

# **International Models of Best Practice in Wilderness and Adventure Therapy: Implications for Australia**

**An Investigation of Selected Innovative Mental  
Health Programs for Adolescents using Wilderness and  
Adventure Activities as a Primary Therapeutic Modality  
in the United Kingdom, United States of America and New  
Zealand.**

**1996 Winston Churchill Fellowship Final Report**

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**Table of Programs Investigated** (chronological order):

1	<i>Basecamp</i> John Barrett	Dumfries, Scotland UK
2	<i>Brathay Hall Youth Program</i>	Cumbria, England UK
3	<i>Eagleville Hospital Challenge Program</i>	Eagleville, Philadelphia USA
4	<i>Lifespan Wilderness Therapy Program</i> Dr Dene Berman & Dr Jennifer Davis-Berman	Dayton, Ohio USA
5	<i>The Browne Centre</i> University of New Hampshire Dr Michael Gass	Durham, NH USA
6	<i>Talisman School - Camp Elliott</i>	Black Mtn, N. Carolina USA
7	<i>Project Adventure - LEGACY Program</i>  Georgia College & State University Department of Psychology Dr Lee Gillis	Covington, Georgia USA  Milledgeville, Georgia USA
8	<i>Inner Harbour Hospital</i>	Douglasville, Georgia USA
9	<i>Three Springs</i>	Huntsville, Alabama USA
10	<i>Colorado Outward Bound School</i>	Denver, Colorado USA
11	<i>Santa Fe Mountain Centre</i>	Santa Fe, New Mexico USA
12	<i>Anasazi Foundation</i>	Mesa, Arizona USA
13	<i>Aspen Youth Alternatives</i>	Loa, Utah USA
14	<i>Special Education Service - Otago</i>	Portobelo, Dunedin NZ

## **1 Introduction**

An investigation into innovative methods using wilderness and adventure interventions in mental health programs is particularly important for Australia at this time. The increase of mental health problems in children and particularly adolescents, includes one of the highest suicide rates in young people in the world; a situation of great concern. This calls for more effective and more accessible means for not only treating, but providing protection against severe mental health problems in adolescence and adulthood.

While conventional mental health treatments for adolescents are typically based upon methods developed for use with adults (Poot, 1997), the needs of adolescence are significantly different, in many important respects. Add to this the high incidence of social problems in adolescence such as learning problems and school refusal, homelessness, delinquency, drug and alcohol abuse, family problems, and unemployment. Young Australians with mental health problems typically find themselves caught in a position of being reluctant to seek help and difficult to engage in a treatment process which may be perceived as adding further stigma to their already tenuous identity and self-esteem.

What is needed is a treatment approach which gives young people the chance to address the core of their mental health issues in a way that minimizes stigma, but also promotes development in crucial areas of competency and performance, responsibility, judgement, social orientation, motivation and identity. Benefit would also be provided by enhanced resilience to stressors and precipitants of mental health problems therefore adding protection against future difficulties. Evidence already points to wilderness and adventure therapy as being able to provide this (Gillis & Babb, 1992; Gass, 1993; Berman & Davis-Berman, 1994).

In Australia, wilderness and adventure experiences have been seen as particularly effective in the promotion of character and motivation in young people since the mid 1950's (Richards, 1977). However, only recent times have seen the application of these interventions in the treatment of mental health problems in Australia (Crisp & Aunger, in press). Many innovative and varied programs have existed and been developed in other countries for many years, even decades. None more so than the United States, and to a lesser extent New Zealand and Great Britain.

A study of different mental health programs that use wilderness and adventure interventions can help the field in Australia in many ways. A hindrance to this field here, but less so internationally, is a lack of professional unity. This appears to be based in part on a lack of clarity around theoretical and practice issues. Additionally, an obstacle the field faces internationally is some confusion around language including universally accepted terms and concepts when describing and discussing program characteristics and methods of practise. A necessary first step in reporting and discussing the field is to define and delineate terms. Learning from experiences overseas we may also be able to clarify some of the challenges facing the field, anticipate pit-falls, and develop clear directions and potential strategies for developing the field to the highest possible standards in Australia.

The Australian context is different from other countries in many respects, not the least in its health and mental health systems. Given this, contextual characteristics of different countries need to be taken into account in drawing conclusions about the best options for Australia.

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Having been involved in outdoor education since the early 1980's and wilderness-adventure therapy since 1992, I am persuaded of the need for better theoretical development and more research that holds clinical currency. Additionally, those programs and outdoor educators in Australia who work with 'at risk' client groups are calling for training in ways that maximise benefits for their clients whilst guarding their mental health. Without clear guidelines for sound models and methods of practice the risk remains high for at best inefficiency and poor outcomes, if not detrimental effects. This need has become highlighted recently by a fatality in the USA (Berman, in press; Carpenter, 1995; Griffin, 1995; Krakauer, 1995).

While undertaking this study tour, it quickly became apparent that culture, history and tradition had a significant influence on methods of practice. In particular, how culture relates to group norms, authority of the therapist, group affiliation, meaning and connotations of language, identity, and so on. In addition, notions of mental health and the sociological influence on problems effect how programs are developed and what their place is relative to other services. Together with historical precursors, this has contributed to the diversity of program types and how they are applied.

The need to develop directions and strategies for the evolution of a profession in Australia is also discussed here. In order to increase accessibility and maintenance of the highest standards, as well as supporting evaluation and improvement of practice, a united profession is desirable.

While this report is written primarily for mental health professionals and administrators, it is hoped that it will be of relevance to professionals and academics in other fields such as juvenile justice, youth work, outdoor education, special education, and so on.

There were four main aims of the study:

- 1) to advise other mental health professionals, administrators and government bodies on the current state of best practice so as to enhance the field in Australia,
- 2) to directly apply and adapt accumulated international experience of direct services in Australia and to determine best practice for Australian conditions through clinical research,
- 3) to propose models and/or strategies for the development of a wilderness and adventure therapy profession in Australia and,
- 4) to advise on, and develop training and education programs for practitioners and program administrators based on 1), 2) & 3).

The first objective of this report is to describe each of the programs investigated in detail (Appendix B) so that they may be compared in key areas (Appendix A). Second, to clarify any theoretical issues which may be relevant to best practice. Finally, to discuss and draw conclusions about practice and professional issues from the programs investigated and discussions with leaders in the field.

It is my hope that this report will be distributed as widely as possible so that my experience can be shared with as many others as possible in the hope that the field, and ultimately clients may benefit. Therefore, small portions of this report may be copied for professional, educational and

research purposes on the understanding that it will not be modified or misrepresented, and that authorship and the Australian Winston Churchill Memorial Trust will always be acknowledged.

## **2 Parameters & Terminology**

### **Scope of the Study and Reliability of Data**

A significant limitation of this study is that most contacts are confined to those known about through published literature and the USA based Association of Experiential Education (AEE). This has resulted in a bias to programs which communicate through the AEE or publications in the English language. It should be noted that there are wilderness and adventure oriented programs in Europe which were not included in this study.

The data for the study is derived from a combination of structured and unstructured interviews, program literature (where available), direct observation and participation in activities with client groups, and observation and participation in training programs.

The report is primarily based on the programs listed in the table on page I. Additionally, many of the published leaders in the field were interviewed including Lee Gillis PhD, Dene Berman PhD and Jennifer Davis-Berman PhD, and Michael Gass PhD. Training programs were also visited including the Masters degree in Psychology (Adventure Therapy track) at Georgia College, Milledgeville, the Wilderness Counselling Stewardship course run by Lifespan Wilderness Therapy Program, and under-graduate and graduate programs in Outdoor Education at the University of New Hampshire at Durham.

### **Definitions and Assumptions**

Travelling between countries, it quickly became apparent that professionals in the countries visited used terms differently. This variability of meaning also occurred between those people interviewed within the same country. For consistency in this report and clarity in communication, I have attempted to define some key terms and draw some distinctions which I feel are useful and important. Additionally, in reading the literature, it is apparent that terms often take on different meanings depending on the author. Much of the empirical research is very poor at providing operational definitions which would allow replication of the study reported. This sloppiness significantly undermines the validity of empirical research.

The definitions I have arrived at are the result of discussions with numerous professionals and through observations of practice within programs. These terms and distinctions are the simplest and most useful I could develop. While some authors may argue about the following definitions, there is a need to be clear about the meanings of key terms I shall be using in this report.

#### ***Therapy versus Program***

‘Therapy’ is a method of clinical practice, including a set of techniques based on a theory of personality, behavioural and psychological problems and process of change (see Crisp, 1996 for further discussion). This is in contrast to a ‘program’ which, in this case is a treatment service and includes all the physical and human resources, administrative structures, service aims,



philosophy, mandates, and so on. While a program may utilise a form of therapy or therapies, it is not in itself ‘therapy’. Therapy is undertaken at a point in time by a person or persons trained to do so with a client who presents for help.

### ***Therapy and Psychotherapy versus Counselling***

While significant variation exists across countries to the degree of this distinction, I believe that to make a clear differentiation will allow more informed description and discussion. Generic Australian, New Zealand and United Kingdom use place ***counselling*** at one end of a continuum of short-term, goal directed, narrowly aimed interventions which typically involve facilitating the client to draw on his or her own resources and overcome a presenting impasse. Typically, client problems that are dealt with here are within the normal range of human difficulties. A diagnosis is not usually made nor utilised in this process. Typically, counselling is done in many non-clinical settings by professionals without training or expertise in abnormal psychology and psychiatric disorders.

This is in contrast to ***therapy*** and ***psychotherapy***<sup>1</sup> at the other end of the continuum. Therapy and psychotherapy typically concerns itself with the amelioration of some condition or disorder which is causing or contributing to significant impairment in function in a client’s life over a period of time, often involving a history of fixed and repetitive behavioural patterns (see also Davis-Berman & Berman, 1994, p199-200). Typically, a diagnostic process helps to understand the nature of this disorder and its impact on the functioning of the client. Therefore the practice of therapy is usually associated with an assessment, or analysis of underlying processes which may not be obvious nor available to the client. Most often therapy is undertaken in a clinical setting by a mental health professional with training and expertise in abnormal psychology and psychiatric disorders.

### ***Adventure Therapy***

Adventure therapy as a term is frequently used to include, more-or-less, the entire field of wilderness, outdoor and adventure interventions. Other times it refers to specifically short-term, non-wilderness based, non-residential approaches such as ropes course and initiative activities. This becomes confusing, and tends to hide important differences in practice and assumptions about therapy.

Here, I define adventure therapy as a therapeutic intervention which uses contrived activities of an experiential, risk taking and challenging nature in the treatment of an individual or group. This is done indoors or within an urban environment (ie. not isolated from other man-made resources), and does not involve living in an environment (eg. participants do not cook their own meals or sleep overnight). The emphasis is on the selection and design of the activity to match targeted therapeutic issues and the framing and processing of the activity (Gass, 1995). Examples of such contrived activities include group trust, initiative and problem solving activities (see Rohnke, 1984, 1991; Rohnke & Butler, 1995), ropes and challenge elements (low

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<sup>1</sup> In Australia, ***psychotherapy*** usually refers to psychoanalytic or psychodynamic therapy and its variants, while in the USA psychotherapy is used very broadly to refer to any form of talking therapy.

and high), indoor climbing gyms, and so on. I would distinguish adventure therapy by its emphasis on the contrived nature of the task, the artificiality of the environment and the structure and parameters of the activity being determined by the therapist, such as setting of rules, goals and criteria for success or failure. Specific outcomes are usually planned and sought for through careful framing prior to the activity. In practice, adventure therapy typically utilises metaphoric, strategic and solution oriented paradigms (for specific applications see Gass, 1993), and often addressed specified behaviours such as impulsiveness, assertiveness, substance abuse relapse, etc. Theory of change tends to be based around the systemic concept of ‘disequilibrium’ (Nadler & Luckner, 1992).

### ***Wilderness Therapy***

Wilderness therapy can be contrasted with adventure therapy through the emphasis given to the impact of an isolated natural environment<sup>2</sup> and the use of a living community. Theory of change was often based on concepts of ‘adaptation’. The combination of environment and community can be encapsulated in the notion of a ‘therapeutic wilderness milieu’, and typically include two different intervention formats: 1) wilderness base camping establishing a camp with minimal equipment in an isolated environment, and 2) expeditioning moving from place to place in a self-sufficient manner using different modes such as back-packing, rafting, canoeing, cross-country skiing, etc. Base camping is frequently combined with expeditioning, while expeditioning is often used exclusively. Therapeutic paradigms frequently include generic group therapy and group systems models, and inter-personal behavioural methods. Experiencing of natural consequences of behaviour was also emphasised. Outcomes are frequently related to social roles, patterns in relationships and notions of adaptation (both social and environmental). Change is often (but not always) seen to be holistic, coupled with personal and inter-personal insight, and to emerge from a social process over time. Perhaps overly simplistic, wilderness therapy involves modified group psychotherapy applied and integrated into a wilderness activity setting.

### ***Wilderness-adventure Therapy***

‘Wilderness-adventure therapy’ can be thought of as distinct from, but related to the previous two types. Here wilderness activities may be done in a short session format, or where a natural (but not necessarily isolated) environment is used for an adventure therapy type of activity. Examples include: rockclimbing or abseiling on natural rock or a caving activity conducted in a real cave, over several hours or within a day. The activity does not extend over night (so there is minimal emphasis on community living), but the activities utilize qualities of the natural environment. For research purposes ‘Wilderness-adventure therapy’ in particular should be differentiated from ‘wilderness therapy’ and from ‘adventure therapy’.

### ***Therapeutic Wilderness Camping***

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<sup>2</sup> An emerging holistic paradigm that emphasises the importance of the wilderness environment and lifestyle in healing is “ecopsychology” (see Roszak, Gomes & Kanner, 1995).

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Therapeutic wilderness camping involves long-term residential camping in primitive accommodation in an isolated area (see Gass, 1993, p10). Typically, the isolated setting underscores a model of community living. Emphasis is placed on the development of pro-social relationships through a structured program of behaviourally moderated privileges. It can be distinguished from ‘base camp wilderness therapy’ through its extended time-frame format (usually a minimum of 12-15 months full-time). Additionally, a focus is given to the comfort that comes from individual effort in shaping the environment through hut building, furniture making, etc. The setting also often involves a developed site with permanent fixtures and ancillary buildings and facilities.

***Wilderness and Adventure Therapy versus Enrichment versus Recreation***

Based on the surveyed aims and program descriptions of a number of different adventure therapy programs for families Gillis, Gass, Bandoroff, et al. (1991) placed these along a uni-dimensional continuum representing “...the depth of intervention used...”(cited in Gass, 1993, p74). This is represented by Figure 1 (adapted from Gass, 1993).

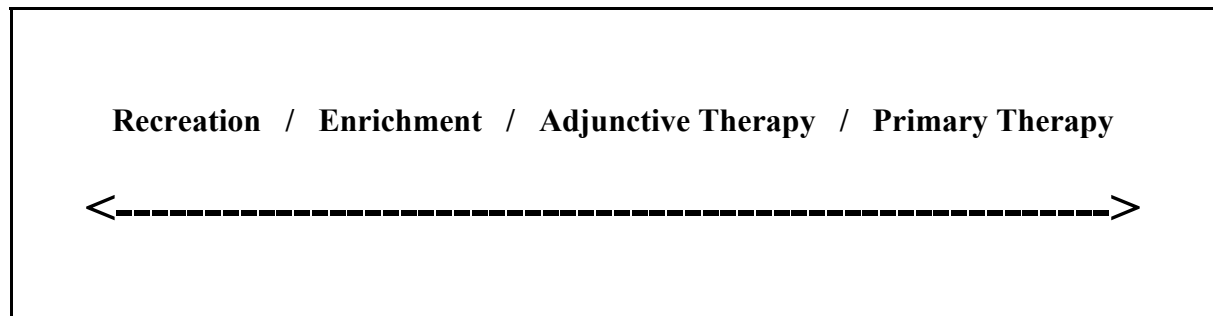


Figure 1.

The level of ‘depth’ is determined according to the following surveyed factors; specific needs of the client and the complexity of therapeutic issues, background training and therapeutic expertise of the therapist, length of time, context of the client, presence or absence of follow-up, availability of adventure experiences, and therapist’s ability/limitations in using adventure experiences in his/her treatment approach (from Gass, 1993, p74).

However, rather than a graduated continuum, it would seem even more useful to highlight distinctions based primarily on the presence or absence of therapeutic procedures, such as an assessment and diagnostic formulation, specificity of treatment objectives that relate to causative processes, and the use of an individual treatment plan (Figure 2.). Length of time, context of the client, complexity of client’s therapeutic issues, availability of adventure experiences and the therapist’s ability/limitations in using adventure experiences in his/her treatment approach, although related are functionally independent of whether a therapeutic approach is being utilised (according to the definition used here).

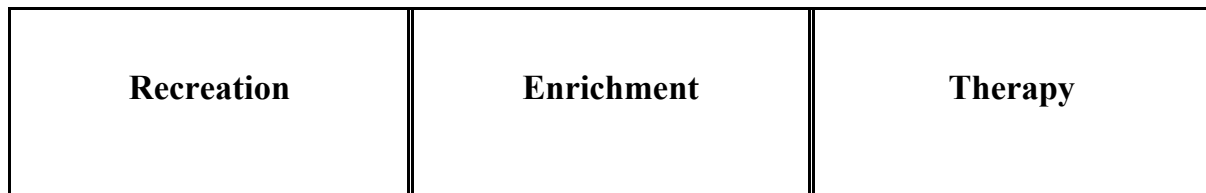


Figure 2.

As described above, *therapy* involves the treatment of an underlying dysfunction which seeks a specific change following a diagnostic analysis of a long standing problem or behavioural pattern (Crisp, 1996).

*Enrichment* is the provision of a positive and potentially beneficial experience which can enhance the client's position relative to their disorder or dysfunction but does not attempt to directly address the underlying cause of a client's problem. Any therapeutic change, which may occur is likely to be unpredictable and unplanned and may be transitory in nature. This likely result occurs because the underlying process which maintained the dysfunction would probably still remain. Indeed, many practitioners report concerns regarding the short-lived nature of some therapeutic changes they had seen clients make because underlying contributing and maintaining factors such as family issues or peer influences were not addressed. Enrichment interventions typically aim to give the client a positive experience which is intended to be of benefit. There is no, or at most only a cursory attempt to understand the causal or maintaining processes underlying the client's dysfunction. Indeed, interventions are commonly made on the assumption that the experience in itself will move the client towards psychological health. That is, individualised outcomes for the client are not specified nor deliberately worked towards.

