EVALUATING A TR PROGRAM FOR TRAUMATIC STRESS RECOVERY: CHALLENGES OF PROGRAM EVALUATION IN A CLIENT-CENTRED, INTERDISCIPLINARY THERAPEUTIC COMMUNITY ENVIRONMENT

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Introduction

We live in an era of evidence and effectiveness, where practitioners are requested to provide proof of the changes that result from program implementation. The notion of best practices looms on the horizon as a challenge for therapeutic recreation (TR) and health promotion practitioners to ensure effective program delivery and interventions. We also have experienced a shift in practice toward approaches that are client-centred, focus on individualized treatment pathways, interdisciplinary or multidisciplinary teams, and in some instances, therapeutic communities. Together these shifts present a number of challenges to conducting program evaluations within today's therapeutic environment. Where program evaluation is the "systematic collection of information about the activities, characteristics, and outcomes of programs to make judgements about the program, improve program effectiveness, and/or inform decisions about future programming" (Patton, 1997, p. 23), traditional models of formative and summative program evaluation (cf. Rossi, Freeman & Lipsey, 1999; Patton, 1997; 1990) require some rethinking in today's context of practice. What is required is critical consciousness of what we are teaching and advocating in program evaluation. To borrow from Paolo Freire (1998), critical consciousness examines things and facts as they exist empirically; it is consciousness that is integrated with reality and emerges through a process of dialogue. This paper brings together reflection on several years of experience gathered through program evaluation research and workshops with TR and health promotion practitioners who work in interdisciplinary teams.

The purpose of this paper is threefold. First, it clarifies the origin of our language around best practices, evidence and program evaluation. Across interdisciplinary teams there are a number of different understandings of these words, often indicating different philosophies and approaches to practice. Second, the paper will present a discussion of the challenges of "doing" best practices and program evaluation within a client-centred, inter-disciplinary therapeutic community environment. This discussion emerges from dialogue with practitioners who have grappled with the challenges of doing program evaluation in current clinical contexts. Third, this paper will describe a program evaluation plan designed to overcome these conceptual and methodological issues. This section of the paper will describe a three year program evaluation designed to evaluate a leisure education group for adults that occurs within a broader therapeutic community context designed to promote healing after trauma.

The New Trinity? Best Practices, Evidence and Indictors in Evaluation

Much of the rhetoric of best practices, evidence and indicators arose from the biomedical field around the development of clinical practice guidelines (CPGs) and standardized indicators of outcomes. Narrow definitions of best practice focus on the

identification of a set of procedures which are the best way to treat a particular problem. While CPGs play an important role in evidence-based medicine, and may have something to contribute to TR and health promotion practice, dialogue with practitioners indicates the need for a broader notion of best practices. Best practices also involve, accumulating and applying knowledge about what is working and not working in different situations and contexts. In other words, it is both the lessons learned and the continuing process of learning, feedback, reflection and analysis (what works, how and why, etc.) to adapt practice to the prevailing conditions (Arai, 2000).

TR and health promotion practice also requires a broader understanding of what constitutes evidence. Evidence—"information used in making a decision or judgement or in solving a problem" (Butcher, 1999, p. 259)—is an essential aspect of best practices. Collecting evidence as the basis for program decisions and compiling evidence of the effectiveness or impact of our work is important; however, the jargon associated with evidence is often unclear and confusing. Often people equate evidence with the type of information that is available only from randomized clinical trials. However, when considering a definition of evidence for use in TR and health promotion, a broader definition is required to encompass the variety of approaches and processes used in this field of practice, else "the notion of evidence is empty without an understanding of the decision type and context in which the evidence is being used" (Butcher, 1999, p. 274). The range of evidence that is available to us in practice may be divided into three types: knowledge of community context/need, peer-reviewed academic literature, and established program indicators (Burke, Johnson & Arai, 2000). The three types of evidence are intended to reflect the importance of both outcomes and process in TR and health promotion.

