A Paradigm Shift in Therapeutic Recreation: From Cure to Care

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Diversity is a cornerstone of our society and culture and thus should be celebrated. Including people with disabilities in the fabric of society strengthens the community and its individual members. (Position Statement on Inclusion, National Recreation and Park Association, 2000)

This quote is indicative of what we believe should be the direction of therapeutic recreation (TR) service delivery in the future. Trends suggest no longer should we focus primarily on providing outcome-based TR services in clinical settings. TR providers must possess the willingness and competencies necessary to include consumers with disabilities in the fabric of society. Only then can individuals with disabilities be empowered to participate fully in community recreation and physical activity.

This chapter provides a guide that will serve as a springboard for action that could be taken at the individual and organizational levels to alter the way we think about recreation services. We explore TR from both clinical and community perspectives, and provide an analysis of trends that will impact TR service delivery. Researchers and practitioners in many service professions, including special education, nursing, occupational therapy, rehabilitation medicine, sports medicine, gerontology, public health, mental health, and adaptive sports documented the prevalence of constraints to leisure. As providers of leisure, it is important that TR professionals not only understand what the constraints are, but also have some knowledge of how they might be overcome. Consequently, we next examine TR and constraint-free environments, providing a basis for inclusive community recreation services. Specific constraints to community inclusion for individuals with disabilities are discussed and strategies are offered which could be used to negotiate, to eliminate, or to reduce substantially those constraints. We conclude the chapter with a futuristic perspective of TR to stimulate individual thought and discussion among members of the therapeutic recreation field.

The Changing Nature of Therapeutic Recreation Service Delivery

Therapeutic recreation has been shown to have beneficial consequences for the physical, psychological, and social well-being of people with disabilities (Coyle & Santiago, 1995; Loy & Dattilo, 2000; Mobily, Mobily, Lessard & Berkenpas, 2000). TR practice delivers services through the use of recreation and leisure activities designed to restore, to remediate, or to rehabilitate the functional capabilities necessary for improving independence and reducing or eliminating the effects of illness and disability (Shank, Coyle, Boyd & Kinney, 1996). It has also been defined as the purposive use of recreation/recreational experiences by qualified professionals to promote independent functioning and to enhance the optimal health and well-being of persons with illnesses and/or disabling conditions (Bullock & Mahon, 2000). As is clear from these definitions, TR is concerned with recreation and treatment. Both are important to understanding service goals, and neither should be deemphasized (Stone, Bullock & Brooke, 2004).

Therapeutic recreation can occur in a variety of settings, but is not defined by the setting in which it occurs. It is defined by its service, and occurs within agencies/organizations that have clear mandates to provide treatment and therapeutic services. This may include clinical
inpatient units or a variety of community options, such as halfway houses, adult day care programs, and independent living facilities. Therapeutic recreation is not any and all recreation services for people with disabilities. Simply having a disability does not qualify one to receive TR services. The individual who has a disability may receive TR services or may receive recreation services (typically referred to as “special recreation,” or therapeutic recreation if it occurs in a segregated community-based setting). The distinction between recreation and therapeutic recreation is made on the basis of individual need and a mandate for treatment rather than on disability and setting. Stone, Bullock, and Brooke (manuscript in preparation) suggested to refer to recreation services as “therapeutic” simply because they involve individuals with disabilities or because they occur in clinical settings is not only inaccurate, but also patronizing and stigmatizing to the people who have been so labeled.

While TR services have typically had a more defined role in medical settings, considerable changes have occurred in health and human services that have implications for the provision of TR services. One change in health and human services that impacted and will most likely continue to impact service delivery is increased medical costs. Community-based treatment alternatives are being developed in response to increased medical costs, shorter hospital stays, deinstitutionalization, and other related factors. Coile (2001) presented several trends that will shape health care delivery over the next decade. For example, the average length of stay in hospitals slipped to 5.9 days and outpatient visits to hospitals increased 4.5% during 2000. Additionally, hospitals in the United States have continued to decrease their number of beds from a peak of one million in 1983 to 830,000 in 1999.

Smith (1995) indicated the changing face of health care has forced the restructuring and reorganization of physical rehabilitation units nationwide “as facilities struggle to increase efficiency without jeopardizing the quality of their health care services” (p. 67). In physical rehabilitation, the trend is toward outpatient services and efforts to reintegrate patients into their home communities where they can live as independently as possible. Obviously, a paradigm shift in health care has occurred; that is, a move away from traditional inpatient clinical settings and toward outpatient, community-based options. These alternatives are not only fiscally sound, but also structurally responsive, situating health care and rehabilitation in the community rather than in higher-cost clinical facilities. This paradigm shift suggests we are moving away from the sole-provider model of medical care and treatment to self-care, prevention, and health promotion teams. According to Shugars, O’Neil, and Bader (1991):

The health care system, which has been focused largely on the treatment of acute disorders or the acute manifestations of chronic disorders, will move gradually to a system that delays the onset of inevitable chronic disorders through prevention and education. Accompanying this change will be a general shift from cure to care as the health care needs of the population change. (p. 7)

This shift in emphasis has significant implications for recreation professionals. In our communities, opportunities will be created for TR programs conducive to prevention of illness and disability and health promotion. Collaboration between professionals working in clinical and community settings will become more necessary than ever before. This collaboration between TR specialists in clinical and community settings will help to ensure a continuity of recreation and leisure services for individuals with disabilities, thus reducing the risk of rehospitalization, reinstitutionalization, or reincarceration.

