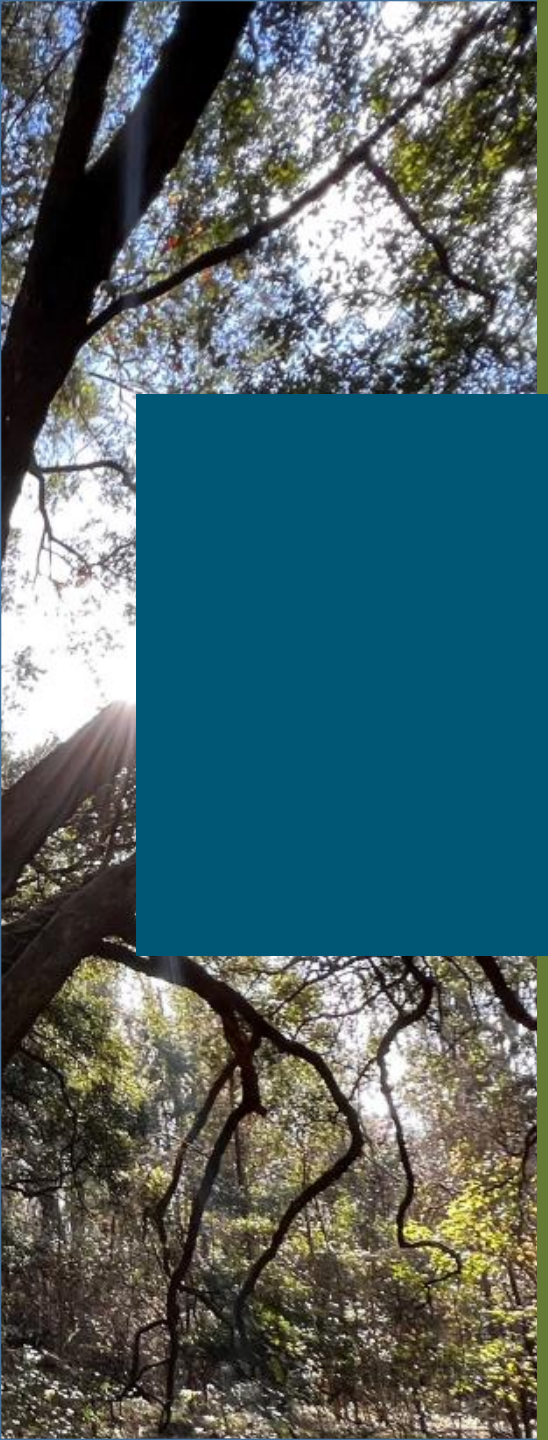
Welcome to the 2022

FRPA Therapeutic Recreation Institute

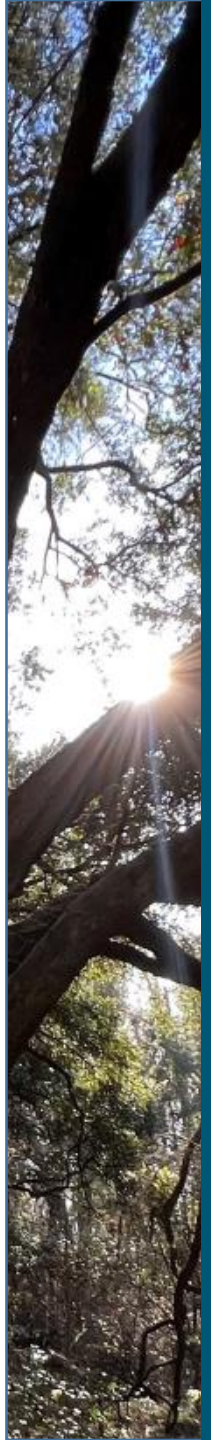
August 27 - August 29, 2022 | Orlando, FL



BE A TRAIL BLAZER USING EVIDENCE BASED PRACTICE

Saturday, August 27, 2022

2:15pm - 4:15pm



BROWARD COUNTY FLORIDA PARKS AND RECREATION

Mary Palacios. CTRS. CPRP

Broward County Parks and Recreation.

Special Populations Manager

Mpalacios@broward.org

FIU Arts, Sciences & Education
FLORIDA INTERNATIONAL UNIVERSITY

Tania Santiago Perez. MS. CTRS
Associate Teaching Professor
Florida International University
305-348-3220 tsantiag@fiu.edu

LEARNING OBJECTIVES

After this session, participants will be able to:

1. Define what Evidence-Based Practice (EBP) is, and how to find EBP resources

2. Identify 2 programs or interventions that are evidence-based for different populations including intellectual and developmental disability, anxiety and depression, and physical disabilities

3. Identity how to incorporate evidence-based practice in their current work setting.

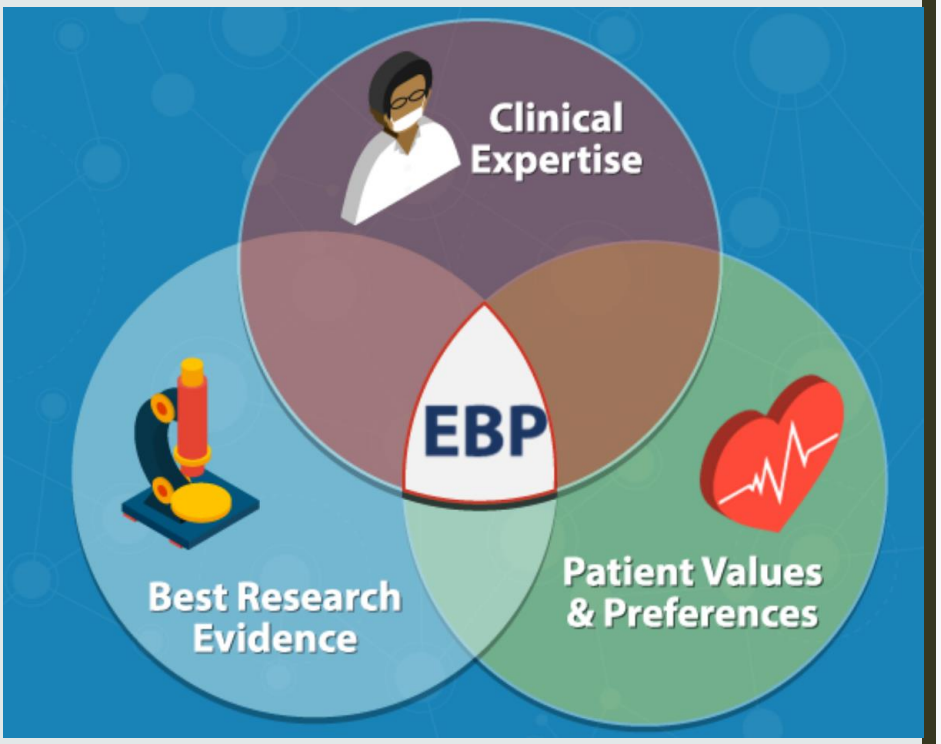
STANDING TALL THROUGH IT ALL
80 years of FRPA
2022

IMPLEMENTATION

“The recreational therapist implements an individualized treatment plan, using EVIDENCE-BASED PRACTICE, to restore, remediate or rehabilitate functional abilities in order to improve and maintain independence and quality of life as well as to reduce or eliminate activity limitations and restrictions to participation in life situations caused by an illness or disabling condition. Implementation of the treatment plan by the recreational therapist is consistent with the overall or interdisciplinary patient/client treatment program” (ATRA, 2019)

EVIDENCE-BASED PRACTICE (EBP)

The process of providing day-to-day services to clients based on the results of outcomes research.

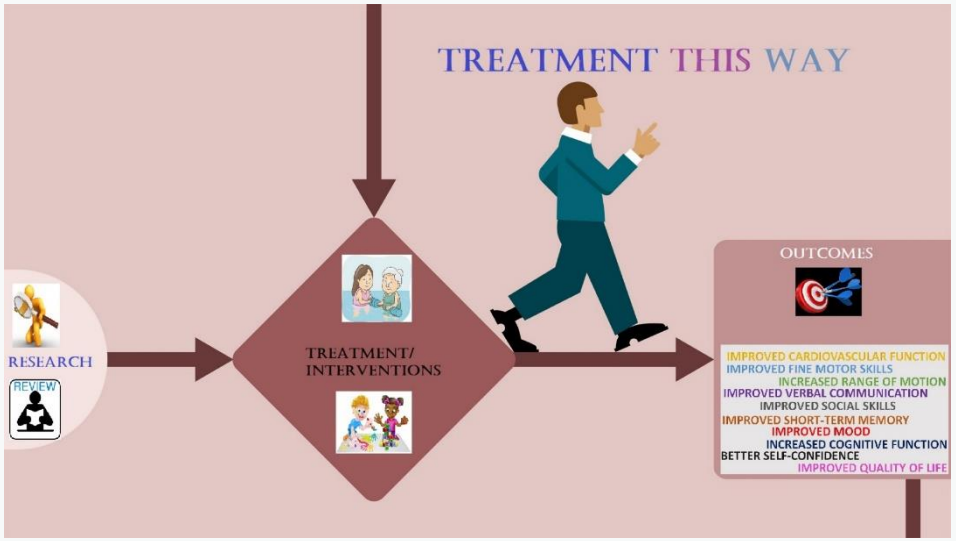


The conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients

- Empirically validated treatment
- Empirically supported treatment
- Empirically evaluated treatment
- Empirical practice
- Research-based practice
- Research utilization
- Evidence-based treatment
- Evidence-based health care

The selection of treatments for which there is some evidence of efficacy.

