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Therapeutic recreation as a developing profession in South Africa

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Abstract

South Africa experiences socio-economic challenges with a high prevalence of poverty resulting in disability and non-communicable diseases affecting the health and welfare of communities. Health services are not always accessible or available to citizens, especially those of previously disadvantaged or rural communities. The South African National Plan for Development 2030 aims to address these inequality and health issues. One focus area of this plan is the inclusion of recreation, leisure and sport as an important service sector to improve the health and well-being of all individuals. Therapeutic recreation could play an important role in this regard. In South Africa, therapeutic recreation is in its developmental stages. This paper aims to provide the reader with an overview of therapeutic recreation in South Africa as a developing profession. An overview of the current status of the profession is discussed in terms of standard of practice and as it relates to health professions and recreation service providers, programmes with therapeutic value and training needs. The study concludes that there is still groundwork to be done, calling for interested parties to embark on an aggressive advocacy and strategic planning process to develop therapeutic recreation as a profession in South Africa.

Introduction

Therapeutic recreation developed historically as a clinical profession with practitioners such as Philippe Pinel (1745–1826) from France and William Tuke (1732–1822) from England, respectively, working in medical institutions allowing individuals with mental illnesses to exercise and move around freely in hospitals (Dieser, 2008). They believed that “people with mental illness were capable human beings who deserved to be treated with compassion and dignity rather than being chained and locked behind bars” (Dieser, 2008, p. 15). Leisure and recreation programmes as treatment modalities were well established practices in Europe and USA by the end of 1800s. Community therapeutic recreation developed historically in settlement houses and community schools during the 1800s. Settlement houses offered human services and took social action on behalf of people with special needs. The “play ladies”, Jane Addams and Ellen Gates Starr, for example, had very modest goals in the establishment of the Hull-House social settlement in Chicago in 1889. However, the role of Hull-House grew beyond its purpose and contributed significantly to the development of community-based therapeutic recreation.

Jane Addams made use of recreation and leisure to help improve the health and wellbeing of people with special needs (Lahey, 1999). As time progressed, recreation as therapy was introduced in various settings. Therapeutic recreation was formally developed from 1966 to 1984 in the USA with the establishment of the National Therapeutic Recreation Society in 1965 and the American Therapeutic Recreation Association (ATRA) in 1984 (Van Anel, 2007). The ATRA serves as the professional association providing guidance and directions to members in terms of qualifications, competencies, practice and conduct. They work collaboratively with the National Council for Therapeutic Recreation Certification (NCTRC), the certification body, to ensure that services are provided by certified therapeutic recreation specialists consistent with the professional standard of practice and code of ethics for enhanced consumer safety. The profession soon spread to other countries with now established associations in Australia (Australian Communities Therapeutic Recreation), Canada (Canadian Therapeutic Recreation Association), Korea (Daehan Therapeutic Recreation Association), New Zealand (New Zealand Therapeutic Recreation Association Incorporated) and the USA. These associations aim to serve the interests and needs of professionals within the field of therapeutic recreation.

Globally, discussions were stimulated when the World Leisure Access and Inclusion Commission began dialogue at the World Leisure Congress held in Rimini, Italy in 2012 regarding the topic of whether the American-based NCTRC is an appropriate credentialing framework for professionals working with people with disabilities in different countries (see Banhidi et al., 2013). South Africa as participating country, reiterated the current stance of rehabilitation and therapy offered being limited to professions such as occupational therapists, physiotherapists, biokineticists, chiropractice, phototherapy, therapeutic aromatherapy, therapeutic massage therapy and therapeutic reflexology regulated by bodies for clinical and natural health professions.¹ These professions, in South Africa, are predominantly located in the public and private health sectors and make use of the medical model approach to rehabilitation and does not have a Therapeutic Recreation Board, thus leaving the profession unrecognized. However, therapeutic recreation is prescribed in the academic curriculum to train biokinetic practitioners to use physical activity and exercise as a modality to prevent diseases of lifestyle or to optimize health and total wellness (Wilders, 2012).

