Evaluation of Therapeutic Recreation Pilot in Hamilton's Residential Care Facilities

February 1, 2016
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Disclaimer: The following report and its contents were prepared by Woodhall-Melnik Research & Professional Services who were contracted by Wesley Urban Ministries. This report was prepared for the Housing Services Division of the City of Hamilton's Community and Emergency Services Department. The data were collected in accordance with industry ethical standards. The views and recommendations contained within this report are those of the authors and do not necessarily reflect those of Wesley Urban Ministries.

Table of Contents

Executive Summary: Evaluation of Therapeutic Recreation Pilot in Hamilton's Residential Care Facilities

The following summary presents the key findings and recommendations from our baseline and follow-up assessments of the Therapeutic Recreation (TR) pilot provided to 5 Residential Care Facilities (RCFs) in Hamilton, Ontario. The RCFs involved in this pilot are subsidized through the Domiciliary Hostel Subsidy Program which is overseen by the Housing Services Division of the City of Hamilton's Community and Emergency Services Department. For more comprehensive information, please see the appended full report.

In 2015, Wesley Urban Ministries was contracted to provide TR services to residents of 5 RCFs. Therapeutic recreation "utilizes functional intervention, education, and recreation participation to enable persons with physical, cognitive, emotional and/or social limitations to acquire and/or maintain the skills, knowledge and behaviours that will allow them to enjoy their leisure optimally, function independently with the least amount of assistance and participate as fully as possible in society" (Therapeutic Recreation Ontario, 2016). This differs from diversion programming which is designed to provide individuals with entertainment.

The TR pilot was designed with the following goals: 1) To increase access to and participation in recreation services for residents involved in the pilot; 2) To improve the quality of life and the health and wellness for residents involved in the pilot; and 3) To improve the capacity of operators to provide therapeutic recreation opportunities for residents.

Wesley Urban Ministries is a non-profit organization that provides services to those in need in Hamilton's downtown core. They are mandated to reduce barriers and increase opportunities for individuals and families experiencing a multitude of complex concerns including but not limited to poverty, addictions, homelessness, unemployment, and disability. Wesley Urban Ministries works with the United Church, other local service providers, community organizations, and different levels of government to improve social and economic outcomes in Hamilton.

At present, RCF operators are mandated to follow by-law requirements dictating building conditions and public health standards. Operators are required to provide residents with supervision and advice; often referred to as custodial services. However, operators are not required to provide therapeutic counseling, therapeutic recreation or case management. The five facilities in the study are privately owned and operated for-profit. This pilot provides TR supports which are delivered by a certified full-time recreation therapist.

An evaluation was requested to determine the ability of the pilot to meet the aforementioned goals. Data were collected 3 and 8 months after the start of the pilot to assess the success of the pilot at early implementation as well as to document residents' recreation needs. The researchers

conducted semi-structured interviews with RCF residents, staff members and owners, and key informants (persons with knowledge of the RCF system or extensive knowledge of TR). The interviews focused on residents' housing histories, medical, social and economic needs, and experiences with recreation. Residents were asked to discuss leisure participation prior to the pilot as well as early experiences with the pilot. Providers were asked to discuss their views of TR and of the pilot and key informants were asked to provide information about and opinions on the RCF system and TR. The recreation therapist who administered services for the pilot provided us with her baseline assessments of residents' participation in meaningful leisure and her program participation data. These data were used to assess the program uptake and are provided in the longer report.

Main Findings & Recommendations:

Goal #1: To increase access to and participation in recreation services for residents involved in the pilot

- Increases in the number of RCF residents who participate in TR activities were observed. The residents were aware of the services and activities they could participate in and generally speaking providers noted an increase in recreation uptake.

- Some barriers to participation in TR persisted. These included residents' motivation levels, mental health, being accustomed to a preexisting routine, and being wary of new situations and people.

Goal #2: To improve the quality of life and the health and wellness for residents involved in the pilot

- Staff/operators and residents indicated that participation in the pilot was beneficial in reducing stress. Residents were able to have new experiences, learn new skills, and develop friendships.

- Both staff/operators and residents expressed that they had seen benefits from the implementation of the pilot which included receipt of more personalized care, more mobility, and increased choice in terms of recreation activity and recreation partners. Additionally, some staff noted that TR decreased household stress and conflict by providing a welcomed distraction, improving mood, and by decreasing constant resident traffic in the home.

- The residents and staff described the need for more community agency involvement in providing support for residents. For example, although requested, some residents were unable to access social work, psychiatric, or case work supports independently. The TR therapist should continue to work with these residents to secure community-based care for mental and physical health concerns.

Goal #3: To improve the capacity of operators to provide therapeutic recreation opportunities for residents

- The RCF pilot remedied the material barriers to providing TR (e.g. space, time, and finances) that providers described in their first interviews. The majority of staff/operators indicated that the pilot was a welcome addition to the RCFs and provided clients with the opportunity to participate in different or new activities.

- Providers were concerned with program longevity, noting that the pilot could have more impact if sustained over a longer and certain period of time. The providers also noted the need for more funding so support could be offered on a more regular and individualized basis. Some providers suggested that the program continue to operate with additional supports, whereas one provider was particularly concerned that the pilot was duplicating preexisting community diversion programs which suggests that there is a need to provide operators and staff with the opportunity to learn about differences between therapeutic and diversion programming.

Our findings suggest that the pilot was beneficial for residents and staff. Individuals who were added to the TR therapist's caseload were generally successful in forming meaningful connections with the community. We recommend increasing staff levels or finding a way to reallocate funding to provide more individualized and frequent recreation supports. Additionally, we suggest that recreation programming be offered to new entrants to the RCF system and that affected parties work together to find a way to get residents to follow through with scheduling including providing frequent reminders and wake-up calls. Additionally, continuing to connect residents with mental health professionals may assist residents in feeling safer with leaving their homes and interacting with others. Our findings also suggest a need for greater social agency and mental health care involvement in the RCFs. The TR therapy program should continue to connect residents with mental health and social services providers in the community.

Evaluation of Therapeutic Recreation Pilot in Hamilton's Residential Care Facilities

INTRODUCTION

The following report presents the findings and recommendations from the evaluation of the Therapeutic Recreation (TR) Pilot in Hamilton's Residential Care Facilities (RCFs). At present, RCF operators are mandated to follow by-law requirements dictating building conditions and public health standards. Operators are required to provide residents with supervision and advice; however, operators are not required to provide therapeutic recreation or case management. The pilot provided TR supports which were delivered by a certified full-time recreation therapist. Hamilton's municipal housing division contracted Wesley Urban Ministries to provide therapeutic recreation services to residents of 5 RCFs with the following goals:

- To increase access to and participation in recreation services for residents involved in the pilot
- To improve the quality of life and the health and wellness for residents involved in the pilot
- To improve the capacity of operators to provide therapeutic recreation opportunities for residents

An evaluation was requested to determine the ability of the pilot to meet the aforementioned goals. The main objective of this document is to provide an evaluation of the use and effectiveness of a therapeutic recreation intervention in five of Hamilton's Residential Care Facilities.

