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Sailing on Troubled Waters: Diversional Therapy in Australia

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This paper seeks to explore the notion of Therapeutic Recreation (TR) in an Australian context. It does so through first reviewing the historical development of Diversional Therapy (DT) services in Australia and then examining the impact on service delivery of ongoing national reform in the health and community care sectors. The paper suggests that such reforms have created a somewhat fluid state of affairs whereby DT staff need decide whether or not they effectively embrace change and the challenges that such reforms have brought, or accept a substantially lesser role in the overall scheme of Australian health services in the not-too-distant future. With this need for positive (and immediate) action in mind, the paper concludes with a discussion of what DT staff need do to establish a valued place in the Australian health care mainstream.

KEY WORDS: *Therapeutic Recreation, Diversional Therapy, Service Reforms, Australia*

Introduction

Therapeutic Recreation (TR), or Diversional Therapy (DT) as it is known locally, is at somewhat of a cross-road in the Australian health care setting. Part of the reasoning for this lies in the reality that health services in this country have been forced to revisit their roles and to effectively re-evaluate just what responsibilities they have to the health care consumer. While much of this has has to do

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with economic rationalism of the health care sector at both the state and national levels, it has also been facilitated at the Commonwealth level by a growing emphasis on professional practice. In turn, this has meant a shift in service orientation to that today whereby service standards are expected to be underpinned by best practice principles and evidence based research is the medium required to document client outcomes. Perhaps stating the obvious, significant changes in the modus operandi of health services, in terms of both the training of staff and the means by which they deliver services, have been part and parcel of these reforms. Amongst all this, those delivering diversional therapy services have been placed under enormous pressure in recent years to reassess the philosophical paradigm of how they serve but also what it is they deliver on a day-to-day basis in any given health care setting. As such, this paper seeks to explore the notion of DT in an Australian context and outline what challenges lie ahead for those who seek to deliver such services. This is undertaken by way of first reviewing the historical development of DT services in Australia and then by examining the implications for DT of the ongoing national reform in the health and community care sectors. The paper then concludes with a discussion of how many of the reforms undertaken in recent years have challenged those who deliver DT services and what it is they need do to establish a valued place in the Australian health care mainstream.

Historical Development of Diversional Therapy in Australia

While TR has been firmly embraced in North America as a purposeful form of intervention to assist individuals to live a healthier and satisfying life, the concept (and indeed the practice) is yet to be fully accepted in the Australian health care setting. There are a number of reasons for this situation. The historical development of recreation therapy and leisure services, the terminology used in this country where "diversional therapy" is used in preference to TR and the variety of vocational contexts in non-medical settings have all played a part. As have, it should be stated, the significant differences in what constitutes DT in a Federation of States, and the impact of new legislation, such the Australian *Disability Discrimination Act, 1992* (DDA), on the construction of appropriate service provision models. It is argued that all of these have led, in some part or other, to a fractured notion of what constitutes DT and, indeed, in what contexts DT should be considered an appropriate service delivery framework.

If a broad workable definition of TR is one that encompasses services that help individuals to develop, make choices about, and participate in, a leisure lifestyle that may ultimately lead to a higher quality of life through increased physical health, emotional well-being, and social connections (Stumbo & Peterson, 2004) then many leisure services providers in Australia would, by default, be regarded as providing TR. In an Australian context, many of these providers recognize the positive link between leisure and health where the benefits of active engagement in leisure by people regarded as being disadvantaged, or at risk in a health or social sense, are well documented. In fact, the undeniable links between leisure and health, rather than perhaps health and TR (or DT), have been noted by many including Lynch and Veal (2006), Caldwell (2005), and Iwasaki, MacTavish, and Mackay (2005).

Adding to this dilution of focus in Australia is the range of staff titles used across the country that are diverse to say the least. For example, these often used include leisure therapist, recreation therapist, diversional therapist, activities officer, and activity therapist. Significantly, the title designated for staff engaged in DT provision may vary significantly based on locality, the employment arrangements under which the individual is engaged, and whether or not the person is in the public or private health care systems. Importantly however, the day-to-day tasks and core service values of many of these positions are generally

consistent with those espoused as appropriate by the primary professional body in this country for DT staff, the Diversional Therapy Association of Australia. The Association, with a current membership of approximately 2,300 individuals is spread across the full gamut of operations in the health and aged care sectors inclusive of rehabilitation and hospital units, community centers, residential aged care, palliative care units and mental health services to list but a few (DTAA, 2005). It has a philosophy and vision similar to that outlined by like-interested overseas organisations such as the North America based National Therapeutic Recreation Society. For instance, the Diversional Therapy Association (2005, p. 1), considers diversional therapy to be: "The facilitation and coordination of recreation and leisure services for individuals who experience barriers to choosing, deciding and participation in activities with the aim of good work practice to ensure that the barriers created by disability, ageing and social stigma are minimized". However, as noted previously, this definition could be applied to many mainstream recreation and leisure services whose personnel would never consider them to be diversional therapists.