Here we can see that although enrichment may not directly deal with the process underlying dysfunction, it is still valuable as the experience may indirectly move the client to a more advantageous position relative to their problem. Alternatively it may strengthen a client's resources or coping mechanisms against the factors causing dysfunction following treatment. An example would be to increase self-esteem for substance abusers rather than deal with the causes of substance abuse itself, such as depression or isolation or sexual abuse, etc.. However, as the process underlying the dysfunction is likely to be unchanged, enrichment does not constitute treatment of the disorder, and is therefore importantly different from therapy.

*Recreation* lies in contrast to both therapy and enrichment, particularly in the assumption of adequate functioning and psychological health. Here, the individual will extend their normal functioning to greater levels of achievement based on a spontaneous learning process which is determined by the interaction of the individual with experience. Clearly the aim is not to set out to address an individuals' problem but to enhance achievement processes. Again, where an individual may be able to increase achievement this is likely to be of benefit but clearly does not involve treatment of dysfunction, and therefore is not therapy.

In practice, the above conceptual distinctions are typically drawn by the presence or absence of a number of important elements. Not least is an implied or explicit contract between client and service provider (see Ringer & Gillis, 1995). This contract includes the intended aim, and therefore outcomes of the intervention, the role the client will take, including the degree and type of disclosure made, and what the role of the person providing the intervention will take with the

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client, that is, as therapist, facilitator or educator. The steps of making some form of diagnostic assessment and deriving a treatment plan based on the specific individual circumstances of the client are crucial elements of a therapeutic process. Further, drawing on a knowledge base and theory about the type of dysfunction or disorder during assessment will guide a therapeutic approach. On the other hand, enrichment and recreation typically takes a universal or standard approach to all clients that relates little to a theory of therapy or psychological disorder.

An analogy may be useful to illustrate these points. In a physically normal person, exercise such as running may be highly beneficial to increase fitness and improve quality of life. However, for someone with a broken leg in need of treatment, what is ‘therapeutic’ is a treatment intervention which takes account of the nature of the dysfunction (ie. Diagnosis of the type and site of the break, and a re-aligning the bones into the correct position) along with a treatment plan that is based on a knowledge of the healing process (ie. immobilisation, followed by graduated specific exercises which are reviewed and modified), and so on. While gentle, cautious walking may be an adjunct to the treatment process at the appropriate time (like enrichment), and running becomes beneficial once the limb is functional (like recreation), neither of the latter two are sufficient as a treatment or therapy for a broken leg.

***Uni-modal therapy versus multi-modal therapy versus adjunctive enrichment***

While enrichment has been differentiated from therapy in the previous section, there are clear differences in the mode of wilderness and adventure therapy which hold important distinctions from what can be termed ‘adjunctive enrichment’ (Figure 3.).

<b>Recreation</b>	<b>Enrichment</b>	<b>Uni-modal Therapy</b>
	<b>Adjunctive Enrichment</b>	<b>Multi-modal Therapy</b>

Figure 3.

Uni-modal Therapy is where wilderness or adventure therapy is the only therapeutic intervention used to treat a disorder. There may be supporting clinical activities surrounding this including such things as an assessment process, case management and follow-up, but the primary therapeutic intervention is the wilderness or adventure therapy. Group size may vary but tends to be similar to other group therapies (ie. 6-8). An example of this includes the Lifespan Wilderness Therapy Program. These types of interventions are typically carried out by highly qualified clinicians with a broad range of therapeutic skills. This should be contrasted and compared with Gillis, et al.’s (1991) description of ‘primary therapy’.

Multi-modal Therapy is where wilderness or adventure therapy is combined with other therapies either concurrently or in series. There is frequently a clear clinical rationale used to guide the way the therapies are combined. Common examples include combining adventure therapy with individual therapy or group therapy as part of an overall therapeutic program (concurrent: eg.

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Eagleview Hospital), or individual or family therapy prior to, or following a wilderness therapy intervention (in series: eg. The Browne Centre, Adventure Development program). The objective of this paradigm is that the different therapies combined will have a complimentary and compounding therapeutic effect.

This is to be differentiated from adjunctive enrichment. Gillis, et al's continuum model uses the term "adjunctive therapy" where it is implied that wilderness or adventure therapy as an adjunct to other therapies involves a lesser (therapeutic) "depth" than "primary therapy". Examples which contradicted this notion were found, such as a number of therapeutic wilderness camping programs. A more useful and accurate distinction can be made between programs which use wilderness and adventure experiences as an adjunctive enrichment to other therapies, and those programs which use multi-modal wilderness and adventure therapy with conventional therapies.

In the former, the wilderness or adventure enrichment does not involve therapeutic practices, while in the latter the therapeutic process of the wilderness or adventure therapy intervention may be just as involved as uni-modal therapy. It seems more accurate and more useful not to use the term 'adjunctive therapy', but rather to differentiate between 'multi-modal therapy', and 'adjunctive enrichment'. Similarly, Gillis, et al's notion of a continuum of therapeutic depth seems less helpful than discrete delineation. By my definition above, either something is therapy, or it is not.<sup>3</sup> What should differentiate the two is whether therapeutic procedures are instituted (therapy) or don't occur (enrichment).

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<sup>3</sup> In the same way someone is either a 'therapist', or they are not. You cannot be 'a little bit' of a therapist, and someone else 'very much a therapist'.

### **3 Typology of Different Programs<sup>4</sup>**

#### **The Programmatic Nature of Wilderness and Adventure Therapy**

From outdoor education origins, and through the practical necessity of providing the physical, safety and support resources for wilderness and wilderness-adventure therapy, interventions have been conducted most frequently in a 'program' format. While group, trust, initiative and problem solving activities usually require minimal physical resources, most other adventure therapy and wilderness therapy interventions additionally require substantial technical, support and safety resources.

Often, the 'frame' within which wilderness and adventure therapy is conducted may be dictated by the resource limitations, or opportunities available (both man-made and natural). For this reason, most therapy tends to be programmatic in its location, time frame, activity types and so on. Where there are greater options in this regard, wilderness and adventure therapy interventions may be better tailored to client need, or altered to be more appropriate to the therapeutic progress of the clients over time.

Many programs including therapeutic wilderness camping and wilderness expedition programs have established frameworks which are based on therapeutic practices, but which are clearly programmatic in the manner in which interventions are implemented. For example, developing a daily or weekly timetable and a universal behaviour modification system based around levels of privilege clearly constitute a program in their conceptualisation and implementation. This approach, although apparently effective, is unusual when compared with conventional clinical application of behaviour modification, which is highly individualised. Wilderness and adventure therapy programs which use a flexible, eclectic approach depending on individual client need, and events as they unfold are much closer to conventional therapeutic practice.

#### **Uni-modal and Multi-modal Based Programs**

A number of different approaches I observed fall into the following definitions.

##### ***Uni-modal programs***

Of those investigated, uni-modal programs tended to be longer-term approaches such as wilderness therapy and therapeutic wilderness camping programs. While no other forms of therapy were undertaken, some screening and assessment sessions were often included prior to the therapy intervention, and/or parent contact was maintained for the purposes of discharge planning and other case management needs. A good example of this type is the Lifespan

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<sup>4</sup> A good discussion of the variety of therapeutic and enrichment programs in the USA is given in Davis-Berman & Berman (1994, p 61-84).

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Wilderness Therapy Program (which also functions as multi-modal depending on client need) and Aspen Youth Alternatives.

### ***Multi-modal programs***

These programs were the majority of those investigated, and spanned a range of settings from clinical in-patient (eg. Eagleville Hospital), comprehensive mental health facilities (eg. Inner Harbour Hospital), experimental out-patient programs (eg. The Browne Centre), therapeutic wilderness camping programs (eg. Three Springs), and wilderness and adventure therapy (eg. Colorado Outward Bound School Survivors Of Violence program, and the Adventure Development program).

Most commonly, the wilderness or adventure therapy was combined and integrated with parent and/or family therapy either concurrently or in series. This indicates the clear need to address broader systemic issues, which is consistent with conventional clinical practice. In larger, highly structured programs, other group therapies such as drama and art therapy, equestrian therapy, horticulture therapy, etc. were combined with wilderness and adventure therapy. Less common was the routine combination of individual therapy with wilderness and adventure therapy. This may be indicative that most programs tended to emphasise the working of individual issues through the group, or that any unresolved individual issues are addressed prior to the wilderness or adventure therapy intervention.

### **Adventure Therapy Based Programs**

Typically shorter term, part-time or one-off over several days, adventure therapy programs tended to be facility based. Examples of this include The Browne Centre, Brathay Hall and Project Adventure LEGACY program. However, the latter two sometimes undertook short camping expeditions. Clinical programs were multi-modal incorporating other group therapies such as Eagleville Hospital, while some non-clinical programs were integrated with out-patient family therapy such as The Browne Centre.

### **Wilderness Therapy Based Programs**

These tended to be medium to long-term and expedition based. They were conducted where and how the environment would allow. They tended to be either larger scale such as Anasazi Foundation and Aspen Youth Alternatives or shorter-term and single group such as with the Lifespan Wilderness Therapy Program and Adventure Development program. The former type used a multi-level staff supervision model where direct-care staff operated a universal approach under supervision, and the latter type tended to use a small staff of fully trained mental health professionals who used generic group therapy approaches, adapting interventions to the individual needs of clients.

### **Wilderness-adventure Therapy Based Programs**

These programs were less common but did exist where environmental conditions were favourable. Examples include the Basecamp, Inner Harbour Hospital, and Colorado Outward Bound School SOV program. In practice, all of these programs would undertake shorter



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wilderness therapy expeditions as well as using wilderness-adventure therapy. Santa Fe Mountain Centre uses this approach in combination with community building activities with a strong emphasis on adapting interventions to reflect cultural, ethnic and native American interpretations.

### **Therapeutic Wilderness Camping Based Programs**

These full-time, residential programs tended to be easier to differentiate from other approaches because of the length of program (usually at least 12 months) and the full-time residential setting (7 days per week, 52 weeks per year). Examples are Talisman School at Camp Elliott and Three Springs. There was often an emphasis on broad-ranging re-socialisation through structured privilege systems using the small community that was created as part of the program. Wilderness and adventure therapy was often used extensively as part of this overall approach. Here the program provided a base community experience within which other therapeutic approaches were included, as well as adapted mainstream schooling.

## **4 The Influence of Context: Economy, Culture & Traditions**

It quickly became apparent that broader systemic and social factors have influenced the establishment and growth of wilderness and adventure therapy in the three countries visited. These variations were also apparent regionally, particularly within the USA. For that reason the following tentative hypotheses and observations are included for consideration. An excellent historical account of the development of wilderness therapy programs in the USA is given in Davis-Berman and Berman (1994).

### **Macro Level**

Health systems varied between countries which appeared to significantly influence the nature and development of wilderness and adventure therapy services. For instance, in the USA the dominance of a large private health system allowed innovative programs to develop and expand. In the UK and New Zealand with a reliance on the public mental health system, treatment services typically stayed within conservative bounds of traditional practice. In these countries innovative programs seemed to have been established in non-mental health sectors such as youth welfare and private outdoor education centres in the UK, and special education services in New Zealand. Consequently links between mental health services and these programs were poor, meaning access for mental health clients became difficult (Basecamp, Brathay Hall).

In the US, access was a significant issue to those with social disadvantage because of the predominance of the private sector in the health system. However, some programs offered scholarships or off-set costs for the economically disadvantaged through higher earning corporate work.

Social class appeared to be an issue in relation to the values many programs in all countries were implicitly encouraging. Not surprisingly, many programs reflected white, middle-class values, particularly around cultural and group norms and inter-personal behaviour. The degree to which this occurred seemed related to the history and traditions embraced by some programs. However, there were some programs which placed a high priority on class and cultural congruence in their service orientation. Notable examples include Basecamp, Santa Fe Mountain Centre, and Colorado Outward Bound School. Santa Fe Mountain Centre saw one of its primary service aims as local ethnic community building and community collaboration.

In a similar way, secular religion significantly shaped one program studied: Anasasi Foundation. Here, values of the Church of Latter Day Saints (Mormon Church) were central in concepts of mental health and family relationships. Daily bible study and parent education in religious philosophy were an integral part of the treatment process.

National history influenced different models significantly. Examples of this are Brathay Hall, which is based on the tradition of character development and personal challenge stemming from events such as the second world war and; therapeutic wilderness camping programs in the southern USA which stem from the history of early pioneer settlement and native American culture. While in the south-west USA, native American life, wilderness exploration and

pioneering history has shaped the format of those programs to be more expedition based.

Cultural notions of mental health seem to have also had an impact on the visibility and community acceptance of mental health services generally. Mental health problems seem to hold a degree of stigma in the UK, which may be diverted into notions of ‘youth at risk’, delinquency, poor character development or class related issues such as social and economic disadvantage. Whilst in the USA, mental health services tend to be seen as a solution for problems such as delinquency, family break-down, family dysfunction and so on. Social and economic disadvantage seem to be given lesser importance as a factor in mental health problems and appears to be associated with greater stigma.

### **Micro Level**

Historical, cultural and class influences seem to have lead to different values and attitudes amongst clients, particularly in relation to authority, the importance of autonomy and individualism and group affiliation. These differences have significant influences over therapeutic approaches and expectations of the therapist when conducting wilderness or adventure therapy. While class issues and expectations appear to be significant in how clients are worked with in the UK, things like street gang culture, attitudes to authority and group affiliation shape methods for USA clients.

Certainly, there seem to be significant differences between Australian adolescent group behaviour and that of other countries. For example, while Australians tend to value independence and coping by oneself, Americans appeared to place a high value on gaining support and acceptance from the group. While, standards of behaviour such as the demonstration of respect, honesty and supportive confrontation and feedback were relatively unquestioned by USA clients, this is less so in Australia. Here, anti-authoritarian attitudes and conflict avoidant behaviour is more prevalent. Again, while authority of the therapist is a relative ‘given’ in the UK and USA, this is often a source of tension with Australian clients. Group approaches such as Adventure Based Counselling (Schoel, Prouty and Radcliff, 1988) require adaptation to take account of these cultural differences. Indeed, it may be the case that such approaches are not as effective for many Australian clients as they are in the USA where they were developed.

## **5 Key Findings & Conclusions**

### **Current Status and Future Directions of the International Field**

It can be concluded that much innovation and program development has occurred in the USA in recent decades, and as such the literature is dominated by North American authors. This places the USA to lead the field internationally which is evidenced through international memberships with the Association for Experiential Education. While countries will, and should develop unique approaches and practices for local conditions, the field in the USA will tend to remain a leading reference point and be a source of information about best practice in the foreseeable future. However, it is important to consider the influences of local issues and how these shape the field, and to appreciate the unique context, needs and opportunities in Australia.

It is clear that health and mental health systems in the USA underpin many of the directions the wilderness and adventure therapy field takes. Concerns and debate around issues of practice seem to be often influenced by economic concerns. Staffing and program format are apparently shaped significantly by funding opportunities and constraints. Indeed, it was not the lack of research that was considered a potential obstacle to the field's development, but funding mechanisms of insurance companies; wilderness and adventure therapy are relatively cost intensive (Michael Gass, private conversation)

This appears to be a reason why brief, strategic and solution oriented therapies, including system approaches, heavily influence models and theoretical development (as is the case generally in the therapeutic professions in the USA). Psychodynamic and other established theories were seldom discussed as offering much understanding. While the relative benefits of different therapeutic approaches will be a point of debate for some time, local factors in the USA (that are not so relevant in Australia) may preclude the development of alternative models which may serve the field well here.

Concerns and debate over the term "therapy" in the USA appear to accompany fears that how this term is defined may exclude many non-licensed or non-therapeutically trained outdoor educators. There is a common belief that the adventure experience is so powerful that it is inherently therapeutic regardless of aims, knowledge, and possibly even skill of practitioners. Not-with-standing the power and value of an expertly delivered adventure experience, it is extremely important to keep separate the concept of *therapy* to a narrow and strict definition in this context as not doing so casts confusion and needless debate over semantic, theoretical and practice issues. At this stage, the profession is both enriched but also handicapped by a diverse range of professional and theoretical affiliations each with their own professional agenda and terms of reference. This continues to lead to obfuscation in language and theoretical assumptions. While it may take some time to form a universal theoretical and semantic base, authors should endeavour to define their terms whenever entering the debate.

The implications for Australia are that while the bulk of literature will come from the USA, Australia needs to maintain and develop local arenas focussed on local needs for developing and debating theoretical and practice issues. There is some risk that one method and theory will dominate (for example, little is published from a psychodynamic or other perspective). There is

a

need to evaluate the relevance and efficacy of North American (or British) approaches and adapt these to local social, cultural, health care and environmental conditions. An indicator of this point may be the limited impact *Project Adventure* has had on the outdoor education scene in Australia since it was established here in the late 1980's, compared with its success in the USA.

Another significant factor that needs to be considered is that Australia has a long and strong tradition of outdoor programs for normal (and to a much lesser extent, mental health) populations. Historical socio-cultural origins of these are similar to the USA, as an early pioneering history, camping programs such as the Scouting movement, and an even earlier establishment of Outward Bound in the mid 1950's. It is for these reasons that outdoor education is well established in this country, the exception being the application of outdoor activities as a treatment of mental health problems.

### **Program Design versus Practitioner Competencies**

Program format, structure and activity types undoubtedly shape the experience for the client and create the frame for therapeutic work. However, the skills of the therapist significantly determine the specificity of psychological and behavioural changes necessary for treatment of underlying dysfunction (Davis-Berman & Berman, 1994; Gillis, 1995). Often these processes and techniques are complex. Frequently with adventure therapy programs, a detailed assessment of the individual or family is used to determine activity selection and metaphoric framing of activities, while elaborate de-briefing and 'processing' following the activity seeks quite specific outcomes. Additionally, in wilderness therapy programs therapists typically bring high levels of skill in case analysis and a range of group therapies. Also, wilderness therapists need to be able to manage aggressive behaviour, to respond to crises and manage psychiatric emergencies in isolation from other assistance. For an excellent discussion on this and related issues see Berman (1996).