It is clear the therapeutic recreation field must respond to these dramatic and inevitable changes in our health care system. To become more responsive to those we serve, efforts will be made to reintegrate clients into their home communities so they can live as independently or interdependently as possible. The time appears ripe to develop more community-based TR programs in conjunction with existing clinically based treatment and rehabilitation programs. Since most patients leave hospitals now when they are medically stable, therapeutic recreation specialists are beginning to focus on discharge planning during the inpatient therapeutic recreation intervention and are preparing those they serve to transition back to the community.

An increasing number of consumers of TR services are choosing to participate in typical community recreation, physical activity, and social settings. Therapeutic recreation specialists have a legal obligation to accommodate them as they attempt to make the transition back into the mainstream. We must become better prepared to include our patients, clients, and participants in constraint-free environments and to help them succeed within their home communities.

**Therapeutic Recreation and Constraint-Free Environments**

The three inalienable rights of all citizens of America—life, liberty, and the pursuit of happiness—imply that
all American citizens have these three rights. Every one of our citizens should have access to all of the services available in one’s community, including medical, religious, educational, social, and recreational opportunities.

We have learned a great deal about the impacts of therapeutic recreation service delivery on the people we have served. We are no longer satisfied with merely assisting the allied health team in ameliorating illnesses or with physically integrating individuals with disabilities into various “therapeutic” programs and settings. Our primary goal has become the facilitation of a better quality of life for all of our citizens, particularly those we serve who have been disenfranchised and underrepresented. We attempt to accomplish this by helping people to become socially included within their communities through active, vital, and healthy lifestyles. This lofty service goal was supported by then-President George Bush in 1990 when he eloquently stated, “With today’s signing of the landmark Americans With Disabilities Act, every man, woman, and child with a disability can now pass through once-closed doors into a bright new era of equality, independence, and freedom.”

Participation in recreation, physical activity, and social settings is an important aspect of life in our society. Active, healthy, and socially connected individuals participate in a wide range of activities within a broad array of environments throughout their lifetimes. This vital lifestyle includes participation in athletic programs in schools and recreational sports on college campuses, as well as in individual, team, and family recreation at home and in the community. Active and ongoing involvement in recreation, sports, and social activities is a positive investment of one’s time. Society has begun to recognize the immense value of quality recreation and physical activity programs and facilities. For example, intramural–recreational sport programs are the most regularly attended activities, with the exception of academic classes, by students on today’s college campuses. Activities that meet the needs of individuals in community and social settings promote physical health and conditioning and provide them with natural opportunities for developing social relationships and new, and potentially lifelong, skills. It has become essential to find a desirable balance between recreation/socialization and work.

The rationale for designing TR service delivery that seeks to promote healthy and active lifestyles in the community is well-established from both theoretical (e.g., social value) and practical (e.g., deinstitutionalization) perspectives. Services that promote active recreation and social participation in the community offer the individual with a disability opportunities to develop a positive self-concept through successful experiences and satisfying relationships with peers. Channels for choice and self-expression, opportunities to interact with the environment, and establishing a more personally fulfilling way of life are other potential benefits.

Therapeutic recreation preference is shifting from providing specialized and separate services to helping include people with disabilities in more typical community programs. In addition to the substantial changes in health care described earlier, this philosophical change is the result of a series of other international trends propelled by the deinstitutionalization movement of the past three decades and the concepts of normalization and what Wolfensberger (1972, 1983, 1995) labeled “social role valorization.”

Normalization is a Scandinavian concept that has served as a guiding principle for all services to people with disabilities since the 1970s. The intent of using normalization as a guiding principle is not to make people with disabilities “normal,” but to set a standard by which all services could be measured. Accordingly, these services and the manner in which they are delivered should be as close to the cultural norm as possible. This suggests TR services and activities designed for people with disabilities should not be different or highly contrived, nor should they be separated from those designed for individuals without disabilities, just because the individual has been labeled.

Deinstitutionalization is a social policy change, partially a reflection of adherence to the least restrictive environment; that is, the environment in which the needs of the individual could be met while simultaneously affording the individual the greatest opportunity to interact with peers without disabilities. Deinstitutionalization refers to changing the residential service system so that people with disabilities are less likely to live in institutional settings and more likely to live in community (or more normalized) settings. Consequently, people with disabilities are more likely to be living in the community, and thus, more likely to be asking for greater access in the community.

As applied to leisure and recreation, a normalization or wellness goal offers people with disabilities opportunities for physical access to settings with nondisabled peers as a means to acquire social, recreational, physical activity, and community skills. Access to socially inclusive programs promotes healthy leisure lifestyles. In short, the concept of normalization implies that recreation providers consider the influence of social inclusion as they design and implement programs.

Wolfensberger (1983) coined the term “social role valorization” to broaden the meaning of normalization: “The most explicit and highest goal of normalization
must be the creation, support, and defense of valued social roles for people who are at risk of social devaluation” (p. 234). Social role value, in other words, implies bringing roles and conditions valued by most people to the lives of typically devalued people. Two paths could be followed to reach this goal: (a) further develop the competencies of a culturally devalued individual, and (b) enhance the individual’s social image or value in the perceptions of other members of society.

Significant evidence supports the benefits of recreation that target improved quality of life outcomes and valued social roles. For example, increased leisure skills and participation in recreation activity typically result in increases in skill level in a variety of other curriculum areas. As a function of enhanced instruction and participation in recreation and physical activity, collateral skill development has been documented for individuals with disabilities in other areas such as language, problem-solving, cognition, personal-social behavior, gross and fine motor skills, and academics (e.g., reading comprehension and mathematics).

It has been found that increases in recreational competencies relate to decreases in negative and inappropriate excess behaviors. By teaching highly preferred skills and activities referenced against nondisabled peers in the community, individuals are less likely to engage in self-stimulating or excess behavior. Constructive recreation learned through TR services has been shown to be negatively correlated with such excess behavior.

