Assessing Balance and Fall Efficacy in Community-Dwelling Older Adults
Evidence-Based Instruments for Use in Recreational Therapy Practice

Thomas K. Skalko
Whitney Sauter
Lacey Burgess
David Loy

Abstract
This manuscript will discuss specific evidence-based assessment instruments including the Activities-specific Balance Confidence Scale (ABC Scale), 8-foot Up and Go (UG), and Multi-directional Reach Test (MDRT), used to assess balance and fall efficacy in older adults. The article will draw on literature and data from two corresponding pilot studies (Burgess, 2012; Sauter, 2012) to discuss the appropriateness, benefits, and effectiveness of the different balance measures used. Information presented in the article will aid in expanding the continuing body of knowledge on the topic of assessment, and more specifically balance assessments with older adults in the practice of Recreational Therapy.

Keywords: Assessment, measurement, recreational therapy, aging, fall prevention

Thomas K. Skalko is a professor of recreational therapy, East Carolina University and an honorary professor, School of Health Sciences, University of KwaZulu-Natal, South Africa. Whitney Sauter is a recreational therapist at Vidant Medical Center Greenville, NC. Lacey Burgess is a recreational therapist with Strategic Behavioral Health Leland, NC. David Loy is an associate professor of recreational therapy at East Carolina University. Correspondence concerning this article should be addressed to Thomas Skalko, skalkot@ecu.edu
Introduction

Older adults, those 65 years and older, characterize the fastest growing age demographic in the United States, with an estimated 20% of the U.S. population being classified as an older adult by the year 2030 (Census Bureau, 2005, p. 15). Statistics on emerging baby boomer population trends predict, that, in the year 2011 alone, the first of approximately 70 million baby boomers will be turning 65 years old (Sedensky, 2011). A new wave of active older adults, nicknamed the “Silver Tsunami,” are continuously emphasizing their increased desire to remain independent for as long as they can, in turn creating a higher demand for the utilization of novel interventions and technologies that assist with healthy, active aging in place (Rantz, Skubic, Miller, & Krampe, 2008).

Intervention programs that get seniors up and moving and on their feet for adequate durations of time have been identified as a key component to physical functioning and the effective reduction in the risk of preventable falls in older adults. To maintain and increase the healthy functioning and independence of our older adult population, the development and study of interactive home and institutionally based interventions and exercise programs focusing on improving overall endurance, strength and flexibility, while simultaneously promoting enjoyable, valued physical activity (PA) is necessary.

According to the National Centers for Disease Control and Prevention (CDC, 2010), falls, in the United States, are the leading cause of injury-related deaths in older adults over 65 years of age, as well as the most frequent cause of nonfatal injuries and inpatient hospital admissions for trauma such as fractured joints, broken bones, and traumatic brain injuries. Supporting research indicates that along with greater levels of inactivity among this older adult cohort, both the rate of falls and the costs to treat fall-related injuries are projected to increase. Carroll, Slattum, and Fox (2005) determined that “among community-dwelling older adults, fall-related injury is one of the most expensive medical conditions” (p. 308). In the year 2000 alone, the fall-rate among older adults cost the U.S. health care system over 19 billion dollars (CDC, 2010).

Additionally, higher rates of hospitalized older adults will create a need for more doctors, orthopedic surgeons, and podiatrists with the clinical expertise to provide effective healthcare services to older adult populations. The American Geriatrics Society indicates that today there is roughly one geriatrician for every 2,600 people 75 years of age and older (Sedensky, 2011).

Although many researchers have concluded that predictors highly associated with falls in this specific population are multifactorial and interactional in nature, a demand remains for the development of clear and brief, cost-efficient and comprehensive measures of overall functional balance in order to effectively identify future fallers (Rantz et al., 2008; Rubenstein, 2006). Therefore, it is essential that recreational therapists utilize effective assessment strategies to identify those individuals most at risk of falls and to prescribe effective strategies to develop the functional skills to prevent fall occurrences.