Historical Development of Diversional Therapy in Australia

Pre 1980s...

While it is generally acknowledged by most researchers that DT had its formal origins in the health care industry in Australia in the early 1940s, its history can actually be traced back to the First World War when nursing staff used forms of recreation to assist in the rehabilitation of injured serviceman who had returned home after fighting in the European sector (Cribb, 1994). Importantly, such services were also geared at the time to assisting those with permanent disabilities to assimilate back into community life as best possible. After the Second World War, and in recognition that there were still a number of gaps in the range of health services offered to those seeking assistance, the Australian Red Cross initiated training courses in basic crafts and the like to health care staff. While the three month long courses were offered to the public until 1976, they were however significantly modified from their original form in the late 1960s to accommodate the growing recognition that the diversional activities required in the health care sector were far broader than just handcrafts alone, and that staff needed, therefore, to be suitably skilled to adapt a range of services to best suit the needs of their clientele (DTAA, 2005). This was considered the case particularly in the aged care sector where there was a growing recognition of the importance of extending services beyond just health care to encompass a concern for the provision of services designed specifically to enhance the quality of life of residents. Concurrent with this shift, the commencement of the deinstitutionalization process in Australia in the late 60s and early 70s) brought forth significant reforms with respect to the psychiatric and intellectual disability sectors (Molony & Taplin, 1990; Trimboli, 1987). In such an environment of change, leisure services became a formally accepted area of study and a vocational outcome in the late 1970s. This was achieved via the progressive establishment of recreation courses at Colleges of Advanced Education throughout Australia from 1976 onwards. It was also at this point in time that the Diversional Therapy Association of Australia (DTAA) was formed. This was an outcome of seven graduates of the Red Cross course coming together with a common interest in seeking to better service the needs of their primary older adult clientele (DTAA, 2003).

1980 to date...

These early and somewhat limited training offerings were usually offered at the undergraduate associate diploma or diploma level. They have however, evolved to the point that present day programs, registered primarily at the undergraduate bachelors degree and post graduate masters degree levels, are now ac-

credited at a wide range of universities located geographically throughout Australia. Such higher education institutions currently include the University of Sydney, Charles Sturt University, the University of Western Sydney, and Griffith University. Worth noting too is the fact that a number of these programs were developed after input from Australian academics who had earlier returned home after having completed post graduate studies in the United States, most often in the subject area of therapeutic recreation. For instance, Dr Ian Patterson, who studied at the University of Oregon in the 1980s, was heavily involved in the development of the TR major at Griffith University as part of the associate diploma, and later a bachelor's degree, program. More recently, he has also had an advisory role in the development of the Bachelor of Applied Science (Therapeutic Recreation), as offered currently at the University of Western Sydney. This program being a particularly good example of a TR based study program that has been developed in recent years by academics in close consultation with a suite of industry and government stakeholder groups. Importantly, and consistent with the early development of these programs in the TR field, empirical research in the Australian setting began to emerge in the early 1980s as to the benefits of such activity with an increased focus on efforts to evaluate the principles and practices to guide interventions with consumers of therapeutic services (Trowbridge, 1988). Such effort has, however, not been an activity widely engaged by many of those working in the field as DT practitioners (Cox, 2000). This being despite the general shift in the Australian health care sector over the last decade or so towards a greater expectation that service development be driven by evidence based outcomes. Importantly, it also entailed an expectation that the productivity and workplace preparation be grounded in the employment of suitably accredited and trained personnel (Glasziou & Irwig, 2004).

Ongoing National Reform in the Health and Community Care Sectors in Australia

National Reforms

Effectively the provision of DT services in Australia over the last decade or so has been greatly impacted upon by a sweeping array of reforms, most initiated at the Federal level, with respect to the health and community services sectors. While these reforms have been wide reaching, three are worthy of particular mention at this juncture. These being, the nation-wide reforms to community-based public health services generally, and those services targeted at people with a mental illness and older adults. Each of these reform agendas has, in one manner or another, been significant in that they have brought forth a greater consideration of quality of life issues with a recognition for, perhaps the first time, that there needs to be proper alignment of legislation, policies, and funding at national and state levels to successfully implement the proposed reforms across the nation.

National Health Strategy

For example, the *National Health Strategy,* a key nation-wide initiative announced by the Commonwealth Government in 1994, noted for the first time at the Federal level, the effects of biological, physiological, socio-economic and environmental issues on health, and identified the real need for health services nationally to be, ". . .holistic and recognise the contribution of the broad range of influences which can impact upon the health of a community, outside of the traditional clinic focus on treating illness" (p. 2). Since then, Government policies and community actions have increasingly reflected the leisure-health relationship. For instance, efforts made in recent years with respect to the Active Australia and Get Activated campaigns within the health care field have focussed on the importance of community-based living and the need for physical activity to be incorporated into a

more holistic and healthy lifestyle (Australian Institute of Health and Welfare, 2000; Australian Sports Commission, 2005).