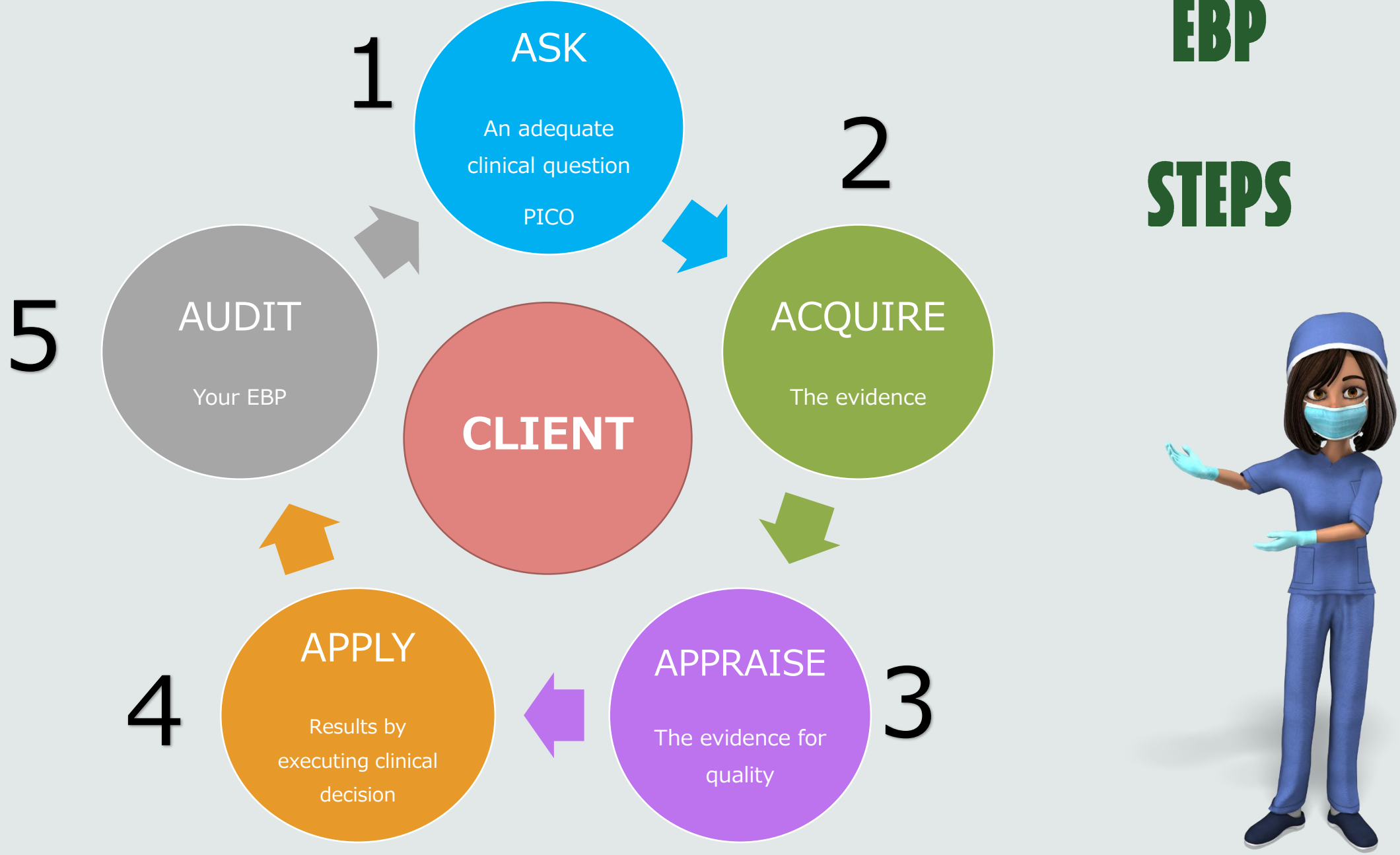
BENEFITS OF EBP



- Informs and guides decisions regarding treatment + program planning
- Ensures that clients receive the most effective + efficient care
- Enhances professional competence + confidence in producing client outcomes
- Standardization of professional practice (APIED process)
- Helps justify therapeutic value of recreational therapy programs, and thus, funding.
- Promotes communication between practitioners, researchers, and other disciplines.

EBP

STEPS


1
ASK
An adequate clinical question
PICO
2
ACQUIRE
The evidence
3
APPRAISE
The evidence for quality
4
APPLY
Results by executing clinical decision
5
AUDIT
Your EBP
CLIENT

ASK AN ADEQUATE CLINICAL QUESTION

PICO

A mnemonic for the key components of a well-focused clinical question

Patient Population

Intervention

Comparison

Outcomes

ASK AN ADEQUATE CLINICAL QUESTION

	Term 1	Term 2	Term 3	Other terms?
Population	Dementia	Neurocognitive Disorder	Alzheimer's Disease	Lewy Body Dementia, Vascular Dementia Frontotemporal Dementia Mixed Dementia
Intervention	Tai Chi	Tai Chi Chuan	T'ai Chi Ch'uan	Yang Tai Chi Beijing Short Form Tai Chi Chen Tai Chi Hao Tai Chi
Comparison	N/A			
Outcome	Fall Fall Risk Fall Prevention	Cognitive function Cognition Cognitive ability	Balance Postural Stability	
Time	12 weeks	3 months		

STEP 1

TYPES OF QUESTIONS

Question Type	Purpose	Question
Benefit	To determine if a specific intervention is beneficial for a specific population	-Is there evidence that _____ (I) improves _____ (O) among _____ (P) -What are the effects of _____ (I) among _____ (P) on _____ (O)
Intervention or therapy	To determine which treatment leads to the best outcome	-Compared to _____ (C), does _____ (I) _____ (O) among _____ (P) -Among _____ (P) how does _____ (I) compared with _____ (C) affect _____ (O) within _____ (T) -In _____ (P) how does _____ (I) compared with _____ (C) influence _____ (O) over _____ (T)
Prognosis or Prediction	To determine the clinical course over time and likely complications of condition	-What signs and symptoms do I need to be aware of when I provide _____ (I) to _____ (P) to _____ (O) for _____ (T), -What is the expected prognosis of _____ (P) when providing _____ (I)_____ to _____ (O)
Meaning	To understand the meaning of an experience for a particular individual, group or community	-How do _____ (P) perceive _____ (O) during _____ (I)?

STEP 1:

ASK AN ADEQUATE

CLINICAL QUESTION

STEP 2: ACCESS THE EVIDENCE TO ANSWER YOUR CLINICAL QUESTION

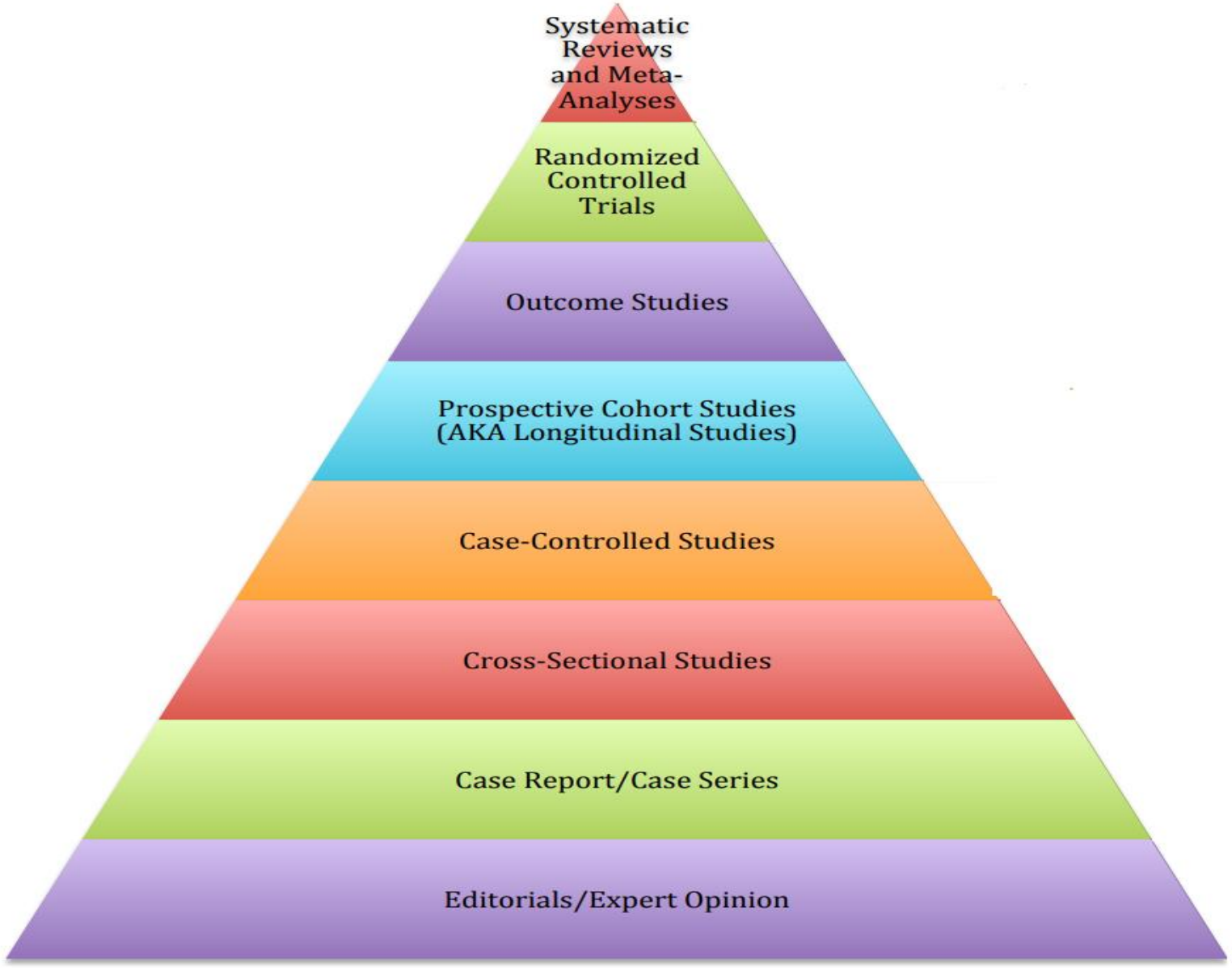
1. **Research databases (subscription vs. open access)**

   - PsycInfo (hybrid)
   - ScienceDirect (hybrid)
   - ProQuest (hybrid)
   - EBSCO Essentials ($)
   - SAGE Journals ($)
   - PubMed (open)
   - DOAJ (open)

2. **University Library or Public Library**
3. **Google Scholar (hybrid)**

4. **RT-specific evidence: RT Wise Owls, Therapeutic Recreation Journal, Annual in Therapeutic Recreation & American Journal of Recreation Therapy,**

HIERARCHY OF RESEARCH STUDIES



STEP 2: ACCESS THE EVIDENCE TO ANSWER YOUR CLINICAL QUESTION

Appropriate Research Sources

- -Peer-reviewed journal articles
- -Published literature reviews
- -Published systematic reviews
- -Published meta-analysis
- -Published meta-synthesis

STEP 3:

APPRAISE THE EVIDENCE FOR QUALITY

Best if you look at research evidence that is no more than 10 years old

Make sure you are only looking at peer-reviewed sources

Know what you are looking for, use strategic keywords

Use filters that are provided by search engines to optimize your search results

Know how to navigate an article

Look at the reference list of the articles for additional resources

Systematic reviews and meta-analyses are strongest evidence of all articles

Are the results valid?

Validity: how well the results among the study participants represent true findings among similar individuals outside the study.

***Internal validity*:** results of study are attributed to the intervention studied and not some other rival explanation

External validity: extent to which results of study can be generalized

Are the results reliable?

Reliability: consistency of results from methods and instruments used in the study

Attribute	Question
Validity	Can I trust this information? e.g., Are the study methods sound?
Clinical importance	Are the valid results of the study important? e.g., What is the magnitude of the treatment effect?
Applicability	Can the results be applied to my patient? e.g., Is my patient so different from those in the study that its results cannot apply?

What does my experience and judgment tell me?

Clinical expertise: ability to efficiently make critical clinical decisions while grasping the whole nature of a situation

What changes/adaptations are needed based on my local context?

Adaptability: capability of adjustment

Can I apply the results in my practice?

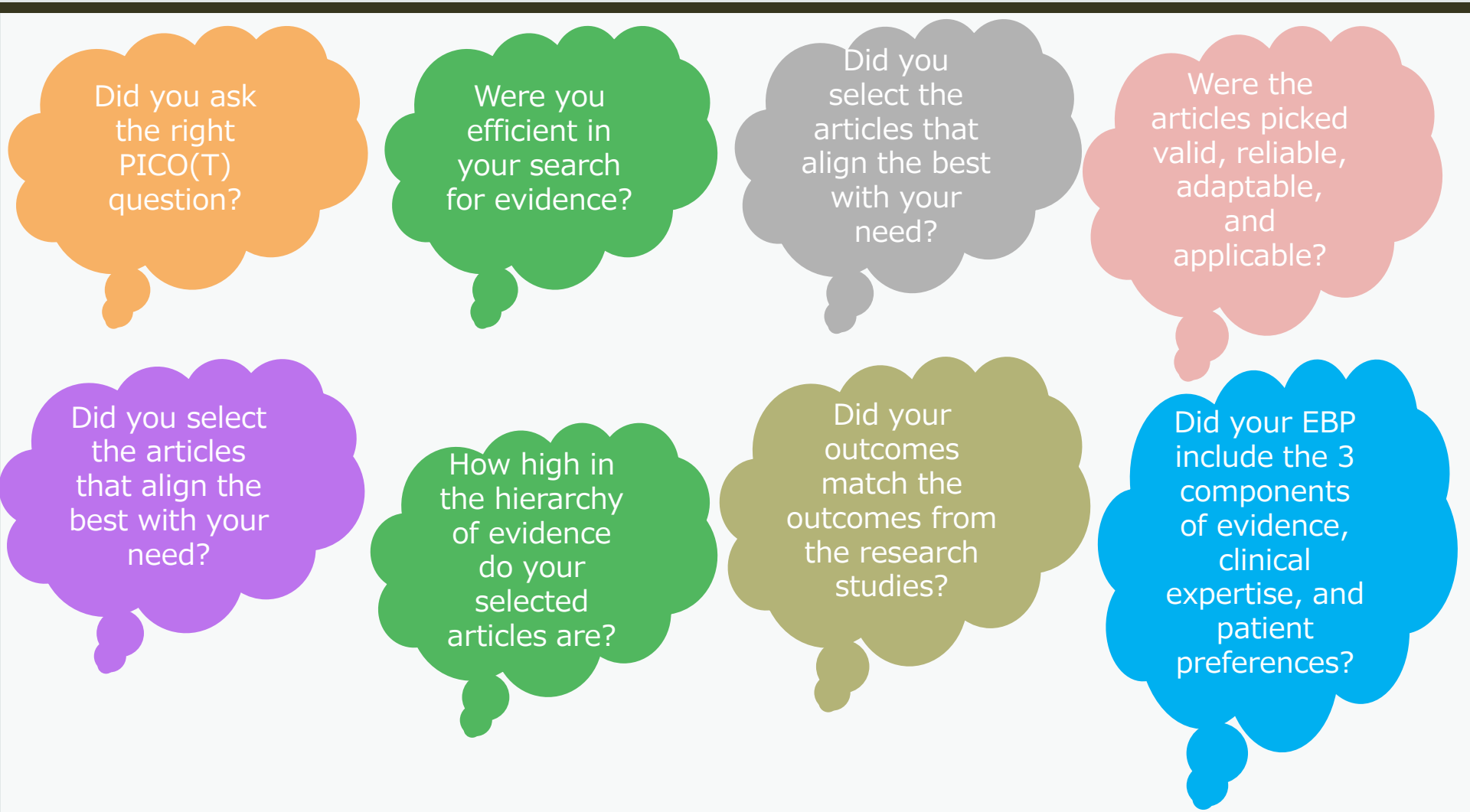
Applicability: the quality of the evidence being relevant or appropriate to my particular situation