We develop our evaluation through first providing the broad context for the pilot. Next we examine the background and history of RCFs in Hamilton and briefly review the relevant literature on the residential care and TR. We go on to describe the research methods employed in the evaluation and conclude with our findings, discussion, and recommendations.

BACKGROUND

For the past 50 years there has been an ongoing move to deinstitutionalize psychiatric and other forms of long-term care in Canada. Initially, there was a rapid release of patients out of psychiatric and community hospitals into neighbourhoods across Canada and a much slower reactive provision of community-based mental health services (Sealy and Whitehead, 2004). Deinstitutionalization is comprised of three processes:

> 1) the shift away from dependence on mental hospitals; 2) 'transinstitutionalization,' or an increase in the number of mental health beds in general hospitals; and 3) the growth of community-based outpatient services for people with mental illness" (Sealey and Whitehead, 2004:250). Deinstitutionalization, initiated in the 1960s, began in earnest in the late 1970s with the highest number of psychiatric bed closures occurring between 1975 and 1981. Ontario had a 67% decrease in psychiatric beds between 1965 and 1981.

Hamilton's early experience of deinstitutionalization has been well documented in Dear and Wolch's (1987) book *Landscapes of Despair: From Deinstitutionalization to Homelessness*. The book outlines how people experiencing mental illness have been placed into inner-city areas. They paint a vivid picture of what happens to individuals after discharge from psychiatric hospitals and the process through which those living with mental illness attempt to find their way back into the community:

> In summary, the experience of discharge can effectively dash the hopes and optimism of many patients as they re-enter the community. They face severely limited (usually downtown) housing opportunities; they are frequently referred upon discharge to core area accommodations and services that are often found to be unsatisfactory and ineffective; and they are forced to turn inward in the face of diminished social networks. In their search for 'community', those ex-patients (who have not already been referred there) gravitate toward the zone of dependence. It is almost self-evident that the impetus behind ghettoization is he search for a wider support network. The inner city has become a coping mechanism where ex-patients can find help in the search for jobs and homes, can locate other support facilities, begin or renew friendships, start self-help groups and operate newsletters. Although still far from an optimal setting, in the absence of any better alternative the ghetto is functional for Hamilton's ex-patients. It is a spatially limited zone where access to different kinds of support is made possible through geographical proximity (2014:137-138).

In the years since Dear and Wolch's book was originally published, Hamilton has arguably become the 'go-to' place for residential care, with anecdotal evidence suggesting that many residents of RCFs come from other cities like Toronto. While concentrating individuals in select urban neighbourhoods been functional for residents of RCF's, Demopolis (1984) found that from very early on, a lodging home or 'service' ghetto was perceived to exist in Hamilton and was seen as a problem by both the government and local citizen groups.

Perceptions aside, the lodging home system has become the dominant system for providing housing for those discharged from care with high needs and low social supports in the City of Hamilton. Dear and Wolch (2014) warn that one must be careful in making changes to this system as it has been relied upon to fill gaps in housing created by deinstitutionalization. However, the community has called for change. Neighbourhood gentrification is creating pressure for service providers and the RCF clientele is also demanding change. Mental health providers like the Canadian Mental Health Association (CMHA) are finding that clients "are requesting to move elsewhere, especially the 'mountain' area of Hamilton, the southern half of the city located atop the Niagara escarpment" as "some clients, particularly those with serious addiction issues, want to get away from the downtown core because they would find it easier to avoid unsafe places and situations" (Foley in Slechta, 2008).

The World Health Organization (WHO) (2014) advocates for community living as a humane best practice. However, in reporting on deinstitutionalization, they also argue that:

> Former institutional residents need access to mental health services, including evidence-based clinical care and also access to social services for help with housing, employment, and community integration (WHO, 2014:14).

In other words, deinstitutionalization is preferred; however, when moves to community-based living are made, efforts must be made to ensure appropriate and comprehensive supports are available to integrate individuals into communities. Past research described the problems associated with community integration (David et al. 1981). However, more recent work has begun to focus on community integration as an outcome (Baumgartner and Herman, 2012). This is highly relevant for residential care providers who work with populations that tend to be chronically disengaged from service providers and their communities. Findings suggest that mental health consumers living in care facilities may not achieve levels of objective community

integration that are comparable with other community members. Psychiatric diagnoses did not account for this difference.

Length of time in neighborhoods is an important factor in facilitating social integration. Yanos et al. (2014) and Wong and Solomon (2002), argue that community integration (measured by participation in local activities) should be an important measure for researchers studying the importance of place for persons experiencing severe and persistent mental illness. In response to this call, Yanos et al. (2014) studied community integration and found that while mental health consumers living in supported housing may not achieve levels of objective community integration comparable with other community members, it was not psychiatric factors that primarily accounted for this but rather the length of time lived in a neighborhood. The presence or absence of TR would appear to be an unstudied aspect of community integration.

The RCF model came into existence in Hamilton as a response to deinstitutionalization. Hamilton's RCFs provide housing for persons who require functional support. Many of these individuals live with severe and persistent mental illness. RCFs operate under a city by-law that requires the homes meet certain physical standards and that the residents receive basic assistance with activities of daily living, medication administration, and supervision. The by-law lists the requirement that RCFs provide "advice" but they are not mandated or subsidized for offering case management. The by-law specifically outlines housing requirements, but is vague in its conceptualization of support.

RCF tenants make a monthly rent and cost of living payment which is usually taken off of Ontario Disability Support, Canada Pension Plan, or Old Age Security payments. Resident contributions, in tandem with municipal subsidies, are provided to private for or not-for-profit RCF owners who in turn provide accommodation, food, supervision, and advice. At the time of the RCF TR pilot's conception, RCFs were not funded to provide therapeutic support to residents. Diversion recreation activities and resources were being provided by other agencies (e.g. CMHA) and through municipal funding supplied to RCF providers. The pilot was introduced with the goals of increasing access to and participation in TR, improving residents' quality of life, health, and wellness, and improving operators' capacity to offer recreation.

A Place for Leisure

Since the late 1990s there has been a global movement to recognize leisure as a human right. Key statements issued over the years that have emerged from a variety of international meetings of scholarly societies include: 1) the Charter for Leisure (World Leisure, 2000), which unambiguously declares leisure is a fundamental human right; 2) the Sao Paulo Declaration (World Leisure and Recreation Association, 1998), which reaffirms the importance of leisure in an increasingly globalized world; 3) the Quebec Declaration (World Leisure, 2008), which acknowledges leisure's role in the development of inclusive, democratic communities; and most pertinent to the present project, 4) the International Position Statement on Leisure Education and Populations of Special Needs (World Leisure and Recreation Association, 2001), which argues that people with disabilities have a right to leisure.