Therapeutic recreation as a profession could contribute in assisting individuals with special needs to engage in recreational activities impacting their overall health and wellbeing. Recreation opportunities for health and overall improvement are gaining interest amongst various advocacy groups and government to serve citizens with special needs. Emma Roos of the Higher Grounds organization highlighted the:

incredible impact that recreational therapy can have in the lives of people with disabilities.(2013, p. 30)

Facilitators at the Drakenstein Association for Persons with Disabilities (APD) noted that:

recreational therapy programs is needed for our work groups to provide them skills to enter into jobs. Our arts workshops has helped our participants to become independent

and identify interests that they could continue to participate in. (Stapelberg, personal communication, 2014)

Moreover, the City of Cape Town conducted a study on recreation participation in 2011, in which community members participating in the study argued that:

there are not enough activities, particularly for elderly and disabled residents. (City of Cape Town, 2011, p. 65)

Conversely, therapeutic recreation has not been explored or documented in the South African context to advocate for the establishment thereof as a profession. This paper aims to provide the reader with an overview of therapeutic recreation in South Africa as a developing profession and to provide information necessary for decision-making related to the potential development of the therapeutic recreation profession in South Africa.

Therapeutic recreation profession in South Africa

There are a number of factors that need to be considered when assessing the possible role of therapeutic recreation in South Africa. Apartheid caused structural challenges leaving a legacy of poverty and underdevelopment impacting service availability (Brynard, 2010). Government practices post-apartheid, particularly the signing of international trade agreements, led to significant job losses and contributed to a growing socio-economic crisis characterized by an increase in poverty and inequality, unemployment and reversal of past development gains (Kotze, 2004). A common denominator for increased numbers of non-communicable diseases and disability is poverty (Lansdown, 2002). These health risks affect people's livelihoods, especially in resource-poor settings (Goudge et al., 2009). A need exists to focus on health promotion for all groups with special needs, including those with disabilities, in specific disadvantaged communities where rehabilitation services are not always accessible. The South African National Development Plan 2030 highlights the fact that health is not only a medical issue, but also should involve interventions that promote healthy lifestyles to reduce the growing number of noncommunicable. Among the poor, such diseases are the leading cause of mortality (National Planning Commission, 2011).

The National Development Plan 2030 plans to address these issues by promoting active efforts and participation amongst all citizens that aligns with the globally endorsed values of the World Health Organization (National Planning Commission, 2011). The World Health Organization provides community-based rehabilitation guidelines to address the social issues related to health. They identify recreation, leisure and sport as an important service sector for improving the health and well-being of individuals, which could then contribute to the empowerment of individuals and promote the development of inclusive communities (World Health Organization, 2010). In effect, this has been addressed in the National Development Plan 2030 as a priority to increase physical activity amongst citizens to combat diseases of lifestyle (National Planning Commission, 2011). Health is one of the strategic development objectives and therapeutic recreation has the potential to fulfil a leading role in combating the health issues in South Africa.

Recreation in South Africa

Historically in South Africa, recreation has been treated as secondary to other professions and was absorbed under the authority of public parks and, more recently, sport. Recreation services are currently constituted through the governmental Ministry of Sport and Recreation and thus governed by the national body Sport and Recreation South Africa (SRSA). Recreation are therefore often misunderstood as referring to sport and other recreation activities such as arts and performing arts and hobbies are disregarded or treated as less important to sport.

Many attempts have been made by national advocating bodies to address these inequalities in the industry. These bodies includes: Recreation South Africa (established 1994) that intended to facilitate fieldwork training and the South African National Recreation Council (SANREC; established 1998) that was intended to facilitate service delivery. Nine provincial recreation councils were established under the auspice of SANREC for this purpose (Provincial Recreation Council – North West, 2003). More recently, the independent body Leisure and Recreation Association of South Africa (LARASA) was established in 2010. LARASA's mission is to advocate for the establishment of recreation as a recognized profession based on its potential to create enabling environments and provide essential services in the public sector (LARASA, 2013). Their mission has been communicated to government structures and since the establishment of LARASA, recreation has been identified as a strategic objective in the National Plan for Sport and Recreation to improve the health and well-being of the nation by providing opportunities through active recreation (Department Sport and Recreation South Africa, 2012). This objective aligns with the National Development Plan 2030 to increase physical activity amongst citizens.