STEP 3: APPRAISE THE EVIDENCE FOR QUALITY

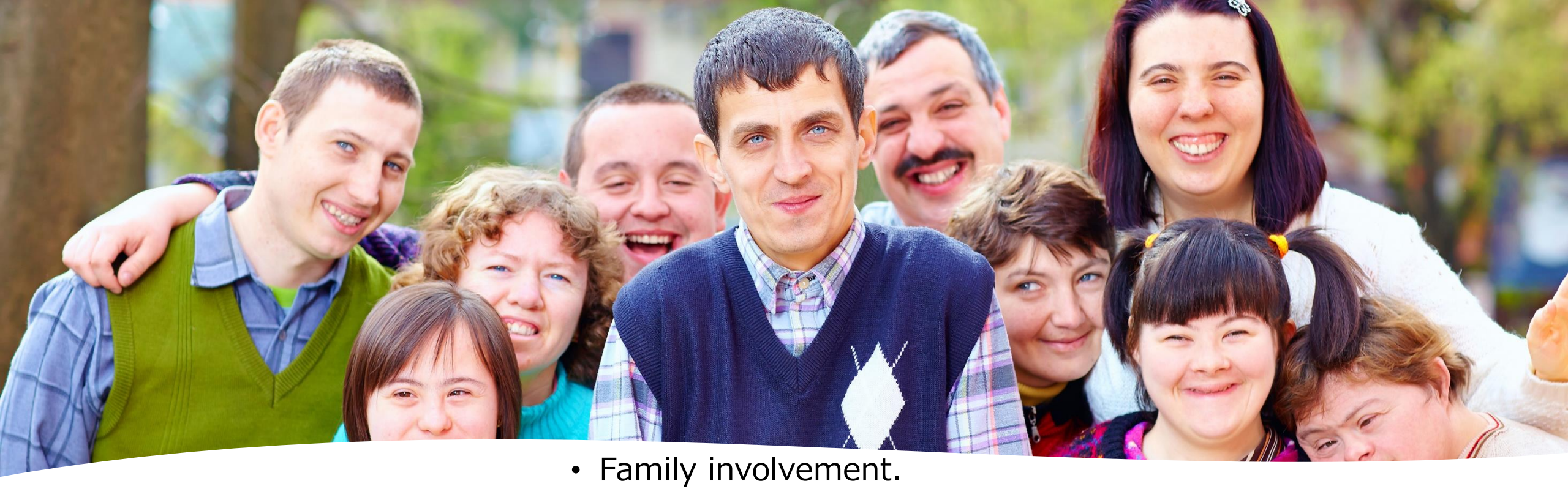
STEP 4: APPLY RESULTS BY EXECUTING CLINICAL DECISION

Here you consider the evidence, your clinical expertise, and your clients' needs and preferences to make your decision and then, execute it.

STEP 5: AUDIT YOUR EBP



EBP FOR TRANSITION-AGED YOUTH WITH IDD



BEST PRACTICES

- Family involvement.
- Individualized planning
- Instruction and experiences that prepare them for employment and/or social inclusion.
- Inclusion with peers without disabilities
- Interagency involvement and collaboration.
- Opportunities to develop self-determination.
- Program structures that are culturally and ethnically sensitive.
- High expectations.
- Adequate resources and highly qualified staff.

(Cobb & Alwell, 2019; Papay & Bambara, 2014)

-Community participation and social inclusion

-Preventative services and health promotion

-Vocational Training

-Quality of Life

-Successful aging

COMMUNITY PARTICIPATION

The World Health Organization's International Classification of Functioning, Disability and Health (ICF Model; 2001) defines participation as "involvement in life" (p.10)

Based on the ICF Model, Verdonschot et al., (2009) defined community participation as individuals' performance in:

Domestic life

Interpersonal life

Education and employment

Community, civic, and social life

(Santiago Perez & Crowe, 2021)

BARRIERS TO COMMUNITY PARTICIPATION FOR TAY WITH IDD

In comparison to peers without disabilities, TAY with IDD:

Participate less in the community

Have access to and/or experience fewer environmental supports/resources

Engage more in passive, isolated activities

Barriers to community participation among TAY with IDD:

-Lack of programming

-Intrapersonal characteristics

-Environmental challenges

Structural accessibility

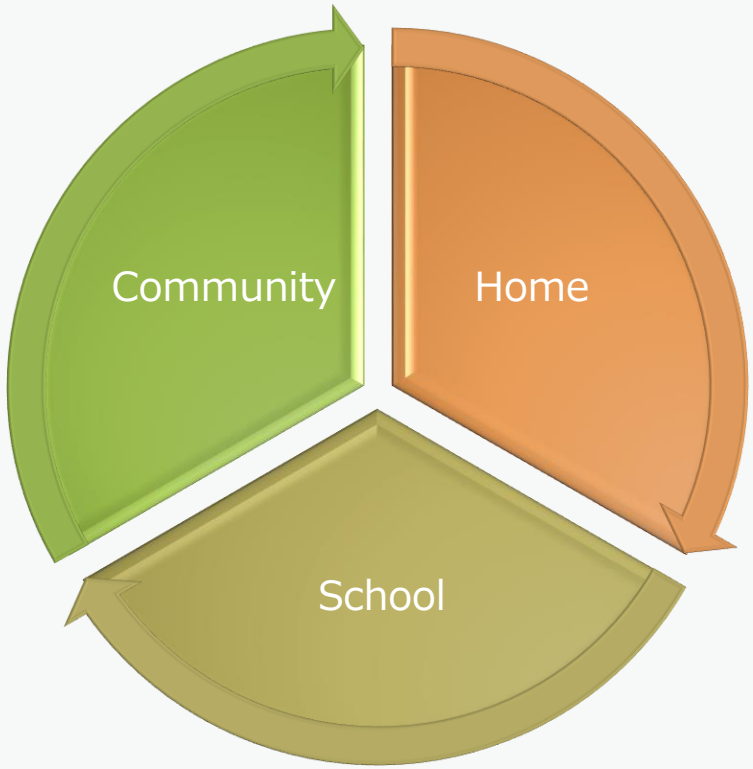
Socioeconomic status

Discriminatory attitudes within society

(Andrews et al,. 2015; Becker & Dusing, 2010; Murphy & Carbone, 2008; Myers et al., 2015; Santiago Perez & Crowe, 2021; Verdonschot et al., 2009; Watts et al., 2017)

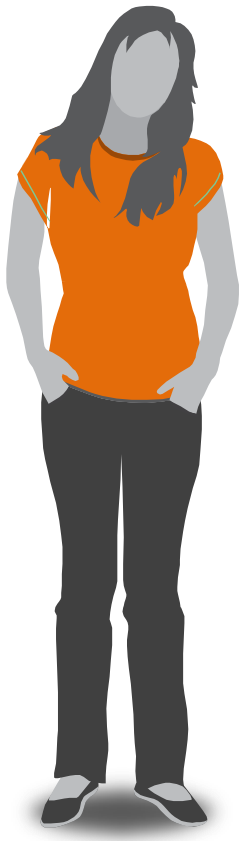
FACILITATORS OF COMMUNITY PARTICIPATION

- Support from all areas of life (e.g., community, home, school, treatment providers)
- 1:1 and group-based services
- Coaching
  - Mentoring
  - Opportunity to apply and practice skills
  - Individualized



(Adair et al., 2015; Andrews et al., 2015; Bigby et al., 2018; Santiago Perez & Crowe, 2021)

RECREATIONAL THERAPY EVIDENCE ON COMMUNITY PARTICIPATION



Programs with Collaboration and Community Supports

Leisure Education

Social Skills Training

(Cobb & Alwell, 2019; Papay & Bambara, 2014)

PROGRAMS WITH COLLABORATION & COMMUNITY SUPPORT

School Systems

- School teachers & IEP team members.
- CTRS use leisure-based programs to assist client in (a) achieving IEP goals; and (b) developing skills necessary for successful transition.
- Partner with local University programs with recreational therapy programs.

Local Community & Organizations

- Experiential and applied learning opportunities.
- Opportunity for increased social networking.
- Opportunity to actively problem-solve barriers to participation.

Parents Guardians

- CTRS can obtain proxy data from parent/guardians to inform clients' treatment planning process, and evaluation of progress.
- CTRS can gather information regarding clients' family unit, and the environment in which the individual resides.
- Include parents/guardians in programs and services provided.

Peers without Disabilities

- Facilitates increased social support and social networking skills.
- Peers without disabilities can serve as peer mentors during community outings.

(Ashton-Shaeffer et al., 1995; Bedini et al., 1993; Crawford et al., 2012; Dattilo, 2002; Hoge et al., 1999; Kunstler et al., 2013; Miller et al., 2002; Santiago Perez & Crowe, 2021; Wilder et al., 2014)

LEISURE EDUCATION

- 5 leisure education programs in RT literature.
- Wide range of duration from 12 weeks to over 10 years
- Emphasis on 1:1 skill instruction and individualized content.
- Most programs offered in 60-minutes increments, 2-3x week.
- Curricula focused on self-awareness in leisure, leisure opportunities, leisure resources, barriers to leisure, leisure and recreation skill development, leisure planning, social skills, leisure decision-making, self-determination, self-advocacy, and self-image.
- All programs incorporated individual or group experiential learning in the community.

