental illness of sufficient severity to require professional help indicates that therapeutic recreation has a viable and growing future (12, p. 42).

This growing realization of the importance of recreation in maintaining mental health has been accompanied by a revolution in the treatment of the mentally ill. The introduction of psychopharmacotherapy in the early 1950's has changed the focus of psychiatric institutions from confinement techniques to techniques involved with activity and adjunctive therapies. The teaching of socialization and living and work skills are now of paramount importance (8, p. 72). Recreation for the mentally ill is no longer merely a diversionary activity whose basic requirement is that it fill free time. Rather, recreation therapy is assuming an important role in the therapeutic community of the psychiatric hospital. It is believed to be the therapeutic medium best suited to provide individuals with opportunities for success, satisfaction and creativity. In addition, recreation services allow for much needed observation of the patient, provide social learning and reality testing experiences and aid in establishing new behavior patterns.

With so much potential and so many demands being placed upon it, therapeutic recreation is struggling to define its priorities and establish itself in the therapeutic community
on the same level as occupational and physical therapy. Studies by Wolfe (1), Robb (14), Jerstad (5) and others (3, 4, 10) have attempted to quantify the results of specific recreation activities on human behavior in the mental institution, but specific evidence relating recreation and behavior is minimal. In 1972, the Joint Commission on Accreditation of Hospitals issued a list of "Standards of Activity Program Services in Psychiatric Facilities" covering administration, programming, facilities and personnel (6). The National Therapeutic Recreation Society and various state societies have established registration and certification criteria but these standards are neither uniform nor widespread. In addition, the state of the profession as it exists in the field today is largely unknown. Thus, recreational therapy is faced with the problem of organizing itself as a profession while remaining sensitive to the profound changes taking place within the field of psychiatric rehabilitation. This problem is especially acute in the state of Texas. The last study which sought to define the major philosophies and practices governing the provision of therapeutic recreation services to hospitalized psychiatric patients was completed in 1970 (9).

Statement of the Problem

The problem undertaken in this study was the evaluation of the status of therapeutic recreation services provided in psychiatric treatment centers in the state of Texas.
Purpose of the Study

The purpose of this study was to evaluate the current status of therapeutic recreation services in in-patient psychiatric treatment centers in Texas. This evaluation was based on responses to a mailed survey covering the following areas:

a) Determination of staffing, goals, programming and organization of the recreation programs,

b) Determination of the status of recreation therapists in relation to other hospital personnel,

c) Determination of the use of concepts associated with milieu theory, unitization and community psychiatry in the recreation programs,

d) Determination of the extent to which community based programming and leisure counseling have been implemented.

In addition, this study included a comparison of the results of this survey with those obtained by Dr. Richard Kraus in 1972. Included also was an evaluation of Texas recreational therapy programs in terms of the National Therapeutic Recreation Society's "Standards for Therapeutic Recreation in Psychiatric Facilities" (6).

Significance of the Study

The results of this study did, for the first time, provide comprehensive, systematic information about therapeutic recreation services for psychiatric patients in the state of Texas. Information of this type can be used to determine
curriculum guidelines for universities which train professionals in this field. It will provide a current body of knowledge concerning the scope of programs, philosophy and trends in therapeutic recreation. It is this information which must provide the framework of university training in therapeutic recreation. It will allow for examination of practical and theoretical applications in terms of the existent practices of the profession.

In addition, information such as this is essential as a basis for the development of adaptable and improved services. Exposure of the working professionals to other programs and the overall condition of the field may stimulate changes and experimentation. In Texas, it appears that many of the therapeutic recreation services are directed by persons with no formal training in recreation (15). Information gathered in this study would help define goals, objectives and programming aspects unique to recreation services which may be unknown to these people.

Lastly, a study such as this, by identifying major aspects of the field, opens the way for extensive further research. It is imperative that therapeutic recreation specialists determine specific relationships between recreation activities, behavior and mental health. If therapeutic recreation is to survive as an independent field, this area must be covered primarily by recreation personnel. Research into many aspects of therapeutic recreation is already being undertaken.
by various fields, most notably psychology and medicine. Such experimentation should be incorporated into therapeutic recreation’s body of knowledge, but care must be taken to avoid overdependence on other fields for research. Such a dependence would ultimately mean the disappearance of therapeutic recreation as an independent field. Thus, the need for research in therapeutic recreation by recreation specialists is paramount. A major hindrance to further research at this time is the lack of comprehensive data which may serve as a basis for determination of specific research problems. It is hoped that this study alleviated this need in this area.

Delimitations

This study was delimited to the sixty-two hospitals in Texas which offer therapeutic recreation services for their psychiatric in-patients. This included both psychiatric institutions and general hospitals with psychiatric units.

Definition of Terms

Definitions pertinent to this study were as follows.

1. **Recreational Therapy/Therapeutic Recreation**

Therapeutic recreation is a special service within the broad area of recreation services. It is a process which utilizes recreation services for purposive intervention in some physical, emotional and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the individual (11, p. 1).

2. **Leisure Counseling**: A program of advisement or discussion with individuals to help them better understand their leisure needs (7, p. 31).
3. **Unitization**: The division of a hospital into organizational units, each of which is staffed by a complete psychiatric team and responsible for the treatment of all patients of a designated geographic area (7, p. 8).

4. **Community Psychiatry**: The recent move towards treatment of the mentally ill in the community through preventive methods and use of mental health centers, partial hospitalization programs, half-way houses and other community agencies (7, p. 6).

5. **Milieu Theory**: The theory that the totality of the hospital setting and experience is part of the therapeutic setting and has a role in the treatment and cure of the patient (8, p. 76).
CHAPTER BIBLIOGRAPHY


CHAPTER II

REVIEW OF THE LITERATURE

The period following World War II has seen the growth of therapeutic recreation as a treatment modality. It appears that this recreation service is grounded in the belief that the recreative experience is necessary to help establish and maintain mental health. Leading psychiatrists such as Davis (6), Barton (2) and Menninger (19) have testified to this function of recreation. Their beliefs may be stated as follows:

Basically, recreation is an experience which leaves one refreshed, rejuvenated, fulfilled, happy, content and at peace with oneself and the world... It is a happy, productive, creative and positive experience, fostering a feeling of well-being... The outcomes of recreation, the very experience itself are so closely related to positive mental health that one may consider them as almost synonymous (16, p. 74).

Aspects of Rehabilitation

In the sphere of psychiatric rehabilitation, therapeutic recreation has gained extensive acceptance. The peculiar problems of the mentally ill are seemingly adapted to recreational intervention. For many of the mentally ill, leisure lacks any type of pleasurable connotation, rather it is a source of boredom and frustration (13, p. 21). A large number of psychiatric patients are withdrawn, unhappy and
anxious people, lacking self esteem and confidence, scared of, and inadequate in social situations and relationships. Studies by Harrington and Cross (10), Gordon (9) and Mullaney and Sheeley (20) have shown the psychiatric client's leisure patterns to be characterized by isolation, inactivity, associability and passivity. If we are to accept that recreation is a human need (11, p. 8), then it appears that many of the mentally ill are lacking in the adequate fulfillment of this need.

Recreation is particularly suited to compensate for the needs of many of the mentally ill. Clinical observation indicates that during participation in an activity, there appears to exist within the patient a feeling of homeostasis, a sense of intra-psychic well-being which facilitates sublimation and allows for relief of anxiety (23, p. 101). These recreative activities have many dimensions for such patients. They provide avenues for creativity, success, enjoyment and expenditure of energy while allowing patients to experiment with the dynamics of successful interpersonal relationships and socialization techniques (8, p. 82). Physical activities have the added advantage of counteracting the lethargy and inactivity associated with depression and they provide patients with a form of "body awareness" which many of them may lack. (3, p. 151). One additional benefit is that recreation experiences often provide a link to the outside world and to the patient's life both prior to and after hospitalization.
In addition to the benefits derived by the patients from recreational therapy programs, they are a valuable tool for diagnosis and evaluation. The "Standards for Therapeutic Recreation in Psychiatric Facilities" produced by the National Therapeutic Recreation Society states that:

...comprehensive records shall be maintained on individual patients and clients and used as tools for diagnosis, treatment, planning, evaluation and individual planning purposes...(14, p. 58).

Recreation activities offer the chance to see the "whole man" functioning and the frequent loss of self-consciousness while engaging in recreation activities offer opportunities for unique insights into each patient's behavior. Progress in such areas as skills and socialization is easily documented and provides valuable information to the rest of the medical staff treating the patient. This function of recreation is particularly suited to several of the recently developed concepts in psychiatric rehabilitation.