This article will provide information on the assessment of functional balance and fall efficacy, specifically in older adults. In addition, examples from two pilot studies (i.e., Burgess, 2012; Sauter, 2012) are used to demonstrate the use of standardized assessment processes in practice. This article will identify and
discuss the purpose and application of the three different balance measures used in each study as pre-post measures of balance. The Activities-specific Balance Confidence Scale (ABC Scale), the Multi-directional Reach Test (MDRT), and the 8-foot Up and Go (UG) were employed as a means to track balance changes for the participants. The instruments are simple, evidence-based assessments that can be applied in recreational therapy practice.

Balance Assessment Approaches

As delineated by the National Council for Therapeutic Recreation Certification (NCTRC),

The scope of recreation therapy practice includes all patient/client services of assessments, planning, design, implementation, evaluation and documentation of specific therapeutic interventions, management, consultation, research, and education, for either individuals or groups that require specific therapeutic recreation or recreation therapy intervention (2004, p. 1).

The assessment of physical functioning, including balance is included in the scope of practice for recreational therapy services and exercise has been determined as the single best intervention for reducing the risk of falls in older adults. To compare the impact of specific activity intervention strategies (e.g., tai chi, Matter of Balance, exercise, weight training, or Nintendo™ Wii) and to quantify functional balance and fall-efficacy, specific balance-related assessments should be utilized. Dynamic balance, agility, and postural stability measures can be conducted at pretest and posttest balance screenings through the administration of the 8-foot Up-and-Go Test (UG) (Rikli & Jones, 2001) and the Multi-Dimensional Reach Test (MDRT) (Newton, 2001). Fall-efficacy (i.e., a measure of one’s fear of falling) can be measured using the Activities-specific Balance Confidence Scale (ABC) developed by Powell and Myers (1995). Cumming, Salkeld, Thomas, and Szonyi (2000) found that individuals with lower fall efficacy had increased risk of falling and a greater decline in the ability to perform activities of daily living. There is evidence to suggest that effectively measuring one's balance and fall efficacy is important to understanding and promoting fall prevention among older adults.

In the example studies that follow, data collection consisted of four components: a basic demographic questionnaire (i.e., age, gender, ethnicity, exercise habits, and falls concern), two balance tests (i.e., 8-Foot Up and Go and Multi-Directional Reach Test), and a fall efficacy questionnaire (i.e., Activities-specific Balance Confidence Scale). Each test has been demonstrated to be valid and reliable measures of balance and fall efficacy for older adults (Newton, 2001; Powell & Myers, 1995; Rose, Jones, & Lucchese, 2002). Total data collection time (i.e., demographic questionnaire, UG, MDRT, and ABC Scale) requires between five and eight minutes demonstrating the ease and practical use of each assessment instrument. In addition, reviews of all three assessments indicate no additional training is necessary for implementation (RIC, 2013).

Activities-specific Balance Confidence Scale (ABC Scale) (See Figure 1). To determine a participant’s fall efficacy, the ABC Scale can be used as an effective, valid and reliable measure. The ABC Scale is 16-item questionnaire/survey with each item having a rating from 0% (no confidence) to 100% (complete
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confident). Respondents are asked to rate their balance confidence (fall efficacy), according to the given scale, of when they felt they would lose their balance or become unsteady in the course of performing daily activities (Powell & Myers, 1995). Scores are then established by taking an average of the individual’s total responses.

Reliability and validity for the ABC Scale were evaluated by Powell and Myers (1995), as a comparison with the Falls-Efficacy Scale (FES) and the physical self-efficacy scale. The ABC Scale was tested on 60 community dwelling seniors with results indicating that both the FES and the ABC Scale demonstrated reliability, convergent and criterion validity (r = .84) and that the physical self-efficacy scale scores moderately correlated with the ABC Scale (r = .49). As results demonstrated, the ABC Scale was a more efficient discriminator of high versus low mobility participants and yielded a wider range of responses. The results thereby indicating that the ABC Score is better
suited in detecting poor fall efficacy in older adults than the FES (Powell & Myers, 1995).