Home-School – Community Leisure Education (Ashton-Shaeffer et al., 1995)

Wake Leisure Education Program (Bedini et al., 1993)

Leisure Education within TREK Transition Services (Wilder et al., 2014)

TRAIL Leisure Education Program (Dattilo, 2002; Hoge et al., 1999)

Leisure Education within the SHC Model of Social Skills Development (Crawford et al., 2012)

(Santiago Perez & Crowe, 2021)

WAKE LEISURE EDUCATION PROGRAM

Setting & Participants	Program Format & length	Assessments Used	Curriculum Content
Public school system 38 high school students ages 17-22 receiving special education services.	26 weeks, 2 sessions per week Small groups or 1:1 sessions. 6 units in classroom 4 units in the community	Leisure Inventory Update (LIU) Student survey: assertiveness, independence, self-esteem, communication, social barriers, perceived control, leisure satisfaction, leisure awareness. Parent survey: parent's perception of their child's leisure interest, leisure involvement and leisure satisfaction	Ten-unit curriculum: 1) Leisure Awareness 2) Self-awareness in leisure 3) Leisure opportunities 4) Community resources awareness 5) Leisure Barriers 6) Personal resources and responsibility 7) Planning 8) Planning an outing 9) The outing 10) Outing evaluation: future plans

(Bedini et al., 1993; Santiago Perez & Crowe, 2021)

HOME-SCHOOL-COMMUNITY LEISURE EDUCATION PROGRAM

Setting & Participants	Program Format & length	Assessments Used	Curriculum Content
School, home, and community 2 TAY with IDD, ages 16 and 21	Participant 1: 7 months, 1x week Participant 2: 12 weeks, 2x week, 1-hr x session	Student: Curriculum based measures and interviews Parents: Inventory for Client and Agency Planning (ICAP) Teachers: ICAP areas of communication, social skills, community living, and personal adjustment.	Leisure Action (LAP) with What, Where, Where, When, Who with and Things I need. 1) Four modules of leisure awareness. 2) Two modules of leisure resources 3) Three modules of leisure communication skills 4) Two modules of leisure decision-making 5) One module of leisure planning

(Ashton-Shaeffer et al., 1995; Santiago Perez & Crowe, 2021)

TRANSITION THROUGH RECREATION AND INTEGRATION FOR LIFE (TRAIL) LEISURE EDUCATION PROGRAM

Setting & Participants	Program Format & length	Assessments Used	Curriculum Content
School (high school) 19 TAY with ID in experimental group, ages 15 to 20	18 weeks, 3x week, 1-hr classroom sessions followed by home community sessions with a leisure coach for up to six months.	Short Form A of Leisure Diagnostic Battery	Five Units of Instruction: 1) Leisure appreciation 2) Social interaction and friendships 3) Leisure resources 4) Self-determination 5) Decision-making

(Dattilo, 2002; Hoge et al., 1999; Santiago Perez & Crowe, 2021)

LEISURE EDUCATION WITHIN THE SCHOOL/ COMMUNITY/ HOME (SHC) MODEL OF SOCIAL DEVELOPMENT SKILLS

Setting & Participants	Program Format & length	Assessments Used	Curriculum Content
School (middle school and high school) 11 students with ASD, ages 16-19	Services occurred over 5 years. Students received weekly sessions with a CTRS, with 2-3 hours of leisure education homework per week. Bimonthly social club outings	Indices of Friendship Schedule	Curriculum based on School-Community Leisure Link Project Components: 1) Building awareness of leisure patterns and attitudes 2) Assessing leisure interests and preferences 3) Facilitating knowledge of leisure resources 4) Teaching leisure and recreation skills 5) Facilitating participation in activities at home, school, and in the community

(Crawford et al., 2012; Santiago Perez & Crowe, 2021)

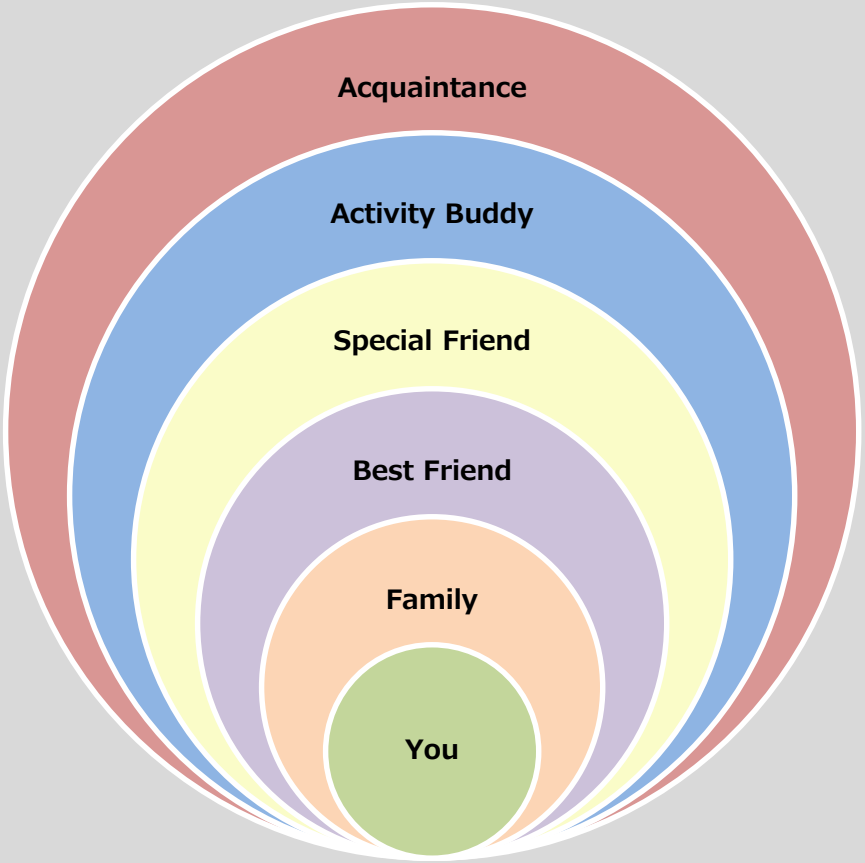
LEISURE EDUCATION WITHIN THERAPEUTIC RECREATION EMPOWERING KIDS (TREK) TRANSITION SERVICES

Setting & Participants	Program Format & length	Assessments Used	Curriculum Content
Public school system Over 100 students served.	Continuum of services: -Elementary school: IEP goals specific to recreational and social skill development. -Middle school and early high school: pre-transition services focused on self-sufficiency and independence -Late high school: transition services focused on independent living skills, social skills, and post-secondary education.	Indices of Friendship Schedule	Leisure education content: 1) Valuing the leisure experience, health, and wellbeing. 2) Social interaction and social skills in leisure 3) Leisure resources 4) Leisure awareness 5) Recreation skill development 6) Self-advocacy and self-image 7) Self-determination and independence

(Wilder et al., 2014; Santiago Perez & Crowe, 2021)

SOCIAL SKILLS TRAINING

- Communication and conversational skills.
- Development of social networks and friendships.
- Social etiquette.
- Social acceptance and belonginess.
- Trio Model of Participation (one adult, one TAY with IDD and one TAY without disability).
- Inclusive recreation participation.
- Inclusive volunteering approach.

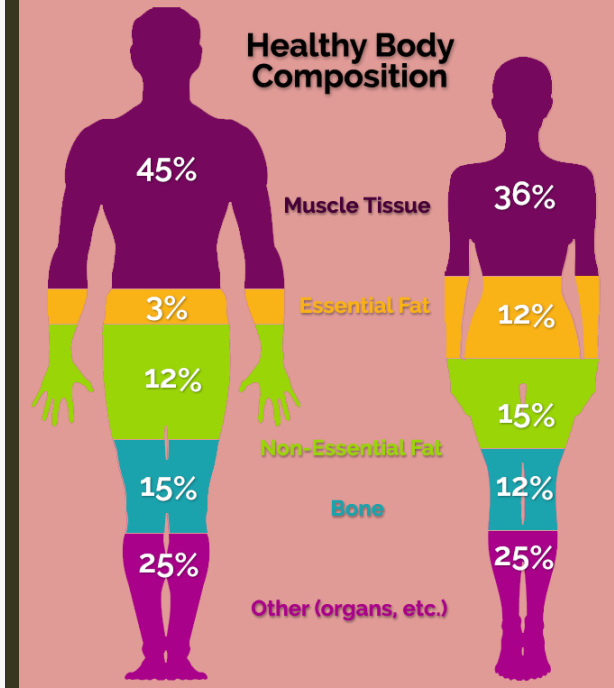


Friendship Circles Model

(Ashton-Shaeffer et al., 1995; Bedini et al., 1993; Crawford et al., 2012; Dattilo, 2002; Hoge et al., 1999; Kunstler et al., 2013; Miller et al., 2002; Wilder et al., 2014)

EBP FOR OBESITY AMONG TAY WITH IDD

- Adolescents with IDD are three times more likely to be obese than those without
- 6 months to 3 years to see and maintain results
- Program should involve the whole family
- Combination of education (on nutrition and benefits of exercise), structured physical activity, behavioral approaches, and meditation lead to improvements.
- Effective behavioral approaches include positive reinforcements and conditioned learning.
- Multidisciplinary approaches are best (collaborate with nutritionists, exercise physiologists, health educators, and mental health professionals).
- Majority of evidence targets mild to moderate ID



(Akhtar & McGibbon, 2022; Bandini et al., 2015; Conrad & Knowlden, 2020)

EVIDENCE-BASED PRACTICE: PHYSICAL DISABILITIES

1 - Mobility and Physical Impairments. ...
2 - Spinal Cord Disability. ...
3 - Head Injuries - Brain Disability. ...
4 - Vision Disability. ...
5 - Hearing Disability. ...
6 - Cognitive or Learning Disabilities. ...
7 - Psychological Disorders. ...
8 - Invisible Disabilities..