Yet, the latter could only be achieved if the service providers are adequately trained as recreational professionals. Recreation professionals include community recreation practitioners and recreational therapists who focus on the inclusion of people with disabilities and chronic illness through the use of recreation The current state of practice is to recruit non-trained citizens through volunteer programmes working as recreation practitioners indicating a lack of appropriate government structures to support the objectives that have been set.

Disability recreation services in South Africa

In the past people with disabilities experienced discrimination on two levels: their race and their disability. Today, while South Africa is a democratic country, people with disabilities continue to experience discrimination on the basis of their disability. This discrimination extends to their participation in sport and recreation. When considering the needs of the population and, in particular, those who have a disability, the Integrated National Disability Strategy (Republic of South Africa, 1997) highlights an area where therapeutic recreation can play a pivotal role in assisting people to reach their full functionality. The document highlights the various factors involved in the marginalization and exclusion of people with disability in terms of social, medical and economic aspects. It discusses sport and recreation in terms of the importance of sport for rehabilitation aimed at physical and mental development. It further addresses the need for supportive rehabilitation services focusing on community action and involvement, the lack of trained

staff specialized in training or coaching people with special needs and the lack of facilities that are able to accommodate people with special needs. This is where therapeutic recreation becomes vital in that the therapeutic recreation specialist is trained in developing programmes and making necessary adaptations to the environment to allow people with disabilities an opportunity to participate in recreation (ATRA, 2011; Diversional Therapy Australia, 2011; Kraus, 1966; Robertson & Long, 2008; Russell & Jamieson, 2008; Stumbo, 2009).

There is a growing volume of evidence based on practice and research within the field of therapeutic recreation internationally. This evidence motivates and affirms the role of the therapeutic recreation specialists in communities and within the health profession. While no profession is without its challenges, therapeutic recreation requires a mixed skill set from specialists and a high standard in order to be credentialed. To achieve and maintain professional certification requires extensive academic studies, completion of clinical fieldwork hours, continuous professional development (CPD) and adherence to standardized guidelines (Braslie, 1992; National Council for Therapeutic Recreation Certification, 2011; Stumbo, 2009). The potential benefit of therapeutic recreation services in the context of the national agenda seems promising; however, it is unclear if the development of therapeutic recreation as a stand-alone profession in South Africa is feasible. Thus, the purpose of this paper was to examine factors relevant to the potential development of therapeutic recreation services in accordance with current services provided by health professions and other service structures.

Health professions in South Africa

Recreational services are not professionalized in South Africa. Recreation practitioners cannot register or become certified as professionals. The leisure and recreation industry is governed by SRSA and no standards of practice guidelines have been developed to date. The scope of practice is, therefore, not clear. In order to align therapeutic recreation within the health industry, one need to compare the scope of practice as it relates to current health professions in South Africa.

Health professions in South Africa are regulated by the Health Professions Council of South Africa (HPCSA). The HPCSA provides general guidelines for good practice in addition to ethical and professional rules for all health care professions (HPCSA, 2008). Rules of conduct for each profession are prescribed under regulating boards established by HPCSA of which two boards are highlighted in this paper: the Board for Occupational Therapy, Art therapy, Orthotics and Prosthetics and the Board for Physiotherapy, Podiatry and Biokinetics. Performance of professional acts is prescribed in terms of the different levels of services as therapists, assistants, technicians and students. The following are the rules of conduct that prescribe the performance of a professional act: (1) the knowledge and skills for functional and clinical diagnoses in the respective fields as it relates to their education and training, (2) relationships with other professionals to communicate and cooperate with them, (3) clients/patients should be referred to other professionals if it falls beyond their scope of practice (4) establishing private practices if the therapists are not employed in public services and (5) appointment of assistance and technicians with approval of the council (HPCSA, 2008). Therapists must be registered with the HPCSA in order to practice and must update their membership on a yearly basis

through activities such as the attendance of workshops, symposiums or conferences to gain CPD points on an annual basis (HPCSA, 2014). Two specific health occupations affected by therapeutic recreation as a developing profession will be addressed: Occupational Therapy and Biokinetics.