National Mental Health Reform

Similarly, the *National Mental Health Plan,* first released in 1992 and updated in 1998, has focussed on promotion, prevention and early intervention; the development of partnerships in service reform; and the quality and effectiveness of service delivery. These core reforms being reinforced further in 2006 with the tabling of the Parliament of Australia Senate (2006) report titled *A National Approach to Mental Health—From Crisis to Community* which recommended, amongst other things, that greater attention (and resources) be given to the issues of social reintegration of consumers and the level and quality of rehabilitation services, inclusive of TR based programs, available to them.

Aged Care Reform

In terms of aged care, the *Home and Community Care Act 1985* and the *Aged Care Act 1997* have become the reform platform used to "support health ageing for older Australians and the provision of quality, cost effective care for frail older people as well as their carers" (Department of Health and Ageing, 2003, p. 3). Such support has included what are considered at the national level to be "other therapies" and it is under this banner that TR and other leisure-based services have been funded to date in residential aged care facilities across Australia.

While it should be noted all of these reforms have been initiated at the national level, each has been impacted upon, in turn, at the state and regional level by the ideology and the policies of the state or territory government in power, and even more locally, by the service provider and health care practitioner overseeing program delivery.

The Service Providers

In terms of DT services in Australia, such practitioners have essentially been either occupational therapists or diversional therapists, with the service offered usually a reflection of the professional philosophy of service provision he or she brings with them. Occupational therapists, for example, continue to align quite strongly with the medical model of health service provision and maintain a role as a key member of case management teams where, more and more, they are being required to undertake large caseloads encompassing largely the evaluation of client competencies and the associated administration of services. Importantly, case management is in Australia today an integral component of the overall services offered by health service providers. With its implementation has come the progressive withdrawal of many occupational therapists from involvement in the face-to-face delivery of programs. As a consequence, the shift in duties for OTs has actually been a boon for many DT based staff as they have effectively been required to step in to fill the void. As such, diversional therapists have remained very much "hands on" with their services now more in demand than ever. That stated, they too have been asked in recent times to be more accountable for what they offer and how they do it. In the work setting, this has caused some problems as a significant number of diversional therapists have expressed the view through their professional association that they are uncomfortable with the notion of being required to undertake any form of critical evaluation to demonstrate client outcomes, or even to formally justify service offerings. While part of this concern may be bedded in lack of evaluative expertise, it is nevertheless an unfortunate stance that has been taken as greater accountability for health care expenditure in the Australian setting is already a reality. As such, and if their current position remains unchanged, it will surely bring them into conflict with the relevant authorities in the immediate future. For instance, a growing recogni-

tion of consumers' rights with respect to interventions and methods of service delivery has led to the expectation that services be firmly grounded in sound research evidence. As a consequence, evidence based practice has become a contemporary preoccupation for policy makers who are now seeking to increase the efficiency and effectiveness of the available health workforce, and improve its distribution (Productivity Commission, 2005). Effectively therefore, DTs need either "shape up or ship out".

Diversional Therapy and Disability/Aged Care Agenda

As much of the activity related to DT in Australia now takes place in the aged care and disability sectors, it is important at this point to undertake some brief review of how DT is currently placed with respect these specific areas since the introduction of the *Disability Discrimination Act* (DDA) in 1992 has radically changed the landscape in which disability is addressed with regards the social and cultural context. While there are clearly noted deficiencies in solely relying on a legislative system to provide social outcomes (Handley, 2001), there is little doubt however that the expectations of people with disabilities are significantly different 14 years post this legislation, as compared to the years before its introduction (Human Rights and Equal Opportunity Commission, 2003). Clearly, no longer will older adults or people with disabilities accept medicalized attitudes, institutional approaches, or segregated practices to service delivery (Goggin & Newell, 2005).

Sadly however, there have been literally hundreds of complaint cases documented against leisure and recreation providers in recent years (Darcy, 2001; Human Rights and Equal Opportunity Commission, 2006). For example, cases at all classes and levels of discrimination against people with mobility, vision, hearing, cognitive and mental health dimensions of disability have been noted. Of particular concern is the fact that a number of the complaint cases were brought against recreation providers in diversional therapy settings on grounds of inappropriate facilities and services. Such negative outcomes suggest that while the profession has continued to work within the operating parameters of the clinical or institutional settings, the staff themselves have not necessarily understood or placed the dignity of individuals at the forefront of their professional activity.