8-Foot Up and Go Test (UG) (See Figure 2). The UG is used to assess balance and mobility in older adults and is a modified version of the Timed Up and Go (TUG). The Timed Up and Go Test (TUG) was developed by Podsiadlo and Richardson (1991) as a basic tool for measuring functional mobility. By incorporating functional tasks such as sit to stand, walking, turning, and stand to sit, the TUG has been determined as an appropriate measure of static and dynamic balance (Podsiadlo & Richardson, 1991). According to the research available on balance measurements and older adults, the Berg Balance Scale (BBS) and the TUG both have published reliability and validity with community-dwelling older adults (Holbein-Jenny, Billek-Sawhney, Beckman, & Smith, 2005; Steffen & Mollinger, 2005). The TUG has been identified as an effective tool for measuring gait speed during several functional tasks, which include standing up, walking, turning, and sitting down (Langley & Mackintosh, 2007).

A modified version of the TUG, the 8-foot Up-and-Go test (UG), was established by Rikli and Jones (2001) as a testing component of the Senior Fitness Test, to safely assess dynamic balance and agility of community-dwelling older adults within space-limited settings, such as participants’ homes. Results obtained from this performance test may be compared to age-related normative values listed in the Senior Fitness Test Manual, if the participant does not require the use of an assistive gait device (Rikli & Jones,

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1. Equipment: chair, tape measure, tape, stop watch.
2. Begin the test with the subject sitting correctly in a chair with arms, the subject’s back should resting on the back of the chair. The chair should be stable and positioned such that it will not move when the subject moves from sitting to standing.
3. Place a piece of tape or other marker on the floor 8 feet away from the chair so that it is easily seen by the subject.
4. Instructions: “On the word GO you will stand up, walk to the line on the floor, turn around and walk back to the chair and sit down. Walk at your regular pace.
5. Start timing on the word “GO” and stop timing when the subject is seated again correctly in the chair with their back resting on the back of the chair.
6. The subject wears their regular footwear, may use any gait aid that he or she normally uses during ambulation, but may not be assisted by another person. There is no time limit. The subject may stop and rest (but not sit down) if needed.
7. Normal healthy elderly usually complete the task in 10 seconds or less. Very frail or weak elderly with poor mobility may take 2 minutes or more.
8. The subject should be given a practice trial that is not timed before testing.
9. Results correlate with gait speed, balance, functional level, the ability to go out, and can follow change over time.

Figure 2. 8-Foot Up and Go (UG)
Timed scores of more than 8.5 seconds are associated with high fall-risk in community-dwelling older adults, with the UG having an overall prediction rate of 82% (Rikli & Jones, 2001; U.S. DHHS, 2006).

The UG requires the use of a standard folding chair with 17-in. (43.18-cm) seat height, stopwatch, a small orange cone, tape measure, and a piece of masking tape to use as a floor marker. Each participant is provided with a demonstration and verbal explanation of how to perform the test by the practitioner and then given one optional practice run and two timed trials. Both times are recorded to the nearest 1/10 second and the lower of the two scores, or the fastest time, is used (Rikli & Jones, 2001).

The entire UG test requires 1 to 4 minutes depending on the physical performance of the individual. Scoring is simple and performance improvements/decline can be tracked.

Multi-Directional Reach Test (MDRT) (See Figure 3). The MDRT can also be used to assess participant balance.

The Multi-Directional Reach Test (MDRT) (Newton, 2001) is a modification of the Functional Reach Test (FRT) (Duncan, Weiner, Chandler, & Studenski, 1990) and designed to provide a quantifiable measure of a person’s voluntary postural control, or margins of stability, which is a strong predictor of overall balance (Newton, 2001). The MDRT utilizes a yardstick or similar measuring tool to assess how far participants are able and/or willing to reach forward, right, left, and backward outside of their base of support in a static standing position (Newton, 2001). Although there is limited evidence on the validity and reliability of the MDRT with community-dwelling older adults, it can offer an indication of reach and balance in all directions (Holbein-Jenny et al., 2005; Cummings & Nevitt, 1994). Supporting research has also found evidence that the measures of postural stability required for the lateral right and left reach directions are important determinants of assessing an individual’s overall postural control (Brauer, Burns, & Galley, 1999; DeWaard, Bentrup, Hollman, & Brasseur,