Currently, there is some debate around specific competencies for the adventure and wilderness therapist, *as a therapist*, in addition to the safety and technical skills needed for the role. The Association of Experiential Education is in the process of drafting guidelines for this. There is an additional issue of wilderness and adventure therapy teams where the therapeutic skills of one person are brought together with the safety and technical skills of another person to cover all competency areas. Some practitioners hold concerns about the adequacy of these arrangements. Simply adding these skills together is not enough to ensure good practice, and how the skills would work together in a complimentary way is perceived as particularly problematic (Colin Goldthorpe, private conversation).

Most practitioners I discussed this with conceded the expediency of combining two people with requisite skills and would acknowledge that to have therapists "cross-trained" (to be fully competent in both safety and technical as well as therapeutic areas) was preferable. The arguments against cross-training were consistently based on economic and practical considerations which were of most concern in the USA. That is, any form of training in the USA (as a mental health professional or in outdoor skills) was very costly to the individual compared with training in New Zealand and Australia.

From a **program** perspective of those I observed, practitioner roles allow a rough dichotomy to be drawn. On one hand, larger scale programs employed many staff within a hierarchical supervision structure. Here, lay-counsellors under supervision of qualified and licenced counsellors undertook the bulk of direct care. They typically took the role of administering a well developed, universal behaviour modification program - most commonly based around a level system which accorded privileges upon achievement of desired behaviour over time. Progress was reviewed routinely and any other issues were addressed through case planning meetings. Additional intervention strategies would usually be implemented by the lay-counsellors under supervision within the structure of this universal behavioural program.

On the other hand, other programs which were usually shorter and smaller, had fewer staff but they were usually qualified mental health professionals with additional wilderness and adventure training. The wilderness or adventure medium was used for the application of sophisticated therapeutic approaches such as systemic, strategic, narrative interventions as well as group psychotherapy. Here, complex assessment of the client (and/or family) was inter-linked with therapy and interventions were highly individualised. Typically, client change appeared more rapid and the therapeutic approach was reviewed and modified more frequently (ie. daily).

This dichotomy could be summarised in that longer-term, larger programs emphasised generic program structures to achieve broad based universal changes, while shorter-term programs emphasised therapist analysis and eclectic, selective intervention to achieve individualised outcomes. According to the definitions given earlier, the former (programmatic type) borders on enrichment in its approach, while the later (practitioner type) would constitute therapy.

### **Client Types, Diagnostic Issues & Differential Outcomes**

Practitioners reported some variation in client outcome between wilderness and adventure therapy. Client factors reported to be associated with better outcomes included;

- having a physical orientation,
- capacity for reflection,
- environmental awareness,
- group composition,
- families with the ability to think metaphorically (family adventure therapy),
- recency of trauma or mental health problem,
- internalizing disorders,
- family support,
- greater understanding of group processes,
- educational success,

Those clients thought to respond well included; voluntary clients (compared with involuntary clients), older and female adolescents, suicidal and depressed clients, and clients with low motivation and low self-esteem. Oppositional-defiant Disorder & Conduct Disorder (if spread amongst other clients), Borderline Personality Disorder and younger males were thought to respond better here than to conventional therapies, but all require longer treatment.

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Outcomes were thought to be poorer for males with long established behavioural patterns, clients with IQ less than 80, clients with sociopathic traits, Attention Deficit Disorder with hyperactivity, Conduct Disorder and family dysfunction. Substance abusers were felt to be more difficult to motivate.

Here Conduct Disorder seems to have both good and poorer outcome. This possibly indicates some other factor which mitigates their response to therapy. Some general comment on applied issues and the value of wilderness and adventure therapy for different mental health problems follows.

#### ***Conduct and other Behavioural Disorders***

These disorders were often the target of the longer term wilderness therapy and therapeutic wilderness camping programs. A broad range of pro-social behaviours are modified using a well developed and structured universal behaviour modification program based on a level system of privileges. With a homogenous client group with behavioural problems this generic approach appears highly successful in making significant changes. Work is typically done with parents to develop better parenting approaches for when the client returns home. It would seem that the isolated, residential and long-term nature of this approach are important factors in its success.

#### ***Personality Disorders***

Not often the stated target client group of any programs, many programs did treat a significant proportion of clients who had emerging personality disorder, or who were at risk of developing one. While no one type of program seemed most suited to this client group, different program types seemed able to offer many important therapeutic benefits. The residential or wilderness based programs appeared particularly so because of the emphasis on an intensified therapeutic milieu and the scope for developing longer-term relationships with therapists and peers. Tippet (1993) provides an excellent discussion of some of the developmental and relational issues that underlie wilderness and adventure therapy for borderline adolescents. With these clients, the opportunities for peer role-models, corrective relationships with therapists as parent figures and development of positive risk-taking, living skill competencies and reality testing are very significant. Such appropriate and intensive therapeutic opportunities seldom exist in conventional treatment modalities. The reader is referred to Tippet (1993) for a discussion of applications of wilderness therapy with borderline personality disordered adolescents.

#### ***Psychosis***

Clients in recovery from psychosis are often included with other adolescents in adventure therapy and less often, wilderness therapy programs. While adults in this client group have psychosis specific programs, this seems not to be the case for adolescents. Because of the psychiatric/medical nature of the disorder, these adolescent clients would generally be treated with conventional approaches such as in-patient admission and out-patient monitored medication. Because of the need for relatively intensive medical monitoring, the financial constraints of this presumably preclude wilderness based programs. Clinical experience in Australia suggests that those recovering from psychosis do benefit from wilderness based therapy as a form of rehabilitation (Pawlowski, Holme, Hafner, 1993). The nature of a simplified and stress reduced environment with an emphasis on living skills, natural and logical consequences and opportunities for reality testing suggest significant potential in accelerating the recovery process.

Of significant benefit to this client group is the ability to engage adolescents who may be reluctant to become involved treatment because of aversive experiences with mental health services, stigma, and/or a lack of insight into their condition. Anecdotal clinical experience suggests that many adolescents with psychosis are attracted to wilderness and adventure therapy programs because of their 'recreational' appearance. Once clients are engaged, it then becomes possible to address many of their core mental health issues as they manifest through the wilderness or adventure experience.

### ***Seriously Emotionally Disturbed (S.E.D.)***

The term **SED** was often used to define target client groups for clinic based adventure therapy programs. This includes clinical depression, clients with suicidal ideation, anxiety, minor behavioural problems, victims of abuse, severe family dysfunction, identity and self-esteem problems. It was considered that these client types responded well to multi-modal adventure therapy which included other therapies such as individual and group psychotherapy, and family therapy. While SED clients were the specified target group for many programs investigated, wilderness therapy and therapeutic wilderness camping programs would also work with more homogenous client groups such as oppositional-defiant and conduct disorders.

### ***Physical & Sexual Abuse***

While many programs worked with clients who had histories of physical or sexual abuse, programs with this as a specified target client group included Colorado Outward Bound School Survivors Of Violence program (Webb, 1993) and Santa Fe Mountain Centre. These client specific programs typically worked alongside conventional out-patient treatment centres, and usually worked with clients in the latter stages of treatment. Usually wilderness-adventure therapy was seen as adjunctive to individual or group counselling aimed at addressing abuse issues. Development of trust, the support of group members and same or mixed sex adventure therapists were important considerations in program planning. The Woodswomen Sexual Violence Survivors Outdoor Program (1996) has produced a pamphlet of guidelines for those working with this client group. The re-experiencing of fear where clients could learn active self-control, self-efficacy and empowerment *in vivo* were major treatment objectives and seen to be pivotal therapeutic experiences in the overall treatment process. See Webb (1993) for a detailed discussion of therapeutic issues. Correcting or improving body self-concept were also seen as important therapeutic objectives.

While programs for court sentenced youth often had clients who were perpetrators of abuse, programs specifically for the treatment of perpetrators were uncommon. Project Adventure's LEGACY (Learning Empathy, Gaining Acceptance, Changing Yourself) program being the only one investigated. Here, a male group of adolescent and pre-adolescent offenders undertook a long-term, residential, predominantly adventure therapy program. The emphasis was on developing empathy through group adventure therapy exercises including ropes courses and group initiative games. It was found that the long time period was necessary to re-socialise clients, while those with sociopathic traits tended to respond less favourably. The program had only been running for 11 months and so no formal results from evaluation measures are available. However, anecdotal evidence is positive especially where family support exists. A brief discussion of another program - Treetop Adventure - is given by Kjol and Weber (1993).

### ***Drug & Alcohol Abuse***

Wilderness and adventure therapy programs for adolescents with substance dependence and



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abuse as primary presentations appeared to be not very common. This is in contrast to many substance abuse specific programs for adults (eg. Eagleville Hospital). However, many adolescent programs had clients with drug and alcohol abuse secondary to mental health problems. This is consistent with general clinical trends in adolescence. That is, substance abuse and dependence commonly accompanies disturbance in mental health and/or external stressors (such as sexual and physical abuse, family problems, unemployment, etc.). Clinically, substance abuse or dependence in adolescence is typically secondary to one or more of these issues. For this reason it makes clinical sense that any treatment be addressed primarily to the cause of the substance use, and that any treatment of substance abuse or dependence be done in context of broader treatment or intervention which addresses the above issues.

Generally, those programs whose clients had substance use issues ensured that treatment was aimed at addressing causative factors such as mental health problems. Wilderness programs were not seen as appropriate settings for detoxification. Wilderness and adventure therapy as a treatment for substance abuse per se was seen as only useful in post-detoxification rehabilitation and relapse prevention.

### ***Suicide prevention***

Many clients of programs had histories of attempted suicide and/or were at significant risk of suicide. Because of mental health problems such as depression and self-harming behaviours, or poor social connectedness, poor coping strategies, a low tolerance to stress, and so on. Because these clients represent a high risk group, the place of wilderness and adventure therapy in suicide prevention is an important consideration.

While few programs talked of this as a major aim, research has generally found a consistently positive impact on locus-of-control which is considered a central factor in learned helplessness and suicidal cognition (see Abramson, Seligman, & Teasdale, 1978). Additionally, certain unique features of this type of therapy have significant prophylactic value. Factors such as the development of resilience to stressful events, flexibility of coping responses, help-seeking, and social connectedness reduce suicide risk (Mason 1990). Specifically, wilderness and adventure therapy is likely to be especially effective in the prevention of suicide because of the following features: development of trusting and supportive relationships, the value of seeking assistance to solve problems, emphasis on successful adaptation and coping, as well as the development of a broad range of problem solving skills.

Dealing with failure, perseverance with problems and enlisting support from others to solve problems are generic themes which run through most elements of wilderness and adventure therapy. The direct analogy between resolving such issues and building protection against suicide is obvious.

### **Holism versus Reductionism**

Paradigms that are central to wilderness and adventure therapy are ***holism*** on one hand, and ***reductionism*** on the other. Balanced co-existence of these two seemingly contradictory paradigms is an essential issue in best practice.

The paradigm of holism extends beyond the individual to incorporate a systems and broader systems framework such as the influence of family, community and culture. None-the-less, at

the individual level, a unique feature of wilderness and adventure therapy is its ***multi-sensorial learning modality***. The intensity of environmental and physical demands engages all sensory systems in a learning and change process. This is particularly important for clients who may be less able to utilise verbally based therapeutic approaches, as was frequently mentioned by practitioners.

In addition to this is the ***multi-functional*** nature of activities. That is, wilderness and adventure activities simultaneously develop a diverse range of skills. This includes personal organisation and living skills such as cooking and hygiene, physical fitness and self-care, judgment about risk-taking, regulation of affect such as anxiety and anger, inter-personal skills including communication of concepts and ideas, expression of emotion, conflict negotiation, empathy and insight into social processes, and cognitive development such as thinking styles and logical reasoning. Both the scope for clinical assessment of a client's bio-psycho-social capacities as well as intervention in all of these areas is considerably more than most conventional therapeutic approaches. It is the broad spectrum of client functions involved that makes wilderness and adventure therapy especially holistic.

Psychological research on information processing and memory strongly suggests that such integration of experience for the client is more deeply anchored because of this broad base. It is the multi-sensorial and multi-functional nature of therapy that may well account for the pervasive and accelerated rate of change reported by practitioners.

For this reason, practitioners need to be able to think at a holistic level about client needs and intervention options. In doing their work, therapists need to have firm theoretical foundations in body systems, psychological processes such as the relationship between cognition and emotion, sensory processing, as well as systemic principles of small groups, family issues and broader systems such as community and social institutions. Indeed, the capacity to analyse complex individual and group phenomena was seen to be an essential skill in the therapist (Colin Goldthorpe, private conversation).

On the other hand, in order to guide and focus a therapeutic approach, practitioners need also to be able to take a reductionistic perspective when considering treatment needs and priorities. That is, to be able to identify what problem or disorder the client is presenting for treatment and how this will manifest in an adventure activity and wilderness setting, what the nature of this disorder's etiology for this particular person is (assessment and diagnostic formulation), and what steps the client needs to take to move towards greater mental health (treatment planning). Davis-Berman & Berman (1993) and Crisp (1996) give further discussion on this point.

### **Relationship of the Field to Different Disciplines**

While the UK and New Zealand are similar to Australia in professional domains, this is less so in most states of the USA. In the USA, different professions are bound to specialised roles to differing degrees, presumably in part as a result of market place competition and economic factors. For instance, psychiatrists are largely limited to hospital based roles, diagnostic assessments and the prescription and monitoring of medication. On the other hand, social workers frequently take on clinical and therapeutic roles. Generally disciplines such as psychology, social work, and licenced generic counsellors take up the bulk of therapeutic roles.

However, the field of occupational therapy largely concerns itself with clinically based medical and rehabilitative settings.

Unique to the USA is the profession of 'Recreational Therapy' which is typically a four year college degree trained therapist who usually works in clinical settings and undertakes roles very similar to that of a psychiatric occupational therapist in Australia. Group activity based therapies are the typical realm of this profession. The less expensive (which usually means lesser trained) professions are preferentially sought for direct care roles in a competitive market place dominated by profit orientated private health insurance companies.

Drawing on a number of different treatment approaches, wilderness and adventure therapy necessarily has strong theoretical and practise links to several different disciplines. In the USA most published research and theory development is commonly psychological in nature making this discipline central in academic development of the field. However, social work is well represented in this arena also. With regard to practise issues, many techniques are being developed by a range of therapeutic and counselling professions: psychology, social work and family therapy.

By necessity, outdoor education is a common base from which the field is heavily influenced. Therefore it is not surprising that the largest professional network both in the USA and internationally is the Association for Experiential Education (based in Boulder, Colorado).

While one of the great strengths of this field is the many influences which shape practice, theory and research, its relationship to various professions is dynamic. Many people interviewed remarked that the professional broadness of its base leaves it struggling to find unity as a profession.

In contrast to the USA, professions within Australia tend to be more specialised. Those professions which concern themselves with group (or family) therapy such as occupational therapy, psychology and social work hold the strongest links with the practise of wilderness and adventure therapy here. Particularly, the paradigm of the therapeutic use of activity of occupational therapy are very similar to those developing in the field of Recreational Therapy and wilderness and adventure therapy internationally. Also, clinical research activities and academic theory development of psychologists are again similar, while family adventure therapy is very closely aligned with principles of social work and family therapy.

While these links between disciplines are conceptual, in practice mental health professionals in Australia frequently specialise in areas which develop skills beyond those which are discipline specific. This is largely because of the relative ease to undertake specialised post-qualification study (eg. family therapy, psychotherapy, and group therapy training, research degrees, etc.)

However, in Australia at this time, because of the lack of development of the field here as therapy, outdoor educators with a range of backgrounds such as recreation, teaching or youth work but with no formal training in therapy or mental health are increasingly attempting to use wilderness and adventure activities to treat mental health problems (eg. Handley, 1996). This should be of concern for the mental health field and the general public. This appears to have occurred because of the lack of awareness and knowledge by both consumers and outdoor educators about many of the ethical and clinical issues as discussed in this paper.

### **Client Rights & Ethical Issues**

It is both surprising and concerning that client rights and ethical issues don't take a greater place in the literature and discussion within the field. Issues around the development of new techniques, program models and industrial issues seemed to dominate much of the discussion about the future of the profession. Exceptions to this are the emphasis on therapist qualifications given by Davis-Berman and Berman (1994), and a nominal code of ethical practice produced by the Therapeutic Adventure Professionals Group of the A.E.E. (Gass, 1993). Despite many publications on theoretical and technical topics, papers on ethical issues pertinent to wilderness and adventure therapy are few and tend to be superficial in their coverage.

However, Hunt (1986) provides a good discussion of ethical issues related to outdoor education generally including risk-benefit analysis, informed consent (including known outcomes and side effects), deception, secrecy, captive populations, sexual issues, environmental concerns, and individual versus group benefit. This is a good starting point for extrapolation to therapy relevant issues. However, ethical issues specific to clinical and therapeutic applications need to be explored and discussed in detail.

Unique and important factors which require consideration include the following. Significant physical dependence clients have on the therapist, forming and maintaining appropriate and therapeutic boundaries where these are frequently challenged by the nature of activities and multiple roles the therapist assumes, the unique and multi-faceted role of the therapist in a living situation with his/her client (including managing 'transference' in the client and 'counter-transference' in the therapist), the use of activities which have the potential to cause injury, death or psychological trauma as a form of therapy, involuntary treatment, using methods whose psychological processes are thought to be powerful but are not fully understood, and peer group coercion to modify behaviour are just a number of complex ethical issues.

Despite the "full-value contract" for clients to negotiate with the peer group as part of the Adventure Based Counselling approach (Schoel, Prouty & Radcliffe, 1988) there are no comprehensive guidelines for therapists on the rights of clients that sufficiently address issues relating to the needs of clients in isolated wilderness programs or adventure therapy programs. While such rights would naturally vary to some degree depending on country, state and mandate of the wilderness or adventure therapy service, every program should have this written and available to clients. Some programs such as Three Springs did endeavour to do this.

### **Consumer Perspectives**

The innovative approaches of wilderness and adventure therapy hold significant novelty for consumers as a form of therapy. With this comes a need to educate consumers about what is therapeutic about these methods and how these methods are different from typical adventure experiences through outdoor education programs. There is a risk that consumers and mental health administrators will attempt to use standard outdoor education as an alternative treatment for mental health problems, and non-therapist outdoor education practitioners may be tempted to encourage this notion. This seems potentially deleterious for consumers and for public support and confidence in the field of both outdoor education and wilderness and adventure therapy.