The first of these is milieu theory. This is best described as a treatment approach which seeks to make the entire hospital setting therapeutic. It seeks to provide the patient with a sheltered environment which will be supportive, yet will also present a model of the outside world in which healthy relationships and coping mechanisms may be learned and tested (15, p. 4). It's main thrust is to provide "integrating, guiding, rehabilitating, socializing experiences" (24, p. 17).

The importance of recreation in this type of system is to provide those socializing activities in which every level of
The patient can participate (22, p. 167). The task becomes one of a social systems specialist who constructs activities and situations in which healthy interpersonal relationships and social interactions can develop.

The acceptance of many of the concepts of milieu theory dictates that other changes be made in the provision of recreation services. The emphasis on socialization and skills for daily living has caused a shifting of emphasis of activities from clearly recreational (sports, arts and crafts) to more informal, less structured activities with a more social learning orientation. These activities may include grooming, cooking, psychodrama and exercise groups. There appears to be an increasing focus on non-verbal communication methods and methods of feeling, caring and cooperation (15, p. 6).

Another new concept in psychiatric rehabilitation is that of unitization. The decentralization inherent in the theory may have different effects on therapeutic recreation services. It may provide recreation personnel with the opportunity to become more fully integrated with other medical personnel. At the same time, it may diffuse recreation staff and eliminate hospital-wide programming (15, p. 27). The exact impact of unitization on recreation services has not yet been determined.

Community psychiatry represents perhaps the greatest change in psychiatric rehabilitation in the last few decades. This model derives its principles from the view that mental
illness has its primary roots in the social environment. The idea of community psychiatry gained great impetus in 1963 with the passage of the Mental Retardation and Community Mental Health Centers Act which made federal funding available for community facilities and programs (8, p. 193). In the last fifteen years, there has been a continual decrease in the number of patients institutionalized. In the ten state hospitals in Texas, there were 7,982 patients in residence on August 31, 1975 while one year later, that number had dropped to 6,623 (26, p. 2). In the same time period, the state hospital out-patient/outreach clinics served over 11,600 patients and the twenty-seven Community Mental Health and Mental Retardation Centers had a caseload of 44,818 mental health patients (27, pp. 28, 100). Pattison states that

...the community mental health model of a social system offers a very viable model for the adjunctive therapies...being in a position strategic to develop theories and techniques for a continuum of human interactional experiences in the therapeutic setting that replicate natural social experiences (8, p. 118).

It is necessary that recreation establish a bridge between the hospital and the community and to integrate its activities between both spheres.

The community setting poses numerous problems to the returning psychiatric patient. One of the greatest of these is social and leisure time adjustment (7). Most psychiatric patients do not understand the importance of establishing healthy leisure patterns (12, p. 17). Recreation counseling
is emerging as a natural bridge to help patients overcome these difficulties. Its main functions are to enable the patients and clients to strengthen existing social ties, form new ones and identify, locate and utilize the available recreation resources for the betterment of themselves and their families (1; 17, p. 97; 157).

Related Research

This review of literature has produced much information concerning theoretical therapeutic recreation principles and practices and new trends in psychiatric rehabilitation, but the number of studies attempting to evaluate the status of therapeutic recreation are minimal. Within the past seven years, no studies of this type have been done in the state of Texas. In 1970, London (18) completed a study entitled "The Status of Therapeutic Recreation in Hospitals and Institutions in the State of Texas." This study dealt with all hospitals in Texas, not merely those dealing with psychiatric patients and her main purpose was a comparison of the programs offered to the different types of patients. The study dealt primarily with the personnel requirements in terms of salary, education and experience, activities offered and facilities available. It did not concern itself with the issues of change in program emphasis and administration.

Additional studies have been done concerning therapeutic recreation services in Texas but these are very old. The latest, completed in 1948 by Brennan (4) was entitled "A
Comparative Study of Recreation in State and Federal Mental Institutions in Texas." His objective was to determine which type of hospital offered the most well-rounded recreation program and to determine which facilities and offerings should be improved. His study was limited to a survey of three federal hospitals and three state institutions. His findings indicated that federal hospitals had a more adequate recreation staff, spent more for recreation, offered more activities and were more likely to accept therapeutic recreation as a viable treatment modality. His information is based on such a small sample that it would be impossible to draw any conclusions about recreation services in other institutions in this time period.

In 1938, Buice (5) presented a study entitled "Recreational Therapy for Mentally and Emotionally Maladjusted Personalities." Based on extensive bibliographic work, observation, interviews and surveys sent to four state hospitals, two private sanatoriums and one federal hospital, she identified many of the goals and activities of therapeutic recreation at that time. Resocialization was already recognized as being a prime component of therapeutic recreation services, but there was also a high emphasis on the awakening of brain activity and the utilization of other body systems. Activities fell heavily into the physical education sphere, but card games, movies, singing and woodworking were offered in all of the institutions surveyed.
In 1959, the National Recreation Association (21) conducted a very generalized, nation-wide survey which sought to identify the groups and types of hospitals most likely to have recreation programs. Over 6,700 questionnaires were mailed and almost half of the 3,500 responding institutions indicated that they had organized recreation programs. Few attempts were made to discover more about these programs. However, this survey took place almost twenty years ago and the rapid pace of change today would indicated that much of the data obtained in that survey is now outdated.

In 1972, Kraus (15) completed a much more specific and comprehensive survey of therapeutic recreation services in psychiatric institutions in the tri-state area of New York, New Jersey and Connecticut. This study examined the

...current practices, programs and administrative trends in the provision of recreation and related therapies in public, voluntary and proprietary in-patient treatment centers (15, p. 1).

Perhaps the most important finding of Kraus' study is that there is an enormous diversity in the provision of recreation services to psychiatric patients. The new concepts operative in psychiatric rehabilitation were seen as threatening and destructive by many of the respondents and many felt that recreational therapy was losing its identity as a separate field of professional service as a result of the implementation of these concepts. There is a major discrepancy between this reality and the literature which emphasizes the increased
importance of recreation in the new forms of rehabilitation. This discrepancy is extremely disconcerting.

A preliminary study completed in December, 1976 by the author (25), has indicated that over 75 per cent of the hospitals in Texas which have in-patient psychiatric units offer recreation programs for these patients. There are only nineteen hospitals which have psychiatric in-patient units, but do not have a recreation program for the patients in these units. In-patient unit size is generally less than one hundred beds and the average duration of a patient's stay in the hospital for psychiatric reasons is only seventy days. Many of the hospitals also have out-patient psychiatric care.

Summary

Therapeutic recreation services, especially in the area of psychiatric rehabilitation, have been in existence for many years. The philosophies governing the need for such services have become widespread and accepted by a majority of the medical profession. New areas of psychiatric rehabilitation have opened vast new opportunities for the development and application of recreational techniques. Yet the professional recreational therapists are mired in disorganization and lack of communication. The almost total lack of current documentation concerning the actual conditions which are present and being practices in the field denies the profession the possibility of development as a single unit. New ideas, theories and philosophies abound when one reads of therapeutic recreation
services, but until the profession becomes unified around a solid and realistic base of information, then these will never be translated into practical applications. The future for therapeutic recreation is bright and hopeful. Milieu theory, unitization and community psychiatry offer opportunities well suited to resolution through the use of recreational techniques. Successful adaptation to and exploitation of opportunities is necessary for survival in the present world. Therapeutic recreation must not lose this opportunity.
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26. Texas Department of Mental Health and Mental Retardation, Data Book A - Texas State Mental Hospitals and State Schools for the Mentally Retarded, 1976.

27. Texas Department of Mental Health and Mental Retardation, Data Book B - Texas Community Programs, 1976.
CHAPTER III

PROCEDURES

This study was designed to describe and evaluate the current status of therapeutic recreation services in in-patient psychiatric treatment centers in the state of Texas. Since the sixty-two hospitals which comprised the population surveyed were spread over a wide geographic area, a mailed survey was conducted. Since the survey was aimed at an educated and special group with an interest in the survey subject and since a preliminary survey elicited a very high response rate, no problems were foreseen in acquiring enough responses to be representative of the survey group (4, p. 179).

Preliminary Procedures

Preliminary procedures involved identification of those institutions which offer therapeutic recreation services for their psychiatric patients and the selection and development of the questionnaire.

To determine the hospitals which offer programs to be examined, the 1976 American Hospital Association Registry was consulted (1). A list of hospitals reporting in-patient psychiatric services was compiled from this source and cross-referenced with similar lists obtained from the Texas Department of Mental Health and Mental Retardation and the Texas
Hospital Association in insure its completeness. A preliminary survey (5) was then sent to the hospital administrator of all the hospitals on the list. Response to the survey was over 85 per cent, so it was assumed that almost all hospitals with recreation programs for psychiatric patients in Texas are included in the population of the present study.

The questionnaire used was based on one developed and tested by Kraus and Avedon in 1972 (2). Due to the time elapsed since this original study, modifications to parts of the instrument were made with the approval of Dr. Kraus (3). The great majority of the questionnaire, however, remained unchanged. A copy of this instrument may be found in Appendix A.