1. Place a fixed yardstick on the wall at the participant’s acromion process and horizontal to the floor.
2. Participants can use whatever arm he or she chooses but need to stay consistent throughout the test.
3. Participant is instructed to lift arm to shoulder height for initial reading.
4. The participant is then instructed to reach as far forward, left, and right as possible for three trials in each direction, along the yardstick without making contact with the wall or relying on an object for balance as well as keeping both feet flat on the floor without moving either or both feet.
5. If the participant touches the wall or relies on an object for balance, or moves either or both feet, the trial is discarded.
6. Start and stop of index finger is recorded and difference is the total reach for that direction.
7. An average of three reaches in each direction is used as the final score.

Figure 3. Multi-Directional Reach Test (MDRT)
For ease of administration, a measurement tool can be constructed to assist in data collection. A yardstick can be replicated by creating a measuring tool made from PVC piping securely positioned on a wall using tape and placed at the level of the participants’ acromion process horizontal to the floor. Participants are instructed to stand with feet shoulder width apart and raise arms to shoulder height (90 degrees) parallel to floor with palm facing medially for initial reading. Participants are then asked to reach as far forward (forward reach), backward (backward reach), left (lateral reach left), and right (lateral reach right) as possible for three trials in each direction along the yardstick replicated measuring tool without making contact with the wall or yardstick and without taking a step or raising their feet from the floor. Location of the tip of the middle finger is recorded in inches at the starting and ending positions of each trial and the “trial distance” (inches) is obtained by determining the difference between the two position numbers (Newton, 2001). Participants are given the option of completing one practice trial to ensure adequate comprehension of instructions followed by three recorded test trials. The average of all three test trials for each direction is recorded as the total distance reached or “measure of total hand excursion for each direction” (Lewis & Shaw, 2011, p. 6). If the participant’s feet move during any trial, then that trial is discarded. For measures of forward reach, participants are given the opportunity of choosing to use either their right or left arm, but required to stay consistent throughout the test.

As the FRT is highly correlated with the MDRT forward reach, a score below six inches has been found to predict recurrent falls in older adults and considers individuals at high risk for falling, while any score less than ten inches indicates individuals who are at moderate risk for falling (Duncan et al., 1990). Regression analysis indicated that scores on forward, right and left reach were influenced by activity level (p < .004) and scores on backward reach were influenced by fear of falling (Lewis & Shaw, 2011). In a study conducted by Duncan et al. (1992), the forward reach was found to be a good predictor of frequent falls in a sample of community-dwelling older adult male veterans.

Using Assessments in Fall Prevention Interventions

While multiple activity intervention approaches exist to reduce and prevent falls in community-dwelling older adults, the remainder of this article will look at the application of the balance assessments in two specific pilot studies (i.e., Burgess, 2012; Sauter, 2012) consisting of three fall prevention interventions (i.e., tai chi, Matter of Balance, and Nintendo Wii™ ). Each strategy was utilized to improve functional balance, fall efficacy and promote higher levels of physical activity among this specific population, with the ultimate goal of providing older adults with an overall improved quality of life (QOL) and sustained independence. Two of the activity interventions, tai chi and Matter of Balance (MOB), are accepted evidence-based approaches used to address fall reduction and fall prevention by the Centers for Disease Control and Prevention (CDC, 2010; 2011). The most effective interventions utilized for improving functional balance and preventing falls in older adults incorporate walking programs, balance training, aerobic exercise programs, resistance training, flexibility, and strength training exercises.
Assessing Balance and Fall Efficacy

As with all recreational therapy (RT) interventions, the assessment of the consumer's functional performance is necessary. Therefore, initial base-line information was generated via the use of the ABC Scale, the UG, and the MDRT. The use of these standardized assessment instruments offered the opportunity to compare pre and post intervention performance for the participants. Important to the process is the recognition that the assessments utilized were:

- Easy to administer,
- Were time efficient (requiring 5-8 minutes to complete all three), Were valid and reliable, and
- Offered the providers and consumers feedback to reinforce participation.