On the other hand, consumers can see this form of treatment as attractive and non-stigmatising and so may well engage in treatment where they might otherwise not. The author's own anecdotal experience supports this. Many programs emphasised a high level of client involvement in activity selection, expedition planning, and choice of venue. This seemed a valuable opportunity for client empowerment where attention was given to developing reality orientation through planning. Much supervision and guidance was given to client decision making with an emphasis on learning about the process and building better reality-testing skills. This is in contrast to simply giving freedom to clients to be self-directed without any support or guidance.

### **Gender and Power Issues**

Many practitioners reported concerns that the field was historically and traditionally dominated by men, and that there was a perception by the general population that wilderness experiences were the domain of males. Additionally, many traditional roles for men were not necessarily positive by current community standards and tended to emphasise control of the environment (in contrast to self-control) and an external, 'acting-out' orientation. On-the-other-hand, traditional roles for females in wilderness and adventure activities were less prominent and tended to be less positive. Cole, Erdman & Rothblum (1995) is a key reference which explores many of these issues as they relate to women.

Many concerns are raised about the differential appeal to both sexes of this form of therapy. It was a consistent finding that females were just as interested in wilderness and adventure approaches as males in mixed sex programs. Indeed, many practitioners commented that the impact for females in these interventions appeared to be greater for females than males. This may be due to the opportunity to break from traditional roles for females.

As much of therapy involves use of the body, physical touch, peer encouragement, overnight living situations and so on, there exist unique opportunities for problems related to gender issues. Power differences that may exist in traditional roles and cultures require that peer influences be carefully monitored so as to not be exploitative nor oppressive. As many clients may have come from oppressive or exploitative relationships (for both male and female clients), there exists a high risk that inter-personal patterns may develop between clients, or between client and therapist that further reinforce their past experience. Mitten (1995) provides a good discussion on many of these issues. For therapists, it seems vital that they have a good clinical understanding of 'transference' and 'counter-transference' issues and are clear about, and skilled in maintaining appropriate and therapeutic boundaries. Mixed sex therapist teams seem important for ensuring therapist self-monitoring of client-therapist boundaries.

Aside from therapist awareness and monitoring of these inter-personal dynamics, it is also imperative that clients have access to therapist role models of both sexes. It is especially useful for therapists to model appropriate non-oppressive and non-exploitative relationships with each other and with clients where appropriate resolution of any power issues and conflict were able to be observed by clients. Therapists should be able to confidently and effectively break from traditional roles in the division of tasks, styles of inter-personal relating, and so on.

### **Community Orientation & Social Values**

Some programs had explicitly stated community aims, and Santa Fe Mountain Centre saw their primary aim as to effect community development with local and ethnic communities. They saw many aspects of wilderness therapy as being particularly useful in enhancing and developing community identity, cohesion and empowerment. Many practitioners saw therapist education about ethnic, cultural and community issues as vital in working with diverse groups. Sensitivity to ethnic and community values were seen by many programs as critical to good practise. Indeed, many programs saw that aspects of their program design, procedures and methods were implicitly endorsing white, middle-class values which may have been in conflict with the values of minority groups.

Programs such as Santa Fe Mountain Centre actively sought to employ staff from local ethnic groups. However, this was difficult to achieve at times because appropriately qualified staff of suitable ethnic background were sometimes difficult to recruit. Access to tertiary education for minority groups is presumably a factor in this.

While some programs sought to incorporate religious practises into their approach, many programs were irreligious. Again, there seemed some benefits in doing this for some populations such as the clients of Anasazi Foundation. This program was based around the teachings of the Church of Latter Day Saints. Here there is a significant emphasis on the value of family relationships and family intactness as well as teachings from the bible. It seems arguable whether such a uniform approach for any, and all clients is appropriate.

### **Principles for Best Practice & Service Design**

In addressing critical issues in best practice, Drs. Jennifer Davis-Berman and Dene Berman stress the need for the practise of professionalism at the level of existing mental health professions. This includes the disciplined application of therapeutic procedures based on established therapeutic theory.

On a practical level, they call for two key professional resources. Fully trained wilderness and adventure leaders with the technical and safety management skills; and wilderness and adventure therapists who are mental health professionals with experience in the clinical treatment of clients with diagnosable disorders. Qualified therapists should be involved in delivery of therapy themselves, or may directly supervise lesser trained counsellors in the field. They are clear about the need to increase the level of training and experience of the therapist, the more isolated the clients are from emergency psychiatric services. Further, comment was made on the need to 'cross-train' professionals in both outdoor education and therapy and develop regulatory mechanisms to ensure good practice. Finally, they argued the importance of high quality, empirical research in maintaining the highest standards of practice, and refinement of best practice generally throughout the field. See further detail in Davis-Berman & Berman (1994).

Specifically Dr Michael Gass described what he saw as essential elements in any Adventure Therapy intervention:

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- 1 Join with the family (form a therapeutic alliance)
- 2 Understand the complexity of families
- 3 Understand the systemic elements of the family and integrate this into the adventure therapy activity
- 4 Physical risk management
- 5 Need to be able to use risk to induce change
- 6 De-briefing and processing skills, especially re-framing

Drawing from the authors above and discussion with many other practitioners, and after distilling aspects of the programs investigated, I conclude the following key elements to be significant in ensuring the highest standards of wilderness and adventure therapy in the treatment of mental health problems<sup>5</sup> (based on the definitions given in the introduction).

#### ***Key Elements in Wilderness and Adventure Therapy Best Practice***

- **Systemic Framework:** any intervention or program takes account of systemic (family/significant others) and broader systems issues (class, culture, ethnicity) in such a way that these elements are involved as an integrated part of the intervention. When working with individuals, these issues inform approaches used.
- **Assessment Processes:** a thorough and individualised intake process occurs, including assessment & diagnostic formulation which assists the understanding of the mental health issue in context of medical, psychological, and social influences.
- **Treatment Planning:** a comprehensive and flexible bio-psycho-social treatment plan is used and is reviewed and modified regularly (eg. daily, weekly).
- **Flexibility:** therapeutic interventions are flexible and tailored to individual need. Individual needs of clients determine the therapeutic approach from the outset and monitoring of client progress informs subsequent interventions.
- **Integration:** all aspects of treatment, including multi-modal therapies and adjunctive therapies such as individual and family therapy are integrated in a reciprocating fashion. That is, assessment information and issues from each therapy type inform the other. Procedures and methods are developed to ensure continuity, such as group processing methods to link therapeutic issues, use of daily progress notes, therapeutic progress and assessment hand-over meetings.

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<sup>5</sup> Many of the elements listed here would not apply to enrichment programs which are not aiming to address underlying causes of mental health problems or specific or individualised psychological or behavioural changes.

- **Monitoring of Client Outcomes:** client evaluation pre & post therapy and follow-up is routine to ensure that clients have benefited. This includes a third party's perspective (eg. family/parent).
- **Theoretical Paradigm:** a clear therapeutic rationale and theoretical paradigm about psychological and behavioural change is well articulated. Established therapeutic methods are delivered by qualified staff in keeping with contemporary clinical frameworks. This paradigm is familiar to all staff and forms the basis upon which treatment decisions are made.
- **Therapist Skills:** include the ability to analyse complex individual and group phenomena. Therapists are able to respond effectively to unexpected client needs in remote settings through a broad range of clinical skills & training beyond their expected role in wilderness or adventure therapy. Additionally, given the rapid growth of knowledge in the area, therapists regularly familiarise themselves with the latest developments in theory and methods.
- **Risk Management:** physical and psychological risk management plans and procedures are developed and reviewed regularly. Standards of program accreditation are adhered to (eg. AEE program accreditation scheme). Procedures for management of medical emergencies, critical and traumatic incidents, and psychiatric crises are developed and reviewed regularly. Precaution and planning and therapist's crisis intervention skills increase as the more inaccessible and physically challenging wilderness therapy interventions become.
- **Ethical Issues:** therapists and program administrators have a thorough and practical understanding of ethical issues unique to this type of therapy (this is a regular topic for staff professional development).
- **Research:** the organisation is involved with evaluative academic research. Research findings are relayed to therapy staff to enrich their understanding of theoretical and methodological issues. Practices are reviewed in light of internal and published research.
- **Training:** the organisation has an internal staff training program or offers open enrolment courses, and maintains a culture of learning and skill development.

While the adherence to all of the above elements pose a challenge, these principles should set a benchmark for best practice. Not-with-standing, these elements should be able to be incorporated into a wilderness or adventure therapy program to varying degrees. Indeed, many, if not most programs investigated did achieve this (Appendix B).

## **6 Recommendations**

### **The Future of the Field in Australia?**



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Recent years has seen an increase in outdoor programs in Australia which aim to work with a client group defined as “youth-at-risk”. These are typically outside mental health services and are funded and staffed by education departments, youth agencies and departments of correction. The approach of these programs has been to use outdoor education with “troubled youth” to enhance self-esteem or improve behaviour related to educational needs, criminal behaviour or drug and alcohol use. Target groups are seldom defined more specifically than “youth-at-risk”(of drug and alcohol abuse, unemployment, etc.) or clients of “juvenile detention centres” and trained mental health professionals are rarely employed or consult to these programs. Additionally, program outcome objectives are frequently general (not individualised) and relate simplistically to the underlying causes of mental health problems. For these reasons, these programs fall into the category of enrichment.

Most recently, mental health services are seeking to utilise outdoor adventure activities as adjunctive enrichment (Pawlowski, Holme and Hafner, 1993) and multi-modal therapy (Kingston & Dwyer, 1996; Crisp & Aunger, in press). While there appears to be a clear and growing interest in developing and extending wilderness and adventure therapy in mainstream clinical services, the scarcity of proven models in Australia means that administrators and clinicians are unsure about how to proceed.

Where attempts have been made to introduce wilderness and adventure programs into clinical services there has frequently been a total reliance on outdoor educators with no training in mental health to advise on how this is best done. Similarly, clinicians and mental health administrators commonly have no experience with, or understanding of programmatic or clinical issues pertinent to wilderness and adventure therapy. Anecdotally, this has lead to adverse outcomes and preventable psychiatric emergencies in some instances. Such a trend is likely to lead to understandable reluctance by mental health administrators to incorporate wilderness and adventure therapy into mainstream mental health services.

It is my belief that this issue alone poses the greatest threat to the acceptance and development of the field here in Australia. It is imperative that the mental health field, politicians and the general public can see the value, validity and efficacy of wilderness and adventure therapy in order to gain the necessary financial and public support. Any adverse outcomes or incidents could quickly see this form of intervention lose its professional and administrative support and have its value and role as a treatment modality questioned. General acceptance of the notion of using high risk activities which induce stress to treat particularly vulnerable people is likely to remain conditional upon freedom from adverse incidents over a sustained period.

There is currently a relatively low demand from mental health services (however this is increasing). Economic and philosophic conditions are favourable to wilderness and adventure therapy being pervasively integrated into existing mental health services as the demand increases. There is substantial need to attract and engage adolescents and cost efficiently treat those with more severe mental health problems who are unsuitable for, or have not responded to conventional therapies. This is especially so for those who pose a high risk for suicide or the development of serious mental health problems in adulthood.

Australia is exceptionally well placed to establish the highest possible quality wilderness and adventure therapy field. A number of key factors make this so. First, Australia has an extensive and highly developed outdoor education industry with good infrastructure and professional

support. Every State has an active outdoor education association which is represented nationally by the Australian Outdoor Education Council. Additionally, a standards and accreditation mechanism is being developed through the Outdoor Recreation Council of Australia (O.R.C.A.). These mechanisms are well placed to ensure high standards of technical and physical safety in activity practices. Second, Australia has many suitable venues for conducting wilderness therapy because of its low population density and relatively abundant natural environments.

Finally, tertiary education is easily accessed in Australia, so obtaining qualifications as a mental health professional as well as gaining cross training in wilderness and adventure activities is realistic and achievable. Indeed, many people are currently striving to do just this now. This is in contrast to the UK and USA where the costs of training in either field can be quite prohibitive. Indeed, this fact alone probably accounts for most of the resistance to acceptance of mental health training as a basic qualification as a wilderness or adventure therapist. Further, minimum qualification to practise as a mental health professional requires a greater number of years in the USA compared to Australia. Currently college training in the USA is 9 years (PhD) for psychologists and 6 years (Masters degree) for Social Work compared to 6 and 4-5 respectively in Australia. Additionally, Occupational Therapy is only 4 years of university training and appears an excellent base qualification (in addition to wilderness and adventure training) to practise as a wilderness or adventure therapist.

### **Rationale for a Professional Practitioner Model Versus Program Development**

With large populations in both the UK and USA, each country could support stand alone wilderness and adventure therapy programs. In contrast to mental health systems in Australia (Department of Health & Community Services, 1994, 1996) comprehensive and uniform public mental health systems do not exist. These private mental health services appeared the only ones capable of employing comprehensive and innovative treatments. These agencies are able to develop stand alone wilderness or adventure therapy based programs to fill a service gap and respond to local demand for mental health services. With this open market consumer base, larger scale programs are more viable.

In the USA there was an obvious trend amongst developing programs to broaden their services to include mainstream out-patient services and conventional adjunctive therapy such a family therapy. However, the likely trend in Australia would follow an opposite direction to this. That is, the existing comprehensive and universal conventional mental health services form an ideal base from which to develop integrated wilderness and adventure therapy programs. The only scope for stand alone wilderness or adventure therapy programs seem to be in the private sector which would likely face heavy competition with public sector services. The most likely option therefore would be to establish wilderness and adventure therapy within existing public sector services.

Because of the recent trend to regionalise mental health services around Australia where small, fully complimented services exist within one community based agency (Department of Health & Community Services, 1994, 1996), any wilderness or adventure therapy program is likely to be small scale. For this reason, large pools of practitioners with a range of skills and skill levels would seem unlikely. Therefore, practitioners need to hold a broad range of skills and have a particular capacity to work along-side non-wilderness or adventure therapists, and within a conventional mental health service.

For these reasons it seems that a practitioner model of service approach is preferable to development of stand-alone programs.

There is a typical path to practising as a specialised therapist in a mental health service in Australia. Usually a professional gains basic qualifications to practise independently giving them the requisite skills and experience to undertake a generalist role in a number of mainstream mental health settings. In order to develop expertise and be considered qualified in a specialised form of therapy extra study and training is expected in addition to one's base professional qualification. Examples include psychotherapist, family therapist, marriage and relationship therapist, and most types of group therapist. This model of specialised therapist training ensures a broad range of clinical skill is brought to more narrow specialist expertise in any particular form of therapy.

This career path has developed in Australia because most mental health professionals train and gain initial professional clinical experience in the public sector. Many public sector services are teaching hospitals (and clinics) making it easy for professionals to access training at minimal cost. Frequently, public sector employers strongly support their staff to develop specialised therapeutic skills in areas where there is a perceived service need. In this situation, where there is a perceived need for wilderness and adventure therapy services in the public sector, it is likely that support for professionals to train in this area would follow. Indeed, this has been the authors experience in recent years. So it would follow that a clear rationale for the need for wilderness and adventure therapy in mainstream mental health services is a necessary first step.

In terms of maintenance of the highest professional standards in this scenario, to have 'cross-trained' therapists would ensure the highest therapeutic standards and regard for ethical issues (discussed above). The importance of professionals being able to hold *independent clinical opinion* about their practise based on the standards of practise held by the field of wilderness and adventure therapy would be critical in this area. Administrators may hold a conflict of interest between administrative, policy and economic imperatives on the one hand, and the best interests of the client on the other. This would be difficult where the outdoor technical staff were externally sub-contracted and had no understanding of clinical-ethical issues and therapy staff had no understanding of wilderness and adventure physical or psychological safety considerations. Indeed, the author has heard anecdotally of many incidents where this very problem has occurred because of this reason.

### **The Need for Professional Accreditation & Steps Towards a Profession in Australia**

The over-riding issue which underpins any argument about professionalism is the ethical question of whether there is a need to protect the public from harm. Hands (1997) raises relevant questions in a discussion of registration of psychologists in NSW. It is clear that where a clear need to protect the public can be demonstrated, a need to be able to regulate people who practise in a particular field also exists. First, the dangers must be identified. Physical dangers in the use of wilderness and adventure activities per se are relatively obvious. Other dangers unique to the application of wilderness and adventure activities as therapy are seldom discussed in the literature and are less obvious (exceptions include Berman, 1996; Davis-Berman and Berman, 1994).

Exposing clients with mental health problems to the normal physical dangers in these activities raises important questions. Many clients who most benefit from this form of therapy also pose a high risk to themselves and others compared with non-therapeutic populations. For example, many young people with mental health problems have histories of, or potential for extreme and unpredictable risk-taking. This may be in the form of self-harm or para-suicidal behaviour such as self-mutilation, impulsive and acting-out behaviour, substance abuse, running away, refusal to eat, refusal to use safety equipment including adequate clothing. Additionally, suicide attempt through either passive exposure to life threatening situations (eg. exposure to extreme cold, entering water when unsafe, refusal to use safety equipment), or active suicidal attempts such as jumping, wrist slashing, drug overdose.

The results of an inability to assess the risk of these behaviours prior to, or during an activity are obvious and profoundly harmful given the potential for disaster. Risk to others can take the form of bullying, physical assault, sexual assault, exposing others to physical risk through rule breaking or not following directions, damaging safety equipment, encouraging others to abuse substances, and so on.

Also, the capacity to cope with stress effectively is frequently severely diminished amongst this population. In the case of a traumatic incident such as serious injury, becoming lost in the wilderness or subjected to environmental extremes, some clients may experience added trauma to their already fragile mental state. Where perceived risk and stress are used therapeutically to induce disequilibrium in the client (see Nadler & Luckner, 1992) tolerance levels of individual clients may be minimal and may vary depending on the individual and situation. The ability to assess this and tailor interventions to individual need is also critical. This requires both a high level of psychological knowledge and intervention skills as well as a thorough understanding of the unique demands of the wilderness or adventure activity.

The recent death of Aaron Bacon (Berman, in press) in the USA highlights the need for practitioners to be able to assess client motivation and differentiate real *illness behaviour* from behaviour thought to be an aspect of the client's psychological presentation. Such examples highlight the importance of therapists holding a broad base of experience and skill in general clinical practice.