In clinical settings there has been a recent move to transition leisure and recreation programming from a diversion activity model towards a therapeutic model (Polatajko, 2001). Diversion activities, as distinguished from TR, are typically conducted by individuals who focus on games and pastimes for fun without the intensive focus on an individual's rehabilitative needs. They discourage participation in antisocial behaviours. In contrast, recreational therapists assess patients' need and develop individualized care plans that seek to promote health and well-being and improve quality of life. The definition of therapeutic recreation endorsed by Therapeutic Recreation Ontario is as follows:

> Therapeutic Recreation is a process that utilizes functional intervention, education and recreation participation to enable persons with physical, cognitive, emotional and/or social limitations to acquire and/or maintain the skills, knowledge and behaviours that will allow them to enjoy their leisure optimally, function independently with the least amount of assistance and participate as fully as possible in society. Therapeutic Recreation intervention is provided by trained professionals in clinical and/or community settings (Therapeutic Recreation Ontario, 2016).

TR has shown positive outcomes for clients and is becoming increasingly adopted in a variety of settings, especially in residential care for older adults (Mclannahan and Risley, 1975; Buettner et. al. 1996; Snowden et. al. 2002).

Although leisure has been deemed important to adolescent development, the importance of adult leisure and recreation for health and well-being has in the past been considered trivial by academics and health care professionals (Caldwell, 2005). While little is known about the outcomes of TR provision for mentally ill residents of RCFs, several large scale literature reviews capture the experience and positive outcomes for a number of similar populations. For example, Kennedy (1987) conducted a literature review of the mental health benefits of wilderness and physical programs. While there was a mixture of results, Kennedy (1987:48) ultimately concludes that, "both physical fitness activities and wilderness programs do contribute to positive changes in self-concept and improvement of social functioning of persons who are emotionally disturbed, particularly children and youth." Kneafsey (1996) reviewed the literature on the therapeutic use of music in care facilities for older adults, finding generally positive mental health outcomes. Arguably, the most germane analysis of TR interventions was conducted by Snowden et al. (2003). They studied the treatment of nursing home residents with depression or behavioral symptoms associated with dementia. Snowden et al. (2003) concluded that non-pharmacological interventions, such as meaningful participation in recreation, have been found effective in decreasing the severity of symptoms associated with depression and to mitigate the effects of dementia. In all of these large scale literature reviews, TR in its various forms was found to be successful in promoting individual and community well-being and in improving the overall quality of life.

To contextualize TR's introduction in the pilot program, it is important to ask "Why is recreation or leisure therapeutic?" In answer to this question, Caldwell (2005:17) finds that leisure and recreation can be therapeutic by contributing to physical, social, emotional and cognitive health through prevention, coping (adjustment, remediation, diversion), and transcendence. In her review she finds that leisure and recreation provide the following protective factors:

- Benefits of personally meaningful and/or intrinsically interesting activity derived in leisure.
- Need for social support, friendships, and social acceptance in leisure.
- Competence and self-efficacy derived from leisure participation.
- Experiences of challenge and being totally absorbed in leisure activity.
- Being self-determined and in control in leisure.
- Feeling relaxed, disengaging from stress, being distracted from negative life events through leisure.

- Ability of leisure to provide continuity in life after experiencing disability.

One of Caldwell's more interesting findings is the link between well-being and control and choice: "for people who experience uncontrollable life events (e.g. death, illness, divorce, work stress, unemployment), an opportunity to experience some level of control and choice through leisure is important" (2005:19). These are frequent conditions that the mentally ill experience in residential care settings. Deci and Ryan (1985) and Ryan and Deci (2000) also find that leisure is a context for self-determined and autonomous behaviour and promotes intrinsic motivation and interest.

Several early studies of RCFs have affirmed the importance of choice and control in leisure experiences as markers of well-being. For example, in a study of RCF's for older adults, researchers found that "allowing more choice and control were associated with better rated resident well-being, less use of health, daily living assistance, and social-recreational services, and more integration in the community" (Timko and Moos, 1989:1). Additionally, policies that promoted more choice and independence improved adaptation among more functional residents, and did not have a detrimental influence on residents on less functional residents. Moos (1981) in an earlier study of agency in residential care facilities for older women found that choice and control were particularly important for women and that in higher functioning populations, increased levels of choice and control that were associated with reduced levels of conflict. Moos recommends that "researchers need to consider the existing opportunities residents have to exercise control, as well as the levels of other relevant personal and environmental resources" (1981: 1).

The following evaluation of the RCF TR pilot program captures the experiences of providers and residents in five RCFs in Hamilton, Ontario.

METHODS

The findings of this report are drawn from two time points. First, we conducted a baseline assessment of residents' needs and experiences with the early stages of the TR pilot in 5 RCFs in Hamilton. These RCFs were chosen by the City of Hamilton to participate in the recreation pilot. We conducted follow-up interviews with the same residents and providers 5 months later. Both residents and staff were interviewed according to the interview schedules as outlined in Appendix 1. In addition to this, baseline data on the role of recreation in residents' lives and program data on TR use were collected. The following section describes the data collection and analysis.

Interviews with 6 staff members and 15 residents were conducted in June 2015. In order to recruit participants, the researchers attended each RCF with the recreation therapist. The recreation therapist introduced the researchers to the residents with whom she had previous contact. These individuals were approached by the researchers and asked to participate in interviews about their experiences with recreation and housing. The researchers then worked with each resident to secure a convenient time and location for each interview. They were informed that interviews were voluntary and confidential. Upon completion of each initial interview, participants were asked if they were willing to be contacted for follow-up interviews. The researchers went back to the RCFs in November 2015 to speak with the same residents and secured times and locations for follow-up interviews. Two people who were interviewed at the baseline period were not able to be contacted at follow-up, as they were no longer RCF residents. The staff and owners were reached via phone to schedule follow-up interviews at a convenient time and location.

In addition to residents, staff, and operators, 3 key informants were interviewed. These people are key members of the community who have extensive knowledge of the RCF system and of TR. These interviews provided the researchers with context and are not described below.

The interviews were semi-structured and lasted for approximately an hour each. Questions focused on residents' housing histories, medical, social and economic needs, and experiences with recreation. Each resident was provided with a $25 gift card to Tim Horton's as compensation for his or her time for each interview. The interviews were tape recorded and the

researchers typed detailed notes, which included verbatim quotes, while the participants answered questions. The recordings were later used to ensure that the notes and quotes obtained accurately reflected the interviews. In addition, notes were made about the particular environment of each RCF and any dynamics that were of interest. Follow up interviews were conducted with the same research team, using the same procedure.

The researcher team preformed a thematic analysis of all of the interview data. In using this approach, text was read several times and the question was asked, "What statement(s) or phrase(s) seem particularly essential or revealing about the phenomenon or experience being described?" (Van Manen,1998: 93). Thematic statements were highlighted in all of the interviews. These statements were grouped into themes or categories. The team then coded all of the transcripts using these focused themes.

In addition to collecting qualitative evidence, we also preformed basic statistical analysis of program data collected. The RCF TR Pilot therapist provided us with data on the number of units of client participation for each month of the pilot. Each unit of participation represents a unique contact with a client. Additionally, at the beginning of the program, the therapist administered the *Vitality through Leisure Assessment* survey to residents from the 5 homes. She provided the research team with the data from these surveys and descriptive statistics and frequencies were calculated using STATA statistical software. These findings are presented below.