- Per the CDC

PEOPLE WITH DISABILITIES. AS DEFINED BY CDC:

One in four U.S. adults is living with a disability,[3] defined as:	**Serious difficulty walking or climbing stairs;**	**Deafness or serious difficulty hearing;**	**Blindness or serious difficulty seeing;**
Serious difficulty concentrating, remembering, or making decisions;	**Difficulty doing errands alone; or**	**Difficulty dressing or bathing.**	Adults with disabilities are more likely to have obesity, heart disease, stroke, diabetes, or cancer than adults without disabilities.[4] Physical activity can reduce the risk and help manage these chronic conditions.

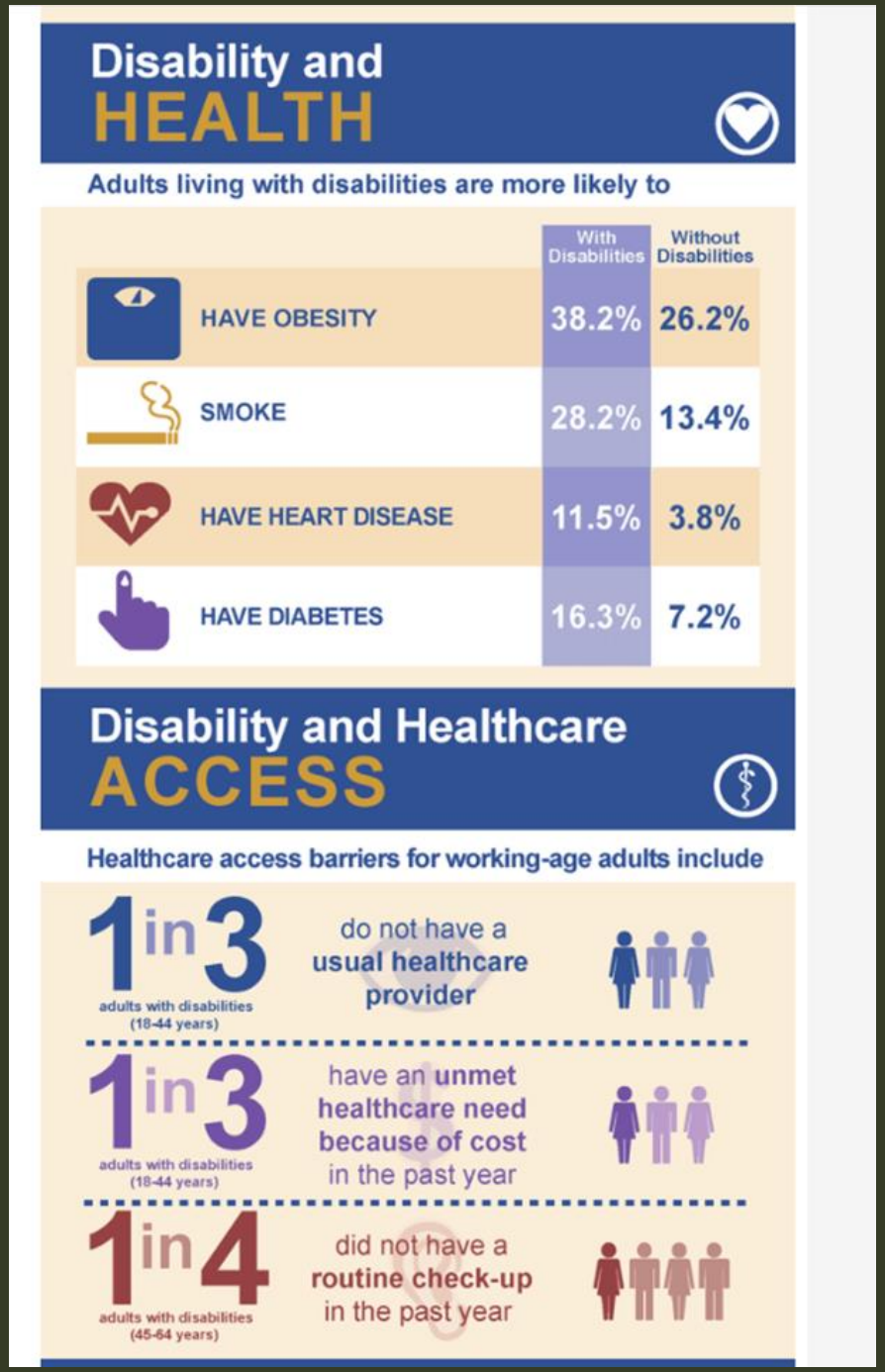
CDC: 3 MOST COMMON DISABILITIES. AND BENEFITS OF PHYSICAL ACTIVITY

1. Arthritis
2. Heart Disease
3. Respiratory Disorder

- PHYSICAL ACTIVITY plays an important role in maintaining health, well-being, and quality of life.
- Can help to:
- control weight, improve mental health, lower the risk for early death, heart disease, type 2 diabetes and some cancers, and can improve mental heatlh by reducing depression and anxiety, helps support daily living and independence.

Content source: Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion


Percentage of adults with functional disability types
13.7%
MOBILITY
Serious difficulty walking or climbing stairs
10.8%
COGNITION
Serious difficulty concentrating, remembering, or making decisions
6.8%
INDEPENDENT LIVING
Difficulty doing errands alone
5.9%
HEARING
Deafness or serious difficulty hearing
4.6%
VISION
Blindness or serious difficulty seeing
3.7%
SELF-CARE
Difficulty dressing or bathing
Disability and
COMMUNITIES
Disability is especially common in these groups:
2 in 5
adults age 65 years and older have a disability
1 in 4
women have a disability
2 in 5
Non-Hispanic American Indians/ Alaska Natives have a disability


Disability and
HEALTH
Adults living with disabilities are more likely to
With Disabilities
Without Disabilities
HAVE OBESITY
38.2%
26.2%
SMOKE
28.2%
13.4%
HAVE HEART DISEASE
11.5%
3.8%
HAVE DIABETES
16.3%
7.2%
Disability and Healthcare
ACCESS
Healthcare access barriers for working-age adults include
1 in 3
adults with disabilities (18-44 years)
do not have a usual healthcare provider
1 in 3
adults with disabilities (18-44 years)
have an unmet healthcare need because of cost in the past year
1 in 4
adults with disabilities (45-64 years)
did not have a routine check-up in the past year

CDC AND PARTNERS:
WHO CAN YOU PARTNER WITH FOR RESEARCH

- **National Center on Health, Physical Activity, and Disability (NCHPAD)**
- **Special Olympics**

The Branch also supports 19 state-based disability and health programs to promote equal access to opportunites for optimal health:

  - Prevent diseases like type 2 diabetes and heart disease; and
  - Increase the quality of life for people with disabilities.
  - Learn more about these State Disability and Health Programs.

- Active People Healthy Nation Initiative. Help 27 million Americans to become more physically active by 2027 to improve overall health and quality of life, and to reduce healthcare costs.
- **Partnerships with agencies for research:** https://healthleadership.org/ Public Health Institute-Health Leadership. Work with foundations, government agencies, nonprofits, and other organizations to advance healthy equity at the local, state, and national level. About Our Programs — PHI Center for Health Leadership & Impact

CONTRIBUTION OF COMMUNITY INTEGRATION TO QUALITY OF LIFE FOR PARTICIPANTS OF COMMUNITY-BASED ADAPTIVE SPORTS PROGRAMS

Program	Misc	Outcomes	Other considerations
Adapted Sports-community reintegration program: Examined quality of life for people with disabilities who participated in community based adapted sports programs.	**Research suggests that active engagement in social engagement is strongly associated with high quality of life with individuals with disabilities**. Study was done from mailing lists of former and current participants of the Adapted Sports center. 240 were sent a research packet.	Results supported the research hypothesis concerning the contribution of community reintegration to physical, social and environmental Quality of Life.	Staffing? Facility? Time and length of program? Participants? Other??

(Chun et al., 2008)

EFFECTS OF A RECREATIONAL THERAPY AQUATICS INTERVENTION: A CASE STUDY OF AN OLDER PERSON WITH UNCONTROLLED ORTHOSTATIC HYPOTENSION

Program	Misc	Outcomes	Other considerations
Aquatic therapy for orthostatic hypertension (sudden fall of BP when stands up)	Aquatic therapy 2Xs a week for 18 months. Completed in chest to shoulder depth water. Per article- there was little data found on this type of research.	Regained ability to ambulate short distances without an assistive device and resumed some premorbid leisure interests. (Pg 15)	Location of pool, session time, pool temperature, depth of pool Staffing? Facility? Time and length of program? Participants? Other??

(Mikula et al., 2010)

SCIREHAB PROJECT (Spinal Cord Injury, 2011)

Program	Misc	Outcomes	Other considerations
Recreational Therapists from 6 US Rehabilitation Centers, program for 1500 clients and developed a RT taxonomy, interventions for leisure education and counseling, leisure skill and knowledge development, community outings, and social activities.	Felt like the best outcomes would come a year after post injury, when they have completed therapy and established everyday routines.	Time spent in CTRS led classes, and outings =Higher FIM scores at discharge. Increased time in Leisure Education and counseling: + correlation with DC to home one year post injury and higher independence scores. Increased time in outings led by CTRS + higher social integration and mobility scores.	Staffing? Facility? Time and length of program? Participants? Other??