In practical terms, it is relatively easy to ensure standards in general clinical practice by using existing mechanisms that regulate the practise of mental health professions. These include, accreditation of university based training programs by professional associations, legislative registration of professions such as psychology, psychiatry and nursing and through membership of professional associations such as Psychology, Occupational Therapy, Social Work and Psychiatry. Ensuring adequate standards in specialised wilderness and adventure therapy requires covering two distinct areas. First, the need for adequate expertise in wilderness and adventure activities. As mentioned above, through ORCA Australia is well on the way to having a nationally recognised system for the regulation of standards of minimum competence. This should be the beginning standard for any wilderness or adventure therapy.

Further, there is a need to ensure minimum standards of *therapeutic* practice like other specialised therapies. In fields such as psychotherapy and family therapy, multi-disciplinary professional associations have been established to set standards for practice, oversee training

programs and accredit individual therapists to practise. The Victorian Association of Psychotherapists, Victorian Child Psychotherapists Association and the Victorian Association of Family Therapists are good examples of this. While these bodies have no legal jurisdiction, membership with these associations is commonly accepted as signifying an acceptable level of training and supervised experience to practise. These associations also act to protect the public by accepting complaints from clients and holding therapists to account, as well as educating and advising mental health administrators and the public on best practice.

This model seems the most effective one to implement and the simplest way to ensure a minimum level of training and experience both in general clinical skills and specialised wilderness and adventure therapy skills. It could be envisaged then that a person calling themselves a wilderness or adventure *therapist* would have **a)** general clinical skills and experience (through discipline specific registration and/or membership), **b)** appropriate technical skills (through industry standard training and conformity with ORCA standards), and **c)** specialised therapeutic skills (through membership with a multi-disciplinary association of wilderness/adventure therapists).

If a professional association of wilderness/adventure therapists were established, it should set minimum standards for membership in line with general qualifications in mental health (or equivalent<sup>6</sup>), ensure that members hold appropriate qualifications in technical skills as per ORCA guidelines, and that they only practise within the area of their expertise (including technical skills and experience). Strong links with Outdoor Education associations would be necessary to ensure technical standards are kept current, and avoid unnecessary duplication of functions. Finally, the association should ensure that therapy is conducted with due regard to the ethical and clinical issues discussed above.

A further role of such an association should be to oversee (through an accreditation process), and assist in the development of training programs in the specialised skills of wilderness and adventure therapy.

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<sup>6</sup> Whether non-mental health professionals should be accepted is a matter for on-going debate. Currently, there is much debate in the USA around minimum standards and therapeutic competencies in the field. Exact specifications are unclear at this time, and some authors argue that people not trained in a mental health profession should be able to practise. Many practitioners have also argued convincingly against this. It seems that economic considerations in the USA are highly influential in those arguments for non-professionalisation. While there may be argument for accrediting those who can demonstrate equivalent competencies to practise, the aim of this document is to report on best practice. It is clear for the reasons already covered why this is a less desirable option if we are to ensure best practice in Australia.

### Practitioner Training Needs & Avenues

Following the professional model proposed above, training would necessarily involve two dimensions. First, therapists need to have appropriate skills in technical wilderness and adventure activities and associated safety, risk management and first-aid skills. As stated this is best done to industry standards according to ORCA specifications. Therapists need to have a working knowledge of what are appropriate levels of skill training for their particular setting. Local sources of information such as state outdoor education associations should be sought for appropriate training resources. Training in these areas could be either undertaken during undergraduate training in any mental health profession or subsequent to qualification. To be minimally qualified in these activities to instruct novices (which is the most common level of activity undertaken) would require commitment to learning these skills, but is not prohibitive. Wilderness and adventure therapists need not have an extensive range of skills in technical wilderness or adventure activities. Therapists should be able to undertake substantial therapeutic work using just a few wilderness or adventure modalities. What they do need is skills in some areas so they can understand generic processes. If activities are to be utilised beyond their expertise then they could enlist another person with an appropriate level of expertise in outdoor education. However, it is likely that therapists will become adept at using a select number of activities that suit their particular client group and therapeutic objectives. This study suggests that it is likely that therapeutic processes and techniques transcend activity type. That is, it is more important *how* therapists use an activity than *which* activity is used. It is in the 'how' that the more complex therapeutic skills lie.

Therefore, of great importance is that therapists become competent in the *therapeutic* skills of wilderness or adventure therapy. Like psychotherapy and family therapy, this could be done through a combination of theoretical courses of study as well as supervised clinical practice. Experience has shown this to be a highly effective method for the training of therapists in these specialised approaches. Having experience in undertaking research in the area would also enable practitioners to make use of, and critically evaluate published research as well as conduct clinical research and quality assurance activities.

Like other specialised therapy training, this could be undertaken on a part-time basis in combination with on-going clinical work in the professional's own work place, or through structured clinical internships. The latter has been successfully offered over a 6 month period for the last two years in the author's service at the Austin & Repatriation Medical Centre. Ideally, paid training positions could be established where qualified professionals could train for more adequate periods of one to two years. Skills could be further developed through a supervised probationary period such as is the case with specialist training in Clinical Psychology.

The ideal curriculum and nature of supervised internship should be advised by a professional association which should set and monitor standards. Again, the author's service has successfully run short courses for mental health professionals covering theoretical bases of therapeutic practise, and critical areas such as ethical issues, psychological risk management, management of psychiatric crises, management of traumatic incidents, and so on. As mental health agencies are able to draw on significant expertise in a range of clinical areas, this valuable resource should be utilised in teaching as much as possible.

As has been the case with other specialised therapy training programs, once a program of

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training has become well developed, universities and other tertiary educational institutions may establish formal qualifications around such a curriculum. Examples of this are the Post Graduate Diploma in Family Therapy and Master of Child Psychoanalytic Psychotherapy which require an undergraduate qualification in a mental health profession. Before this is to happen for wilderness and adventure therapy, it is likely that a substantial demand for training would need to be demonstrated, and a generally accepted knowledge base and curriculum be identified.

#### **Public Sector Service Development in Australia**

Any public sector development requires commitment from the professional sphere, government administrative bodies including mental health administrators and ultimately the broader political arena.

As mentioned above, the public sector is well suited for the establishment of integrated wilderness and adventure therapy programs on a small scale. This is in part due to the community based, regionalisation of mental health services. Here, regional managers would need to be committed to the specific needs of such programs which would require specialised resources such as equipment (vehicles, outdoor gear, ropes course equipment, etc.) and human resources such as specialised wilderness and adventure therapists and funds for training and updating staff in wilderness and adventure skills. However, these costs would be relatively minor for small scale programs which were integrated into existing mental health services.

There is also potential for larger scale programs which might service larger populations. There has been some development of a statewide model like this in South Australia. Wilderness or adventure therapy based programs could be established which might complement regional mental health services. It is the authors' view that there would be some inherent disadvantages to this approach such as greater difficulty integrating other therapeutic interventions, not being able to offer a graduated range of treatment services and the dislocation for, and requirement for community re-integration of the client with longer term residential interventions. However, it seems that for severely behaviourally disordered adolescents this approach may hold some advantages by removing the client from systemic influences (peers and family) which may reinforce and maintain problem behaviour. Therefore, large scale, behaviour disorder specific programs may be effective if they are well linked with regionalised mental health services. For such a program to be established, substantial resources would be required. However, many of the programs investigated were viable on such a scale.

#### **Private Sector Service Development in Australia**

Any private sector development would require the following. First, a relatively high demand for wilderness and adventure therapy from the consumer. Second, commitment from private health insurers who would need to see the cost effectiveness of such an approach as compared with conventional treatments. Third, private mental health service providers would also need to see financial and other advantages of offering such a service. Presumably, successful trends in the public sector eventually spill over to the private sector as long as there is private health insurer support.

The fact that almost all programs investigated in the USA were dependent on private insurers and

managed care systems to refer and pay for services demonstrates their viability. Here, economic factors seemed significant. While conventional in-patient treatment in the USA tended to be short-term, many residential programs were significantly longer. However, the fee difference was also substantial with a typical hospital in-patient stay costing around US\$1,000 per day, wilderness therapy and therapeutic wilderness camping programs cost around US\$150 per day. Such a wide cost variation is not likely in Australia (as in-patient costs are typically less than half of that in the USA).

Therefore, large scale, stand-alone private sector programs are unlikely to be so popular here. None-the-less, small scale, integrated programs may be more viable. Presumably staff might be employed on a sessional basis where the onus of standards of practice would rest with the therapist not the organisation. This is another argument for the need for professional accreditation. Obstacles to this may be a perceived lack of legitimacy in the eyes of consumers or insurers, and/or a fear for private service providers of attracting litigation if there was physical injury as a result of accident during an activity. Also, an insurance rebate structure would need to be determined.

### **Needs of Mental Health Administrators**

Besides the need to understand the significant range of potential benefits wilderness and adventure therapy can have in engaging and treating adolescents discussed above, the following are areas which should be considered by mental health administrators.

Of major importance is what type of service is to be established, what complimentary services exist or need to be put in place and what relationship will any wilderness or adventure therapy program have to other aspects of the service, and external agencies. This is especially important for support services such as individual or family therapy, case management and follow-up processes. As discussed above, issues of how wilderness and adventure therapy is to be integrated with other therapies need careful planning and support. Issues of access, referral processes, suitability for inclusion, etc. need to be determined to ensure appropriate wilderness and adventure therapy services are employed for the right types of clients in the right time frame in relation to all other case management arrangements. Therefore, a coherent set of therapeutic aims and objectives should be generated and discussed with the entire service that is consistent with other service components. For further discussion on this process in private hospital settings the reader should refer to Roland (1993) and Gilliam (1993).

An initial consideration is that the infrastructure required to provide such services can span from the relatively minor up to a major undertaking. However, service aims and client need should guide what level of commitment is made. It seems clear that a larger scale wilderness therapy program may not achieve much more than a smaller scale adventure therapy one, depending on a number of factors. For example, when servicing families on an out-patient basis an integrated, multi-modal program may be sufficiently effective. On the other hand, while a small scale adventure therapy program may be inadequate for conduct and behaviourally disordered adolescents, a longer term (eg. 2-15 months plus) wilderness therapy or residential therapeutic camping program is likely to be required. Obviously, the infrastructure needs of these two ends of the continuum will be significantly different. There are real potential dangers in being under resourced in attempting to establish a viable service because many resource needs are invisible.



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Further detailed discussion is beyond the scope of this report, but equipment resources will need special consideration in both initial acquisition as well as maintenance and periodic replacement (for detail see Berman & Davis-Berman, 1991). Further, adequate capacity for staff to update qualifications in first-aid, risk management and technical skills, new staff training needs are likely over a period of time, transport, and equipment hire cost need to be taken into account. Time taken to implement all of these requirements translates to 'down time' in client service as well.

Less tangible considerations also include the very high potential for staff burn-out and the need to build in, and allow for protective mechanisms against this. This would include balancing the number of field days to non-field days, regular time off after long expeditions, and so on. Again, this raises the potential for high staff turnover which creates the need to retain staff by ensuring attractive career paths, and being prepared to invest in training new staff in appropriate skills should that be necessary. This was an issue that many programs raised which potentially threatened the overall quality of the therapeutic service.

Administrators need to be aware of and familiar with quality and safety assurance mechanisms. For instance, ensuring an appropriate safety audit is undertaken and reviewed and safety committees established. Following the lead of the Association for Experiential Education (AEE) in the USA, it is likely that program accreditation will be seen in the industry as a standard for wilderness and adventure programs of all types.

Not-with-standing all of the above, of foremost consideration and priority are partitioner competencies & ethical issues as discussed above. This form of therapy holds quite unique ethical issues and holds the potential to do harm to clients both physically and psychologically. It behoves employers and administrators to be fully informed of these issues in staff selection, review and supervision. Additionally, it is in the administrators and agencies interest to be informed of, and support any future professional association in maintaining the highest standards of wilderness and adventure therapy practice in those claiming to undertake wilderness or adventure therapy with clients with mental health problems.

#### **Research issues**

A detailed discussion on research issues is beyond the scope of this paper and the reader is referred to Gass (1993, Section 5).

However, Gillis (1995) highlighted some important research areas. The literature to date has shown significant effects in improved self-concept, behaviour, attitudes and school grades. While increases in clinical functioning and greater internalization in locus of control showed important clinical value, no comparisons have been made with other treatment interventions. He also notes that as there is no one clearly defined and researched method of therapy in adventure or wilderness therapy, leaving the question of which intervention (therapeutic approach or activity) is most efficacious with which clients still unanswered. Along with many other authors, he also calls for greater specificity and accuracy in conducting research and reporting on method.

He suggests that detailed case study methods may be just as informative as pre and post testing in advancing understanding, as well as more regression based statistical analyses which look to answer who does well or better following different types of wilderness or adventure therapy. Finally, to follow mainstream psychotherapy research and look at 'significant change events' in

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wilderness or adventure therapy may be particularly useful in informing practitioners about most effective intervention methods.

There are other areas of particular significance for Australia. While much research on locus of control suggests a significant potential of wilderness and adventure therapy to affect a reduction in risk of suicide in high risk adolescents, the author knows of no research which has attempted to investigate the impact of wilderness or adventure therapy on suicide prevention per se. This has obvious and significant implications for Australia at this time. Further, the ability to develop resilience in high risk groups through wilderness and adventure therapy appears high given the research already done and anecdotal clinical reports. It should be of major priority to investigate the potential benefits with high risk groups for the development of resilience and suicide prevention.

Obstacles to furthering knowledge through research include funding issues, therapeutic skills and commitment from research facilities, universities and mental health services.

First, being a novel and unconventional treatment modality, clinical and mental health researchers do not accord research in this area much priority. In the mental health field, typically medical and psychiatric interventions are given priority for funding, such as drug trials. Where non-medical intervention research is afforded funding, this tends to be mainstream therapeutic approaches such as behavioural and other interventions. So the opportunities for wilderness and adventure therapy research attracting funding is poor.

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The other avenue for research is through university post-graduate student research. Disciplines most suited would be Psychology, Occupational Therapy and possibly Social Work. Having no basis in clinical applications and little in empirical research methodology, Outdoor Education is not well suited to this type of clinical research. Even graduate Psychology or Occupational Therapy research is problematic because of the complex and poorly defined nature of the field, and it being eclectic and clinically based. Research at Honours and even Masters level requires uncomplicated research topics that are easily investigated in a short time-frame, in a rigid experimental framework, and in topics familiar to supervising academics. In the USA, most empirical research is done by Masters and Doctoral level students, but is constrained by academic requirements inherent in producing a thesis, as mentioned above.

In the foreseeable future, the only realistic avenue for any substantive research in Australia is through specially funded, clinically based research which has the flexibility to investigate clinically relevant issues and can incorporate qualitative methods along with more rigorous quantitative approaches.

A second problem in doing research is being able to establish best practice and a high level of competency in therapists so that the research may be done. This would require further development of existing training programs for mental health professionals so that a sufficient pool could be established of practitioners who were adequately skilled to carry out the interventions being investigated.

Last, a commitment would be required from research institutions and mental health services to conduct this type of research. Sufficient priority would have to be given by any mental health agency to doing clinical research so that services were offered in a way that allowed research to be undertaken. University affiliated or research oriented mental health agencies would be most suitable so that academic and clinical resources could best be integrated. Within the existing context, teaching hospitals and community based services would be best placed for this.

### **Summary Recommendations**

1 Existing wilderness and adventure therapy practitioners, particularly those working with children and adolescents should take account of the need to include families (and/or significant others) as an integral part of the intervention in a way that involves all members of the system in a change process. Applications should be made with an understanding of ethnic, cultural and community issues both in how services are orientated, and how individual cases are managed.

2 The application of wilderness and adventure interventions always be undertaken with due regard to conventional ethical principles of professional and therapeutic practise. The very nature of the activities and role of the therapist requires an especially great awareness and understanding of ethical issues and the needs and rights of the client. Ethical issues should be central to any training for practitioners. Practitioners should always be very clear about practising within the limits of their expertise, both technical and therapeutic.

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3 Where clinical judgement dictates, access to wilderness and adventure therapy be available for clients, so they may have access to effective, brief treatment in the least restrictive manner, with least stigma and greatest regard for client involvement, collaboration and empowerment.

4 Public sector mental health administrators consider directing appropriate funds, and put in place support mechanisms to enable mental health services to develop wilderness and adventure therapy services.

5 Public sector mental health services develop appropriately resourced wilderness and adventure programs tailored to the specific needs of their client groups as a front-line treatment in combination with conventional therapies and case management.

6 Private sector mental health services investigate health insurance funding and rebate arrangements for adventure therapy and wilderness and camp-based treatment as an alternative or adjunct to clinic based in-patient and out-patient services.

7 A professional body be established at state and/or national levels to develop guidelines for minimum competencies, training needs and to advise the mental health field, consumers and the general public on standards of practice, ethical and professional issues.

Accreditation of wilderness and adventure programs/services be undertaken by organisations such as Outdoor Education associations or health service accreditation bodies based on criteria equivalent to those of the Association of Experiential Education.

8 To meet the increasing demand, existing training programs in wilderness and adventure therapy be further developed, and standards and curricula developed according to guidelines of minimum competence as determined by a professional association. Involvement with tertiary education institutions be investigated as part of this.

9 Mental health professionals be encouraged to undertake training to develop requisite skills in basic adventure and wilderness activities in addition to specialised skills in the implementation of wilderness and adventure therapy.

10 Special funds be allocated to clinical research with a priority to investigate suicide prevention. This be conducted through teaching or research affiliated mental health services (such as teaching hospitals) in conjunction with universities to clinically evaluate the most effective methods of delivering wilderness and adventure therapy in local mental health service contexts.

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## **Appendix A: Summary of Program Profiles in Key Areas**

**Length of program/time frame design:** Varied from 2-3 days through to 15 months plus (eg. Therapeutic wilderness camping). Time frames varied from entirely part-time through to entirely full-time (eg. Therapeutic wilderness camping: 7 days/week, 52 weeks/year)

**Other therapy:** Varied from none to extensive range of multi-modal group therapies, only few uni-modal programs

**Peak number of clients / group sizes** Varied from 8 through to 165, group size typically was 6-8.

**Costs per client** Varied from US\$120 to US\$500 for residential day costs (ie. clinical or wilderness), typically US\$120-150.

**Staff qualifications** Varied from minimal safety/technical/first-aid through to cross-trained PhD mental health professionals (eg Psychologists, Social Workers, etc.)