Administration of the Instrument

The questionnaire was mailed, with a cover letter and a stamped, self-addressed envelope, to the director of the recreation services for each institution. In order to encourage a high response rate, in almost all cases the material was addressed to a specific individual whose name was obtained in the preliminary survey (5). Two weeks following the first mailing, an additional copy of the cover letter and survey was mailed to those recreation directors who had not yet returned the completed survey. All mailings were done on Mondays in order that the surveys would arrive in the middle of the week. It was expected that within six weeks of the first mailing sufficient responses would have been received to proceed with an analysis of the data. This was defined to be 60 per cent.
Since this was the case, no further follow-up attempts were made.

Analysis of the Data

The intent of the analysis was to give a descriptive evaluation of the programs and services offered in therapeutic recreation for psychiatric patients in the state of Texas. Since an evaluation of status was the concern of this study, only a descriptive analysis was undertaken. The data was analyzed to determine frequencies and percentages. Extra information and comments volunteered by the respondents were included within the narrative portion of the analysis or in Appendix C.

The results of the study were then compared to the results obtained by Dr. Kraus in his 1972 study in New York, New Jersey and Connecticut (2). Major similarities and differences from his findings were noted and discussed.

Lastly, the results of the survey were examined in terms of the National Therapeutic Recreation Society's standards. Deficiencies in Texas programs were noted and recommendations made concerning these deficiencies.
CHAPTER BIBLIOGRAPHY


CHAPTER IV

RESULTS OF THE STUDY

Introduction
This study sought to delineate the components and dynamics operational in therapeutic recreation services provided for hospitalized psychiatric patients in the state of Texas. To fulfill this goal, a survey instrument was sent to all recreation directors of institutions with in-patient psychiatric units. Two mailings were made of the survey and its accompanying cover letter. Six weeks following the initial mailing, a 74 per cent response rate had been obtained with forty-six of the sixty-two institutions having responded to the questionnaire. There were four invalid responses and since three of these indicated that their institutions did not have either a recreation program or a psychiatric unit, all further calculations were made on a total survey population of fifty-nine hospitals with forty-two valid responses.

The purpose of the study contained six major points, which were as follows:

a) Determination of staffing, goals, programming and organization of the recreation programs,

b) Determination of the status of recreation therapists in relation to other hospital personnel,
c) Determination of the use of concepts associated with milieu theory, unitization and community psychiatry in the recreation programs,

d) Determination of the extent to which community based programming and leisure counseling have been implemented,

e) Comparison of the results of this study with those obtained in a similar study conducted in 1972 by Dr. Richard Kraus (2),

f) Evaluation of recreational therapy programs in Texas in terms of the National Therapeutic Recreation Society's "Standards for Therapeutic Recreation in Psychiatric Facilities" adopted in 1971 (1).

This chapter was concerned with an examination of the data collected as it directly related to each purpose. For descriptive purposes, in some instances, the responses have been converted to percentages.

Elements of Recreation Service

As stated earlier, there were forty-two valid responses to the survey. More than half of these came from federal, state and county institutions. All federal and state institutions receiving the survey responded to it. A breakdown of responses in terms of auspices is shown in Table I. Similar conditions were found upon examination of the size of the in-patient units in the responding hospitals as shown in Table II. While the distribution was fairly uniform among the various
categories, virtually all the hospitals in the survey group known to have psychiatric units in the 100-250 and the 250+ categories responded to the survey.

**TABLE I**

AUSPICES OF HOSPITALS

<table>
<thead>
<tr>
<th>Auspice</th>
<th>Number</th>
<th>Per Cent</th>
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<tr>
<td>Federal</td>
<td>8</td>
<td>19.0</td>
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<tr>
<td>State</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>County</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>Private</td>
<td>5</td>
<td>11.9</td>
</tr>
<tr>
<td>Voluntary/Non-profit</td>
<td>4</td>
<td>9.5</td>
</tr>
<tr>
<td>Proprietary</td>
<td>5</td>
<td>11.9</td>
</tr>
<tr>
<td>Church-related</td>
<td>3</td>
<td>7.2</td>
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<tr>
<td>Other</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>100.0</strong></td>
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**TABLE II**

SIZE OF IN-PATIENT UNIT

<table>
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<tr>
<th>Number of Beds</th>
<th>Number</th>
<th>Per Cent</th>
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<tr>
<td>0 - 25</td>
<td>7</td>
<td>16.7</td>
</tr>
<tr>
<td>25 - 50</td>
<td>12</td>
<td>28.6</td>
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<tr>
<td>50 - 100</td>
<td>8</td>
<td>19.0</td>
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<tr>
<td>100 - 250</td>
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<tr>
<td>250+</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>100.0</strong></td>
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Administrative independence of the recreation department was found in 40.5 per cent of the institutions. As shown in
Table III, the occupational therapy department held responsibility for recreation in 21 per cent of the responding institutions. This relationship between recreation services and occupational therapy departments and personnel will become even more defined later in this discussion.

**TABLE III**

**ADMINISTRATIVE STRUCTURE OF RECREATION PROGRAMS**

<table>
<thead>
<tr>
<th>Administration</th>
<th>Number</th>
<th>Per Cent</th>
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<tbody>
<tr>
<td>Separate Department</td>
<td>17</td>
<td>40.5</td>
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<tr>
<td>Occupational Therapy</td>
<td>9</td>
<td>21.4</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>3</td>
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<tr>
<td>Activities Therapy</td>
<td>3</td>
<td>7.1</td>
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<tr>
<td>Nursing</td>
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<tr>
<td>Psychiatry</td>
<td>2</td>
<td>4.8</td>
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<tr>
<td>Others*</td>
<td>6</td>
<td>14.3</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>42</strong></td>
<td><strong>100.0</strong></td>
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</tbody>
</table>

*Physical Medicine, Voluntary Services, In-Patient Unit, combined Occupational Therapy and Nursing, Group Services, one unspecified.

Hospitals providing recreation had a mean number of 5.1 persons on their staff with a primary responsibility for this service. Over 80 per cent of the institutions employed full-time personnel. Of all the hospitals, only 38 per cent used part-time staff. There was a mean number of 4.7 full-time staff and 2.2 part-time staff members. Over 80 per cent of the hospitals had an average of one administrator/supervisor while 71 per cent employed professional level therapists and 60 per
cent utilized sub-professional level personnel. Numerous responses revealed that college students and occupational therapy aides were used in the recreation programs.

An examination of the educational backgrounds of the directors of the recreation programs showed an enormous diversity of formal schooling. This is illustrated in Table IV.

**TABLE IV**

**EDUCATIONAL BACKGROUND OF THE RECREATION DIRECTORS**

<table>
<thead>
<tr>
<th>Degree</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.A./B.S. Recreation</td>
<td>10</td>
<td>24.4</td>
</tr>
<tr>
<td>Other Fields</td>
<td>8</td>
<td>19.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>M.A./M.S. Recreation</td>
<td>4</td>
<td>9.7</td>
</tr>
<tr>
<td>Other Fields</td>
<td>7</td>
<td>17.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>26.9</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>6</td>
<td>14.6</td>
</tr>
<tr>
<td>Others</td>
<td>6</td>
<td>14.6</td>
</tr>
</tbody>
</table>

It is interesting to note that, although well over half of the recreation directors have college degrees, only fourteen have degrees in Recreation or Therapeutic Recreation. Other areas of specialization mentioned included Education, Music, Art, Sociology, Physical Education, Psychology, Biology and various levels of Occupational Therapy certification. In fact,
thirteen of the directors have training in occupational therapy. This is most likely due to the close similarity of these two services and the fact that occupational therapy is a much older and more established field of service.

As could be expected from the diversity of educational backgrounds, certification in NTRS and TRAPS was not very widespread. As noted in Table V, 60 per cent of the institutions reported no certification with recreation associations. It appeared that state institutions were the most likely to have certified recreation personnel.

### TABLE V

**CERTIFICATION OF PERSONNEL**

<table>
<thead>
<tr>
<th>Auspices</th>
<th>NTRS</th>
<th>TRAPS</th>
<th>Both</th>
<th>Neither</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>State</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>County</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Private</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Voluntary</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Proprietary</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Church</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>2</td>
<td>9</td>
<td>23</td>
</tr>
</tbody>
</table>

Actual programming in recreation appeared to be fairly extensive. The twenty-three activities most frequently offered by the hospitals are listed in Table VI. Passive, unsupervised activities were offered most commonly. Social
activities, discussion groups, dance and drama, while offered by many of the institutions are absent from the top of the list. Perhaps the concepts of milieu theory which would stress this type of activity have not yet exerted much influence on actual provision of activities.