Constructive use of leisure time is related to the success of people with disabilities living in community environments. There is longstanding literature in the disability field that relates success in community living to adaptive behavior and, particularly, to the absence of a need for constant supervision. If a TR program could prepare individuals with disabilities to deal constructively and enjoyably with breaks in routine and free time, and thus reduce the need for supervision and decisions made by others, successful community living could be greatly enhanced.

Finally, having a repertoire of enjoyable and preferred recreation and social activities is essential for quality of life and the development of positive relationships with family and friends. Clearly, any personal relationship—friendships, best friends, family, and intimate relationships with partners and spouses—is nurtured by opportunities to share enjoyable leisure with one another and to explore mutual interests and activities. If an individual has few leisure skills and interests, or is prevented from participating in the kinds of activities enjoyed by his or her peers, one is also effectively being barred from the many opportunities to develop friendships and other meaningful personal relationships. Surely, few dimensions of an individual’s life could be as essential to healthy and quality lifestyles as having good relationships with family and friends.

Therapeutic recreation services that enhance participation in socially inclusive community activities could produce positive, life-changing outcomes for people of varying abilities. And it is not only people with disabilities who benefit from these programs; the community overall benefits from this diversity. As a result of these positive experiences, practitioners in parks and recreation are expanding options that are inclusive for their constituents. Not only do accommodation and inclusion make good sense to consumers and program planners, but also family members of individuals with and without disabilities advocate for these services. For instance, the community benefits as recreation and park professionals grow more accepting and welcoming of individuals with disabilities and accommodating of all people. On attitude assessments, practitioners indicated inclusive services taught them not to be afraid of people who are differently abled, and individuals with disabilities are disabled only to the extent that we perceive them to be. Programming specialists are learning that with careful attention to design and accommodation, inclusion works to everyone’s benefit over the long term.

State-of-the-Art Inclusive Community Recreation Services

Since the mid-1970s, the need to provide community services for individuals with disabilities has received increased attention from lawmakers. For example, PL 94-142, the Education for All Handicapped Children Act of 1975, and its recent reauthorization (Marchand, 1997), PL 105-17, the Individuals with Disabilities Education Act (IDEA), address therapeutic recreation as a related service for people with disabilities. Published federal regulations for rehabilitative services, such as Section 504 of the Rehabilitation Act, indicate the importance of recreation programs in the community for individuals with disabilities. Several states’ developmental disabilities plans designate recreation/leisure as a priority area for children and adults with developmental disabilities. The Americans with Disabilities Act (ADA) of 1990 comprehensively eliminates discrimination against people with disabilities in the areas of employment, transportation, public accommodations, public services, and telecommunications. Additionally, the ADA states all areas of public accommodation, including recreational areas, must be made accessible, and nondiscriminatory
practices must be implemented. ADA guidelines also have implications for other community environments where people play and socialize. For example, playground equipment designers and landscape architects will have to take these guidelines into account in their design of new playgrounds and in modifying old ones. A certain proportion of play components will be required to be accessible, along with accessible surfacing, ramp access, and transfer system access to elevated structures for people with physical disabilities (Burkhour, 2001; Hunter, 2001).

Therapeutic recreation is devoted to using treatment, education, and recreation services to help people of varying abilities to develop and to use their leisure in ways that enhance their health, functional abilities, independence, and quality of life (NTRS, 2001). The National Recreation and Park Association, through its Position Statement on Inclusion (NRPA, 2000) strongly advocated for the encouragement and enhancement of inclusive leisure experiences for people of varying abilities to participate and interact together in activities with dignity. NRPA espoused four concepts:

1. right to leisure for all individuals.
2. quality of life enhancements through leisure experience.
3. support, assistance, and accommodations.
4. barrier removal in all park, recreation, and leisure services.

Unfortunately, programming that includes people who have traditionally challenged our service delivery systems has had relatively low priority in community recreation and sports. Segregated programming was and continues to be the primary service delivery model for people with disabilities. At first, special after-school recreation programs and summer camps were designed for children with developmental disabilities. In 1968, the Special Olympics program began. During the past 30-plus years, there has been a proliferation of segregated recreation and sports services as a number of organizations (e.g., Association for Retarded Citizens of the United States, International Sports Federation for Persons with Intellectual Disability) attempted to meet the needs of their constituents.

Why has there been this proliferation of segregated recreation programs? Several constraining factors that continue to contribute to inaccessible community opportunities for those on the fringes of society and to the continuous growth of homogeneous (i.e., for people with disabilities only) programs include the following:

- In spite of dramatic shifts in health care, the medical model and deficit-oriented approaches to TR services continue to be prevalent ways that services are provided to people who are disabled.
- Voluntary service organizations that provide segregated programs are hesitant to relinquish their participants to agencies that previously had ignored them lest the agency program be inadequate or inferior.
- Many family members and other advocates of individuals who are disabled oppose inclusive programs for reasons including fear of the unknown and limited success with generic agencies previously.
- People with disabilities and their advocates do not voice their desires for greater access loudly enough and to the right people.
- People with disabilities often fail to participate successfully in typical community programs for a variety of reasons, including inability to make good choices, perceived skill deficits, low self-esteem, and minimal programmatic support from the agency.
- Recreation service providers often doubt their own professional abilities to design and implement inclusive programs within the wellness model.

Several studies have attempted to describe and to explain the current state of community recreation and physical activity options for individuals of varying abilities. The findings have been discouraging. In spite of a growing list of laws mandating the inclusion of people with disabilities in all community programs in the least restrictive environment, many constraints remain.