**Activities undertaken** Indoor trust and initiative activities, ropes course, back-packing, mountaineering, peak ascent, canyon decent, hand-cart pushing, rock climbing & abseiling, canoeing, kyaking, white-water rafting, cycle touring, caving, survival training, hut building, solo.

**Restrictions to access** Typically acute psychiatric & suicidal, self-harming, eating disorders, sociopathic traits, history of extreme violence/substance abuse, IQ<85.

### **Diagnostic types**

***Adventure Therapy*** Varied from: substance abuse, depression, ‘youth-at-risk’, sex-offenders, ADHD, Conduct Disorder & Oppositional-defiant Disorder, sociopathy.

***Wilderness Therapy*** Varied from: all &/or any diagnosis, depressed, suicidal, Oppositional-defiant Disorder, Conduct Disorder, eating disorders, substance abuse, ADHD, sex offenders, substance abuse, family dysfunction, sexual/physical abuse, learning disorders, impulse problems.

***Therapeutic Wilderness Camping*** Varied from: learning disorders, social skill deficits, Conduct Disorder, Oppositional-defiant disorder, Post Traumatic Stress Disorder, sexual/physical abuse, ADHD, substance abuse, runaways, anxiety, depression and treatment resistant clients.

### **Outcome Differentials**

***Adventure Therapy:*** Varied from: universal benefit to just low achievers, environmentally aware and reflective clients, group composition, unified view of the problem in the family, home support. IQ<80 makes processing more difficult.

***Wilderness Therapy:*** Varied from: physically oriented otherwise same as for any other type of therapy, older and female respond quicker, short-term substance abusers, older males, depressed and suicidal. ADHD, Conduct Disorder and family dysfunction are harder to treat.

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**Therapeutic Wilderness Camping:** Varied from: younger make better progress, recency of trauma, internalizing problems, borderline personality disorder, Conduct Disorder & Oppositional-defiant Disorder, low self-esteem. Substance abuse is difficult to motivate.

**Individual versus group approaches** Universally an emphasis on the group as the preferred therapeutic medium, some programs gave virtually no individual consideration, while most gave variable amounts.

**Involvement of families/parents** Varied from none to primarily out-patient and adventure family therapy. Typically parent support during or on completion of program.

**Adjunctive therapies** Varied from none to ad hoc individual therapy, monthly family therapy, pre and post program individual and family therapy. Often agencies were left to institute whatever adjunctive therapy was considered necessary.

**Therapeutic models** Included: Adventure Based Counseling, eclectic approaches, systemic, narrative, brief, strategic and solution oriented approaches, humanistic, social learning models, therapist as role-model, Reality Therapy, behavioural and cognitive-behavioural, metaphor development, eco-psychology.

**Presumed therapeutic factors** Included: holism, systemic, peer culture, rites of passage, success experiences and solution orientation, adaptation, novel context, wilderness environment, competency, risk, questioning, community and group cohesion, natural consequences, interpersonal learning, creation of disequilibrium, goal setting, re-capitulation of family unit, role-modelling, development of resilience, supportive relationships with adults, shared unique experience.

**Methods of transfer and follow-up** Varied from none to follow-up days and booster groups, weekly phone calls for months following, home/school trials, parent skill development, ongoing out-patient individual and family therapy, optional return to program for 1-2 weeks, community development activity, transitional housing program, hand-over to agency.

**Staffing ratios** Varied from 1:1 to 1:12, typically 1:3 (families, 1:4 families)

## **Appendix B: Adventure Therapy Program Profiles**

### **PROGRAM 1**

**PROGRAM NAME:** Basecamp

**CONTACT PERSON:** John Barrett

**ADDRESS & CONTACT DETAILS:** 10 Kindar drive, New Abbey, Scotland, DG2 8DG, UK

Phone/Fax: 013-8785-0493

**AUSPICE ORGANISATION:** None

**FUNDING&/OR FEE STATUS:** Self-funding Charity: ~12% contract fees, remainder fundraising

### **SUMMARY DESCRIPTION**

**Medium-term, base camp and expedition facility, water and mountain based wilderness-adventure enrichment program for ‘youth at risk’ referred by various youth agencies.**

### **PROGRAM PARAMETERS**

**PROGRAM AIMS:** 1) genuinely assist young people in trouble or ‘at risk’ to address their difficulties and improve the quality of their lives: to enable young people to increase confidence and self-esteem, learn more about themselves and how they relate to others, become empowered to be more effective in their lives. 2) provide training and resources to care and custodial agencies who wish to develop adventure based experiential work as part of their own practice. 3) undertake and disseminate research into effective adventure based programs and promote good practice in the use of adventure as a developmental medium with young people in trouble or at risk.

**PROGRAM PHILOSOPHY:** None articulated.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** Varied, tailored to client and agency needs, short and long-term.

**NUMBER OF CLIENTS:** Maximum of 12, average 8.

ANNUALLY: 250-300 for short-term, 40 long-term.

**STAFF NUMBERS/QUAL.S/EXPERIENCE/BACKGROUNDS:**

3 program staff (1 Director, 1 Deputy Director, 1 Project Worker), 3 support & administration staff, up to 3 volunteers (from pool of ~12)

**NUMBER OF DAYS PER PROGRAM:** Ranges from 3 days (W/E) to 26 weeks (non-residential, part-time, 1-2 days per week)

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:**

Canoeing/kyaking, climbing/abseiling, mountaineering expeditioning, initiatives (in/outdoor) which varied depending on group and/or agency preference.

**OTHER THERAPY TYPES:**

General group work (inc. Counselling, processing, ad hoc issues), 1:1 counselling around issues related to offending, incidents, behavioural triggers, etc.. Group social skill training (ref. Robert Ross: cognitive reasoning theory). Family/parent work done on case-by-case basis by referring agency (infrequent).

### CLIENT & SYSTEM CHARACTERISTICS

**REFERRAL SOURCES:** Local regional govt. Social services, special education, secure residential units, young offender institutes including prison inmates.

**REFERRAL MECHANISMS:** Agency referral, some agencies solicited, networks developed. Programs developed according to agency need.

**RESTRICTIONS TO ACCESS:** Client needs to be able to verbally contract on participation guidelines. Psychiatric, drug and alcohol dependent clients, or those disruptive to group may not be accepted (have 1:1 counselling before attending?). Attempt to be as inclusive as possible.

**COST PER CLIENT PER DAY:**

**SUPPORT ORGANISATIONS:** Dept.s of Social Work, offender institutions.

**CLIENT AGE RANGE:** 12-15, 15+ (~21-22), 17+ for young offenders.

**DIAGNOSTIC TYPES:** None targeted; Youth-at-risk.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** Young offenders receptive to physical challenge but have difficulty with responsibility.

### PROGRAM MODEL / FRAMEWORK

**TIME FRAME DESIGN:** Variable (short-term: W/E through to 1 year), typically intensive course at least 5 weeks

**INDIVIDUAL vs GROUP APPROACHES:** Both on individual needs basis, individual work to support group experience.

**FAMILY / PARENT THERAPY:** Very rarely in individual cases.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): Individual in-house counselling concurrent with program.

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** Not applicable.

### THERAPEUTIC PARADIGM

**THERAPEUTIC PHILOSOPHY:** Humanistic

**THEORETICAL MODELS:** Adventure-based Counselling, challenge by choice assumptions (Karl Rhonke)

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** Gary Dennim Offender Curriculum (where applicable), usually individual goal setting (1:1), Transactional Analysis group models to aid understanding of group process with clients.

**SPECIFIC THERAPEUTIC FACTORS:** Opportunity to experience something unique and shared with others.

### DIAGNOSTIC &/OR OTHER ASSESSMENTS

**CLINICAL:** none

**NON-CLINICAL:** informal assessment is made via adventure activities in vivo, relevant background information is made available by youth agencies upon referral.

### INTEGRATION / TRANSFER / FOLLOW-UP

**INTRA-PROGRAM INTEGRATION METHODS:** Staff hand-over meetings before and after sessions, end of session de-brief, participant review record, community based days on non-program days, repeat previously successful activities.

**POST-PROGRAM TRANSFER METHODS:** concurrent days back in community, otherwise no formal methods.

**FOLLOW-UP METHODS & TIME FRAME:** Done by case worker, feedback information gained during course (ie. Assessment information).

## EVALUATION METHODS

**EVALUATION TIME FRAME DESIGN:** Post-program, staff de-brief after each session in structured format. Individual review record forms basis of final assessment and evaluation.

**MEASURES USED:** coping skills observed/reported, successful participation

**FOLLOW-UP EVALUATION:** None

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** staff hand-over, case & program planning.

**CLINICAL UTILITY OF DATA:** Highly useful for program planning, and individual case planning and assessment.

**ANALYSIS OF DATA:** Forming programming conclusions and directions.

## RESEARCH ACTIVITIES

**ADDITIONAL RESEARCH ACTIVITIES:** *Why Adventure?* research report, Robert Ross (criminologist) cognitive development theory, 1992 survey and directory of Adventure Based Programs (published by Chris Loynes)

## STAFFING & TRAINING NEEDS / ISSUES

**STAFF TO CLIENT RATIOS:** 1:1 with smaller groups, usually 1:2

**LEVELS OF STAFFING:** 3 direct intervention staff, ~3 volunteers, 3 admin./support.

**STAFF QUALIFICATIONS:** basic Mountain Leadership Certificate, first-aid, etc. in-house training and external training depending on individual staff need (eg. Counselling skills).

**STAFF TRAINING IN THERAPY:** external training for staff if required (eg Diploma course in counselling), short external courses (various)

**SUPERVISION STRUCTURES:** Director and Deputy Director supervised Project Worker (Director sought external supervision), external personal supervision encouraged.

**INTERNAL STAFF TRAINING PROGRAMS:** staff meetings, re: wider issues such as ethics, volunteers exposed to practical skills with view to understanding psychological processes.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** inter-personal skills, facilitation skills, basic group counselling theory and practice. Staff should experience their own counselling. Team functioning crucial and requires long time period to develop.

## KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** Professional Association is required to promote research-practitioner model, membership for individuals not organisations to promote dialogue and set up or accredit training programs.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING ISSUES:** Cross-training not necessary if time to develop common understanding

**OTHER:** Stimulation and support to individual rather than organisations. Old, established traditions/philosophy in Outdoor Education create resistance to new (therapeutic) models. Foundation for Outdoor Education lacks effectiveness to support & promote profession.

## KEY STRENGTHS OF PROGRAM

- Programs are tailored to specific groups (agencies and clients), and dependent on ideas of clients.
- Small scale of operation facilitated flexibility and adaptability to client need.

### PROGRAM LIMITATIONS

- Inexperience of staff
- Size of operation increased intensity for staff - stressed importance of staff selection
- Inadequate space and facilities
- had to exclude some clients occasionally because of lack of expertise (eg. Psychiatric problems)
- Director carried most responsibility and skills, difficulty in delegating aspects of role.

### KEY PROGRAM FEATURES

- flexibility & adaptability to individual need
- client input into program components
- cohesive and clear direction in approach

### CONCLUSIONS

Resource limitations create greatest strain. Programs have a natural (short-medium term) life-span? This client group is the most difficult to provide for, especially in terms of staff selection and level of skills required by staff. Program worked best with residential services when there was good concurrent and post-program support. Program and concept is biased towards white, middle class assumption and values. Program no longer exists due to inability to secure on-going funding.

### PROGRAM 2

**PROGRAM NAME:** Brathay Hall Youth Program

**CONTACT PERSON:** Steve L Manager Youth Services, Aileen MacEachen

**ADDRESS & CONTACT DETAILS:** Brathay Hall Trust, Brathay Hall, Ambleside, Cumbria LA22

OHP, Phone 015-3943-3041, Fax 015-394-3-4424 Email: 1015222306@compuseve.com

**AUSPICE ORGANISATION:** Brathay Hall Trust

**FUNDING&/OR FEE STATUS:** Charity, not-for-profit

### SUMMARY DESCRIPTION

**Base facility and mountain based Adventure Based Counselling program for ‘youth at risk’ as part of broader adventure training facility utilising adventure and water activities, and overnight expeditions for youth agency referred adolescents.**

## PROGRAM PARAMETERS

**PROGRAM AIMS:** Develop self-confidence, maximise opportunities, empowerment of clients. Give choice to clients to make their own decisions.

**PROGRAM PHILOSOPHY:** None specified

**DESCRIPTION OF TYPE(S) OF PROGRAM:** Adapt resources to particular client group needs using a variety of methods while maintaining a small peer based context. Usually residential.

**NUMBER OF CLIENTS:** Average of 8, ranging between 6 to 10.

PEAK: 60-80 maximum, usually 40.

**STAFF NUMBERS/QUAL.S/EXPERIENCE/BACKGROUNDS:** All have youth work or related background, often with additional training in drama methods, NLP, music, etc.

**NUMBER OF DAYS PER PROGRAM:** varies from 2 day weekends through to 12 day programs, typically 3-5 days.

**TYPES OF ACTIVITIES UNDERTAKEN:** initiatives, ropes course, canoeing, mountaineering, climbing, arts/drama/music/video/screen printing. General principal is that activity involves some form of problem solving.

**OTHER THERAPY TYPES:** only via agency or on individuals' own initiative, 1:1 support if individuals require it because they are having difficulty within the group. Ad hoc in vivo communication, leadership and social skills

## CLIENT & SYSTEM CHARACTERISTICS

**REFERRAL SOURCES:** Brathay is approached by various agencies including Youth-at-Risk UK, youth services, police, and public schools(ie. Fee paying). That is, clients must already be clients of another service.

**REFERRAL MECHANISMS:** Agency negotiates program parameters depending on their needs and financial constraints. All client agencies are means tested

**RESTRICTIONS TO ACCESS:** limited to access via intermediate referring agency. Individuals with violent or self-harming behaviour who lack support may be excluded.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** varied referring agencies.

**CLIENT AGE RANGE:** 14 - 25, typically 16-25

**COST PER CLIENT PER DAY:**

**DIAGNOSTIC TYPES:** no assessment history sought except where physical safety issues may be relevant.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** Subjective impression is that low achievers benefit the most, those with the capacity to reflect and who have an awareness of the environment benefit the most. An important factor regarding outcome appears to be the peer group composition.

## PROGRAM MODEL / FRAMEWORK

**TIME FRAME DESIGN:** variable

**INDIVIDUAL vs GROUP APPROACHES:** greatest emphasis on using the group and the peer experience as the medium for change.

**FAMILY / PARENT THERAPY:** referred to agency if issues are identified.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): only if provided by referring agency.

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** hand-over assessment information to agency at the conclusion of the program.

## THERAPEUTIC PARADIGM

**THERAPEUTIC PHILOSOPHY:** individual determines their own objectives/goals. Any program is always based around agency involvement post-program.

**THEORETICAL MODELS:** eclectic approach used to achieve program objectives. Individual facilitators use their own models based on their own training. Generic model is "Do-Review-Apply".

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** depends on individual facilitators repertoire

of skills

**SPECIFIC THERAPEUTIC FACTORS:** environment, community, supportive relationship with adults, freedom to express themselves.

#### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** none

**NON-CLINICAL:** informal assessment is made via in vivo adventure activities, youth agencies make available relevant information upon referral.

#### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** same facilitation staff in all activities, daily review meetings involving facilitators, support (technical) staff, agency staff, and (occasionally) clients.

**POST-PROGRAM TRANSFER METHODS:** post-course meeting within one week of the end of a program (either face to face or by telephone)

**FOLLOW-UP METHODS & TIME FRAME:** disclosures of important information/incidents are contracted with the client to be followed up by the agency. This is confirmed with the agency post-program.

#### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** within approximately 3 months

**MEASURES USED:**

PSYCHOMETRIC: none      NON-PSYCHOMETRIC: none

**FOLLOW-UP EVALUATION:** verbal discussion and feedback regarding agency satisfaction and client feedback, ie. Youth workers and clients anecdotally report changes.

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** client satisfaction.

**CLINICAL UTILITY OF DATA:** individual facilitators attempt to consolidate learning from the feedback received.

**ANALYSIS OF DATA:** none

#### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** none

#### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 1:12 maximum depending on activity, average is 1:8

**LEVELS OF STAFFING:**

Course Director ---> Trainers (group facilitation) ---> Technical support staff (physical safety) ---> staff volunteers

**STAFF QUALIFICATIONS:** Trainers: Youth Work / Teaching or equivalent, Technical Staff: various Outdoor Education qualifications

**STAFF TRAINING IN THERAPY:** none in-house, depends on individual facilitators' previous external training

**SUPERVISION STRUCTURES:** 1) management evaluation structures per organisation procedures ie. Skills training, 2) Co-training, peer training group, 3) informal collegial support, 4) external de-briefing service. Presently considering a mentor system.

**INTERNAL STAFF TRAINING PROGRAMS:** staff induction tailored to individual needs, staff are endorsed on skills and observe sessions. Ad hoc twice yearly staff development with external consultants: eg. Myer-Briggs training, drama methods, Neuro-linguistic Programming, etc.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** processing skills, specific and specialist areas; new skills, eg. Drama, NLP, etc.



### KEY PROFESSIONAL ISSUES

Need for university level training where theory is strongly linked to practice, and evaluated/trialed on site. Need to experiment with service models, ie. Community integration models. Questions regarding how does this field benefit an understanding of other areas (eg. Corporate)

### KEY STRENGTHS OF PROGRAM

- capacity for variety in programs reduces stress on staff
- staff and management structures are strong giving a cohesive team ethos, strong sense of community, and commitment of staff.
- programs are driven by client need - high degree of flexibility
- high quality of staff recruited
- clear organisational direction, while staff are encouraged to take initiative
- corporate training ethos encourages high standards and professionalism

### PROGRAM LIMITATIONS

- Agency is dominated by white, middle-class staff and values
- creativity in approach is only limited by practical and financial constraints
- stratified and compartmentalised management hierarchy

### KEY PROGRAM FEATURES

- adjunctive and collaborative programs with *Youth-at-Risk*, *Fair bridge* and other agencies.
- funding for youth programs is partly derived from corporate programs

### CONCLUSIONS

- program is highly dependent on referring agency to transfer behaviour change
- what value short-term programs?
- referral routes exclude socially disadvantaged and marginalised populations, as clients must already be engaged and motivated to get referred?