TABLE VI
RECREATION ACTIVITIES AVAILABLE TO THE PATIENTS

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number of Hospitals Offering</th>
<th>Average Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cards</td>
<td>40</td>
<td>Daily</td>
</tr>
<tr>
<td>Television</td>
<td>39</td>
<td>Daily</td>
</tr>
<tr>
<td>Crafts</td>
<td>38</td>
<td>Daily</td>
</tr>
<tr>
<td>Music</td>
<td>38</td>
<td>Daily</td>
</tr>
<tr>
<td>Team Sports</td>
<td>38</td>
<td>Daily</td>
</tr>
<tr>
<td>Arts</td>
<td>38</td>
<td>Daily</td>
</tr>
<tr>
<td>Calisthenics</td>
<td>36</td>
<td>Daily</td>
</tr>
<tr>
<td>Individual Sports</td>
<td>36</td>
<td>Daily</td>
</tr>
<tr>
<td>Social Activity</td>
<td>35</td>
<td>Daily</td>
</tr>
<tr>
<td>Discussion Groups</td>
<td>34</td>
<td>Daily</td>
</tr>
<tr>
<td>Game Room</td>
<td>34</td>
<td>Daily</td>
</tr>
<tr>
<td>Hobbies</td>
<td>32</td>
<td>Daily</td>
</tr>
<tr>
<td>Bingo</td>
<td>39</td>
<td>Weekly</td>
</tr>
<tr>
<td>Movies</td>
<td>38</td>
<td>Weekly</td>
</tr>
<tr>
<td>Trips</td>
<td>37</td>
<td>Weekly</td>
</tr>
<tr>
<td>Swimming</td>
<td>36</td>
<td>Weekly</td>
</tr>
<tr>
<td>Bowling</td>
<td>35</td>
<td>Weekly</td>
</tr>
<tr>
<td>Dance</td>
<td>34</td>
<td>Weekly</td>
</tr>
<tr>
<td>Cooking</td>
<td>27</td>
<td>Weekly</td>
</tr>
<tr>
<td>Gardening</td>
<td>25</td>
<td>Weekly</td>
</tr>
<tr>
<td>Drama</td>
<td>22</td>
<td>Occasion</td>
</tr>
<tr>
<td>Talent Show</td>
<td>21</td>
<td>Occasion</td>
</tr>
<tr>
<td>Camping</td>
<td>14</td>
<td>Occasion</td>
</tr>
</tbody>
</table>

Similarly, facilities available to the psychiatric patients appeared extensive, although the exact condition of
these facilities was not determined. Many of the hospitals indicated that either they were building facilities at this time or that they had use of public facilities and did not feel the need to build their own. The diversity of facilities available is shown in Table VII.

### TABLE VII

RECREATION FACILITIES AVAILABLE

<table>
<thead>
<tr>
<th>Facility</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indoor Gym</td>
<td>24</td>
<td>58.5</td>
</tr>
<tr>
<td>Outdoor Courts</td>
<td>28</td>
<td>68.3</td>
</tr>
<tr>
<td>Swimming Pool</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>Athletic Fields</td>
<td>27</td>
<td>65.9</td>
</tr>
<tr>
<td>Arts and Crafts Center</td>
<td>36</td>
<td>87.8</td>
</tr>
<tr>
<td>Dark Room</td>
<td>5</td>
<td>12.2</td>
</tr>
<tr>
<td>Game Room</td>
<td>34</td>
<td>82.9</td>
</tr>
<tr>
<td>Auditorium</td>
<td>18</td>
<td>43.9</td>
</tr>
<tr>
<td>Park</td>
<td>37</td>
<td>90.2</td>
</tr>
<tr>
<td>Others*</td>
<td>21</td>
<td>51.2</td>
</tr>
</tbody>
</table>

*camp, activity building, bowling alley, library, music room, miniature golf, tennis courts, exercise room, lounge, passenger van, movie theater, skating rink, patio with grills.

Some unexpected findings were encountered when one looks at the goals governing the provision of recreation services. These objectives, with their scores translated into rank order, are shown in Table VIII. As expected in accordance with the philosophies governing milieu theory, objectives emphasizing resocialization, reality experiences, improvement of patient self-concept and emotional release ranked high. The low
rank assigned to the teaching of leisure skills was unexpected in that it is traditionally regarded as a major objective of recreational therapy and current research suggests that psychiatric patients are often deficient in these skills. The low rank assigned to keeping patient morale high is more easily explained by the fact that present day emphasis in treatment of psychiatric patients is on getting them out of the hospital rather than expending energy keeping them happy while they are in the institution.

TABLE VIII
OBJECTIVES OF RECREATION SERVICES

<table>
<thead>
<tr>
<th>Rank</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>to improve the self-concept of the patients</td>
</tr>
<tr>
<td>2.5*</td>
<td>to help patients become involved in reality situations</td>
</tr>
<tr>
<td>2.5*</td>
<td>to provide avenues for emotional release and cultivation of interests outside the self</td>
</tr>
<tr>
<td>4</td>
<td>to help withdrawn patients become socialized</td>
</tr>
<tr>
<td>5</td>
<td>to provide release from hostility and aggression</td>
</tr>
<tr>
<td>6</td>
<td>to create patient awareness of leisure needs and improve motivation for participation</td>
</tr>
<tr>
<td>7</td>
<td>to provide information useful for diagnosis and evaluation</td>
</tr>
<tr>
<td>8</td>
<td>to teach skills useful for leisure after discharge</td>
</tr>
<tr>
<td>9</td>
<td>to improve patient morale</td>
</tr>
</tbody>
</table>

*The second and third objectives were tied and are expressed as 2.5.

It is also interesting to note that fifteen hospitals responded to this question by stating that all objectives were important and that they could not be ranked. Some
hospitals noted that the rank of these objectives was only important in how it pertained to individual patients and a different ranking could be had for each patient. This is a further indication of the premium given to individualized care given to the psychiatric patient.

The second purpose of this study was to determine the relative status of recreation therapists in the psychiatric community. Two methods of measuring this were used. The first dealt with the inclusion of recreation therapists on treatment teams. In such a situation, recreation personnel have the opportunity to interact on a relatively equal basis with other trained medical personnel. The participation of recreation therapists on treatment teams was found to be widespread with 88 per cent of the institutions reporting such participation.

The second method of determining status was through an examination of the extent to which recreation services are formalized. Formalization of methods and procedures indicates development of the service to conform with medical requirements of documentation and accountability. In addition, it implies that information obtained by recreation specialists is readily available for use in diagnosis and treatment. In doing this, recreation therapists elevate their status to integral members of the medical community and treatment team.

The first item of formal assessment was concerned with admissions practices. Sixty-three per cent of the hospitals
responding had this service, usually in the form of an interview or a questionnaire. Formalized record-keeping within the recreation program was found to be much more widespread with 93 per cent of the hospitals reporting this practice. A great variety of methods were used for this service ranging from simple attendance sheets to a recreation-specific database system. Examples of specific responses received may be found in Appendix C.

Evidence of a substantial flexibility in the methodology associated with recreation appeared again when one examined how patients became involved in the recreation programs. Most hospitals indicated that more than one method was used for this. The results are summarized in Table IX.

**TABLE IX**

**MEANS OF PATIENT INVOLVEMENT IN THE RECREATION PROGRAM**

<table>
<thead>
<tr>
<th>Means</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete free choice</td>
<td>20</td>
<td>47.6</td>
</tr>
<tr>
<td>Assigned individually</td>
<td>31</td>
<td>73.8</td>
</tr>
<tr>
<td>Assigned by group</td>
<td>26</td>
<td>61.9</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>11.9</td>
</tr>
<tr>
<td>Total</td>
<td>82*</td>
<td>195.2</td>
</tr>
</tbody>
</table>

*A high proportion of the respondents gave more than one answer.

This is evidence, also, of a belief that dealings with psychiatric patients should be, by the nature of the illness,
an individualized process. If this is the case, then no one method of involvement would be sufficient. Rather, a combination must be used and this was the case in many of the hospitals. Specific illustrations of this may be found in Appendix C.

The third major area which was examined was that of the impact of the trends in psychiatric rehabilitation towards milieu theory, unitization and community psychiatry. The findings of this study indicated a very definite commitment of recreation services to the role model put forward by milieu theory. As noted earlier, recreation therapists participated on treatment teams in 88 per cent of the hospitals. Comments received concerning this practice were highly favorable. A second major tenant of milieu theory is an emphasis on practicing skills of daily living, work and activity. In 74 per cent of the hospitals, it was indicated that there had been an increase in emphasis on these skills. Observations regarding this made by several of the respondents are listed in Appendix C.