The development of "indicators" related to practice remains a challenge to the process oriented nature of our work. Indicators—"tangible and measurable evidence of a particular phenomenon or a condition" (Kar, 1989, p.2)—can be used to evaluate a state or condition and/or changes in the condition, to monitor progress over time. Indicators may be qualitative or quantitative in nature. While there is often pressure to generate quantitative measures of outcomes, by nature TR and health promotion practice necessitates the incorporation of qualitative evidence. Concepts such as freedom, satisfaction, interaction, and personal meaning and development cannot be fully understood by using tools that equate phenomenological concepts with numbers. As Burke (1993) notes, the task of analyzing benefits and the texture of the experiences of individuals and communities demand a qualitative approach.

Understanding Best Practices and Evaluation in the Context of the Inter- or Multi-Disciplinary Team

In speaking with practitioners about conducting program evaluations, and developing evidence about their practices, a number of concerns have been consistently raised. These concerns arise around the changes that are being made in the approach to practice and the limitations in traditional program evaluation approaches to address those changes. The move toward individualized treatment pathways, interdisciplinary or multidisciplinary teams, and in some instances, the development of therapeutic communities means that we have moved away from a standard program design and implementation process. This challenges traditional approaches to program evaluation.

This paper will examine six challenges to traditional evaluation strategies that arise from advancements in the way we approach program development (see items 1 & 2 in the Table), situate the client or person who is the focus of the intervention (see items 3 & 4), and position practitioners in clinical and community contexts (see items 5 & 6)

Shifts in practice	Challenges practitioners raised to program evaluation
1. (a) outcomes vs. (b) processes	A focus only on outcomes will miss important aspects of clinical interventions, how do we capture important processes in the program evaluation?
2. (a) fragmented client care vs. (b) holistic and flexible approaches	How do we ensure that the program evaluation reflects a holistic understanding of clients and their individualized treatment pathways, and is flexible and sensitive to social contexts, language and cultural practices of clients?
3. (a) client responsibility for health vs. (b) addressing systemic issues	Should program evaluation focus only on individual client outcomes or, should we be addressing systemic barriers to leisure and health (e.g., access, extraneous psychosocial factors etc.)?
4. (a) standardized practices vs. (b) adaptations to individual & community context	With the shift to client centred approaches we no longer have a standardized "product" (i.e., implementation varies), how does this affect program evaluation?
5. (a) sole practitioner vs. (b) multidisciplinary interdisciplinary teams	When we practice in interdisciplinary teams, how do we know that the changes experienced by clients are the result of our specific program or intervention?
6. (a) guidelines vs. (b) practitioner experience and innovation	How can program evaluation reflect practitioner innovation and creative processes?

Evaluation Design to Move Beyond the Challenges: A Program Evaluation of a Leisure Connections

The Leisure Connections Group is part of a broader eight-week program for traumatic stress recovery within the setting of a psychiatric hospital. The eight-week program for traumatic stress recovery was originally designed as an inpatient treatment program for adults suffering from post-traumatic stress disorder (PTSD) at Homewood Health Centre in Guelph, Ontario. The program is built upon therapeutic community concepts and clients have access to supports from a number of disciplines, including TR. As Wright & Woo (2000) state, "many individuals are traumatized as a result of interpersonal violence, they experience a social wound" and therefore "the therapeutic community offers an environment where social wounds can have the necessary social healing" (p. 109). Leisure Connections is a four session psycho-educational group that focuses on creating awareness of how a client's current leisure choices may enable maladaptive coping patterns and potentially re-enact aspects of a

traumatic experience (Griffin, 2002). The group focuses on creating awareness of how to re-experience leisure from a healthy self-nurturing perspective. The group is fluid and dynamic whereby the direction of the group is largely influenced by the group's process. Information is conveyed in traditional education and discussion formats, and experiential exercises. In this context, evaluation must concern itself with both community processes and individual client outcomes. Consequently, the six challenges identified by practitioners are also of concern in designing the program evaluation. This presentation reports on innovations in a 3 year program evaluation process that combines qualitative and quantitative approaches toward the development of a staged approach to program evaluation beginning with: year one—an exploratory within group evaluation of processes and outcomes, year two: an between-group comparison of processes and outcomes; and year three: a program evaluation using a quasi-experimental design to compare participants in Leisure Connections to individuals involved in the broader program.

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