FINDINGS

Quantitative Analysis

The Recreation Therapist for the pilot provided the researchers with the number of unique program contacts with residents by month. Each unit represents a single person making contact in either a group or one-on-one environment. For example, if 4 clients attended a fishing trip in July, and the Recreation Therapist had 5 one-on-one meetings, the number of units for July would be 9. The number of units of client participation by month are displayed in Table 1. Generally speaking, program participation, measured through units of participation, showed a positive growth trend. In other words, the longer the program operated, the more participation occurred. The exceptions are April where a decrease in participation from the initial month was

observed, and September and November where we see slight decreases in participation from the previous months.

Table 2 displays summary statistics and means by indicator for the data collected at the beginning of the TR pilot using the *Vitality through Leisure Assessment*. 80 residents were surveyed. Complete assessment data were available for 79 participants. Appendix 2 provides frequency scores by indicator. These are useful when looking at compiled scores as they illustrate the proportion of individuals who fall into the low, moderate, and high ranges.

Table 1: Units of Client Participation by Month

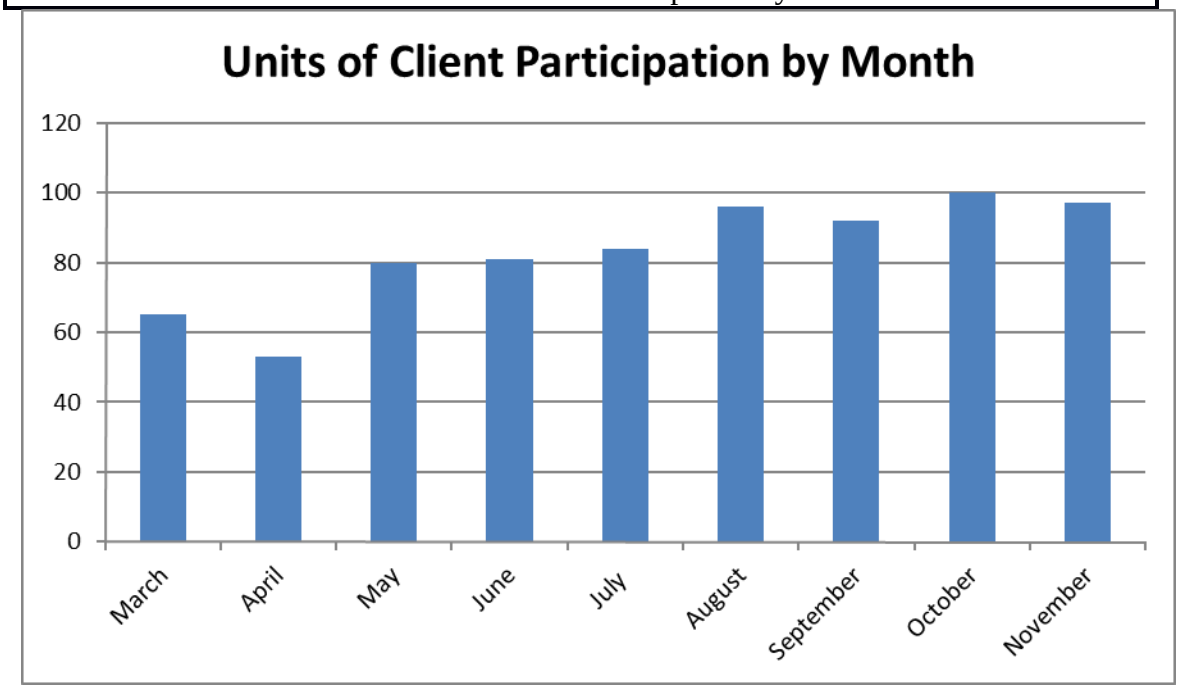

Table 2: Vitality Through Leisure Assessment: Summary Statistics and Means by Indicator

Variable	Observation	Mean	Standard Deviation	Minimum	Maximum
Broaden-and-Build	80	18.2875	3.965656	12	28
Physical Condition	80	18.75	4.675549	10	30
Relaxation and Stress Control	80	20.4125	3.76087	13	28
Optimal Arousal	80	20.825	4.021383	12	30
Personal Betterment	79	14.25316	2.238752	11	19
Total	79	92.40506	16.411	67	134

Participants were asked to respond to a variety of questions and a numeric score was assigned to each response following the scoring schematic provided in the *Vitality through Leisure Assessments*' scoring guide. The total scores for each category were calculated by adding together all of the scores in each category. The first four categories discussed used the cut-offs of below 17 for low and above 23 for high. Personal betterment scores are interpreted differently than the other scores. Scores under 11 are considered low and those over 15 are considered high.

The mean calculated score for assessing the role of leisure activities in broadening and building clients' horizons is 18. This average is on the low end of the moderate range. Over a third of respondents (36%) are classified as low scoring in this category and the majority (60%) of respondents scored a 17 or lower. Generally speaking, these data indicate that pre-existing leisure activities were not useful in broadening and building clients' horizons.

The second category provides a score for the impact of leisure on clients' physical conditions. The mean score was 19 and roughly one quarter (23%) of respondents fell into the low range. This suggests that leisure activities could be reoriented to better assist in improving physical vitality.

The mean score for assessing the role of activities in promoting relaxation and stress control was 20 which sits right in the middle of the moderate range. Only 10% of clients fell into the low

range for this indicator. While this moderate ranking indicates that improvements can be made to promote higher levels of stress control and relaxation through leisure, this score is higher than those received for the two aforementioned categories.

A high moderate mean score of 21 was achieved in the category displaying the role of leisure in providing excitement and arousal and controlling boredom. Small proportions of clients were classified as low (6%) in this category. Roughly a fifth (21%) were classified as high scoring. In other words, the majority (73%) were classified as experiencing moderate arousal through leisure. Although the proportion of clients classified as low is not overly significant, the high proportion of individuals who had moderate scores suggests a need for improvement.

As noted above, personal betterment scores are interpreted differently than the other scores. Scores under 11 are considered low and those over 15 are considered high. The average score was 14 which is on the high end of moderate. Roughly one quarter (26%) of participants fell into the high category for this measure and the remainder (74%) were classified as moderate. Again, the high proportion of individuals with moderate scores suggests a need for improvement.

The scores from five categories were summed to provide an overall score. This score is designed to demonstrate the total level of vitality a client experiences through leisure. A score over 104 indicates high vitality resulting from leisure activities and a score of 69 or below indicates that alterations to leisure activities could improve clients' experiences of vitality. The average was 92. The large standard deviation (16.41) indicates wide variation in scores. A small proportion were scored as receiving low vitality through leisure (6%) and less than a fifth (16%) had high total scores.

Generally, this analysis indicates that leisure was providing moderate benefit to clients at the baseline period. This can be interpreted two ways: 1) pre-pilot leisure activities provided in the RCFs surveyed provided moderate benefits to clients, and 2) attempts can be made to improve the scores. The lowest scores were calculated for broadening and building clients' horizons and improving physical condition, suggesting a need to invest more in these areas.