Occupational therapy

Occupational Therapists use scientifically chosen meaningful activities to assist diverse clients with a range of problems to maximize their functioning, thus empowering clients to be as independent as possible and to experience dignity and quality of life at work, at home and at play (Occupational Therapy Association of South Africa, 2000). The scope of practice for occupational therapists in South Africa lies in the evaluation, improvement and maintenance of health, development, functional performance and self-assertion of individuals with an impairment or displaying at risk behaviour. They provide prescription and guidance towards participation in normal activities by implementation of appropriate techniques. Practice thus falls within the scope of activities of daily living, work and education, social participation and leisure activities (Ancer, 2007). The Professional Board for Occupational Therapy and Medical Orthotics/Prosthetics set the minimum standards of practice viewing it as part of clinical governance. The majority of occupational therapists are employed in public urban sector hospitals, rural hospitals or health care facilities to provide rehabilitation to people with physical and psychiatric conditions and disabilities to become functional members of society.

Occupational therapy and therapeutic recreation grew from the same historic roots and seem to be similar in that both occupations offer services to improve functional skills (Marcil, 2007). Despite the similarities, leisure and recreation do not receive much attention within the occupational therapy scope of practice, mainly due to time constraints. In countries such as the USA, faced with similar dilemmas, play and leisure areas as therapy were turned over to therapeutic recreation (Marcil, 2007). There are, however, distinct characteristics differentiating the two professions. While occupational therapy focuses on the promotion of finer functioning and increased independence of day-to-day living activities, perceptual motor skill development and sensory integration, the difference lies in therapeutic recreation focusing on access to and participation in recreation programmes (Maine Task Force on Applied Physical Education, 2000). Therapeutic recreation employs a stronger focus on leisure and leisure education as well as the removal of barriers to participation, with the purpose to expose the patient/client to an appealing and realistic leisure option (Gassaway et al., 2011). This is to create conditions enabling the patient/client to successfully experience leisure with customized treatment focusing on the whole person and their environment for lifelong leisure interests, skills and strategies for improved health, well-being and quality of life (Green & McAdory-Coogan, 2008; Kunstler & Daly, 2010). In practice these professions could be complementary to one another with occupational therapists focusing on the functional skills of patients/clients, while therapeutic recreation therapists focus on leisure skills.

Biokinetics

Biokinetics is the science of movement as an essential part of everyday life and the application of exercise in rehabilitative treatment to improve physical functioning. The

goal is to enable the individual to interact more fully in work and recreation as well as to promote health (Biokinetics Association of South Africa, 2013). Biokinetics Association of South Africa (BASA) is the professional body representing Biokinetic practitioners, academics and students in South Africa. They serve the needs of both the members of the organization and the profession in a continually changing health environment. They do not prescribe standards of practice, but work as a collaborating partner in promoting standards of education amongst training institutions. BASA evaluates training programmes along with the HPCSA at a regular basis. The scope of practice identified for biokineticists by the Department of Health in 1994, falls within four categories: (1) wellness, disease/injury prevention and health promotion, (2) optimal performance, (3) final phase orthopaedic rehabilitation and (4) management of chronic disease and disabilities (Biokinetics Association of South Africa, 2013). Specialized education for practice is a requirement in order to work in a variety of settings, including the public and private sector in urban and rural settings. The focus of practice lies in the use of knowledge in exercise, physical activity and health education to enhance health in general.

Biokinetics is a distinct health profession to South Africa, not well known by the international community. Currently biokineticists work in public and private hospitals and private practices that are clinical in nature. Financially, it is not accessible to many South Africans as not many can afford private practice services. Biokineticists already apply some knowledge of therapeutic recreation in their practice in terms of health promotion catering for people with disabilities and chronic disease. There is a need to take biokinetics programmes to communities providing home-based exercise programmes and to promote community health and wellness through physical activity. Therapeutic recreation could contribute well to this aspect of biokinetics, providing services beyond the scope of current biokinetics practices. Therapeutic recreation programmes could be used for reintegrating patients/clients back into community via leisure lifestyle and for promoting participation in community recreation services for health and wellness. Community therapeutic recreation models would be valuable in this context as a means of providing services such as individual home-based fitness programmes, wellness education, advance functional skills in the leisure domain, community engagement, network and resource development and recreation skill development (Sable & Gravink, 2005).