### PROGRAM 3

**PROGRAM NAME: Eagleville Hospital Adjunctive Therapies Department Challenge Program**

**CONTACT PERSON:** Vaughan Coleman Recreation Therapist, Sue Wiese Snr Adjunctive Therapist

**LOCATION:** Eagleville, Philadelphia, Pennsylvania, USA

**ADDRESS & CONTACT DETAILS:** 100 Eagleville Road, Eagleville, Pennsylvania, USA. Post: P.O. Box 45 Eagleville, PA 19408-0045, USA. Phone: 610-539-6000, Fax: 610-539-6249/7678

**AUSPICE ORGANISATION:** Eagleville Hospital (private non-profit medical service)

**FUNDING&/OR FEE STATUS:** Medical Insurance funded, non-profit

### **SUMMARY DESCRIPTION**

**Integrated, private hospital based, multi-modal clinical adventure therapy program as part of in-patient treatment for adults with substance dependence referred by health insurance companies.**

### **PROGRAM PARAMETERS**

**PROGRAM AIMS:** provide an holistic adjunctive treatment for substance dependent adults to increase efficacy of multi-disciplinary approach to recovery from substance dependence

**PROGRAM PHILOSOPHY:** holistic and action oriented methods activate therapeutic modalities which may not be reached using traditional treatments, with an emphasis on peer support through group oriented approaches.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** group based daily adventure activities integrated within a multi-disciplinary group and individual in-patient program.

**NUMBER OF CLIENTS:** 116 beds: 64 male, 42 female, 10 dual-diagnosis.

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** (previously 18, now 2) adjunctive therapists: primarily Recreation Therapy, additional training in Adventure Based Counselling & ropes course instruction, as well as art therapy, horticulture therapy, etc. Clinical teams consist of psychologist, nurse, addiction counsellor, group psychotherapist, and social worker.

**NUMBER OF DAYS PER PROGRAM:** 28-30 day in-patient program with a 3 week cycle

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** socialisation activities, co-operative skills, trust activities and 'challenge' ropes course (high & low elements) half-day.

**OTHER THERAPY TYPES:** music therapy, art & movement therapy, horticulture therapy, educational module, leisure education, group psychotherapy, individual therapy (as needed).

### **CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** insurance company referred.

**REFERRAL MECHANISMS:** 'managed care' assessment and referral by insurance co.

**RESTRICTIONS TO ACCESS:** require private health insurance or full-fees, dependent upon approval from insurer

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none

**CLIENT AGE RANGE:** 18+

**COST PER CLIENT PER DAY:**

**DIAGNOSTIC TYPES:** must have primary substance dependence, must have a medical or psychiatric diagnosis to qualify for insurance

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** appears to be universal degree of benefit

### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** 3 week cycle of 4 groups (1-2 hours) each day

**INDIVIDUAL vs GROUP APPROACHES:** primarily group based (open entry format), referral for individual therapy only if needed for specific issue, eg. Anger management, or addictions counsellor for additional work.

**FAMILY / PARENT THERAPY** some family therapy as needed, family education groups on week-

ends

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): as part of overall program

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS** hand-over meetings, individualised therapeutic objective setting.

#### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** multi-modal, holistic and integrated approach.

**THEORETICAL MODELS:** Adventure Based Counselling

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** see above

**SPECIFIC THERAPEUTIC FACTORS:** peer support, goal setting, success and solution orientated.

#### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** assessment regarding addictive behaviour and any concomitant psychopathology via usual range of clinical assessment processes and psychometric tests

**NON-CLINICAL:** assessment is made during adventure activities in vivo.

#### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** hand-over and case review meetings, multiple role of adjunctive and traditional therapists.

**POST-PROGRAM TRANSFER METHODS:** none

**FOLLOW-UP METHODS & TIME FRAME:** none

#### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** ad hoc

**MEASURES USED:** clinician observation and documentation

**FOLLOW-UP EVALUATION:** none

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** none

**CLINICAL UTILITY OF DATA:** feedback to clinician to inform practice

**ANALYSIS OF DATA:** N/A

#### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** none

#### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 1:8, usually 2:16

**LEVELS OF STAFFING:** co-therapy roles

**STAFF QUALIFICATIONS:** qualified and licenced mental health professionals, usually Recreation Therapists (Bachelor degree)

**STAFF TRAINING IN THERAPY** orientation/education to other clinical staff in adventure therapy.

**SUPERVISION STRUCTURES:** comprehensive 5 level supervisory process from observation through to independent practice; individual ad hoc

**INTERNAL STAFF TRAINING PROGRAMS:** introductory activity for all staff entering the hospital

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** N/A

#### **KEY PROFESSIONAL ISSUES**

**STANDARDS & ACCREDITATION:** needs some form of accreditation scheme

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** none stated

**60 Churchill Fellowship Report: International Models of Best Practice in Wilderness and Adventure Therapy**

**OTHER:** Adventure therapy needs legitimisation with insurers who will see it as value for money. There is a push to out-patient based services (less expensive), and reduction in therapeutic resources hence less individualised treatment. There is a lot of interest from other staff in these methods.

**KEY STRENGTHS OF PROGRAM**

- highly integrated, multi-modal
- good level of resourcing: ie. 2 therapists per group
- high level of therapeutic training and skill of staff, ie. All qualified mental health professionals
- individualised treatment focus and planning

**PROGRAM LIMITATIONS**

- dependency of funding on insurers values, hence it is precariousness (eg. Reduction from 18 to 2 adjunctive therapists)

**KEY PROGRAM FEATURES**

- onsite ropes course
- supported and highly integrated therapy of equal prominence in overall program

**CONCLUSIONS**

- health insurance and funding climate is highly influential over resources, access and integrity of program
- stronger evaluation program may bolster position of program when under scrutiny of insurance companies.

**PROGRAM 4**

**PROGRAM NAME:** Lifespan Wilderness Therapy Program

**CONTACT PERSON:** Dr Dene Berman & Dr Jennifer Davis-Berman

**ADDRESS & CONTACT DETAILS:** 1698 Forestdale Ave, Dayton, Ohio 45432, USA

Phone: 513-426-2079 Fax: 513-848-8655

**FUNDING&/OR FEE STATUS:** private fees / private health insurance

**SUMMARY DESCRIPTION**

**Clinical Psychology & Social Work private practice, extended wilderness expedition based therapy for adolescents with mental health problems, self and mental health professional referred. Extensive, published high quality empirical evaluations and unique general text book: *Wilderness Therapy: Foundations, Theory & Research.***

## PROGRAM PARAMETERS

**PROGRAM AIMS:** psychotherapeutic treatment of adolescent mental health problems

**PROGRAM PHILOSOPHY:** a primary therapy for addressing the needs of troubled adolescents starting with strengths and filling out areas of deficits

**DESCRIPTION OF TYPE(S) OF PROGRAM:** various, usually extended wilderness expeditions of weeks duration

**NUMBER OF CLIENTS:** maximum of 8

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** qualified and licenced mental health professionals with industry standard qualifications in wilderness activity technical, risk management and safety/first-aid

**NUMBER OF DAYS PER PROGRAM:** minimum of 9 days up to 14

**TYPES OF ACTIVITIES UNDERTAKEN:** backpacking, canoeing/kyaking, climbing/abseiling

**OTHER THERAPY TYPES:** pre and post trip individual and family therapy

## CLIENT & SYSTEM CHARACTERISTICS

**REFERRAL SOURCES:** therapists, schools, medical practitioners

**REFERRAL MECHANISMS:** self-referral, inter-professional referral

**RESTRICTIONS TO ACCESS:** limited to behavioural suitability which is assessed by graduated activities

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none

**CLIENT AGE RANGE:** 13 - 17, typically 14 - 17, streamed into older or younger groups

**COST PER CLIENT PER DAY:**

**DIAGNOSTIC TYPES:** all with the exceptions of: severe ADHD/ADD, inability to internalise group values or participate in therapy, violent, acute psychiatric conditions. Those with recent acute psychiatric conditions must be stabilised and with medications having had effect.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** physically orientated adolescents do better, otherwise outcomes are the same as with any other therapy

## PROGRAM MODEL / FRAMEWORK

**TIME FRAME DESIGN:** 10 days, several day sessions pre and post expeditions which include full psycho-social assessment if one not completed already

**INDIVIDUAL vs GROUP APPROACHES:** primary emphasis on group therapy to deal with conflicts and issues, individual focus only if approached by the individual while on expedition

**FAMILY / PARENT THERAPY** family meeting prior to expedition

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): always concurrent individual counselling pre and post expedition

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** joint goal setting for Wilderness Therapy Program and individual counselling. Adolescent goals are negotiated with parents. New issues that arise during expedition are 'flagged' for future post expedition counselling if beyond the scope of dealing with them during the wilderness therapy expedition.

## THERAPEUTIC PARADIGM

**THERAPEUTIC PHILOSOPHY:** application of contemporary therapies where appropriate within the parameters of extended wilderness expeditions. Additionally, therapist adopts role as group therapist/parent figure

**THEORETICAL MODELS:** systems and humanistic therapy base; social learning theory, therapist as role model

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** range of contemporary psychotherapeutic methods as used by psychologists and social workers.

**SPECIFIC THERAPEUTIC FACTORS:** 1) establishment of community, re-capitulation of the family unit and transfer of control and authority to the adolescents, 2) role modelling, 3) issues are confronted and dealt with as they are projected into the wilderness-group context, 4) development of learned optimism which leads to resilience

#### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** family and adolescent diagnostic assessment via conventional clinical and psychometric methods pre expedition.

**NON-CLINICAL:** continuing clinical assessment is made via adventure activities in vivo.

#### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** mid-day group meetings, in addition to morning and evening meetings.

**POST-PROGRAM TRANSFER METHODS:** on-going group and individual therapy, family meetings post expedition, graduate groups, reunion bar-b-que, writing letter to parents (a) listing gains, b) this is what I need from you.

**FOLLOW-UP METHODS & TIME FRAME:** first week is especially important (see 1980's article)

#### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** pre and post psychometric clinical inventories - see JEE article -

**MEASURES USED:** - see numerous articles -

**FOLLOW-UP EVALUATION:**

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** empirical scrutiny of efficacy of program and for publication for the development of the field

**CLINICAL UTILITY OF DATA:** highly utilizable

**ANALYSIS OF DATA:** pre-post, quasi-experimental design

#### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** - numerous Journal papers -

Publication of *Wilderness Therapy: Foundations, Theory & Research* (1994, Davis-Berman & Berman)

#### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 2:8, kyaking 5:1+

**LEVELS OF STAFFING:** PhD clinicians who are cross-trained as primary therapists, outdoor instructor with some counselling/therapy training

**STAFF QUALIFICATIONS:** Therapists: PhD licenced Psychologist/Social Worker

**STAFF TRAINING IN THERAPY:** - see above -

**SUPERVISION STRUCTURES:** in field supervision, progress notes written daily

**INTERNAL STAFF TRAINING PROGRAMS:** Wilderness Education Association Stewardship Course; "Counselling Skills for Outdoor Leaders", plus technical outdoor training.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** In addition to qualifications as a therapist, appropriate range of technical wilderness skill training including remote first-aid, etc.

#### **KEY PROFESSIONAL ISSUES**

**STANDARDS & ACCREDITATION:** (refer *Wilderness Therapy*), there should be the same accreditation standards for wilderness therapy as there are for any other clinical therapy program (eg. Hospital unit), that is, a basic qualification as a clinician. There should be an increase in therapeutic skills and experience with increasing isolation and remoteness due to increased difficulty in accessing specialist mental health services in the case of

psychiatric crisis.

**OTHER:** crisis intervention skills are essential

### KEY STRENGTHS OF PROGRAM

- therapy for adolescents who don't respond to conventional therapy
- least restrictive form of treatment
- more intense and less structured than other forms of therapy
- power of the group experience
- highest level of therapeutic expertise
- highest level of published clinical evaluation of efficacy of program

### PROGRAM LIMITATIONS

- requires independent (private health insurance) funding
- difficulty for socially disadvantaged to access?
- difficulty with collaborative work because of the scarcity of similarly qualified wilderness therapists

### KEY PROGRAM FEATURES

- highest level of clinical therapy training (PhD)
- comprehensive, high quality empirical evaluation and numerous publications including text book on theory and practice
- continuity of therapy through pre and post expedition clinical assessment and therapy

### CONCLUSIONS

- stands as a model of 'best practice' on its own: highest clinical standards of therapeutic practice applied throughout all components and phases of program
- is a distinct model of wilderness therapy which provides a contrast to adventure therapy type programs
- has clear theoretical and clinical paradigm which is in line with contemporary therapeutic practice in mainstream clinical settings

### PROGRAM 5

**PROGRAM NAME: The Browne Centre - University of New Hampshire: Family Therapy Program**

CONTACT PERSON: Professor Michael Gass PhD \ Dr Ann Driscoll

ADDRESS & CONTACT DETAILS: 340 Dame Road, Durham, NH 03824-4800 USA

Phone: 603-862-2070 Fax: 603-862-0154

AUSPICE ORGANISATION: University of New Hampshire

FUNDING&/OR FEE STATUS: means tested dependent on financial status, service costs off-set by corporate training income

## SUMMARY DESCRIPTION

Adventure therapy research and development branch of the Department of Physical Education, University of New Hampshire: concurrently providing training to undergraduate and post-graduate students in outdoor leadership through experimental therapeutic programs to adolescents and their families. Family Therapy program is the latest therapeutic program for adolescents with mental health problems.

## PROGRAM PARAMETERS

**PROGRAM AIMS:** Research & development of new techniques and theory in systemic and strategic adventure therapy for adolescents while simultaneously providing experimental services to adolescents and their families as well as training graduate and post-graduate students in outdoor leadership

**PROGRAM PHILOSOPHY:** to further theory and techniques in adventure therapy while providing an effective and accessible therapeutic services in addition to training students.

**DESCRIPTION OF TYPES OF PROGRAM:** adventure therapy prototypes which are developed, researched and evaluated. Predominantly group action methods, initiative and ropes course based.

**NUMBER OF CLIENTS:** variable, usually 30 per year

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** Psychologists, social workers, marriage and family therapists as supervisors, post-graduate students as primary counsellors.

**NUMBER OF DAYS PER PROGRAM:** 10-12 weeks of one day every weekend, alternating adventure therapy day and 2 hour home visit family therapy session.

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** full range of conventional and experimental ropes/challenge course activities in addition to action methods and initiative tasks, undertaken on a day basis

**OTHER THERAPY TYPES:** crisis family therapy out-patient sessions on needs basis

## CLIENT & SYSTEM CHARACTERISTICS

**REFERRAL SOURCES:** mental health professionals/agencies, teachers, parents, police.

**REFERRAL MECHANISMS:** direct referral to Browne Centre

**RESTRICTIONS TO ACCESS:** geographic, ie. Must be within travel distance of Browne Centre

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** University of New Hampshire

**CLIENT AGE RANGE:** minimum of 6 y.o., usually adolescents (NB child care available for under 6yo)

**COST PER CLIENT PER DAY:**

**DIAGNOSTIC TYPES:** any except Pervasive Developmental Disorders

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** those families who have failed traditional family therapy do well, families who are able to think metaphorically (mothers especially good at this), and those families who have a unified view of what the problem is have good outcomes.

## PROGRAM MODEL / FRAMEWORK

**TIME FRAME DESIGN:** weekly, weekend time frame: alternative week-ends are home visit traditional family therapy sessions (2 hours) which include some initiative/problem solving tasks.

W1 orientation and engagement day

W3 rockclimbing and abseiling day

W5 initiatives day ---> overnight ---> problem solving initiatives day

W7 family issues day

W9 low elements ropes/challenge course day



W11 high elements ropes/challenge course day & graduation

**INDIVIDUAL vs GROUP APPROACHES:** family groups of 6 - 8 (minimum of one child/adolescent and 1 parent)

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): none offered in addition to program

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** reports from previous therapists upon referral

### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY/THEORETICAL MODELS:** brief, strategic, systems orientated changed based on solution focussed processing (see Gass & Gillis, 1995)

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** conventional and experimental ropes/challenge course activities combined with action methods, initiative exercises and alternating with traditional family therapy.

**SPECIFIC THERAPEUTIC FACTORS:** action centred methods, unfamiliar environment, climate of change, assessment capabilities, small group development/genuine community, focus on successful rather than dysfunctional behaviour, unique role of therapist, family resilience, and emphasis on parent-child metaphor development

### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** family assessment and adolescent assessment within family context, diagnostic information from referring therapists may be given. Further clinical assessment through adventure activities.

**NON-CLINICAL:** continuous through adventure activity by non-clinically trained facilitators.

### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** adventure therapist is co-therapist in home based traditional family therapy, hand-over weekly individual (family) objective setting (framing)

**PROGRAM TRANSFER METHODS:** ad hoc out-patient traditional family therapy week-days

**FOLLOW-UP METHODS & TIME FRAME:** none

### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** pre and post program

**MEASURES USED:**

- 1) Index of Family Relations (Hudson)
- 2) Behaviour skills checklist (Gass)

**FOLLOW-UP EVALUATION:** ?

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** evaluation of program efficacy in changing adolescent behaviour in family context

**CLINICAL UTILITY OF DATA:** ?

**ANALYSIS OF DATA:** ?

### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** many! As part of graduate theses at University of New Hampshire

### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 2:6-8 families

**LEVELS OF STAFFING:** adventure counsellors supervised by qualified marriage & family therapist/psychologist/social worker, family therapists conduct family therapy with adventure counsellors

as co-therapists

**STAFF QUALIFICATIONS:** qualified mental health professionals, supervised post-graduate adventure counsellors

**STAFF TRAINING IN THERAPY:** supervision as part of post-graduate outdoor counselling course

**SUPERVISION STRUCTURES:** weekly, session by session

**INTERNAL STAFF TRAINING PROGRAMS:** as part of post-graduate outdoor counselling skills unit

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** activity framing, re-framing, de-briefing and processing skills

### KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** Necessity of the Association for Experiential Education program accreditation scheme

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** require training in adventure counselling, especially processing and de-briefing skills, the ability to frame metaphors with families and adolescents collaboratively

**OTHER:** need for strong professional networking and professional affiliation. Lack of support and growth of the profession is not primarily lack of research, but ability to show cost effectiveness of what is a high skill level therapeutic technique.

### KEY STRENGTHS OF PROGRAM

- strong research and evaluation and strive for 'best practice' focus
- innovation in effective and time efficient methods
- strong attention to high level of facilitation skills
- research and development linked to graduate adventure counsellor training

### PROGRAM LIMITATIONS

- No long-term follow-up?