Qualitative Analysis

Interviews with 6 staff members and 15 residents at baseline and 6 staff members and 13 residents at follow-up in 5 residential care facilities in Hamilton, Ontario were conducted in June and November of 2015. Initially, staff depicted, with varying degrees, an environment where the overwhelming demands of looking after the daily needs of residents, multiple roles, and limited financial and physical resources constrained the degree to which leisure and recreation was a focus. Clients expressed varying degrees of difficulty in managing their daily lives and in interacting with staff, fellow residents, and service providers. It should be noted that in contrast to other settings such as long-term care facilities for older adults, residents are composed of a variety of ages and suffer from a variety of physical and mental health illnesses. It is in this general context that the therapeutic recreation intervention was initiated in 2015.

Demonstrated Strengths of the TR Pilot

Both staff and residents expressed that there were benefits to the pilot which included more personalized care, more mobility, and increased novelty and choice in terms of recreation activity and people with whom to recreate. The improvement came from not only the increased TR staff and volunteers but from the increased capacity for engaging in recreation and leisure activities in both the RCFs and the community. We review some of the program strengths in more depth below.

Conflict Management

At its inception, the TR pilot was found to be a welcomed intervention from both the perspective of staff and the clients of the RCFs. The perceived effectiveness of the intervention appeared in part to be related to whether or not there was diversion programming in place, the length of time that staff and owners had been running these facilities, and the physical and monetary resources (space, funding, etc.) available to the residents and staff of the RCF.

A common theme of staff/operator burnout was present. Providers were exhausted by the routine and stress of managing the residents and dealing with repetitive and ongoing conflicts. As one staff member expressed, “It’s a lot of effort. Some days I’m exhausted. I’m not physically tired.

I'm mentally burnt." Similarly, residents also expressed the 'draining' aspects of being with other residents and the difficulty in managing conflict and interactions with other residents in the RCFs.

Generally speaking, the staff viewed the TR as an effective mechanism for relieving the stress of continuous care for residents and conflict management. Many welcomed the novelty that the TR introduced in the lodging home in the form of different people (Recreation Therapist and volunteers) and in the different recreation and leisure opportunities presented. It was a welcomed break in the routine of the RCF for both staff and residents and functioned, as one staff member/owner stated, as a "social lubricant." The following quotes illustrate these sentiments:

> **Staff** - *I can't say that we have had less people doing criminal acts – but there are better attitudes and less friction in the social interaction in the house. There is something that people are looking forward to and fosters something like an esprit de corps. Which is more than camaraderie. More like a family.*
>
> **Resident** - *She [the Recreation Therapist] also offered help if I have any problems and she knows who to go to which is kind of nice, she'll. If there's an issue, I have an issue with somebody, go to her and she'll deal with it. Because I don't want to be locked up in my room. That's what caused my issues in the first place.*

The Recreation Therapist provided clients with referrals to community-based resources and assisted clients when conflicts emerged. This increased clients' comfort levels with leaving their rooms, participating in their houses, and becoming involved in their communities.

The perception that TR reduced conflict in the RCFs was also brought up by staff during the follow-up interviews:

> **Staff -** *Yep, when people get cabin fever because they have nothing to do we get verbal conflict and occasional minor property damage which costs them money because I send them to the police or have them pay for the damage. With the TR program some of them have access to the SoBi and it's right there so that gives them an option and that gives them the ability to go for a ride. And those who don't do the activities benefit because everyone isn't on top on one another all of the time. Someone does an activity, their mood improves, everyone else is in better shape.*

Although not all staff perceived lower levels of household conflict, for those who did, they attributed this to residents' new found ability to find activities and space to calm down when conflicts erupted. This increased quality of life and wellbeing in the houses. They also

commented that TR helped to reduce conflict because people were leaving the RCFs to participate in activities, which provided residents with breaks from their houses and from one another.

Connecting Residents to Other Resources:

Some of the staff noted the Recreation Therapist's ability to connect with and refer clients to other services, programs, and agencies:

> **Staff -** *With your program you have professionals who understand this population and they are willing to work with any other agency to facilitate the rec therapy. And that flexibility to work across and with the other agencies to facilitate things. For example, she would go speak with brain injury services if a client was working with them. Victim impact services, etc. The Hamilton police surprisingly gives us support through VIS sometimes they are the only person we can turn to because they don't want to see the person on probation fail so Chelsea will communicate with them. I like the flexibility. It's marginally helped the staff alleviate stress etc. but any little bit helps.*

RCFs are not mandated to provide case management supports and thus do not always have the resources to assist clients with meeting their goals. The ability to assist residents with navigating the system and the desire to work with other agencies to meet unmet needs were strengths of the pilot and filled a gap as clients were able to make connections with other agencies and learn about and participate in community programming.

Therapeutic Benefits: Expanding Horizons and Friendship:

One of the therapeutic benefits of TR is the ability for participation to expand horizons and expose people to new experiences. One of the staff members spoke of one of the resident's experiences:

> **Staff -** *Well they really enjoyed some of the activities. The bowling the music, even [one resident] joined in and he's very very mentally ill. He comes out with things that are so off and he's just in his own little world. He really enjoyed the music.*

The resident described above seldom participated in activities prior to the TR pilot. He began engaging with the Recreation Therapist and the staff and residents in his RCF through

participating in TR.

One of the residents described adding nail painting--an activity taught to her by the Recreation Therapist--into her daily routine:

> **Resident -** *She taught me how to paint my fingernails. All of the ladies did. I do that on my own now...I like to do it every day.*

The therapeutic nature of the programming exposed participants to new things. This participant described the pride she took in having her nails freshly painted. Although this could be perceived as a little step, she showed the researchers her nails with a smile on her face.

The program assisted residents by adding variety to their daily schedules and introducing them to new friends:

> **Staff -** *New friends, new experiences number two, but I would say it's just realizing that there's more to life than they were just doing before. You're expanding and now they have or they feel like they have the ability to do more because someone held their hand and showed them they can go and do things and it's not hard.*

> **Staff -** *I'm glad to say they have the benefit now of going ok, what do you wanna try? There's a list of things. By having an activity-based program that changes their routine for the better that's great. Changes – immediately is the fact that the residents talk about someone coming in and having a conversation with them on a regular basis. It's predictable. So far there are those that say this is going great, it's the greatest thing since sliced bread, and others don't care so much. We need to see this sustained over a longer period of time. In order to get the real benefits, or even the real answers from residents.*

This staff member described the program as showing the residents that they are capable of doing more than they were doing. In this sense, the program served a capacity building function. It provided residents with the confidence to try new things and engage with others in new ways.

The residents also felt a sense of friendship and comradery with the Recreation Therapist. The Therapist took some clients onto her individual caseload, this happened through a self-referral process. Others participated in group-based TR programs in the home. These others stated:

> **Resident -** *We play the games, whenever she shows up she brings some stuff and prizes that we can win. She's a very nice person. We are friends, she comes here and we talk to each other, sometimes I am not really interested in what she is doing but if I'm interested in it I will do it.*

> **Resident -** *Oh I like her. She is a good friend. I really like her a lot. Sometimes, she comes, there's a guy called Jason who plays the music, we sit here and sing we do arts and crafts with her. Sometimes we do outings, we do different parks, and she does cards, arts and crafts and bingo. I miss her coming. I wish she would come more often.*

The Recreation Therapist provided the residents with someone to speak with in a friendly fashion. This provided the residents with enjoyment and social interaction which is important for wellbeing.