In studies on the social and leisure inclusion of adults with developmental disabilities living in foster homes and small group homes, Hayden and colleagues (Hayden, Lakin, Hill, Bruininks & Copher, 1992; Hayden, Soulen, Schleien & Tabourne, 1996) concluded the movement away from large, institutional settings to small, community-based home environments often involves little more than a change of scenery. Participation in typical community activities by people with disabilities remains low. Most recreation participation takes place in a passive manner. Watching television, listening to the radio, and taking car rides remain prevalent. This lack of participation translates into a lack of opportunity for the development of new skills and positive social
relationships. Few residents reported having ongoing social contact with nondisabled peers other than staff and family members. Few residents had more than one friend, and most reported being satisfied without any friends. Most said that their best friend was another resident or a staff member. A majority stated, also, that their best friend was their only friend. These studies indicated that the underparticipation in community activities is, in part, attributable to care providers’ low expectations of their dependents’ leisure and social potential. It was evident many care providers and service providers offered little opportunity for increased socialization and community participation. It must be understood that the deinstitutionalization movement alone cannot ensure one’s active community participation, good health, or improved quality of life.

In an earlier study, Schleien and Werder (1985) surveyed 405 parks and recreation, community/continuing education, and adapted physical education programs in Minnesota to determine the status of recreation services available to individuals with disabilities. Although this study is over 15 years old, we believe it remains relevant today across a broad range of community settings. Results revealed activity selection was based most often on instructor choice. Participant preferences and needs were seldom taken into account. Activities were segregated in nature and provided little variety from the stereotypical norms (e.g., bowling, swimming, arts and crafts). An unwillingness to take ownership and responsibility for providing activities for people with disabilities was glaringly evident. Seventy-eight percent of the parks and recreation agencies stated community/continuing educators should be held responsible for providing services to their constituents with disabilities, while 93% of the community/continuing education respondents said the responsibility belongs to parks and recreation. Less than 20% of the supervisors of adapted physical education reported having collaborated with community agencies, and 83% stated they were not concerned with the recreation or social skill needs of their students because others were already doing so.

More recently, a study was undertaken by the American Park and Recreation Society/National Therapeutic Recreation Society Joint Commission on Inclusion to identify accommodations and barriers encountered in providing inclusive leisure services throughout the United States (Devine & Kotowski, 1999). Although the inclusion of individuals with disabilities into existing recreation programs is becoming more prevalent in our public parks and recreation agencies, problems remain. Among the most frequently cited barriers that inhibited inclusive programming were lack of financial resources, constraints on staff (e.g., accessible community transport, adaptive equipment, resistance to inclusion by community members), lack of staff training, negative staff attitudes, and too much demand for inclusion. Although a national trend toward more inclusive options was noted, these barriers point to a need to continue to design ways to prepare people and environments so a supply of inclusive opportunities could keep pace with demand for them.

The fact that few inclusive recreation services are available throughout our communities is not confined to any one community, state, or country. Furthermore, few of the existing leisure service delivery systems address the total lifestyle and leisure needs of people with disabilities and their families. Many people with disabilities may now live in the community, but they are not part of the community. Thus, although the delivery of TR services in the least restrictive environment is legally mandated and although many administrators and staff members have at least given lip service to access and accommodation, the necessary personnel, methods, and budgets to implement the mandates and draw people with disabilities into the mainstream of the community have not been developed adequately. A variety of constraints many people encounter on a daily basis as they attempt to become a part of the community mainstream must be identified, studied, and overcome. Only in this way will we be able to design a set of “best professional practices” that will enable our most challenging citizens to have access and success in their communities.

Prevalence of Constraints

Unfortunately, many individuals with disabilities remain unable to take advantage of the vast recreation and social opportunities in their communities. The challenge to therapeutic recreation specialists is to identify constraints to participation and inclusion and to develop strategies to negotiate or remove them. TR specialists must also provide ample opportunities for participants to develop skills, awareness, and the understanding needed to freely choose leisure experiences. Problems encountered could be a result of any number of circumstances related to organizational or programmatic structures, individual skill deficits, social/cultural issues, and environmental concerns.

Sources of barriers to successful community participation have been categorized in a variety of ways (Crawford & Godbey, 1987; Crawford, Jackson & Godbey, 1991; Henderson, Stalmaker & Taylor, 1987; Malik, 2000; Schleien, Ray & Green, 1997; Smith, Austin & Kennedy, 2001), including intrapersonal, interpersonal,
and structural; intrinsic, extrinsic, and political; and antecedent and intervening. While most of the therapeutic recreation literature embraced the intrinsic/extrinsic or internal/external categorization, problems often arise concerning where to place certain constraints. For example, some authors place lack of time and money in the external category while others categorize them as internal. Also, this method of classification fails to account for the relationship between leisure preferences and any environmental factors that inhibit participation. An example would be someone who wishes to play basketball, but who believes facilities are unavailable due to a lack of knowledge on where to look. Would the barrier be with the individual (lack of knowledge) or with the environment (lack of facilities)? Classification in either category fails to show the relationship that exists between the internal and external factors that explain why the individual does not play basketball.

Of the different categorization models, the framework for categorizing barriers first introduced by Crawford and Godbey (1987) best captures this relationship between an individual’s leisure preferences and the activities in which he or she actually participates. Therefore, we have chosen to use the categories of intrapersonal (psychological), interpersonal (social), and structural (environmental). Intrapersonal barriers stem from the person’s psychological state and include feelings of inadequacy or incompetence, fear of failure, and individual behavioral issues that might affect the individual’s leisure preferences. Interpersonal barriers generally stem from an individual’s social interactions and include the attitudes of family/significant others and participants without disabilities, lack of family support, and social/cultural issues that intervene between an individual’s leisure preferences and participation. Structural barriers are those that interfere between an individual’s leisure preferences, capabilities, and actual participation, and include architectural, geographic, or physical obstacles in the environment and economic or financial restrictions (Jackson, Crawford & Godbey, 1993).