A second major area of change in psychiatric rehabilitation is that of unitization. The concepts associated with unitization did not appear to be as widespread as those of milieu theory. Only 39 per cent of the hospitals responding indicated that unitization was in use. Reaction to the implementation of this feature varied. Approximately half of the respondents either had no comment or stated that it had
not affected the recreation program. There was only one positive comment and several negative comments. These are listed in Appendix C.

The final concept in this area involved the notion of follow-up services and community psychiatry. Unfortunately, the relationship of recreation with these concepts did not appear to be very well established at this time. Only 19 per cent of the hospitals responding offered follow-up services in recreation. Earlier research has indicated that this may be one of the primary areas of responsibility for therapeutic recreation. Leisure patterns displayed by patients upon their return to the community indicate a great need for this service, yet it is practically non-existent. More formalized out-patient care, as illustrated by Table X, utilized recreation to a much greater extent.

**TABLE X**

**OUT-PATIENT RECREATION SERVICES**

<table>
<thead>
<tr>
<th>Program</th>
<th>Number*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hospitals w/ program</td>
</tr>
<tr>
<td>Day Care</td>
<td>23</td>
</tr>
<tr>
<td>Night-Weekend Care</td>
<td>17</td>
</tr>
<tr>
<td>Ex-Patient Social Club</td>
<td>3</td>
</tr>
<tr>
<td>Half-way Houses</td>
<td>9</td>
</tr>
<tr>
<td>Family Care</td>
<td>7</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
</tr>
</tbody>
</table>

*Many respondents indicated that they had more than one program.*
This situation was unexpected because of what is found upon examination of the findings of this study in terms of community based programming and leisure counseling. These two areas are the concern of fourth major purpose of this study.

It appeared that actual hospital in-patient recreation programs relied rather heavily on community resources and personnel. Almost 90 per cent of the hospitals utilized community areas and programs in a great variety of ways including sports programs, entertainment, shopping, community service, education, rodeos, museum visits and many others. In addition, 81 per cent of the hospitals brought community groups or individuals into the hospital. These people were used as volunteers in the regular program, for entertainment programs and for special activities. This adds variety and diversity to the recreation programs and reduces the sense of isolation from the community.

Leisure counseling services did not appear to be very well developed at this time. Only 62 per cent of the hospitals reported having this service and in most cases, trained recreation personnel did not provide this service. This may simply be due to the heavy reliance of hospitals on occupational therapists and other personnel to administer the recreation programs.
Comparative Analysis

The findings of this study and those of Kraus' 1972 study (2) are very similar. His total survey population numbered 146, of which he had a 61.6 per cent response rate. The present study began with a much smaller total population of sixty-two and a response rate of 74.2 per cent was obtained.

In terms of the section dealing with staffing, goals, administration and programming, very little difference is seen. In terms of auspices, Kraus' study had a high representation of state and voluntary institutions. Staffing of the programs proved very similar also. As indicated in Table XI, the only major difference is seen in assignment of recreation personnel. The emphasis on hospital-wide assignment in the Texas study may simply indicate a greater percentage of smaller institutions responding to the study. In his discussion, Kraus does not indicate the size of the psychiatric units of his respondents.

TABLE XI

A COMPARISON OF STAFFING

<table>
<thead>
<tr>
<th>Staffing Category</th>
<th>Kraus</th>
<th>Steinfeld</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean # of recreation personnel</td>
<td>7.2</td>
<td>5.1</td>
</tr>
<tr>
<td>% hospitals with full-time staff</td>
<td>80.0</td>
<td>82.0</td>
</tr>
<tr>
<td>Mean # of full-time staff</td>
<td>4.6</td>
<td>4.7</td>
</tr>
<tr>
<td>% assigned to single ward or unit</td>
<td>50.7</td>
<td>41.5</td>
</tr>
<tr>
<td>% assigned hospital-wide</td>
<td>17.0</td>
<td>51.2</td>
</tr>
<tr>
<td>% assigned in both ways</td>
<td>32.0</td>
<td>7.3</td>
</tr>
</tbody>
</table>
One of the most interesting differences lies in recreation therapy's affiliation with occupational therapy. When this is examined in terms of administrative independence of the program, as summarized in Table XII, Texas programs show a much higher correlation with occupational therapy. It may be that the programs in this area have not yet developed sufficiently to assert their independence from the related programs of occupational therapy. The lack of formal training in 66 per cent of the directors of recreation services would tend to support this explanation.

**TABLE XII**

**A COMPARISON OF ADMINISTRATIVE STRUCTURE OF RECREATION PROGRAMS**

<table>
<thead>
<tr>
<th>Administration</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kraus</td>
</tr>
<tr>
<td>Separate Administration</td>
<td>42.7</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>12.0</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>13.3</td>
</tr>
<tr>
<td>Activities Therapy</td>
<td>10.0</td>
</tr>
</tbody>
</table>

When one examines the goals governing provision of recreation services, there are few differences in the two populations studied. Several individual rankings of goals are changed, but the clusters of goals in the top, middle and lower ranges of relative importance are similar. Exact rankings are shown in Table XIII. The major difference lies in the
ranking of the number one objective. The importance given to improving patient self-concept in Texas is probably due to the very strong and stated beliefs in the individualization of treatment for psychiatric patients. In both studies, the importance of those objectives associated with milieu theory are noted.

**TABLE XIII**

A COMPARISON OF RANK ORDER OF OBJECTIVES IMPORTANT IN RECREATION SERVICES

<table>
<thead>
<tr>
<th>Rank</th>
<th>Kraus</th>
<th>Steinfeld</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>2.5*</td>
<td>to help patients become involved in reality situations</td>
</tr>
<tr>
<td>2.5*</td>
<td>2.5*</td>
<td></td>
<td>to provide emotional release and interests outside the self</td>
</tr>
<tr>
<td>2.5*</td>
<td></td>
<td>4</td>
<td>to help withdrawn patients become socialized</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1</td>
<td>to improve the self-concept of the patients</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>6</td>
<td>to create awareness of leisure needs and improve motivation to participate</td>
</tr>
<tr>
<td>6.5**</td>
<td>5</td>
<td></td>
<td>to provide release for hostility and aggression</td>
</tr>
<tr>
<td>6.5**</td>
<td></td>
<td>7</td>
<td>to provide information useful for diagnosis and treatment</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td></td>
<td>to keep patient morale high</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
<td></td>
<td>to teach skills useful for leisure after discharge</td>
</tr>
</tbody>
</table>

*In both studies, the second and third objectives were tied and are expressed as 2.5.

**In Kraus' study, the sixth and seventh objectives were tied and are expressed as 6.5.

Activities offered in both study groups are very similar. Cards and television head both activity lists and a great
diversity of activities was evidenced by both populations. Many of the hospitals in Kraus' study made reference to new programs in self-care, creative writing and psychodrama. These more experimental types of activities appear to be missing from Texas programs.

As in the previous section dealing with actual components of recreation service, the impact of trends in psychiatric rehabilitation appears similar in both studies. The major comparisons in this area are shown in Table XIV. The only major difference is that assignment to activities is on an individual basis more often in Texas institutions. This is definitely in line with the emphasis on the individual noted earlier in this study, but may also be a result of smaller patient populations and thus more opportunity for individual contact.

**TABLE XIV**

A COMPARISON OF THE IMPACT OF CHANGES IN PSYCHIATRIC REHABILITATION

<table>
<thead>
<tr>
<th>Aspects of Rehabilitation</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kraus</td>
</tr>
<tr>
<td>Work as part of a treatment team</td>
<td>89.3</td>
</tr>
<tr>
<td>Have formal admissions procedures</td>
<td>60.0</td>
</tr>
<tr>
<td>Patient involved by free choice</td>
<td>40.0</td>
</tr>
<tr>
<td>Patient involved individually</td>
<td>38.7</td>
</tr>
<tr>
<td>Patient involved by group</td>
<td>46.7</td>
</tr>
<tr>
<td>Increase emphasis on living skill</td>
<td>77.3</td>
</tr>
<tr>
<td>Unitization implemented</td>
<td>41.3</td>
</tr>
</tbody>
</table>
It was in the area of community relations and psychiatry that the greatest differences between the two studies were seen. In Kraus' population, recreation was seldom part of formal outpatient services, while in Texas, 88 per cent of the day care, night-weekend care and ex-patient social clubs included recreation services. Similarly, community-based programming, either inside or outside the hospital, was found in 73.3 per cent of Kraus' institutions but was present in over 95 per cent of Texas institutions. Only two of the responding hospitals in Texas did not offer at least one of these services. This is definitely a positive step as such community involvement both enriches the programs and helps to prevent isolation of psychiatric patients from community life.