Changes in engagement with the community were more evident with residents who joined the Therapist's caseload. These individuals set goals with the Therapist. Examples of goals included getting a library card or YMCA gym membership, learning the bus system to feel comfortable moving around the community or going to appointments, finding and using community resources, joining activity groups, and volunteering. In his baseline interview, one resident described his desire to play the guitar:

> **Resident -** *We need a little more variety, things to do. I need to get out of the house and get more exercise in everyday life. I need to slow down on the smoking. It's hard. I need a guitar. If I had a guitar I could play some songs. I played guitar before but not very well. But you know the G, C, and the D can play a lot of songs. I used to write my own little tunes. Just getting out, touring around a little bit more, I'd like more appointments to go places.*

The gentleman who discussed his need to play the guitar during the baseline interview worked with the Recreation Therapist to get access to a guitar to play. During his follow-up interview, he talked about playing the guitar and how it brought him happiness and contributed to a more positive outlook on life.

Two of the residents volunteered with their local church. One individual had a prior history of volunteering with the church and the other connected with the Recreation Therapist for assistance with establishing a volunteer routine with a friend. Both of these individuals described the sense of community and pride they gained from volunteering at the church. One resident

stated:

> **Resident -** *For fun I work at the church. They give me extra jobs like I light the candles for mass during the week, change the candles that are burnt out and if it's a different guy who's on I help him set up the sacraments, bring out the bells, and I load the fridge. I consider that to be fun because I am giving back to the community…I found a church that accepts me for being me, not for what I have done, I've met a lot of new people especially at the church, they know me by name and it feels good. Or somebody saying oh you've done a great job and it comes back to me because my boss tells me, because i like when people are smiling and appreciative.*

The Recreation Therapist connected clients on her caseload to community agencies and resources where they could participate in meaningful leisure activities. This contributed to community integration as they made connections with members of the community. It helped residents feel accepted within their communities.

Barriers to Participation in Recreation Programming

During the interviews, staff and owners described residents' capacity to participate in recreation activities as a barrier. Residents also described reasons why they may be less likely to participate in TR activities. The following subsection describes both systemic and personal barriers to participation.

At the beginning of the pilot, the staff and owners described the barriers as being a lack of staff, a lack of knowledge on how to implement recreation programs, residents' motivation levels, space restrictions, and financial restrictions. The following quotes illustrate some of these perceived barriers:

> **Staff/Owner -** *So maybe in that aspect, not having enough room, prevents some things we want to do in house. It would be a challenge. But they aren't active anyways. They want to drink coffee and smoke, like I said, or play video games all day. Not having enough room in the house is a restriction.*

> **Staff/Owner -** *In terms of rec activity, I'd say they need someone to help them, escort or accompany them to things they want to do. If I buy them baseball tickets and send them, or dog shows and so on, it stretches my budget for my staff to go to something like that. So we like to keep it to things they can go on their own. But if there is somebody...who has RT training, they would get to be engaged in rec activities that are more of their choosing that might actually benefit them more than the ones we would choose. Because we choose ones*

that go to staff ability and comes back to budget. A benefit is that they can choose to do it. The professional can accompany them and know what is appropriate and so on.

Not having enough staff, space and financial resources to provide recreation to residents was an early concern for staff and owners. However, these concerns were not discussed during the follow-up interviews, suggesting that providing a Recreation Therapist assisted with some of the practical concerns of providing programming. Staff and owners also articulated the need to have someone to accompany residents when they enter the community. The Recreation Therapist assisted by accompanying residents in to the community during the pilot.

At the beginning of the pilot, residents articulated barriers to their participation as being interpersonal relationships and mobility concerns. The following quotes illustrate this:

Resident - *Mobility issues basically, I wouldn't mind going to football games. But I can't do stairs, there's no railing at football games, and I need someone to help me so I can't go I guess.*

Resident - *This place is affecting my treatment, basically. Because if I gotta listen to him all day, or whatever. I can't deal with him. Me I just go to the mall, walk around look at stores, even if I don't have any money. I would be inclined to go with Chelsea depending on who's involved.*

A lack of trust in the continuity of the program was a barrier raised by both staff and residents at the baseline period. Some of the staff felt that it was a good program, but it needed to continue to have a lasting impact, whereas some of the residents were hesitant to participate in programming because they were unsure as to whether or not it would be available for them to continue forward with in the future.

The barriers to participation in and implementation of the pilot provided by residents and staff in the follow-up interviews were broadly related to residents' capacities and needs. Pre-existing routines, mental illness, fear, a lack of perceived benefits, and residents' unreliability were all discussed multiple times by both staff and residents as being barriers to program participation. The residents and staff commented on barriers:

Staff - *I would say unreliability, just the nature of the residents who they are. Sometimes they wake up they are not in the mood to do anything.*

Staff - *Within here a lot of our residents have a reluctance, a lot of them are not equip to try something new, they are on such a routine for years, trying to break that routine really throws them off. It's very very difficult especially when you are dealing with mental health*

or someone of the norm who lives the way they do they get up at 7am and they do this this and if anything abnormal gets in there its fine, but with mental health if you throw something off they get really weirded out. In house is easier because they feel safer, they are more secure, this is their surroundings, obviously this is where they are at.

Resident - *I am social phobic I guess... No I just don't like crowds, I have enough of a crowd here [at the RCF] and seeing them even more isn't…plus its hard getting along with [a particular resident].*

Staff - *Fear was one where they didn't feel comfortable to get involved and the second one was a disbelief that this was actually going to benefit them...those are the two main barriers that I would found.*

Staff - *To try and get these people to go somewhere unless it's a set appointment a lot of them just aren't going to go. In fact, about 90% wouldn't go. Some of it is logistics, its leaving the space, this is their environment where they feel safe and protected.*

Resident - *I would like someone to go with me to be safe, for safety. People stalk me. They follow me I just don't like it. I don't trust them here and that's the truth I don't lie.*

Generally speaking, the many of the residents seemed to avoid or were hesitant of entering new situations. This was attributed to mental health, feeling unsafe or uncomfortable. Staff also noted the difficulty with changing routines for residents. From their perspective, residents were comfortable with their daily regiments and making changes was difficult. Despite these barriers, the program data show increased participation in TR activities over time which means that residents and staff were able to overcome difficulties associated with fear, unreliability, and routine.

Opportunities for Improvement

At both the baseline and follow-up periods, staff and residents were asked about improvements that could be made to the pilot. At the outset of the program, staff and residents suggested that the program would benefit from having a longer guaranteed duration (i.e. past the pilot year) and from providing individualized and varied recreation supports to clients based on their interests and needs. The following quotes illustrate these suggestions:

Staff - *Now is it going to be consistent to realize its potential? This isn't unique to my home, and I'm sure that my experience would be echoed in all the lodges. We've had residents that say oh that person will never stay, and they end up staying for a year. And it's because they are looking for some consistency.*

Staff - *Because you have to remember that they are individuals and you have to individualize it. Sometimes you can't just take an idea and slap it at them and expect them*

> *all to say okay. You go to school and get told to go on a class trip, well obviously the kids are going to go. Walk into a lodging home and say okay guys this is what we're gonna do, they're gonna sit there and look at you and wonder what?*

These residents and staff members described the importance of offering individualized, varied supports in a consistent fashion. Individualized supports were provided to residents who engaged with the Recreation Therapist on a one-to-one basis (i.e. were formally enrolled on her caseload). This suggests the importance of increasing the capacity of the program to allow for more caseload enrollment.