**Intrapersonal Barriers**

Intrapersonal barriers stem from the person’s particular psychological state and pertain to concerns such as limitations in social, leisure, physical, or functional skills and abilities and knowledge of recreational opportunities (Crawford, Jackson & Godbey, 1991; McAvoy & Lais, 1999; Schleien, Ray & Green 1997).

**Skill Limitations**

People need various skills and abilities to participate actively in recreation, physical, and social activities. Many people with disabilities do not possess the appropriate skills to enjoy a number of leisure pursuits. These limitations may be attributed to a lack of or limited leisure competencies and skills, lack of opportunities for leisure, and lack of functional skill development as a result of a particular disability. The inability to participate physically in various recreation activities secondary to loss or lack of physical endurance, balance, strength, and flexibility has also been found to be a constraint to community participation (Dattilo, Caldwell, Lee & Kleiber, 1998). The physical skill requirements of many recreation and sports activities discourage many people from participating.

Additionally, individuals with disabilities have traditionally been excluded from opportunities to interact socially with their peers. Because of this, many lack the social skills necessary to engage in positive and appropriate behaviors within community settings. Often times, recreation activities require partners, making it necessary for participants to display appropriate social skills. We believe TR in the community recreation setting is an ideal place for an individual with a disability to gain social skills, and perhaps to develop genuine friendships.

Sometimes the very nature of a person’s disability may limit further skill development. However, more often than not, individuals are not provided opportunities to develop the skills necessary to enhance their participation. Consequently, they have low self-esteem, resulting in a belief they are incapable of participation. This often means noninvolvement and minimal community participation.

Modifications could be made to accommodate the current skill levels of participants with disabilities. For example, functional skill limitations are a result of the unique disability characteristics of the individual. TR specialists should be encouraged to conduct functional, strength-based assessments and to discuss the individual’s current skills and abilities with him or her, family members, teachers, and advocates. They could discuss past leisure participation patterns and identify any limitations and barriers related to functional skills. At that point, task and activity analyses could be conducted and appropriate modifications made to enable the individual to successfully participate at his or her optimal skill level. If deemed appropriate, programs could then be developed that encourage socialization among participants with and without disabilities. Appropriate social skills could be modeled by staff as well as peers as socially
inclusive programs provide opportunities to observe and imitate peers’ appropriate behaviors in natural social contexts.

Lack of Knowledge

An additional barrier to an appropriate leisure lifestyle is the lack of knowledge about leisure and recreation. Consumers are placed at a major disadvantage when they lack information concerning available community recreation programs and support systems needed to access those programs. An adequate knowledge of programs, facilities, transportation options, legislative rights, and other resources is needed to make informed choices.

Some people, such as those with learning disabilities or mental retardation, possess cognitive limitations that interfere with learning about recreation or social opportunities. Knowledge deficits usually result from inadequate information and lack of opportunity. Several possible solutions to these problems are addressed next.

Leisure education programs, sponsored by recreation agencies or initiated in collaboration with TR specialists who work in clinical facilities from which many individuals with disabilities are being discharged or transitioned, could be instituted. A primary goal of such programs is to develop an awareness of accessible programs in the community, their importance, and how to access them. TR specialists may also wish to consider implementing leisure education programs that incorporate systematic procedures for transitioning people into inclusive community programs.

Another suggestion is to develop written or web-based materials that describe accessible recreation and social programs available within the community, such as a resource booklet or resource file. Recreational and social opportunities could be described that include specific details about accessibility, program dates/times, activity fees, and skill requirements. These materials must be developed in a user-friendly manner, and should be made available on the Internet for broader access. Agency staff and volunteer advocates could be trained as liaisons between community recreation and other agencies to ensure program and resource information is continuously updated and disseminated.

Interpersonal Barriers

Interpersonal barriers stem from an individual’s social interactions. This type of barrier includes attitudes of family/significant others and participants without disabilities, the extent of dependence on others for assistance to participate, and poor communication that may all interfere with an individual’s leisure preferences and participation.

Negative Attitudes

One of the most difficult barriers to overcome is the existence of negative attitudes of people without disabilities, professional service providers, and care providers. Attitudinal barriers experienced by consumers in recreational settings could manifest themselves in the form of stigmas, stereotypes, unequal treatment, lack of social acceptance, and lower expectations of abilities (Bedini & Henderson, 1994; Devine & Broach, 1998; Hayden et al., 1996).

Despite legislative mandates and the good intentions of advocates of people with disabilities, recreational programs and services are developed and conducted in ways that keep people with disabilities socially isolated. Schleien, Germ, and McAvoy (1996) surveyed 484 community leisure service agencies to identify barriers encountered and inclusive practices employed. Twenty-nine percent of the agencies cited the program in and of itself as being resistive to inclusion (e.g., too dangerous, highly competitive, unadaptable equipment, highly technical material). Thirteen percent of the respondents cited poor public attitudes as a barrier, and reported unaccepting beliefs in the community at large to be more of a barrier to inclusion than the attitudes of participants with disabilities (12%) or program staff (6%). Negative attitudes of the participants with disabilities included the strong desire to be with like (disabled) peers, perceived skill deficiencies, fear of a novel situation/failure, and negative reaction of others in the program.

Positive attitudes toward people with disabilities could be nurtured through opportunities for personal contact and education, organized small group work, the use of team and cooperative experiences, and improving the social skills of people with and without disabilities. Additionally, community agencies and schools could host educational workshops or other educational forums to help people with and without disabilities learn how to facilitate socially inclusive programs. TR providers could also solicit the perspectives of consumers regarding misconceptions about disabilities and develop recreation and physical activities free of assumptions about their capabilities.