Current programmes with a therapeutic recreation focus. Beyond recreation services, disability recreation services and health professions (in particular occupational therapy and Biokinetics) there are a number of human service programmes that are therapeutic recreation in nature. Below are case study examples of therapeutic reaction being implemented in health care programmes, public sector programmes, private non-profit sector programmes and tertiary institution programmes.

Health care profession programmes

Registered professions such as art therapy, music therapy, dance therapy and play therapy are all forms of psychotherapy using these different activities as forms of communication and fall under the occupational therapy and/or psychology health professions. These therapists are not primarily concerned with making aesthetic or

diagnostic assessments of clients, but rather with enabling the client to affect growth and change at a personal level. They register with the HPCSA and the Board of Healthcare Funders in order to practice (Rackstraw, 2014). These occupations see the benefit of recreational practices and activities, but due to therapeutic recreation being in its developmental stages in South Africa, it is regarded as a separate entity.

A programme offered in the art, music, dance and play therapy domain is the Community Art's Therapy programme originating in previous disadvantaged communities in the Western Cape. Their focus is to provide therapeutic space for marginalized community members, women and especially children traumatized by the environmental and historically sociopolitical circumstances with the hope to offer a safe place where these members can experience empathy, hope and healing towards a sense of self and wholeness. Therapeutic programmes entails art, drama, storytelling, reading, sewing and gardening. These programmes are offered in groups. The programme also offer individual counselling and support, bereavement and after-school groups (Rackstraw, 2014).

Public sector programmes

In reality, the majority of fieldworkers offering recreation programmes as a means of therapy are working in the public sector either as sport and recreation officers or volunteers. In essence, only a few of these practitioners might have obtained a formal degree in the field of Sport and Recreation Management or at least a certificate or diploma that does not necessarily relate to the field of practice.

In focus group discussions with participants from a local government institution in the Western Cape, it became evident that the majority had never heard of the term therapeutic recreation yet, they offer a variety of programmes to serve vulnerable groups such as the elderly, children, youth at risk and people with disabilities. These programmes follow a three-legged approach: individual and community development, prevention to high social and health risk behaviours and rehabilitation. Partnerships are formed with nongovernmental/not for profit organizations that offer programmes to vulnerable groups, especially people with disabilities. Practitioners are faced with challenges of multiracialism or religious groups with specific expectations. Challenges are dealt with by the hosting of multiple events throughout the year amongst different communities to encourage integrative participation.

Private non-profit sector programmes

Higher Ground Camping Adventures for the Disabled originated in 2004 after two South African's met working together at a summer camp in Pennsylvania, USA. After much deliberation, they initiated the programme in KwaZulu-Natal providing summer camps for people with disabilities. These programmes branched out to other provinces including the Western Cape and Gauteng. They mainly make use of volunteers to assist them in these programmes. Their programmes make use of outdoor adventure recreation activities and serve to impact the participants in overcoming their personal challenges and changing the mind-sets not only of the people with disabilities but also that of volunteers (Higher Ground, 2014).

Amelia aftercare-centre is a safe haven that caters to adults with disabilities with the intellectual capacity of a five- to seven-year-old. The centre accommodates live-in as well as day-care adults, the adults are given household responsibilities such as food preparation, doing the laundry and washing dishes. Other activities include metalwork, woodwork and needlework and they also cultivate their own vegetable garden. Amelia aftercare-centre and their personnel make every effort to create a working atmosphere for the adults to provide them with a sense of belonging. Students and lecturers from the school of Biokinetics, Recreation and Sport Science at the University of the North-West visit the centre regularly with the purpose to assist in providing a quality of life for the people at this centre and it also serves as a learning experience for students (Kriel, 2014).