During the follow-up interviews, the residents and were again asked to suggest improvements to the program. The staff were vocal in suggesting the need for more resources. They stated:

> **Staff -** Yes I would, let's clone [the therapist]. She understands the population, her background where she has worked in the past, ability to deal with extreme ends of the spectrum, gives her the ability to interact effortlessly. The students with her, there were a number of groups throughout the pilot, her ability to put them at ease and guide them with their interaction with the residents made me thinks we should clone her. She isn't territorial because a lot of the stuff she is accessing is publically run so she is able to interact with everybody. Basically more support. The stuff being offered is fine basically and everything is an improvement over nothing. I think we are better off with the program than without it the program would be missed if it doesn't continue after the pilot is complete.
>
> **Staff -** More often, more than once a week. More funding and more staff for the program. It was great to have the volunteers, they did the drums, and then there were a few students. The one was making the laughing and then all crying they were having a hoot out there. They loved making noise, making the noises. More times a week, just more often. I would want to continue.

The staff's quotes suggest a need to fund more program staff to allow for more programming and contact with the residents. The first quote also suggests the importance of hiring more staff, but it also points to the need for staff who understand the population and can work with them comfortably.

The staff above noted their desire to increase funding to the program. However, one staff member suggested that changes to how funding is allocated and used should be prioritized. This person also suggested that each RCF should be responsible for administering supports. These sentiments are echoed in the following quotes:

> **Staff -** There was a comment made by another agency that they are just doubling up. so one agency is doing the exact same thing now and then they see the other agency and they wonder why they are doing the same thing. There are 2 places that are getting funded. I know that everybody's trying to get funding and create jobs and get a program going out there but we need to evaluate the whole city and try to not duplicate services. If they said we are going to give the RCFs the money and then we pay an activity person in house to do them that would have been more beneficial because then there's someone here more than one day a week and she can personalize herself more with the clients and then there's a routine going, they know what to expect.

This staff member in particular was concerned about duplication of services, as he or she made the argument that another agency was already providing the residents with recreation supports. He or she was referring to the diversion recreation offered by CMHA. There is an opportunity to provide training to staff and operators on types and therapeutic elements of recreation. This could assist staff members with working with the Recreation Therapist to assist with providing TR which would allow for more frequent engagement.

At the follow-up, the importance of program longevity was again discussed. One staff member stated:

> **Staff -** I would always harp back to longevity...if you give them the opportunity to get that next wave of people who move in I think you will get the cascade effect too if it goes long enough. I don't think there's going to be a mass exodus of people singing kumbaya, but at least they will know that in their lives they will now know that they do this. Their lives now include this.

Getting residents involved in recreation from their entry into the RCF system, while they are in the process of forming new routines, was suggested as a way to increase involvement.

<u>Unmet Needs:</u>

At follow-up, each resident and staff member was asked about unmet needs. In analyzing the responses, the themes of the need for additional community-based supports and additional economic support were most prevalent. The following quotes are indicative of the staff's concern for a lack of community support for residents:

> **Staff -** *There's no funding. I've got 12 people here right now and only 2 of them have professionals that they communicate with on a regular basis apart from their primary care physician. There's nothing. I've applied for support for*

people, we've done assessments, and it's all tied up in if they get funding. Some people have been here for three years and they get nothing.

Staff - *More team work needs to be done, when someone gets into an RCF all the other agencies back off, but things should follow the client wherever they go, but if I have a client leaving and going into the community the supports should following them and they don't and that client fails.*

The residents were asked about the supports they currently access in the community and the needs that they have. Their responses were indicative of shocking gaps in the provision of community supports:

Resident - *I'm not using anything. I don't know Hamilton. I only know Jackson Square and back…No don't see a doctor. No case workers, you are the only people who have come to see about me.*

Resident - *I need a case worker, I need a social worker, can you get me that?…I've got a phone number, [he's] the one that brought me here...and every time I phone I get an answering machine. He wouldn't answer and I don't hear nothing. I need a social worker really bad. They (staff) cause me trouble and I can't talk to them. I need someone to talk to.*

Resident - *I would still like to get a job for a couple hundred a month. I won't end up with much after they deduct but I could go across to no frills and it would give me some initiative and maybe keep me busy. I would also like to get a social worker. I haven't had one since I worked...a social worker and a psychiatrist. This is basically the most I've had with structure with professionals.*

All of the residents we spoke with lived with mental illness or developmental disabilities. The majority of them also received income through the Ontario Disability Support Program (ODSP) which provides insurance in tandem with OHIP for accessing care. Despite overwhelming need which they acknowledged, these residents had not yet been able to secure community support.

In addition to unmet professional community support needs, many of the residents described experiencing financial limitations. Each resident who is receiving public assistance pays for room and board, which covers group meals, at his or her RCF. He or she also receives a very modest living allowance. The majority of the residents

described being constrained by this allowance; however, one quote about a woman's desire to have a slice of pizza was particularly indicative of the economic deprivation experienced by the residents:

> **Resident -** *Pizza I need pizza...there's that store over there but I always run out of money. Pizza never comes around for me no matter how much I want it. There's a place over there that's $3.50 for two big slices.*

Despite her desire to purchase pizza, this resident found that her cost of living funds did not allow her the extra $3.50 to buy pizza for herself on an occasional basis.

SUMMARY and CONCLUSIONS:

The TR pilot began in 2015 with the goals of increasing access and participation in recreation, improving residents' quality of life, and improving the capacity of the operators to offer recreation. The research team collected data in the 3rd and 8th months of the pilot and the Recreation Therapist tracked program involvement. Generally speaking, from the outset, we saw an increase in participation in recreation. As the program progressed, participation in the recreation activities offered through the pilot increased.

The qualitative data indicate that for participants, the TR program helped them broaden their horizons, have new experiences, learn skills, engage with their communities, overcome fears or obstacles to performing activities of daily living and develop friendships. Some of the staff noticed that interpersonal conflict decreased in the homes as some of the residents' time was occupied with recreational activities. This provided space for those who stayed behind. The staff and residents were very happy with the Therapist. Some of the traits they noted that were important in choosing recreation staff were friendliness, understanding of the population and approachability.

Despite general positivity about the pilot, the staff and residents did note that barriers to participating in recreation persisted. These barriers to participation included fear, mental illness, routines, forgetting activities or appointments, and lack of motivation/desire to leave the house. To improve the program, some providers suggested that resources and staffing levels be

increased whereas others suggested that the city explore how the funding is being allocated. Specifically, they were concerned that the program is duplicating other supports already provided by the CMHA. The CMHA is mandated to provide diversion recreation and not TR. Additional training may allow staff and operators to participate in assisting with the administration of some of the TR.