Dependence on Others

Closely related to skill deficits discussed in the interpersonal barriers section is the physical and/or psychological dependency people with disabilities develop on others (Henderson, Bedini, Hecht & Schuler, 1995;
Poor Communication

For individuals whose speech and language abilities are affected by developmental or congenital disorders (e.g., cerebral palsy, hearing impairments), acquired neurologic disorders (e.g., stroke, head injury), or progressive degenerative disorders (e.g., Parkinson’s disease), communication may be compromised or limited. Problems associated with communication present barriers that may inhibit leisure participation and satisfaction. Communication difficulties may occur during the interactions with nondisabled peers because some people with disabilities do not function as an active and equal member in the communication exchange. Dattilo and Light (1993) stated engaging in reciprocal communication “enhances a person’s ability to communicate preferences, make meaningful choices, and subsequently, experience leisure” (p. 167). Recreation professionals could compound communication problems if they lack the necessary skills, such as sign language and telecommunication systems (e.g., TDD) to communicate effectively. Schleien, Ray, and Green (1997) suggested lacking such skills and systems within an agency is predominantly an external barrier issue, even though having such impairments is an individual barrier encountered by the potential consumer. Following are possible strategies that TR providers could use to overcome communication constraints.

A major component to successful communication is being comfortable with the person with whom one is interacting. For many people, there is some awkwardness in attempting to communicate with people with disabilities. They are unsure of how to act and what to say. Learning more about people’s disabilities, including their strengths and interests, will increase the comfort level in interactions with them. When interacting with people with disabilities, it is important to extend them the same respect shown to others. One of the major accomplishments in communicating with and about people with disabilities is “people-first” language. People-first language emphasizes the person and not the disability. By placing the person first, the disability is no longer the primary, defining characteristic of the individual, but one of several aspects of the entire person (McCormick, 1999). Accommodations could be provided in community recreation programs to reduce communication concerns, including the use of adaptive equipment (e.g., assistive listening devices), personal assistants (e.g., readers), and alternative means of communication (e.g., large print materials, sign language interpreters). Another strategy is to invite a communication disorders specialist to conduct in-service training on communication disorders and alternative communication systems (e.g., electronic
devices, word boards) to TR specialists and community recreation personnel. Additionally, TR specialists and other leisure service personnel should consider enrolling in sign language courses.

**Structural Barriers**

Although an individual’s disability may inhibit access to a full range of community activities, structural barriers place additional restrictions on the individual. Organizations and other environmental factors may further reduce the likelihood people with disabilities will successfully engage in community experiences. Architectural or physical obstacles, economic or financial restrictions, and lack of transportation could all potentially interfere with successful participation.

**Architectural or Physical Obstacles**

People with disabilities cannot participate in community activities when they are unable to maneuver through doorways or throughout facilities. Lack of adequate and accessible facilities is frequently reported as the primary obstacle to participation. Devine and Broach (1998) identified physical barriers in an agency, such as lockers mounted too high and the unavailability of raised lettering or Braille signage, that prevent many people from participating successfully. Dattilo et al. (1998) reported numerous instances of accessible recreation facilities and activities, but indicated there were also occasions where participation was constrained due to lack of physical access or difficult terrain. Getting to the setting where an activity is taking place is crucial, particularly for individuals with limited mobility.

Eliminating architectural constraints is not as difficult or expensive as many believe. In the event facilities and areas cannot be made completely accessible, agencies could make reasonable accommodations or program modifications that may not necessarily require physical changes to the environment. For example, a program could be moved to the ground floor or to a more accessible facility rather than requiring expensive architectural changes. Community mapping could be used to develop a comprehensive inventory of potential resources in the community, including people and facility resources. This implies identifying resources available in organizations throughout the community before the fact and developing plans that integrate each organization into the community as a whole. If necessary, arrangements could then be made with other organizations, such as community centers, schools, YMCAs, or churches/synagogues to use their facilities and/or other resources for support. A TR specialist could also implement a “buddy system” where a person with a disability is paired with a nondisabled companion to assist one another to overcome physical barriers in the environment. For example, a person with one arm paired with another individual could work together to perform gardening tasks, such as planting seeds and transplanting small plants.

Architectural accessibility surveys of indoor and outdoor environments, using the Americans with Disabilities Act Accessibility Guidelines (ADAAG), should be conducted under the direction of recreation service agency staff. Accessibility specialists, including TR specialists, could serve as agency consultants to conduct these surveys, to make recommendations, and to prepare reports of their findings to park and recreation personnel and board members. It is beneficial to include individuals with disabilities, as self-advocates, on park and recreation boards and commissions, as they could make significant contributions in planning to remove constraints.

**Financial Restrictions**

People with disabilities typically have less discretionary funds available to spend on recreation and physical activities. This could be attributed to the fact that employment rates of people with disabilities are lower than those of their nondisabled peers. One purpose of the ADA was to increase the employment rates of people with disabilities by making it illegal to discriminate against people who happen to have a disability. However, October 1994 through January 1995 survey data confirmed that employment rates, while gradually increasing, continue to be a problem for people with disabilities. For example, 82% of people without a disability had a job or business, compared with 77% of those with a nonsevere disability, and 26% of those with a severe disability (McNeil, 2000). Also, low wages, limited assistance from social service agencies such as Medicare, and greater expenses associated with the need to purchase specialized equipment, such as vans with wheelchair lifts and/or custom-made clothing, come into play.