(Porter, 2015)

INFLUENCE OF SPORT PARTICIPATION ON COMMUNITY INTEGRATION AND QUALITY OF LIFE: A COMPARISON BETWEEN SPORT PARTICIPANTS AND NON-SPORT PARTICIPANS WITH SPINAL CORD INJURY

Program	Misc	Outcomes	Other considerations
Community Reintegration- Comparing sport and non-sport participants with SCI. Cross- sectional study, greater than >age 15, ≥12 months post injury requiring a wc > 1 hr. Per day. Self-reporting	Use a Community Reintegration questionnaire (CIQ) and Normal Living Index. Did the study using a scripted semi-structured telephone interview.	Higher scores for those who played sports vs those who didn't. Individuals who participated in sports prior to SCI were more likely to participate in sports post SCI. Limitations: small sample size of 90,didn't account for individual vs team sports.	Staffing? Facility? Time and length of program? Participants? Other??

(McVeigh et al., 2016)

EVIDENCE-BASED MENTAL HEALTH AND WELLBEING PROGRAMS FOR SCHOOLS: NSW DEPARTMENT OF EDUCATION

- **Mental Health and Wellbeing Program Template, NSW Department of Education.**
- The following programs were identified in a literature review by Monash University as demonstrating longer term mental health and wellbeing outcomes for students. Refer to Monash University Evidence Brief for further details (Berger et al., 2020).
- **Focus: anxiety and depression**
- https://education.nsw.gov.au/student-wellbeing/counselling-and-psychology-services/mental-health-programs-and-partnerships/evidence-based-mental-health-wellbeing-programs-for-schools#Download3

NSW Department of Education

Evidence-Based Mental Health and Wellbeing Programs for Schools

The following programs were identified in a literature review by Monash University as demonstrating longer term mental health and wellbeing outcomes for students. Refer to Monash University Evidence Brief for further details (Berger, Reupert & Allen, 2020).

Focus: Anxiety and Depression

Program Name	Target Audience	Universal / Targeted	Outcomes for participants from research	Program Facilitator & Requirements	Delivery Mode	Cost	Program Length
Adolescent Depression Awareness Program (ADAP)							
Aussie Optimism Programme-Positive Thinking Skills (AOP-PTS)							

education.nsw.gov.au

EVIDENCE-BASED PSYCHIATRIC REHABILITATION INTERVENTIONS FOR SEVERE MENTAL ILLNESS (SMI)

Evidence-based interventions----------	Main Outcomes
Assertive community treatment	Decrease in length of hospitalization
Social skills training	Reduce in negative symptoms and Improvement in social skills
and	social functioning
Physical aerobic exercise including healthy lifestyle intervention	Positive and negative symptoms reduction, mood, cognition and social functioning

Table 1 evidence-based psychiatric rehabilitation interventions for SML
Table - PMC (nih.gov)

Need interventions supported by scientific evidence, and to include principles of recovery.

(Vita & Barlati, 2019)

YOGA FOR ANXIETY: A SYSTEMATIC REVIEW OF THE RESEARCH EVIDENCE

Program	Misc	Outcomes	Other considerations
Yoga for Anxiety- Systematic review of the research evidence for treating anxiety and anxiety disorders.	**Anxiety disorders** (can include generalized anxiety disorder, phobia, OCD, and panic disorders) **No systematic reviews published on benefits of yoga** in anxiety or anxiety disorders. Yoga studies for epilepsy, but inconclusive due to low number of studies. Positive results with Yoga for anxiety.	Some evidence- aerobic exercise is more beneficial than non-aerobic exercise, # of studies that look at effects of yoga on anxiety levels in non-clinical samples. Yoga treatment group only one particular study group recorded reduced anxiety among male students.	Other psychiatric dx, psychosis, other medications may affect outcomes Staffing? Facility? Time and length of program? Participants? Other??

(Kirkwood et al., 2005)

MINDFULNESS-BASED INTERVENTIONS FOR SOCIAL ANXIETY DISORDER: A SYSTEMATIC REVIEW AND META-ANALYSIS

Program	Misc	Outcomes	Other considerations
Mindfulness and acceptance-based interventions (MABI) are being considered for tx of mental disorders. **Meta analysis:** examination of data from a number of independent studies of the same subject, in order to determine overall trends. Looked at 19 studies.	Reviewed studies of only programs that used mindfulness interventions (MABI) for those with dx of anxiety disorders. Acceptance based approaches: attempt to teach clients to feel emotions and bodily sensations more fully and without avoidance, and to notice the presence of thoughts without following, resisting, believing or disbelieving them	No significant effects on variable examined, but showed benefits with adding Psychotherapy and individual and group treatment. MABIs are receiving attention as a potential treatment modality for a variety of psychosocial problems.	Staffing? Facility? Time and length of program? Participants? Other??

(Vollestad et al., 2003)

CDC RESOURCES FOR EVIDENCE-BASED PRACTICES

- CDC Guidelines and Recommendations
  One-stop shop for guidelines or recommendations developed by CDC (and CDC collaborations with other organizations and agencies), or by CDC federal advisory committees; includes recommendations, strategies, and information to help decision makers choose courses of action in specific situations
- Prevention of HIV/AIDS, Viral Hepatitis, STDs, and TB Through Health Care Website
  Information on policies and practices that leverage the healthcare system to help prevent HIV/AIDS, viral hepatitis, STD, and TB infections
- Compendium of Proven Community-Based Prevention Programs
  Compendium of 79 evidence-based disease and injury prevention programs that have saved lives and improved health
- Guide to Community Preventive Services (The Community Guide)
  Resource that helps users choose evidence-based programs and policies to improve health and prevent disease in communities
- Prevention Status Reports
  Reports that highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce 10 important public health problems
- US Preventive Services Task Force
  Independent panel of nonfederal experts in prevention and evidence-based medicine that conducts scientific evidence reviews of a broad range of clinical preventive health care services and develops recommendations for primary care clinicians and health systems

Compendium of Proven Community Based Prevention Programs

Guide to Community Preventive Services (The Community Guide)

https://www.cdc.gov/publichealthgateway/program/resources/evidence.html

NATIONAL AUTISM CENTER– DEFINITION OF EBP

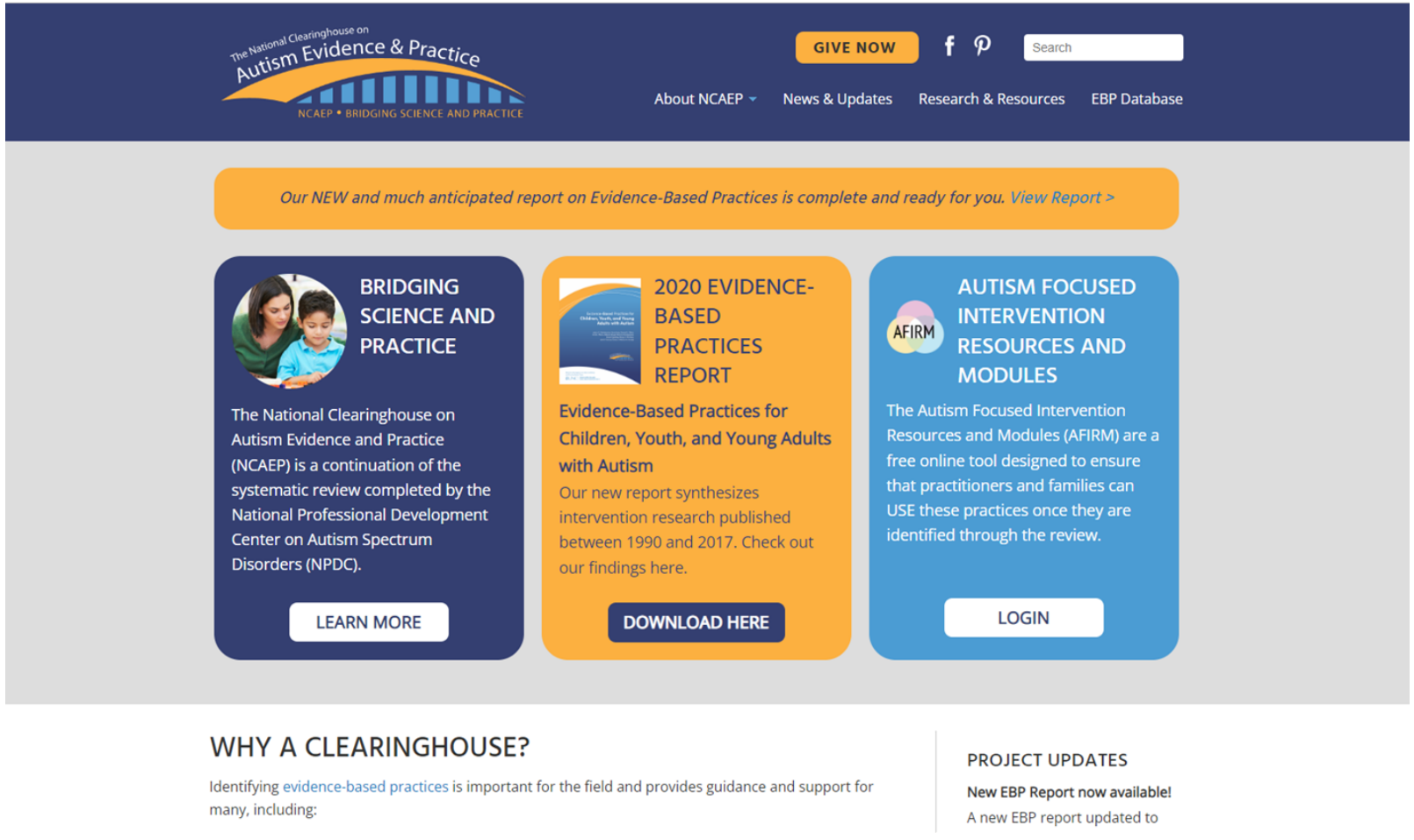
The National Autism Center has adopted the definition of evidence-based practice offered by Dr. David Sackett and his colleagues in Evidence-based medicine: In a publication, the authors define evidence-based practice as **"the integration of the best research evidence, professional judgment, and values and preferences of clients."**