The lack of connection between the residents and the health/mental health care systems was shocking. Many of the residents wanted to speak with a professional therapist, counselor, case worker, or social worker. These services are available to people through OHIP and ODSP, yet some of the residents were having trouble connecting with these services. The Recreation Therapist was able to assist members of her caseload with accessing these supports. We recommend that all residents have the option to work with a Recreation Therapist, social navigation, case management, or assertive community treatment teams. Residents should be actively and frequently engaged by mental health professionals and community support workers in the homes. This should occur on a regular basis as access to care and needs change over time.

Our findings suggest that the pilot has had value for residents and staff. We recommend increasing staff levels or finding a way to reallocate funding to provide more individualized and frequent recreation supports. Additionally, we suggest that TR programming be offered to new entrants to the RCF system and that affected parties work together to find a way to get residents to follow through with scheduling including providing frequent reminders and wake-up calls. Additionally, working more closely with mental health professionals may assist residents in feeling safer with leaving their homes and interacting with others.

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Appendix 1: Interview Guides

Interview Guide: Participants (3 Months)

Demographics

1. Gender:

2. Age: _____

3. Tell us a bit about yourself. How would you describe yourself?

4. How long have you been living in your current house?

    a. Before you lived here, where did you live? [Probe to learn more about housing history]

    b. Can you tell me a bit about life in your house? What is it like?

5. What did you do before you met Chelsea? [Probe to find out how they decided what to do with their time, etc. if possible]

6. How do you like to spend your time?

7. What kind of things do you do with Chelsea? [Probe to find out how they choose what to participate in if possible]

8. What would you say are the things you need in your everyday life?

    a. How do you get these things?

    b. Which community services (i.e. health care, social services) do you use?

    c. Are there any services that you need that you can't get?

Interview Guide: Staff (3 Months)

1. What is your job title?

    a. How long have you been employed in your current position: Less than one year, one to three years, or more than three years?

    b. What duties are listed in your job description?

2. Can you please describe a typical work day? What tasks do you complete?

3. Can you explain the difference between diversion recreation and therapeutic recreation?

    a. Do you think that therapeutic recreation provides benefits? If so, what are these benefits? If not, why not?

    b. How do your clients spend their time? [Probe to see if this has changed since Chelsea has arrived]

4. What type of needs do your clients have?

    a. How do they meet these needs?

    b. What programming may be useful in helping them meet any unmet needs?

5. Can you comment a bit on your clients' quality of life?

    a. What do you think could be done to improve their quality of life?

Interview Guide: Participants (8 Month Follow Up)

Before beginning, match this interview up with the interview done for the same person at 3 months.

1. What do you do for fun?
    a. How do you decide what you are going to do with your day?
2. What kinds of activities are available for you to participate in?
3. What would you say are the things you need in your everyday life?
    a. How do you get these things?
    b. Which community services do you currently use?
    c. Are there any services that you think would be useful to you that you currently don't have access to?
4. Do you feel like you belong in
    a. Hamilton?
    b. Your house?
    c. Is there anything that would make you feel more included in the community?
5. Who do you spend your time with? Tell me a bit about these people and what you do together.

Interview Guide: Staff (9 Month Follow Up)

1. Can you identify some of the barriers, if any, that have gotten in the way of implementing the recreation program?

2. What are some of positive outcomes of the recreation program that you have noticed?

3. What type of needs do your clients have?

    a. How do they meet these needs?

    b. What programming may be useful in helping them meet any unmet needs?

    c. Can you comment a bit on your clients' quality of life? What do you think could be done to improve their quality of life?

4. What kind of recreational behaviours do you observe in your clients?

5. Have you noticed any behavioural changes in your clients since the program started? If so, please describe.

6. What suggestions would you make to improve the program?

Appendix 2: Vitality through Leisure Assessment Scores

Table 2.1: Broaden-and-Build Horizons: Frequency by Score

Scores	Frequency	Percent	Cumulative Percent
12	4	5.00	5.00
14	5	6.25	11.25
14	5	6.25	11.25
15	8	10.00	21.25
16	12	15.00	36.25
17	19	23.75	60.00
18	6	7.50	67.50
19	3	3.75	71.25
20	2	2.50	73.75
21	4	5.00	78.75
22	1	1.25	80.00
23	2	2.50	82.50
24	9	11.25	93.75
25	1	1.25	95.00
28	4	5.00	100.00
Total	80	100.00	

Table 2.2: Physical Condition: Frequency by Score

Scores	Frequency	Percent	Cumulative Percent
10	5	6.25	6.25
12	4	5.00	11.25
14	4	5.00	16.25
15	1	1.25	17.50
16	4	5.00	22.50
17	9	11.25	33.75
18	25	31.25	65.00
19	1	1.25	66.25
20	4	5.00	71.25
21	4	5.00	76.25
22	2	2.50	78.75
23	4	5.00	83.75
24	4	5.00	88.75
25	1	1.25	90.00
26	4	5.00	95.00
30	4	5.00	100.00
Total	80	100.00	

Table 2.3: Relaxation and Stress Control Frequency by Score

Scores	Frequency	Percent	Cumulative Percent
13	4	5.00	5.00
16	4	5.00	10.00
17	12	15.00	25.00
18	12	15.00	40.00
19	4	5.00	45.00
20	5	6.25	51.25
21	9	11.25	62.50
22	8	10.00	72.50
23	5	6.25	78.75
25	9	11.25	90.00
26	4	5.00	95.00
28	4	5.00	100.00
Total	80	100.00	

Table 2.4: Optimal Arousal Range: Frequency by Score

Scores	Frequency	Percent	Cumulative Percent
12	5	6.25	6.25
17	4	5.00	11.25
18	14	17.50	28.75
19	10	12.50	41.25
20	1	1.25	42.50
21	17	21.25	63.75
22	12	15.00	78.75
25	8	10.00	88.75
27	5	6.25	95.00
30	4	5.00	100.00
Total	80	100.00	

Table 2.5: Personal Development: Frequency by Score

Scores	Frequency	Percent	Cumulative Percent
11	10	12.66	12.66
12	10	12.66	25.32
13	13	16.46	41.77
14	8	10.13	51.90
15	17	21.52	73.42
16	9	11.39	84.81
17	4	5.06	89.87
18	4	5.06	94.94
19	4	5.06	100.00
Total	80	100.00	

Table 2.6: Overall Scores: Frequency by Score

Total Scores	Frequency	Percent	Cumulative Percent
67	5	6.33	6.33
72	4	5.06	11.39
78	4	5.06	16.46
82	8	10.13	26.58
83	4	5.06	31.65
84	6	7.59	39.24
85	4	5.06	44.30
86	5	6.33	50.63
90	5	6.33	56.96
91	1	1.27	58.23
94	1	1.27	59.49
96	5	6.33	65.82
98	3	3.80	69.62
100	3	3.80	73.42
102	4	5.06	78.48
103	4	5.06	83.54
108	3	3.80	87.34
109	1	1.27	88.61
117	1	1.27	89.87
122	4	5.06	94.94
134	4	5.06	100.00
Total	79	100.00	