Financial constraints may also affect staffing patterns, facilities, equipment, and supplies. Municipal park and recreation departments often work with limited budgets, restricting their ability to develop new programs and services, to make their buildings more architecturally accessible, to hire qualified staff, and to acquire necessary specialized equipment and materials. Possible solutions to these barriers are discussed next.
We must challenge assumptions that financial resources are limited. Sliding-scale user fees for participants with personal financial constraints based on one’s ability to afford to pay for the activity could be used. People with disabilities could donate their services in other areas of an agency to offset the cost of activity participation. For example, an individual with a disability could volunteer her time in a recreation agency by staffing the front desk in exchange for activity fees in a desired cooking class. Perhaps recreation staff and volunteers could sponsor funding drives and use the money raised to establish scholarships for individuals with financial need. Collaborative efforts between leisure service and civic or corporate agencies could also be useful in developing innovative strategies for supplementing funding needed by people who are unable to pay for services.

Financial constraints of agencies and program priorities also interfere with the ability to hire staff with the appropriate skills to implement inclusive programs. TR consultants could be hired to train various park and recreation agency staff in areas such as conducting needs assessments and modifying programs, as necessary. Well-trained volunteers with and without disabilities are also valuable assets to agencies that lack funds to hire additional staff. Providing in-service training to existing agency staff, as an investment, could reduce the need for specialized staff to design and implement inclusive programs.

There are times when specialized equipment is required to ensure program accessibility. Agencies could pursue funding from outside sources, such as private foundations and corporate agencies, to purchase expensive equipment. This may be accomplished through grant applications written by skilled agency staff in collaboration with advocacy organizations, universities, and so on. Homemade equipment and materials could be developed that are more cost-effective than commercially marketed adapted equipment.

Lack of Transportation

One of the most prevalent constraints individuals with disabilities face relates to transportation. Securing accessible transportation often proves to be extremely difficult for people with mobility problems. And, when accessible transportation is available, its quality and reliability are sometimes called into question. Public transportation systems, such as city buses and private taxis, may not be physically accessible, or may be too expensive. If adapted vehicles are used, they are typically available on a limited, reservation-only basis. Consumers often report available transportation is distanced too far from home, transportation services to their neighborhoods are generally unreliable, and vehicles are inaccessible. Individuals with disabilities are often faced with the choice of either staying home or asking family members or friends to transport them to recreational activities.

Accessible transportation is essential if individuals with disabilities are to lead more independent lifestyles and become more involved in community experiences. Following are possible solutions to consider.

According to the ADA, communities are obligated to provide transportation to people with disabilities as they do for people without disabilities. Door-to-door transportation for people with disabilities who cannot travel to a recreation or park facility could be provided. TR specialists could provide individualized services and support, such as home visits when appropriate, to teach functional skills in preparation for future community recreation participation. The costs associated with providing door-to-door transportation or home visits may be prohibitive, and therefore more immediate and practical considerations may become necessary. For example, recreation agency personnel could consider offering rate reductions for users of accessible transportation with limited incomes, or establishing car or van pools using volunteers, parents, and advocates. Individuals with disabilities or their advocates could contact public or private transportation agencies to determine the availability, costs, and scheduling information of accessible vehicles. Examples of these transportation agencies include city or county transit systems, private taxicab companies, or churches/synagogues. It is imperative that TR specialists, family members, advocates, and educators teach participants how to independently access and utilize available transportation systems within their communities.

What Next? Future Perspectives

It was our intent to shed some light on those issues that best exemplify the types of constraints people with disabilities address each day to become active, healthy, and socially connected members within their communities. If people are to become valued socially, TR services must facilitate opportunities for people who have traditionally been excluded to participate actively. To return to the recently adopted position of the National Recreation and Park Association (2000), opportunities, programs, and environments will have to foster the physical, social, and psychological inclusion of people with diverse experiences and skill levels. In this manner, therapeutic services, community supports, and attitudinal changes that reflect functional abilities, independence and interdependence, self-respect, dignity of the human being, and self-determination will be facilitated.
Current national health initiatives that support the overall health and well-being of our citizens have recently been promoted by the Centers for Disease Control’s “Healthy People 2010” (U.S. Department of Health and Human Services, 2000). To promote a healthy citizenship, this report supports helping all people—including people with disabilities—to become more active to prevent depression, and to spend more time in social and community activities. Special attention was given to the reduction of environmental constraints that inhibit participation across all of life’s domains (Sable, Craig & Lee, 2000).

If consumers, advocates, and professionals are to support the new mandates of the National Recreation and Park Association, the Centers for Disease Control, and the Americans with Disabilities Act, we will have to be creative in the ways we design, market, and implement our services. Recreation and physical activity programs will need to be designed so their participants become valued members. Leisure service organizations and other institutions that deliver “therapeutic” recreation services will need to eliminate the constraints that lead to dependence and a lack of social value and social inclusion (Devine, 1997). Structural, as well as interpersonal and interpersonal, solutions must become the focus of our agencies and services. Smith, Austin, and Kennedy (2001) and Soe-Ahola, Gay, and Green (1997) suggested our efforts at elimination go well beyond the obvious intrinsic (health) problems we have addressed in years past through therapeutic recreation services.

Hah (1987) and Devine and Dattilo (2000) argued we have traditionally attempted to improve the physical, cognitive, and emotional skills of people with disabilities to address their handicaps. Discovering that traditional medical treatment, rehabilitation, and amelioration of illness do not necessarily lead to social acceptance and health-promoting lifestyles. We must become aware of the many forms that constraints take, including the roadblocks we confront in our services, environments, and society. Rather than continue to require people of varying abilities to conform to society’s ways and stereotypes by improving people’s functional abilities only, it may be time to radically alter our “therapeutic” approaches to help society conform to individual differences. Possibly, the more effective approaches to supporting social acceptance, healthy lifestyles, and community inclusion will include the reduction of stereotyping and stigmatizing people who have been underrepresented and disenfranchised.