This is unfortunate to say the least as the future direction for many service providers is very much steeped in developing community networks where the interdependence of clients is encouraged through peer to peer empowerment (Smith, 2002). This new direction sees people with disabilities supporting people with disabilities and, in turn, creating a resource to assist practitioners within institutions (Smith, 2006). It is a model that has been used to good effect with the "Gone Walking" program that was initiated via Federal funding to encourage greater participation of older adults in physical activity. In such a dynamic environment, the role of the DT is therefore very much different from the traditional role that remains the norm in Australia today. The changes now occurring in the disability and aging sectors perhaps best exemplify what may be achievable for the individual. It also serves to highlight the fact that DT services per se have effectively not kept pace with the social and healthcare paradigm shifts now occurring in the Australian setting.

Remaining Issues

DT professionals in Australia, through their everyday interactions with consumers, should play a major role in supporting individuals with a wide variety of care and health needs. Often this is achieved by way of facilitating an improved level of leisure functioning resulting in a better quality of life. Despite this fact however, DT services in the Australian setting continue to be dismissed by many professionals and para-professionals in the health and community care field as little more

than "time fillers". The delivery of these diversionary activities, while largely historical, can also be tracked back to the pervading nomenclature of the Diversional Therapy Association which has tended to dominate the professional discourse in clinical and institutional settings.

Added to this is harsh reality that a range of dualities exist with respect to DT services. For instance, on the one hand services can be largely diversionary in intent against being viewed as a legitimate form of intervention. There is also the issue of DT staff tending to align with the more traditional medical model of provision as against a more modern social model of care. Adoption of the social model is important in that it better recognizes the rights of the consumer and which focuses on the individual, and his or her long term health. This, in turn, raises the issue of service philosophy. For instance, are DTs primarily concerned with long term care or are they focussed more on rehabilitation? The two-sided nature of how services are provided for those who are, for example, ageing, as against those with a disability, is also an issue not yet adequately addressed by the profession in Australia. Finally, the reality that the practice of many older DTs, who have been trained on-the-job, is quite different when compared to that of the newer and younger crop of trained DT staff that come to the profession with a university education. This speaks volumes about the significant variations in practice that exist within the profession in Australia. This being particularly the case with respect to service philosophy, level of TR/DT knowledge and expertise, level of understanding of evaluative and research techniques, and support for evidence based practice.

As noted by Martin (2002), the code of practice for many DT specialists in Australia remains imbedded in a notion of "leisure for leisure sake". Stumbo, Martin and Ogborne (2004) have argued more recently that, in their collective view, this was a very much outdated ideal given the rapidly changing Australian landscape. It is perhaps not surprising to report therefore, that the primary professional agency in Australia for DT, the Diversional Therapy Association of Australia (DTAA), has itself been under attack from within from its membership in recent years as it has sought to move to a more professional, and evidence based form of leisure service provision to that endorsed previously. It must be said that a number within the profession accept the need to move away from the provision of services often interpreted as being largely "entertainment" to a position whereby they are valued professionally for the services they offer. Importantly, this need also include being valued for the outcomes they achieve as much has still to be done to reaffirm the key importance of DT in the Australian setting (Pegg, 2004). To this end, recent action by the DTAA to establish its own journal and to set minimum standards for the professional preparation and ongoing in-service education of DT therapists is clearly a purposeful step in the right direction. Additionally, the efforts of the Association to try and bring individual state branches under the control of the national executive has been instrumental to providing clear leadership and a strategic vision for its membership. Efforts by the Association to lobby the relevant Federal Ministers of State with respect to policy reform and the role that DT services might play in the health setting is also a positive sign that the Association appreciates fully that it exists in a political, as well as economic, social, and environment. For all these initiatives, as positive as each is, much still needs to be done.

For instance, the profession has not been active in understanding the broader social change that has occurred to empower people with disabilities (Smith, 2006). With the exception of several key figures within the Association proper, there has been all too little evidence of professional leadership driving these social and policy changes to collaborate with disability advocacy groups with a view to improving the position of leisure for people with disabilities within the broader policy context. One might wonder where the profession

was when the rights of people with disability were being challenged at the Commonwealth level, when it came to representation on the national disability coalition, and when the process of allocating individualized funding to people with disabilities was under threat? Similarly, the question can also be asked where was the professional representation on significant government and socially-based committees when public debate was (and still is) occurring? Clearly, too few visionaries within the DT ranks are being asked to do too much on behalf of their collective peers with the end result being less than satisfactory. Of real concern therefore, and as argued by Stumbo, Martin and Ogborne (2004, p. 91), until action is taken by DT specialists in Australia to collectively articulate and document a clear purpose to service provision; develop more standardized services to clients; demonstrate an ability to target and achieve valued client outcomes; improve the credibility of service provision and service providers to other providers and payers; and achieve greater equity with other health care and human service professionals, such employees and the services they offer will continue to sail on troubled waters.

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