It was unusual, then, to find that follow-up services were offered by 42.7 per cent of Kraus' population and only 19 per cent of the Texas hospitals. Although no comments on this were received in the present study, many of Kraus' respondents indicated that they lacked the funds and qualified personnel for such services. As has already been noted, Texas programs are handicapped by a lack of trained recreation personnel. Since follow-up services involve close cooperation with community recreation personnel, it is possible that many of the people responsible for such programs simply do not have the training or knowledge enabling them to institute this service.

Leisure counseling services was another area which illustrated the close relationship between occupational therapy and
recreation services in Texas as opposed to the Northeast. The percentage of hospitals offering this service was approximately sixty-five in both studies. However, Kraus indicated that, in a majority of cases, the recreation therapist provided this service. No mention was made of occupational therapists. The Texas study showed occupational therapists having equal responsibility for this service.

Both studies, as has been noted, have reflected a great diversity of thoughts, concepts and techniques associated with therapeutic recreation. Considering the time difference between the two studies, it was remarkable how similar they were. In both we saw an adaptation to the new trends of psychiatric rehabilitation. In both there was an apparent breakdown of services for the post-psychiatric patient, although recreation had made substantial advances in terms of formal out-patient programs in the 1977 Texas study. Community-based programming had expanded tremendously in both number and variety. Leisure counseling had not made much progress and was not even under the domain of trained recreation personnel in many of the cases.

It would not be justified to say, based on a comparison of these two studies, that the Texas programs today are roughly comparable to those in the Northeast five years ago. Many parallels do exist, but advances in community programming give services now a different face. Texas has shown a much greater alliance between occupational and recreational therapies which, in many cases, has modified both. Occupational therapists are
found to be sensitive to new recreation concepts and will implement them in their programs. Whether this will prove harmful or beneficial to recreation services remains unanswered.

Evaluation of Programs

On October 22, 1971, the National Therapeutic Recreation Society's Board of Directors adopted a set of standards for recreation services in psychiatric facilities (1). These are the only national set of standards and while the authors admitted that some of its features are idealistic, this does not diminish the importance of this list.

In general, Texas hospitals with recreation programs for psychiatric patients have made a good start towards meeting these standards. In all the areas addressed by this survey, except staffing, the majority of services in Texas conform to the standards in some way.

Standard I deals with organization and states that

The written organizational plan of the Therapeutic Recreation Service shall be an integral part of the overall organizational plan of the institution and shall be available to all therapeutic recreation personnel. The written statement, which should be reviewed periodically, shall include specific functions of therapeutic recreation positions described and establish levels of responsibility required to achieve a well-operated, competently directed program of services (1, p. 53).

While the survey did not directly address this statement, other information obtained may be relevant. The fact that less than half of the recreation departments are administered independently indicates that written plans based solely on
recreation are not widespread. While sections dealing specifically with recreation may be incorporated into occupational therapy, rehabilitation or activities therapy plans, this is insufficient to meet the requirements of the NTRS. Also incorporated into this first standard are requirements that "communications practices with other services be written and defined" (I, p. 53), that recreation staff should serve on administrative and clinical committees and that hospital in-service programs include therapeutic recreation staff. It is unknown whether compliance with any of these exists.

Standard II deals with staffing and qualifications and reads as follows:

The Therapeutic Recreation Service shall be under the direction of a National Therapeutic Recreation Society qualified therapeutic recreation specialist. There shall be an adequate number of supervisors, leaders, assistants and specialists to provide administrative and clinical services in therapeutic recreation (l, p. 54).

It is in this area that programs in this state falter badly. Specific criteria are quite exact concerning staffing and are almost never met. Only a small number of directors meet the requirement of a master's degree in therapeutic recreation or a closely allied field. It appears that few of the directors are "professionally qualified in the field of recreation and the clinical practice and application of the principles of recreation for the mentally ill" (l, p. 54). Most of the hospitals meet the requirement of at least one administrator or supervisor, but in many cases, it appeared that their area of
responsibility encompassed more than just recreation. While 70 per cent of the hospitals admitted to using professional level therapists, it is doubtful that many of these were schooled in recreation. In addition, well over half of the respondents indicated their use of aides, trainees, students and untrained personnel. The NTRS standards require at least an A.A. in recreation with field work for sub-professional level personnel. Thus, staffing standards are far from being complied with in this area.

Standard II deals with policies and procedures.

A written manual of Therapeutic Recreation Service's administrative policies and procedures shall be developed to provide staff with guidelines to achieve established goals and methods of practice (1, p. 55). While the existence of a written manual itself was not ascertained, it did appear that most programs adhered to commonly accepted goals and objectives. Further criteria under this standard stated that written policies should include methods of initial diagnostic assessment and treatment, methods of personnel assignment and methods of documenting patient progress. The survey results indicate that Texas hospitals score well in these areas. Sixty-three per cent reported initial assessment procedures, all reported personnel assignment techniques and 93 per cent have documentation methods.

Program planning was the concern of Standard IV.

Therapeutic Recreation Service shall establish and keep current written criteria and procedures to develop and maintain high quality activity programs for patients or clients (1, p. 56).
Once again, while many of the recreation programs seemed to fulfill many of the criteria of this standard, whether actual written criteria and procedures are in existence is unknown. There are numerous individual criteria to be met under this standard which deserve to be mentioned. The first states that recreation programs shall "include written procedures indicating the method of approval for patient participation in activities" (1, p. 56). Means of patient involvement, as reflected in the survey responses, appears to be well-developed and sensitive to the individualization of psychiatric treatment. Other criteria state that the recreation service should maintain agreements and liaisons with community agencies and personnel for use in providing recreation experiences both within and outside the institution. As noted earlier, 95 per cent of the responding institutions provide that service. In addition, a final objective stated that activities should be diversified and flexible, affording experiences in the sensory-motor domain, the affective domain and the cognitive domain. The number and diversity of activities in Texas programs is large and through sports, social activities, discussion groups, hobbies, music, trips and others appear to meet this requirement.

Standard V concerns facilities, areas and equipment.

Therapeutic Recreation Service facilities, areas and equipment shall be designed and constructed or modified to permit all recreation services to be carried out to the fullest possible extent in pleasant and functional surroundings, accessible to all clients regardless of their disabilities (1, p. 57).
It is difficult to accurately determine if this standard is being met. Certainly, the rather large number of facilities reported by the hospitals would indicate compliance, but the quality of these facilities is unknown. Little is known concerning office areas, storage space, equipment and supplies available for recreation programs. Many of the hospitals admit to using numerous public facilities and this would serve to increase the diversity of areas available for recreation.

Standard VI refers to records and communications and is as follows:

Therapeutic Recreation Service shall have written procedures for providing continually updated interpretations of its purposes, objectives and services within the hospital or institution's total program, as well as the community at large (1, p. 57).

This survey did not address itself to the questions of interdepartmental workshops, meetings, distribution of information to the community, the keeping of statistical and personnel records, budgeting or program analysis, all of which are individual criteria of this standard. A further criterion states the need for records concerning attendance and follow-up reports. The former appears almost universal but the latter was rarely mentioned. A last criterion deals with maintenance of comprehensive individual records including periodic patient surveys, levels of patient participation and progress reports. The existence of the first is unknown, but in approximately half of the institutions responding, the latter two procedures have been implemented to some extent.
Standard VII, the final standard, concerns itself with education and research and states that:

Therapeutic Recreation Service staff should be included and should participate in intradepartmental as well as interdepartmental education, research and demonstrations projects or in related research projects conducted outside the hospital or institution (1, p. 58).

Little information concerning this is available, but an examination of articles in Therapeutic Recreation Journal over the last nine years reveals very few articles written by people in this state. This would indicate that little research is being done or reported in this area.

Thus, when one is to evaluate the therapeutic recreation programs in psychiatric facilities in Texas, one is left with the feeling that a start has been made, but there is still much to accomplish. While staffing with qualified and trained recreation personnel is significantly inadequate, other areas such as activities programming, facilities and use of community resources appear to be developing well. It appears that much work lies ahead before full compliance with these standards is achieved.
CHAPTER BIBLIOGRAPHY


CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study has shown that a great diversity exists in the provision of therapeutic recreation services to psychiatric patients in Texas. A large volume of data was gathered and it is appropriate to review the major findings of this study at this time.

a) Administration. In 40 per cent of the hospitals, recreation was administered independently. Almost 25 per cent of the recreation programs were under the jurisdiction of the occupational therapy department. The remainder were scattered among numerous other departments.

b) Staffing. Recreation staffs had a mean number of 5.1 persons. Almost 85 per cent of the hospitals used full-time personnel while 38 per cent employed part-time staff. At least one administrator was found in 80 per cent of the institutions while 71 per cent used professional level therapists and over half employed sub-professional level personnel. These were often students or occupational therapy aides.

The alliance with occupational therapy was supported by the finding that, while 70 per cent of the directors of the recreation services had college degrees, only 34 per cent had formal training in recreation and 32 per cent had degrees in occupational therapy.