**Intervention Strategies**

The intervention strategies to address balance and falls prevention were chosen from a host of options. Two of the strategies (i.e., tai chi and Matter of Balance) have been recognized by the CDC as evidence-based interventions to address falls in older adults. The third strategy, Nintendo Wii™ was chosen to test its effectiveness as compared to the MOB strategy. The assessment protocol allowed for consistent comparison of balance measures for all three intervention strategies.

**Tai chi.** Tai chi originated from an ancient Chinese martial art and involves flowing movements involving all body joints. Tai Chi is not only used for self-defense, but also for health benefits such as improved balance, cardiorespiratory functions, strength, flexibility, and concentration. Tai Chi incorporates mind and body and has benefits for both when practiced correctly and over time. Incorporating deep breathing techniques and mental focus helps to promote coordination, greater flexibility and range of motion, increased muscular strength, proprioception (i.e., body awareness), and muscle control and postural alignment, all of which help to improve balance as well as to enhance the total body and mind (McKenna, 2001; Sarnataro, 2006).

Tai Chi has been adopted by the CDC as an evidence based approach to fall prevention and fall reduction (CDC, 2011). As an intervention, Tai Chi is a relatively new therapeutic modality used in western medicine for balance and condition. The approach uses different moves performed slowly and rhythmically from side to side, emphasizing weight bearing at different points while relaxing muscles that are not being used at that moment. The intervention also incorporates techniques in breathing, concentration, and body flow (Chan & Bartlett, 2000; Greenspan, Wolf, Kelley, & O'Grady, 2007; Lan, Lai, Wong, & Yu, 1996).

Numerous studies (Fuzhong et al., 2008; Gatts & Woollacott, 2007; Greenspan et al., 2007; Hakim, Kotroba, Courts, Teel, & Leninger, 2003; Mihay, Boggs, Breck, Dokken, & NaThalang, 2006; Takeshima, Rogers, Islam, Koizumi, & Lee, 2007; Tsang, & Hui-Chan, 2005; Tsang, Wong, Fu, & Hui-Chan, 2004; Wolf et al., 1996) examined the effects of a Tai Chi intervention program on balance in older adults. Tai Chi research has been proven to be a more effective modality for reducing falls by increasing balance, fall efficacy, and decreasing reaction times than any other modality. Implementing a Tai Chi program into the lives of older adults could help prevent falls and increase one's independence and overall quality of life.

**Matter of Balance (MOB).** In 1992, MOB was supported by the CDC as an evidence-based falls management education program designed to reduce fear
of falling and associated activity restriction in community-dwelling older adults (2010). The fear of falling community education intervention engaged participants in group discussions about their concerns regarding fear of falling, daily behaviors, and habits that increase their risk of falling. There is increasing evidence of the importance and benefits of physical activity (PA) in maintaining health status and slowing the rate of the aging process, the MOB strategy educates participants on the importance of involvement in physical activity (PA).

In these studies, PA was incorporated in the MOB sessions through a 30-minute warm-up, stretching, and cool-down routine in five of the eight sessions. Participants were required to attend five of the eight sessions in order to successfully complete the MOB training program and receive a certificate of completion.

Balance and fall efficacy with the MOB program has been studied by numerous researchers (Healy, Peng, Haynes, McMahon, Botler, & Gross, 2008; Org, Smith, Wade, Mounce, Wilson, & Parish, 2010; Southard, 2006; Tennstedt, Howland, Lachman, Peterson, Kasten, & Jette, 1998). Data from these studies propose that the Matter of Balance program is an effective falls management program that can be utilized to assist older adults in improving overall functional balance and fall-related self-efficacy and managing potential fall risks, therefore reducing their overall rate of falls in older adults.