Although mandates for independence/interdependence, self-determination, social inclusion, and accessibility seem clear, a wide range of constraints that impede progress toward achieving these goals continue to exist. Society’s negative role perceptions of people with disabilities, as well as its low tolerance for individual differences, increase the likelihood obstacles such as community and organizational stigmas and other pervasive negative attitudes will continue to support the medical versus wellness model, decrease leisure service delivery, and diminish rates of participation by people with disabilities. A more positive view suggesting the individual with a disability is a person first may help to change societal perceptions. A change toward more open and inclusive service systems could be a reflection of these perception and attitude changes. Passing the ADA, including its comprehensive discussions of rules regulating play, recreation, and physical activity environments, is reflective of these attitudinal changes and provides helpful guidelines for ensuring that citizens of all abilities are reasonably serviced, accommodated, and ultimately, included in programs.

We have attempted to identify and categorize persistent constraints to successful leisure lifestyles of people with disabilities. It is our firm belief many constraints could be avoided or eliminated if recreation professionals incorporated the perspectives and strategies that have been presented to change and improve existing therapeutic recreation and leisure service delivery systems. Taken as a whole, this chapter presented a direction for service delivery that welcomes people with disabilities who want to participate in our communities and enhances their feelings of self-worth and sense of belonging to the communities and neighborhoods in which they live, learn, work, and play. In an interview by Mobily (2000), Soe-Ahola noted therapeutic recreation will make a huge difference in our society if it can make people believe in themselves (e.g., self-efficacy) on the one hand and make them motivated about life and various activities on the other: “Believing in your skills and capacities (however limited), and finding enthusiasm for life’s activities, set the stage for subsequent improvement in psychological and physical well-being” (p. 302).

Ongoing cooperation among key players, including therapeutic recreation specialists in both clinical and community settings, recreation programmers, advocates, consumers with disabilities, and their family members should ensure the recreation and social needs of people with disabilities are met in the community. Socialization and the development of relationships with nondisabled peers will be stressed, and the spirit and intent of the ADA will be realized. Both TR and other recreation professionals are reminded to take a proactive, rather than a reactive, approach to systems and personnel change and to avoid making the erroneous assumption that constraints to inclusion and accessibility are created solely by the individual characteristics of people with disabilities.
If therapeutic recreation professionals begin to engineer environments to remove constraints to social inclusion—in addition to improving the functional abilities and health of the people they serve—they will have progressed in developing and manifesting positive, accepting attitudes toward citizens with disabilities. To serve as a role model, the people of Sweden have adopted a social sense of collective responsibility, whereby all members of the community are valued for who they are. A central premise in the Nordic countries is that all people have a right to a decent standard of living. Efforts are made to discover the value and talents of each individual so every person could make his or her unique contribution for the good of all. As a result, all members of Swedish society are viewed as valuable, and it is understood and accepted that all people with disabilities will receive whatever support is necessary to become active and contributing citizens of society (Pedlar, 1990).

The inclusion of people with disabilities in programs and communities is an essential element in recognizing the inherent dignity of every member of our society. Successful social inclusion requires that major stakeholders of our service delivery systems espouse philosophies and value systems that reflect the right of every individual to participate to one’s fullest potential. Of central importance in this philosophy is the recognition that all individuals have valuable contributions to make. Agencies must articulate and practice a policy of making existing programs inclusive. The creation and provision of service delivery based solely on the correction of disability is exclusionary and results in the further alienation of people with disabilities from the remainder of society.

In conclusion, the following four principles should guide the development of exemplary recreation service delivery:

1. Programs designed for all people must be age-appropriate and based on personal interest, not diagnosis and stereotypes, or the preferences of agency staff only.

2. To the maximum extent possible, programs must occur within home communities, and not in restrictive, contrived, or irrelevant environments.

3. Continual communication and coordination among participants, family members, advocates, therapists, recreation practitioners, and program administrators must occur to ensure program longevity in the community.

4. Participants with and without disabilities, family members, and programers must share the responsibility to ensure that every community member’s needs and interests are met, including the recreation, health, social, physical, and lifestyle needs of entire families.

As potential contributors to overall health and wellness, family members, peers, and recreation practitioners continue to advance inclusive community services for people of all abilities; they help to enhance the development of community life itself. No longer shunted off to constricted, contrived, and segregated environments, people of varying abilities who live in, learn in, and use the community also teach their peers without disabilities new lessons in diversity, personal growth, empowerment, and self-fulfillment. Until we are able to empathize with others who are disenfranchised and on the fringes of community life, we will be unable to mature into the fine professionals and citizens we aspire to be. We must work to broaden the community’s definition of diversity by bringing those who have been excluded into the discussion. By building a creative vision of wellness, inclusion, and self-efficacy, rather than continuing to adopt and nurture solely deficit-oriented and clinical perspectives, a common vision of truly welcoming and inclusive communities could appear and take hold. We must build organizations committed to community and disperse our services throughout communities.

A mandate for welcoming and accommodating communities makes us all responsible as advocates, educators, role models, catalysts, and spokespersons. The Brazilian story of the hummingbird’s work during a destructive forest fire exemplifies this point. The hummingbird was observed flying back and forth carrying water in its minuscule beak, and dispersing droplets over the overwhelming fire, while other, much larger and stronger animals were running briskly in the opposite direction. An observant “king of the forest,” the mighty lion, asked the tiny bird if she understood it was impossible to extinguish the ferocious forest fire with such tiny droplets of water, and in fact, would probably get killed in the process. Without missing a wing flap or beat, the exhausted hummingbird simply replied, “I’m just doing my part!” It is time that we all begin to do our small parts in making our communities more welcoming, inclusive, and stronger. It is our responsibility and it is our area of expertise.
References