54
Certification with either NTRS or TRAPS was in evidence rarely as 60 per cent of the institutions reported no certified personnel. State institutions appeared most likely to have certified recreation staff.

c) Programming. Passive, unstructured activities such as cards and television proved most pervasive. Other frequently mentioned activities included crafts, sports, music, movies and bingo.

The majority of the institutions reported extensive facilities available for recreation but the quality of these areas is unknown. Hospitals appeared most likely to have a park and an arts and crafts center.

d) Objectives. Institutions assigned the greatest importance to goals commonly associated with milieu theory. Specifically, highest priorities were assigned to improving patient self-concept, involvement in reality situations, emotional release and improving socialization. Lowest priorities were assigned to improvement of patient morale and the teaching of skills useful for leisure following discharge from the hospital. The low rank of the latter is surprising in that the literature indicates that it should be one of the more important goals in recreation services for psychiatric patients.

e) Formalization of procedures. Formalized methodologies were found in a majority of the hospitals. Admissions procedures, usually consisting of an interview or questionnaire were found in 63 per cent of the hospitals. Slightly more than 90
per cent reported record-keeping methods ranging from simple attendance sheets to comprehensive progress notes and a recreation-specific data base system.

Means of patient involvement in recreation programs reflected the individualization of patient care as most hospitals reported using a combination of free choice, individual assignment and assignment by group.

f) Impact of psychiatric trends. Treatment teams, a basic concept of milieu theory, were found to be pervasive as recreation personnel reported operating as part of such a team in 88 per cent of the institutions. Emphasis on daily living skills, another requirement of milieu theory, was found to be increasing in 74 per cent of the hospitals. This data suggests that milieu theory is exercising a profound influence on recreation services.

The concept of unitization had not yet become widespread with only 39 per cent of the hospitals reporting its presence. The majority of these were state hospitals that probably implemented unitization because of their large size. Reactions to unitization were generally neutral although one positive and several negative comments were received.

Follow-up services were found to be lacking as only 19 per cent of the hospitals offered this service. However, when recreation was allied with formalized out-patient programs, it appeared much more frequently.
g) Community programming. Involvement of the community in hospital recreation programs proved extensive. Almost 90 per cent of the institutions reported using community facilities such as movies, sports leagues, shopping areas, community education, museums and historical sites, special events and many others. In addition, 81 per cent of the hospitals used community personnel in their in-hospital programs as volunteers, special activities directors and for entertainment programs. This adds a substantial variety to the the programs in addition to counteracting the isolation of the mental patient from the community.

h) Leisure counseling. This form of counseling had not yet become very widespread. While over half of the institutions reported this service, in no more than 34 per cent of them were recreation therapists responsible for this service. It is questionable that persons not trained in recreation would have sufficient knowledge of recreation philosophy and practice within the community to adequately provide this service.

i) Comparison with Kraus. The comparison with the 1972 Kraus study (2) revealed many similarities between the two studies. The major differences were in a greater affiliation of recreation services with occupational therapy programs and personnel in Texas and a much greater use of community resources and personnel in this state.

j) Evaluation. The evaluation in terms of the NTBS standards proved less than definite. While it appears that most
hospitals in Texas are complying, at least in spirit, with many of the standards, it was not determined whether the requirements of written procedures, goals and policies were being met. The data suggests that they were not. In terms of staff qualifications, Texas hospitals fall short of the standards. Only 10 per cent of the directors were qualified in terms of the NTRS standards and a great majority of the other personnel appeared basically untrained in recreation. The heavy reliance on aides, occupational therapy personnel and students indicated a significant lack of trained recreation personnel. Nonwithstanding the staffing problems, it did appear, however, that a start had been made toward meeting the NTRS standards.

Conclusions

It appears that, in the Texas area, therapeutic recreation is a widely accepted form of treatment service in psychiatric rehabilitation. That therapeutic recreation is still struggling to define specific goals, intake procedures, record-keeping methods and numerous other administrative matters is indicated by the great variation found in the provision of these services. The development of recreation services is being further complicated by the concepts of milieu theory, unitization and community psychiatry which, as has been seen, are exerting pressure on recreation programs at this time. Recreation personnel are adapting to these changes and seemingly incorporating them into their programs. Recreation services showed increasing emphasis
on daily living skills, use of community facilities and personnel, treatment team participation, socialization techniques and individualization of treatment and patient care. All of these represent consequences of the acceptance of the aforementioned trends in psychiatric rehabilitation.

The close association of occupational therapy and recreation services found in Texas deserves special consideration. This is probably most likely due to the fact that the basic programs of these services are very closely related and occupational therapy has the advantage of being an older, more established field. Whether this affiliation will prove detrimental to recreation will apparently remain unanswered for some time. It is interesting to note, however, that many of the occupational therapists responding to the survey, demonstrated a notable sensitivity to new concepts and changes in therapeutic recreation. In many cases, the new recreation concepts have been implemented within their services. Thus, it appears that therapeutic recreation services will continue to develop, no matter who administers its programs.

Closely related to this last point is another rising from the comparison with Kraus' study. It is seen that therapeutic recreation, as a set of concepts and practices, is responding in essentially identical manners to the changes wrought by the dynamics of psychiatric rehabilitation. This is occurring regardless of time, place, personnel or administrative structure of the recreation program. This similarity of response indicates
that, within the psychiatric setting, there exists a body of concepts and practices we may call therapeutic recreation. In this comparison, there are preliminary indications that therapeutic recreation, as it exists in actual practice, is a specified field whose elements can be defined and whose adaptations to change will be similar and predictable. The importance of this for planning and development cannot be underestimated.

It was helpful to determine that progress is being made towards defining and delineating concepts fundamental to the actual practice of therapeutic recreation, but one must not forget the deficiencies uncovered by the study. While it appears that a start has been made towards compliance with the NTRS standards, one is left with an understanding that a formidable task lies ahead. There exists a significant shortage of trained recreation personnel at all levels. While it is not known just how widespread actual written, formalized procedures are, the great diversity displayed in the survey responses indicates that there is a lack of communication and knowledge among recreation professionals. More uniformity of practices should help to more explicitly define the role, objectives and methodologies in therapeutic recreation, especially for the majority of personnel with not formal training in the area of recreation.

Much work then, is still to be done, both in terms of practical applications in therapeutic recreation and in research
in this area. Although a beginning has been made, this survey has resulted perhaps, in more new questions to be resolved than in the number it answered.

Recommendations

As a result of the findings of this study, the following recommendations are made.

A field investigation of selected institutions participating in this study should be carried out. This would help to clarify many of the ambiguities found in the present study, especially in the area of compliance with NTR3 standards.

The differences and similarities between recreation programs directed by persons with formal recreation training and programs directed by persons with no formal recreation training should be determined.

A compilation of forms, questionnaires and assessment instruments used in recreation programs should be undertaken. Subsequent to this, standard assessment forms for admissions, in-program record-keeping, counseling and community services should be developed.

The quality of the recreation facilities available to psychiatric patients should be determined.

Causes for the breakdown in follow-up services and post-hospitalization recreation programs should be specified. If indicated, joint community/hospital committees should be formed to facilitate the provision of these services for the patients.
A list of all persons working in therapeutic recreation for psychiatric patients should be compiled and a copy of the NTRS list of standards sent to them.

A checklist based on the NTRS standards should be developed and periodically remitted to hospitals in this state.
APPENDIX A

COVER LETTER TO THERAPEUTIC RECREATION SERVICES QUESTIONNAIRE

May 10, 1977

Dear _____________________________,

It has been over seven years since any attempt has been made to analyze, in a comprehensive manner, the therapeutic recreation programs for psychiatric in-patients present in the state of Texas. Current information regarding these recreation programs is necessary for further development of professional services and for curriculum development in universities.

A preliminary study has indicated that you offer a recreational therapy program for your psychiatric in-patients. Since my thesis will be concerned with an analysis of such programs in Texas, it would be of great help to me if you could take a few minutes and complete this questionnaire. All data will be treated in an objective and confidential manner.

I would greatly appreciate it if you could complete the questionnaire and return it to me by May 24, 1977 in the enclosed envelope. If desired, a copy of the survey results will be sent to each individual participating in the study.

Thank you very much for your time and cooperation.

Sincerely Yours,

Janis Steinfeld
Master of Science Candidate
North Texas State University
Questionnaire

Please complete this questionnaire by placing, in the space to the left of the question, the number of the applicable answer. With questions in which more than one answer may be correct, please check each correct answer.