Nintendo Wii™. Innovative advancements in technology have resulted in a shift toward implementing less traditional forms of physical rehabilitation interventions through the use of novel, virtual reality (VR)-based technology (Holden, 2005). There is growing evidence that the opportunity to experience enhanced feedback and guided practice in a virtual environment (VE) is, in some instances, superior to learning in real-life settings where motions may be restricted due to fear of injury or pain (Todorov, Shadmehr, & Bizzi, 1997). VEs can be developed to incorporate game-like elements that could improve patient motivation to participate in therapy, and may be used as self-guided independent training for continued practice after discharge from rehabilitation (Deutsch & Mirelman, 2007). The popularity of the Nintendo Wii™ has provided greater access to exercise-themed videogames, more recently coined “exergames,” and continues to create versatile intervention strategies that can be used as an effective modality for promoting increased rates of physical activity (PA) participation in people of all ages.

The Nintendo Wii™ has been proven effective in increasing PA and mild to moderate energy expenditure (EE) in various age groups. However, there is limited evidence based research available on the effects of the Nintendo Wii™ on functional balance in the older adult population. Clark and Kraemer’s (2009) study indicated that the effectiveness and quality of VR training environments can be enhanced by increasing enjoyment and motivation. Betker and colleagues (2006) determined from their study that a video-game based exercise program motivated patients to increase their amount of practice and attention span, and indicated that novel video gaming did have a positive effect on the static and dynamic balance of their older adult subjects. Games such as Nintendo Wii™ bowling were used in studies examining the Wii™, and selected because of their related movements to activities of daily living such as crouching for gardening or home tasks. It seems there is a consensus among researchers that virtual reality is unique
in that it provides users with a nonthreatening VE that promotes safe, positive learning experiences, while being entertaining and motivating at the same time.

Using the Nintendo Wii™ gaming console’s unique motion-sensitive controller, the interactive Wii™ video games require body movements similar to conventional therapies, but incorporate games that help to create an inner competitiveness that repetitively encourages participants to improve their performance. The Nintendo Wii™ has been proven beneficial to the older adult patient population as a way to increase cognitive functioning, interpersonal interaction, and overall health-related quality of life (QOL) (Rosenberg et al., 2010). The results from the study by Sauter (2012) support these findings and the implications for using the Nintendo Wii™ video gaming console with older adults to improve levels of regular physical activity.

**Application of Balance Measures in Practice**

The Burgess (2012) and Sauter (2012) studies were aimed at providing more evidence-based research on the use of sound assessment approaches in combination with the evidence-based intervention strategies, tai chi and MOB, and the two-dimensional interactive video gaming intervention in the measurement and functional improvement of balance among community-dwelling older adults with the overarching goal of improving functional balance and reducing risk of falls. The application of valid and reliable assessment measures was critical in demonstrating the outcomes of the interventions employed. The use of the Nintendo Wii™ in a variety of healthcare settings for clinical purposes is consistently increasing (Rosenberg et al., 2010). No significant differences were found between the intervention groups, with regard to UG and MDRT scores, suggesting that they both measured very similar aspects of the construct of functional balance. No significant changes were found between the UG and MDRT pretest and posttest performance scores of both intervention groups, which may suggest the acceptability of using the Nintendo Wii™ to promote an overall increase in the average PA levels of older adults that subsequently may result in reducing the risk of falls.

**Using Assessment to Compare Outcomes**

While the results from both the Burgess (2012) and Sauter (2012) studies showed limited statistically significant outcomes between each intervention employed, the results did demonstrate improvements in the balance measures among all members of the intervention groups. When compared to pre-post intervention measures of a control group that did not participate in any intervention, the intervention groups did perform better on all assessment measures. The use of the standardized assessments served as a means to support the use of each intervention strategy. From a practice perspective, the use of similar assessment measures will prove invaluable when demonstrating the efficacy of RT practice. However, as presented by Witt, Connolly, and Compton (1980), the assessment process is often seen as “an end in itself” (p. 5) and too often the recreational therapist does not use assessment information as an integral aspect of treatment planning and as a means to track progress. There is a general lack of use of standardized assessment instruments and processes in recreational therapy as evidenced by a paucity of literature in recreation therapy on instruments such as the three used in the pilot studies: And as noted in recent research by Witman
and Ligon (2011, p. 3), “The vast majority (80%) of respondents indicated that they do not use standardized commercial assessments.”