The APD is a national organization with nine provincial headquarters branching out into the local communities. The APD is a non-profit organization that serve as an organization to persons with mental, physical and emotional disabilities from previous disadvantaged communities with a growing need for rehabilitation, special care centres, practical skills training and job creation. The main purpose is to enable individuals with disabilities (age 18–59) to attain their maximum level of independence and integration into the community. The Drakenstein centre adopted a programmed approach allowing for individuals to be assessed, identifying their shortcomings, skills and abilities with the intention to admit them into a skills training programme, thus creating a better sense of social interaction and integration into the community. Facilitators to these working groups identified the need to formalize the programmes to be more outcomes driven and to adopt a process of assessment, planning, implementation and evaluation that falls within the scope of therapeutic recreation practices (Williams, 2014).

Tertiary institutions community-based intervention programmes

The HealthWise programme that was developed in the USA was adapted for use in South Africa high schools to address risk factors among South African teenagers (Wegner, Flisher, Caldwell, Vergnani, & Smith, 2008). The HealthWise intervention is an evidence based leisure education intervention promoting positive youth development and prevention against sexual risk and substance use with the intent to educate teenagers to take charge of their leisure time functioning as healthy humans in their respective communities. Interventions are linked with lessons as a systematic process towards achieving outcomes (Caldwell et al., 2004). This programme was launched in the Western Cape as a collaboration between the University of the Western Cape, University of Cape Town and Pennsylvania State University in the USA. In short, recreational practices served as a means of therapy and are offered by qualified professionals from different educational backgrounds including health professionals, social workers, educators and people with a degree in sport and recreation management. There are, however, a large amount of services provided by practitioners without any formal qualification raising ethical and competency concerns.

Conclusion

Scope of practice as prescribed by ATRA have been reviewed in relation to professional health services in South Africa and current recreational services offered to people with special needs. Standards as prescribed by ATRA and the requirements for formal qualification and certification by NCTRC prompt challenges for implementation in South

Africa due to the social, cultural, ethnic, economic and political challenges faced by our communities. Although South Africa will be able to align therapeutic recreation standards of practice with current health professions, the need for practice lies more within community-based rehabilitative programmes.

Therapeutic recreation should not be developed as a stand-alone practice at this point of development. Various options for development should be considered. The first option is the alignment with one of the current health professions, in particular Biokinetics or Occupational Therapy, as an extended service for community-based practice. Discussions with the different regulating professional bodies should take place. The second option is to provide training to general recreation practitioners to provide inclusive recreation practices. In both instances the academic qualifications should be reviewed to include therapeutic recreation and inclusive recreation content and internship opportunities as a second career option.

Advocacy to the South African Government is necessary to support creation of positions for community-based health promoting services and further education in this field. Opportunities for current recreation practitioners, challenged by their work obligations, to develop into certified therapeutic recreation therapists should be investigated. Short courses, certificate programmes and workshops geared towards certification should be developed to accommodate these practitioners. A career development path option should be created within a certification system. A registration system for current recreation practitioners providing inclusive or special needs recreation programmes could be developed through one of the current professional boards. This would allow for practitioners to voluntarily register with an organization where they could identify themselves as a member of the profession and could evolve into the development of a certification system within context of the South African culture. Certification should be aimed at different levels of therapeutic recreation services to suit South Africa's dynamic situation.

Although ATRA and NCTRC provides a valuable model in which one could operate, South Africa would have to use the model to develop their own standards of practice and certification processes to align with the requirements of the HPCSA and South African legislation. This will not be without its challenges. Groundwork needs to be done along with aggressive advocacy and strategic planning to develop therapeutic recreation as a profession in South Africa.

Note

1. Health professional bodies:

HPCSA: Health Professions Council of South Africa, the statutory body in terms of the Health Professions Act No. 56 of 1974 that guides and regulates the clinical health professions.

AHPCSA: Allied Health Professional Council of South Africa, the statutory body in terms of the Allied Health Professions Act, 63 of 1982 (the Act) to control all allied health professions (natural medicine), which includes Ayurveda, Chinese Medicine and Acupuncture, Chiropractic, Homeopathy, Naturopathy, Osteopathy, Phytotherapy, Therapeutic Aromatherapy, Therapeutic Massage Therapy, Therapeutic Reflexology and Unani-Tibb.

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