1. Is your recreation department administered as a separate, independent department?
   1. yes
   2. no

If no, please indicate what department is responsible for the administration of the recreation program:

2. Please indicate if you have full-time personnel whose primary responsibility is recreation. If yes, how many:
   1. yes Number: ___
   2. no

3. Please indicate if you have part-time personnel working in the recreation program. If yes, how many:
   1. yes Number: ___
   2. no

4. Please indicate the levels at which all your personnel work and the number at each level:
   a. administrative/supervisory. Number: ___
   b. professional level therapist. Number: ___
   c. sub-professional level (aide, trainee). Number: ___
   d. other. Please specify: ___

5. What is the educational background of the director of therapeutic recreation services:
   1. B.A./B.S. Major: __________________
   2. M.A./M.S. Major: __________________
   3. Occupational Therapy
   4. Other: __________________

6. If any of your staff is certified with the National Therapeutic Recreation Society or with the Texas Recreation and Parks Society, please indicate which organization they are certified with:
   1. NTRS
   2. TRAPS
   3. Both
   4. Neither
7. Please indicate the basis on which recreation leaders are usually assigned:
   1. assigned to a single ward, unit or building
   2. assigned to a hospital-wide responsibility

8. Do recreation personnel operate as part of a treatment team:
   1. yes
   2. no
   Comments: ________________________________

9. Do you have formal procedures upon admission to determine a patient's recreational interests and needs:
   1. yes
   2. no

10. If yes, what means do you use:
    1. questionnaire
       2. interview
       3. other. Please specify: ________________________________

11. Do you have formal record-keeping materials and methods relating to each individual participating in the recreation program:
    1. yes
       2. no
       Comments: ________________________________

12. In what ways may a patient become involved in the recreation program:
    a. complete free choice
    b. assigned on an individual prescription basis
    c. assigned as part of a group assigned activity
    d. other. Please specify: ________________________________

13. In your hospital, has there been an increase in emphasis on activities centered around practicing skills of daily living, self-care activities and work skills:
    1. yes
       2. no
       Comments: ________________________________
14. Please indicate those activities which are available to your patients and the frequency with which they are available: (Occ. = occasionally)

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<tr>
<th>Activity</th>
<th>Daily</th>
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<th>Occ.</th>
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<td>Others</td>
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15. Please indicate which of the following facilities you have available for your patients:

- a. indoor gym
- b. outdoor courts
- c. swimming pool
- d. athletic fields
- e. arts and crafts center
- f. dark room
- g. game room
- h. auditorium
- i. park
- j. others. Please specify: __________________________
16. The following statements are objectives which are often stated to be important in therapeutic recreation services. Please rank these objectives, from 1 - 9, on a scale of decreasing importance to your program: ( #1 most important, #2 next most important...#9 least important )

1. to help patients become involved in reality situations
2. to provide information useful for diagnosis and evaluation
3. to improve the self-concept of the patients
4. to teach skills useful for leisure after discharge from the hospital
5. to help withdrawn patients become socialized
6. to keep patient morale high
7. to provide avenues for emotional release and cultivation of interests outside the self
8. to create patient awareness of leisure needs and improve motivation for participation
9. to provide release for hostility and aggression

other: _______________________________

17. Has unitization (def: program in which residents are grouped according to their geographic residence and various hospital services are combined in closely cooperating team relationships in these units) been utilized in your institution:

1. yes
2. no

18. If yes, how has they affected the recreation program content or the assignment of personnel:

_________________________________________________________________________

19. Do you involve your patients in community based activities:

1. yes
2. no

20. If yes, please indicate which of these activities are included in your community programs for in-patients:

a. sports programs and leagues
b. shopping trips
c. entertainment (movies, theater, special events)
d. others. Please specify: _______________________________
21. Do you bring community groups into the hospital as part of the recreation program:
   1. yes
   2. no

22. If yes, please indicate what these groups may do:
   - a. entertainment programs
   - b. volunteers in regular program
   - c. special activities
   - d. others. Please specify:

23. Is leisure counseling (a program of advisement or discussion with individuals or groups of patients intended to help them understand their leisure needs) offered in your institution:
   1. yes
   2. no

24. If yes, who is responsible for this counseling:
   - a. recreation therapists
   - b. doctors and other medical personnel
   - c. Occupational Therapists
   - d. social workers
   - e. others. Please specify:

25. Do you provide follow-up services for discharged patients such as counseling after discharge and consultation with community recreation leaders:
   1. yes
   2. no

26. If your hospital offers any of the following, please indicate. Then indicate if recreation is provided with the program:

<table>
<thead>
<tr>
<th>Program</th>
<th>Hospital Has</th>
<th>Recreation Offered</th>
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<tr>
<td>day-care program</td>
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<td>night-weekend care</td>
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<td>ex-patient social clubs</td>
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<td>half-way houses</td>
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<td>family care programs</td>
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<tr>
<td>others</td>
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</table>
27. What are the auspices of your institution:

1. federal
2. state
3. county
4. municipal
5. voluntary non-profit
6. proprietary
7. church-related
8. other. Please specify:

28. Please indicate approximately how many psychiatric patients are receiving 24-hour in-patient care in your institution at any given time (during the course of a typical week):

1. 0 - 25
2. 25 - 50
3. 50 - 100
4. 100 - 250
5. 250+

Thank you very much for taking the time to complete this questionnaire. It will be very helpful in determining a realistic picture of current practices in therapeutic recreation services for hospitalized psychiatric patients in Texas. If there are any additional comments you wish to make concerning your program, please do so in the space below. If there are any pamphlets or other printed material you would like to enclose, please do so. Once again, thank you for your help.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Please check if you would like a copy of the survey results sent to you:
APPENDIX B

LISTING OF RESPONDING INSTITUTIONS

Arlington Neuropsychiatric Center
Austin State Hospital
Baytown Medical Center Hospital
Beaumont Neurological Center Inc.
Belhaven Hospital
Bellaire General Hospital
Ben Taub Hospital
Beverly Hills Hospital Inc.
Bexar County Hospital
Big Spring State Hospital
Brooke Army Medical Center
Central Brazos Valley Mental Health Center
Galveston County Memorial Hospital
Hermann Hospital
Hospital and Home for the Jewish Aged
John Peter Smith Hospital
Kilgore Children's Psychiatric Center and Hospital
Kerrville State Hospital
Medicenter Psychiatric Hospital
Memorial Hospital Center - Corpus Christi
Memorial Hospital System - Houston
Methodist Hospital - Houston
Methodist Hospital - Lubbock
Parkland Memorial Hospital
Psychiatric Institute of Ft. Worth
Rusk State Hospital
St. Joseph Hospital - El Paso
Sam Rayburn Memorial Veteran's Center
San Antonio State Hospital
Santa Rosa Medical Center
Shoal Creek Hospital
Terrell State Hospital
Timberlawn Psychiatric Hospital Inc.
TRIMS
Vernon Center
Veteran's Administration - Dallas
Veteran's Administration - Houston
Veteran's Administration - Temple
Veteran's Administration - Waco
Wichita Falls State Hospital
Wilford Hall US Air Force Medical Center
William Beaumont Army Medical Center
APPENDIX C

COMMENTS BY RESPONDING INSTITUTIONS

Means of Patient Involvement

Day time participation is expected; evening and weekend participation is optional, but physician may insist on participation.

Combination of all depending upon ward, doctor, preference, ward structure and staff's capability.

Daily classes are for those specifically referred; evening and weekend are open for all who choose to attend.

Participation on Treatment Teams

Recreation leader is present at many physician-staff meetings or is represented by the OT department.

Includes Patient Staffing, Patient Community Meetings, Charting, Physician's Refferals, Adult Patient Program, Advisory Board.

Emphasis on Daily Living Skills

As modalities and techniques change, so does the staff. Continuing education is a must in our medical center in order to meet the changing needs of our clients.

Patients in a domiciliary are expected to care for daily living activities and to work within the hospital. We develop and maintain social skills for them.
Development of socialization skills, increased structured use of leisure time.

This is increasing more due to physical disabilities involvement in patients.

OT, Speech and PT do the above, primarily with rehabilitation patients.

Unitization:

Staff has to have more diversified program to meet the needs of various patients - much harder to be completely therapeutic.

Has divided the recreation program.

We have much more paperwork and less time to devote to patients in a relaxed atmosphere. More pressure on our time so that therapy given has to be limited to a certain time space.

More socialization in each unit has been emphasized, reaching for the withdrawn and depressed patient. Scheduling of areas and RT personnel is important to allow equal time for each unit, as needed.

This has made it necessary to adjust our programs to involve as many patients as possible.

More continuity with relationships after the program.

Record Keeping

Recreation Therapy maintains an observation sheet in the patient's medical chart.
All clients have attendance cards and a periodic note is written as to their progress and participation. Treatment plan, daily notes and weekly recapitulation.

Attendance/Participation form for monthly summary statistics. Written treatment plan stating goals and group times. Progress notes.

We keep accurate attendance records and regular progress notes as related to therapeutic goals.
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Publications of Learned Organizations


Unpublished Materials