Our colleagues in Occupational Therapy, for example, make extensive use of standardized commercial assessment tools (Alotaibi, Reed, & Nadar, 2009). These research studies were specifically designed and implemented to support the field of Recreational Therapy and efforts toward increasing efficacy research among the profession, specifically in the area of geriatric healthcare. Findings estimate that fear of falling can be reduced in community-dwelling older adults through the participation in fall prevention education and physical activity group-based programs. Risk factors for disease morbidity and mortality increase as physical activity decreases (U.S. DHHS, 2006). Many older adults remain physically inactive even though research supports that regular PA can improve one's general well-being, muscle strength, overall endurance, functional balance, and the ability to effectively perform regular activities of daily living (ADLs) (Shephard, 1994). According to the Centers for Disease Control and Prevention (CDC), physical inactivity is highest among individuals 65 years of age and older (2010). By increasing physical activity among older adults in a community-based setting, the physical functioning and functional balance levels of these individuals may advance, leading to improvements in the ability to maintain performance of ADLs, increased independence, and overall quality of life (QOL), as well as a decreased risk of experiencing falls and/or institutionalization (Yeom et al., 2009). The integration of standardized assessment instruments and protocols for measuring distinct outcomes of RT practice is warranted.

**Assessment in Geriatric Recreational Therapy**

Effective assessment and measurement techniques continue to be critical to evidence-based practice in recreational therapy (Stumbo, 2002). Assessment in long-term care is even more crucial to the care of older adults due to the progressive nature of many disabling conditions effecting the population (Buettner & Fitzsimmons, 2003). Understanding and addressing the assessment issues in the field provides improved services for older adults.

One of the most significant problems in the assessment in RT among older adults is the overall lack of standardized assessment instruments used in the field (burlingame & Blaschko, 2010). Connolly (2013) suggested that many RT practitioners focus solely on a model of leisure behavior and therefore the focus of assessment is directed toward a preference for leisure involvement rather than a direct assessment approach aimed at treating the holistic needs of clients. The BANDI-RT (Buettner, Richeson, & Connolly, 2011) remains one of the few standardized functional assessment instruments designed exclusively for use by recreational therapists in long term care settings. Until other RT-specific instruments are developed and tested for use with older adults, it seems important to utilize standardized instruments like the MDRT, TUG, and ABC Scale.

Connolly (2013) suggested that the recreational therapy field is currently too dependent on homemade assessment instruments and non-standardized surveys. Whitman and Lignon (2011) further highlighted this problem when they reported that 96% of recreational therapists tended to use non-standardized instruments that focus primarily on participant interests and leisure history. However, it
appears RT is not alone in this regard. Similarly, Jette, Halbert, Iverson, Miceli, and Shah (2009) reported that 52% of physical therapists use non-standardized assessment instruments. It is critical for RTs to become aware of standardized assessment instruments to use in all practice settings including long term care.

The inability of RTs to use standardized instruments may be related to a limited awareness of valid and reliable assessment resources. Connolly (2013) offered there are many psychometrically sound assessment instruments available to recreational therapists that are often easy to administer and free of financial burdens often associated with standardized assessments.

The Rehab Institute of Chicago (RIC, 2013) has provided a data base of rehabilitation-related assessment instruments called Rehab Measures Database. This database is a valuable resource for allied health professionals, including recreational therapists, who wish to locate assessment resources to meet the outcome needs of clients.

Recreational therapy professionals are often engaged in a wide range of treatment strategies that address consumer needs in the physical domain. Choosing appropriate, standardized assessment instruments like the MDRT, TUG, and ABC Scale to place participants into needed services is the initial step in the Assessment, Planning, Implementation, and Evaluation (APIE) process. Using these same instruments to show consumer progress advances the field and demonstrates the efficacy of our services.

References


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