One of the primary objectives of our Findings and Conclusions: National Standards Project, Phase 2 is to identify one component of evidence-based practice, "best research evidence." This is what we term "evidence-based intervention."

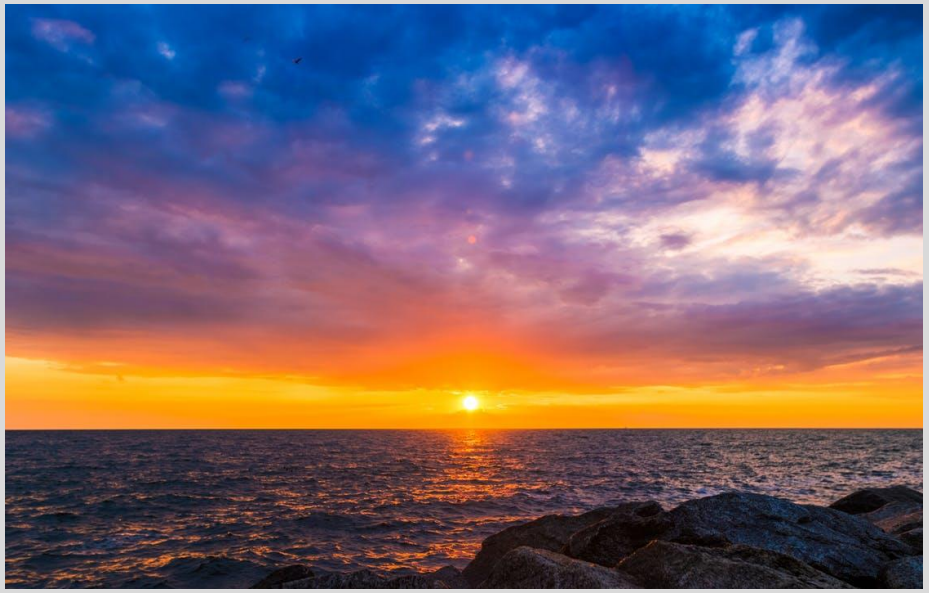
The following three research groups have completed systematic reviews in recent years:

- **The National Professional Development Center on Autism Spectrum Disorder (NPDC)**
- **Centers for Medicare and Medicaid Services (CMS)**
- **Agency for Healthcare Research and Quality (AHRQ)**

Home | NCAEP | The National Clearinghouse on Autism Evidence and Practice (unc.edu)_



RECREATIONAL THERAPY AND RELATED DISCIPLINES: WE ALL CAN MAKE A DIFFERENCE WITH EBP!



Why EBP?

- Effective and efficient treatment and planning.
- Ensures effective and efficient care.
- Enhances professional competence to produce client outcomes.
- Justifies therapeutic value of RT Programs and potential funding.
- Promotes communication among practitioners, research, and other disciplines.
- Could potentially reduce healthcare costs.

- **We add proven value and can show this through EBP!**

LEARNING OBJECTIVES

After this session, participants will be able to:

1. Define what Evidence-Based Practice (EBP) is, and how to find EBP resources

2. Identify 2 programs or interventions that are evidence-based for different populations including intellectual and developmental disability, anxiety and depression, and physical disabilities

3. Identity how to incorporate evidence-based practice in their current work setting.

STANDING TALL THROUGH IT ALL
80 years of FRPA
2022

Mary Palacios. CTRS. CPRP

Broward County Parks and Recreation. Special Populations Manager

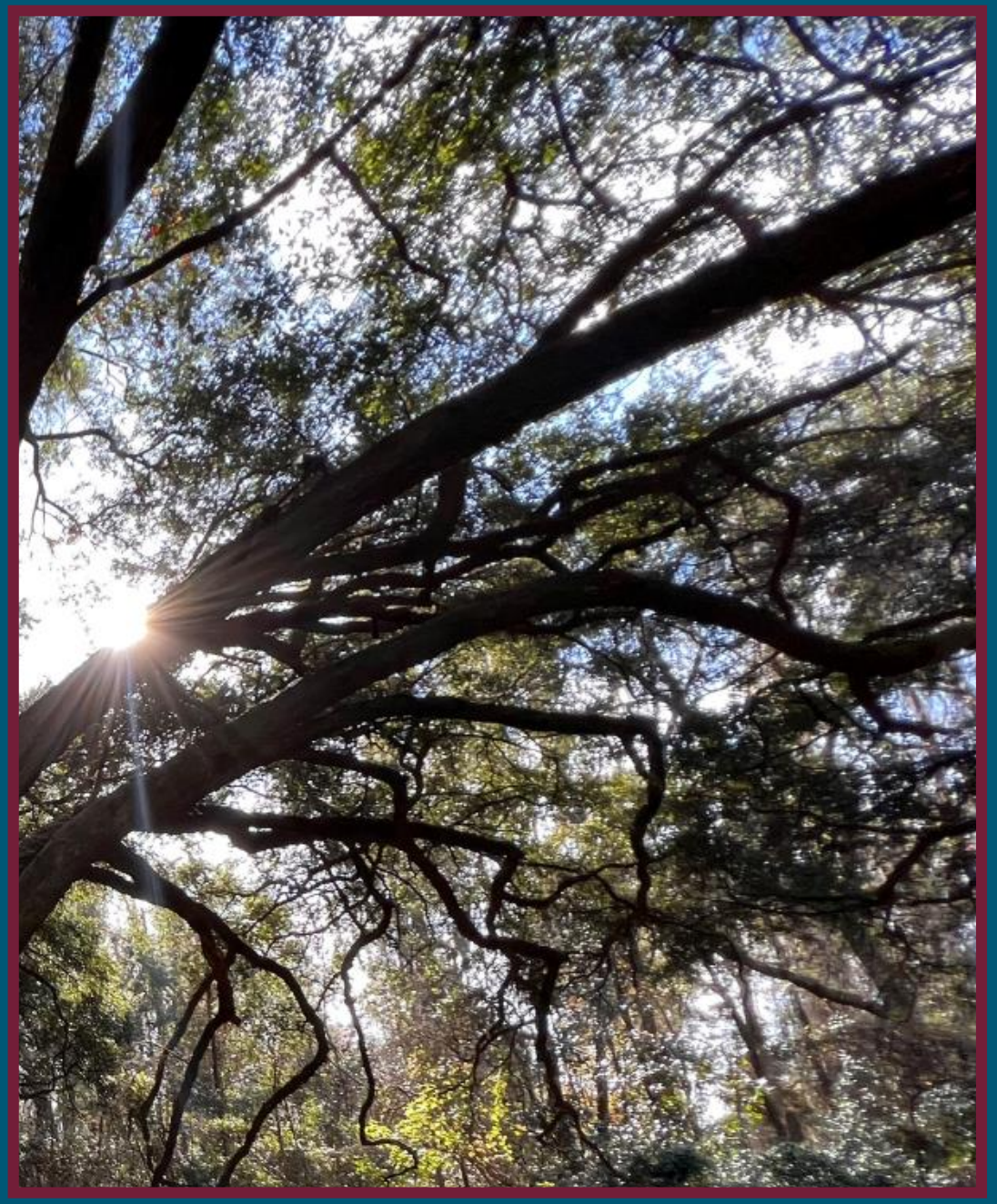
954-357-8170 mpalacios@broward.org

Tania Santiago Perez. MS. CTRS

Associate Teaching Professor

Florida International University

305-348-3220 tsantiag@fiu.edu



Thank You!

FRPA
FLORIDA RECREATION & PARK ASSOCIATION

For more information about the Florida Recreation and Park Association visit frpa.org