### KEY PROGRAM FEATURES

- links between research and development, traditional and adventure therapy, university training at post-graduate level through an accessible therapeutic service.

### CONCLUSIONS

- linking corporate training programs to therapeutic programs can enhance skill development in adventure counselling trainees and offset costs of service making it more accessible to socially disadvantaged clients.

### PROGRAM 6

**PROGRAM NAME:** Stone Mountain School at Camp Elliott

**CONTACT PERSON:** Director: Catherine (Cat) Buie-Jennings

**67 Churchill Fellowship Report: International Models of Best Practice in Wilderness and Adventure Therapy**

ADDRESS & CONTACT DETAILS: 601 Camp Elliott Road, Black Mountain, North Carolina, 28711 USA. Phone: (704) 669-8639 Fax (704) 669-2521

AUSPICE ORGANISATION: Talisman Schools

FUNDING&/OR FEE STATUS: previously: state sponsored on client by client basis, currently: private health insurance funded on client by client basis, non-profit organisation

**SUMMARY DESCRIPTION**

**Long term, residential, therapeutic wilderness camping based school for adolescent males with mental health problems.**

**PROGRAM PARAMETERS**

**PROGRAM AIMS:** to provide a quality wilderness program for male children and families.

**PROGRAM PHILOSOPHY:** to develop curiosity and a creative spirit of self-enquiry leading to personal, family and emotional growth. To instil motivation and develop excitement about learning.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** long-term residential school treatment for a wide range of adolescent and pre-adolescent problems.

**NUMBER OF CLIENTS:** 21 males, ages 10-18, between 9-18 months duration (usually 12-15; preferred).

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** 15 staff (core of permanent), graduate educated as minimum (preferably psychology, social work, counselling, etc.)

**NUMBER OF DAYS PER PROGRAM:** 24 hours, 7 days per week, all year except few days over Christmas and Thanksgiving.

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** domestic, residential, camp based and wilderness (usually out-of-state) at least 2 weeks and 6 weekends per year. Usually, every second weekend dependent on trip preparation of adolescents. Regular classroom school is 10 months of the year, 3 hours per day (equivalent to normal school hours, plus 3 hours of options/work projects/life skills (eg. Drugs & alcohol, hygiene, racism). Routine is regimented and planned ahead of time.

**OTHER THERAPY TYPES:** individual therapy if treatment team (inc. family and staff) feels is necessary, routine peer/group counselling regarding 'here-and-now' issues.

**CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** via direct marketing, schools, educational consultants, other programs, some state mental health referrals.

**REFERRAL MECHANISMS:** contact via parents, then parental application, site visit, then a final decision made by staff.

**RESTRICTIONS TO ACCESS:** female, acute psychiatric conditions, aggressive or assaultive outside the family, physically handicapped (out of practical resources limitations). Enrollment is voluntary, with some court ordered.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none.

**CLIENT AGE RANGE:** 11-17+, 14-15 usually.

**COST PER CLIENT PER DAY:** US\$125 per day or US\$3,500 per month

**DIAGNOSTIC TYPES:** Include Learning Disorders, social skills deficits, Conduct Disorder, Oppositional-defiant Disorder, Post Traumatic Stress Disorder, sexual/physical abuse, Attention and Hyperactivity Disorders, substance abuse (post detox.), runaway, promiscuity, anxiety, depression, etc.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** younger boys have better prognosis (especially in the wilderness component), the more recent the trauma or pathology the better prognosis, internalizing disorders

respond more quickly. Conversely, boys with long, established behavioural patterns do less well.

#### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** 24 hours, 7 days, 12 months. Daily routine includes domestic duties, schooling, free time options, meals, domestic tasks, etc.

**INDIVIDUAL vs GROUP APPROACHES:** emphasis is on peer group resolution of conflicts - here-and-now. Eg.s conflict resolution, peer authority, problem solving, etc. The highest possible level of group autonomy is encouraged.

**FAMILY / PARENT THERAPY:** families may choose to be involved in the treatment planning, families make monthly visits to liaise with teachers, monthly parent education seminars are given.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): - see time frame design -

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** staffing is the same for 21 hour periods, with a one hour hand-over meeting between each shift. Teacher hand-over with staff before and after school session, as well as teacher being involved in review meetings. Weekly 1-2 hour case & group review with clinically trained Social Worker (MSW).

#### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** build responsibility and autonomy based on the earning of privileges from the practical (eg. Knife use) to the social (eg. Respect/honesty)

**THEORETICAL MODELS:** Glasser, W. Sequential model of hierarchy of needs and behaviours. Premises: 1) all behaviour is purposeful, 2) behaviour needs to be socially acceptable and involve choice, 3) people need to be able to generate alternative behaviours.

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** group counselling

**SPECIFIC THERAPEUTIC FACTORS:** 1) natural and logical consequences which instills responsibility, 2) staff; dedicated and involve boys in an extended family, need to have passion about the work and a capacity for demanding relationships.

#### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** none done by centre, made available by referring professionals/agencies

**NON-CLINICAL:** educational assessments are made prior to referral, or informally by teacher. Informal behavioural and other assessments made by staff on an on-going basis.

#### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** hand-over meetings between shifts.

**POST-PROGRAM TRANSFER METHODS:** termination and follow-up sessions with parents to transfer strategies, establish an individualised exit program including one week home and school trials (transition visits; 1 week on, 1 week off), teacher hand-over to new school (informal meeting or phone contact if too far away)

**FOLLOW-UP METHODS & TIME FRAME:** establish structures for dealing with family conflicts, hand-over strategies and expectations, train up parents in strategies/routines and boy's skills.

#### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** none

**MEASURES USED:** N/A

**FOLLOW-UP EVALUATION:** none formally on boys, however, certification as a Mental Health program every 3 years, National Association of Therapeutic Wilderness Camps (NATWC) accreditation review, regular Public Schools inspections.

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** quality assurance

**CLINICAL UTILITY OF DATA:** N/A

**ANALYSIS OF DATA:** N/A

## RESEARCH ACTIVITIES

**ADDITIONAL RESEARCH ACTIVITIES:** none

## STAFFING & TRAINING NEEDS / ISSUES

**STAFF TO CLIENT RATIOS:** 2:8

**LEVELS OF STAFFING:** Executive Director, Program Director, Senior Counsellor, Counsellor. Promotion to different positions is encouraged from within existing staff.

**STAFF QUALIFICATIONS:** Minimum for all staff is 4 year Bachelor's degree and technical and first-aid wilderness skills

**STAFF TRAINING IN THERAPY:** professional education program (counselling skills, relevant special skills, etc.), staff are encouraged to attend external workshops/training in technical skills, support given to undertake graduate study (psychology, social work).

**SUPERVISION STRUCTURES:** Senior Counsellor supervises Counsellors on trips and spends time with groups (40% of the time).

**INTERNAL STAFF TRAINING PROGRAMS:** orientation program; crisis management, documentation, medication, group dynamics, plus on the job training to integrate this. External consultants come in to do specialised training.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** capacity to work within a team, willingness to learn, have practical experience with children (of any age).

## KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** staff are expected to have formal certificates in counselling, etc. program accreditation is preferred to certification.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** 4 year Bachelor degree in social science area plus additional counsellor training.

**OTHER:** National Association of Therapeutic Wilderness Camps needs to increase networking, form strong links between programs as a profession utilising research. Professionalism and professional ethics need to be taught as part of under-graduate study. Reasonable career option upon graduation as salary rates are relatively good for graduates.

## KEY STRENGTHS OF PROGRAM

- capacity to anticipate needs of individuals and groups and so plan ahead.
- good quality staff from base counsellor level through to senior management
- flexibility to individualise approach
- focus on 'real life' issues without the distraction of a contemporary community environment, incl. peers, etc.
- isolated and ideal setting
- small and experientially based academic program which is an accredited school

## PROGRAM LIMITATIONS

- restricted in doing more whole family work; would require a full-time family worker and some assistance with getting families on-site.
- school amenities are comparable to mainstream school but an increased range would enhance appeal and motivation for students.
- relatively frequent turn-over of staff places pressure on a high need for staff training.
- having a more solid financial base would improve program planning and development

## KEY PROGRAM FEATURES

- medium to small and individualised school base allows a good degree of program flexibility
- truly full-time, long-term nature of program gives considerable scope for addressing a broad range of needs
- highly committed staff with clear therapeutic model and good system of training/supervision and clinical review.
- having an accredited full-time school program gives a solid base for integrating educational needs with therapeutic needs.

## CONCLUSIONS

- an innovative and sound program that offers a viable alternative treatment for a range of severe mental health problems, utilising a highly integrated holistic approach
- well structured therapeutic systems appear to provide an effective and high quality intervention within a minimumally resourced service.
- good supervision structures are important in this form of long-term and geographically isolated program.

## PROGRAM 7

### **PROGRAM NAME: Project Adventure - LEGACY (Learning Empathy, Gaining Acceptance, Changing Yourself) Program**

CONTACT PERSON: Lisa Galm, Program Director, LEGACY Program or Cindy Simpson, Director, Project Adventure.

ADDRESS & CONTACT DETAILS: PO Box 2447, Covington, Georgia, 30210 USA

Phone: 770-784-9310 Fax: 770-787-7764 Email: pase@mindspring.com

AUSPICE ORGANISATION: Project Adventure, Inc.

FUNDING&/OR FEE STATUS: Non-profit, individual clients are most frequently sponsored by Department of Children and Youth Services, State of Georgia

## SUMMARY DESCRIPTION

**Specialized treatment program of Project Adventure which is a long-term residential adventure therapy and short-term expedition program for court ordered adolescent / pre-adolescent sex offenders. Program began in October 1995.**

## PROGRAM PARAMETERS

**PROGRAM AIMS:** Treatment of (court sentenced) juvenile and adolescent sex offenders who are court ordered in the least restrictive setting.

**PROGRAM PHILOSOPHY:** Sex offending is seen as a disorder of intimacy and empathy which can be

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remedied through a positive peer adventure learning environment.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** long-term residential adventure-based counselling treatment.

**NUMBER OF CLIENTS:** open group with a maximum of 12 places

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** Teams comprising masters trained direct care staff matched with bachelor trained direct care staff.

**NUMBER OF DAYS PER PROGRAM:** 5 days per week full-time, 12 months (to date)

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** Initiative games, ropes course, 5 day back-packing expeditions once per month.

**OTHER THERAPY TYPES:** group counselling, individual counselling, family therapy, school.

### CLIENT & SYSTEM CHARACTERISTICS

**REFERRAL SOURCES:** Court Service Workers

**REFERRAL MECHANISMS:** Court service worker refers upon involvement with client through sex offending charges.

**RESTRICTIONS TO ACCESS:** minimum age is 14. Clients with history of severe violence are not accepted.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** Department of Child Services

**CLIENT AGE RANGE:** 14-18, typically 16

**COST PER CLIENT PER DAY:**

**DIAGNOSTIC TYPES:** Primary sex offending, including molestation, rape. Frequently concurrent ADHD, dysthymia, conduct disorder/oppositional disorder (~75%), substance abuse (mostly alcohol & marijuana), sociopathy.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** IQ <80 makes verbal processing difficult, any home support improves outcome.

### PROGRAM MODEL / FRAMEWORK

**TIME FRAME DESIGN:** Residential full-time (5 days): minimum of 10 months, average of 11 months dependent on home placement. Daily school, physical education, Adventure Based Counselling (1 high element 4-5 hours per day), daily domestic duties; weekly individual therapy, psychotherapy group, and drama therapy; 5 day expedition every month.

**INDIVIDUAL vs GROUP APPROACHES:** Primarily group focus with supplementary 1:1. Emphasis is on group regulation of behaviour, consequences in group, positive peer culture. Weekly individual and group psychotherapy by consulting psychologist.

**FAMILY / PARENT THERAPY:** Family meeting with primary counsellors (dependent on travel/availability) at least once per month, more frequently where victim remains at home or there are significant family issues.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): 1:1 weekly, grief/gender/psychotherapy group, drama therapy group weekly, school, physical education,

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** Weekly case review and milieu analysis, progress on level system is reviewed weekly.

### THERAPEUTIC PARADIGM

**THERAPEUTIC PHILOSOPHY:** Sex offending is a disorder of intimacy and empathy, positive peer experience is the best way to teach and correct these.

**THEORETICAL MODELS:** Behavioural, Cognitive-behavioural, work books and personal development projects.

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** 1:1, family therapy, multi-modal group therapies.

**SPECIFIC THERAPEUTIC FACTORS:** inter-personal learning, group cohesion, community, natural consequences, consistency and immediacy of staff responses.

### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** Mental Status Exam & intake interview, MMPI-A, complete behavioural, cognitive-behavioural and family analysis of sex offending.

**NON-CLINICAL:** Peer relationship patterns assessed through adventure activities.

### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** Sessional hand-overs, level system reinforces behaviour change (linked to privileges such as w/e leave).

**POST-PROGRAM TRANSFER METHODS:** Weekly review sessions with Court Services Worker, toll-free phone number that clients can call program anytime following discharge,

**FOLLOW-UP METHODS & TIME FRAME:** Booster groups weeks/months post-discharge.

### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** Repeated measures design at 8 week intervals; pre and post program.

**MEASURES USED:** MMPI-A, Beck Depression Inventory, Tennessee Self-concept Scale, 'sensation seeking scale'

**FOLLOW-UP EVALUATION:** Anecdotal, regular follow-up with Court Services Worker

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** Client progress, evaluation of program

**CLINICAL UTILITY OF DATA:** High

**ANALYSIS OF DATA:** Statistical analysis of difference between pre and post-program

### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** Attached to Department of Psychology at Georgia College

### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 1:2, variable

**LEVELS OF STAFFING:** Primary Counsellors / Program Director / Consultant Psychologist (on call)

**STAFF QUALIFICATIONS:** Primary Counsellor: usually Masters level, Program Director: at least Masters, Consultant: PhD.

**STAFF TRAINING IN THERAPY:** Basic qualification training (Bachelor degree), Project Adventure training.

**SUPERVISION STRUCTURES:** Consultant Psychologist provides group supervision and is available on call.

**INTERNAL STAFF TRAINING PROGRAMS:** Project Adventure training programs.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** At least Bachelor degree and Adventure Based Counselling training

### **KEY PROFESSIONAL ISSUES**

**STANDARDS & ACCREDITATION:**

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:**

**OTHER:**

### **KEY STRENGTHS OF PROGRAM**

- effective treatment / rehabilitation in the least restrictive environment
- use of Adventure Based Counselling
- peer initiated group sessions, peers assigning logical consequences for inappropriate behaviour



## PROGRAM LIMITATIONS

- ?

## KEY PROGRAM FEATURES

- Adventure Based Counselling used from site where national training occurs
- empathy training
- level system
- group consequences
- employment for higher level trained therapists

## CONCLUSIONS

- this is an extremely difficult client population to treat because of the degree of sociopathy.

## PROGRAM 8

### **PROGRAM NAME: Inner Harbour Hospital**

CONTACT PERSON: Ron Scroggy / Jay Mcleod

ADDRESS & CONTACT DETAILS: 4685 Dorsett Shoals Rd, Douglasville, GA 30135, USA

Phone: 770-942-2391 Fax: 770-489-0406

AUSPICE ORGANISATION: Inner Harbour Hospital, Inc.

FUNDING&/OR FEE STATUS: non-profit, private. Clients are means tested upon referral and flexible fee re-payment is offered.

## SUMMARY DESCRIPTION

**A large, semi-isolated facility offering a full clinical and therapeutic range of secure in-patient, open residential programs, transitional housing and out-patient mental health services for children, adolescents and families. A strong, integrative experiential therapy approach runs throughout all aspects of all programs. A broad range of adventure and other activities is offered on a site which has over 100 acres of Forrest and a lake, while extended overnight expeditions are run in local areas.**

## **PROGRAM PARAMETERS**

**PROGRAM AIMS:** to offer a comprehensive range of treatment for long-term, seriously disturbed children, adolescents and families who may have had unsuccessful treatment by conventional services.

**PROGRAM PHILOSOPHY:** long-term treatment of psychiatric disorders utilizing experiential therapy approaches in all aspects of treatment, with the aim of assisting identity formation by developing meaning through experiential metaphor.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** separate male and female (10-17): acute secure psychiatric in-patient, open residential units, transitional housing and full range of out-patient treatment services. Child (6-8) residential services. Dual-diagnosis and juvenile court-ordered treatment program. Every service includes a multi-modal group therapy and school program based on principles of experiential therapy.

**NUMBER OF CLIENTS:**

**COST PER CLIENT DAY:** residential: ~ \$US500/day (compared with ~\$US1,000 for traditional hospitalisation)

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** multi-disciplinary teams and sessional consultants including, licenced counsellors, psychologists, social workers, psychiatrists, nurses, recreation therapists.

**NUMBER OF DAYS PER PROGRAM:** dependent on client need, typically clients are admitted for assessment

in the secure in-patient unit, then progress to residential unit, transitional housing and out-patient treatment.

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** numerous; conventional group and individual therapies, adventure therapy (initiatives, ropes courses, climbing, abseiling), wilderness therapy expeditions, drama and movement therapies, art therapy, horticulture therapy, etc. all based on principles of experiential therapy.

**OTHER THERAPY TYPES:** out-patient therapies; family and individual therapy.

## **CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** mostly from insurance companies; managed care, other treatment services, word of mouth.

**REFERRAL MECHANISMS:** approval granted by insurer (managed care), client and family makes site visit, assessment admission arranged and documentation from other professionals compiled.

**RESTRICTIONS TO ACCESS:** extreme violence, substance dependence as primary diagnosis (de-tox needs to be done prior), borderline intelligence.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** Inner Harbour Hospital Inc.

**CLIENT AGE RANGE:** 6-8, 10-17

**DIAGNOSTIC TYPES:** all and any

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** greater intelligence increases the client's understanding of group process, Conduct Disorder responds well with concrete experiences, drug and alcohol abusers are difficult to motivate.

## **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** multi-modal, full-time group therapy program with fortnightly to monthly wilderness therapy expeditions

**INDIVIDUAL vs GROUP APPROACHES:** most emphasis is on group process, individual counselling is offered if there are crises or disclosure of significant issues. 'Vision Quest' (1-2 night solo) involves a 1:1 experiential activity (eg. An element on the climbing tower that the client chooses)

**FAMILY / PARENT THERAPY:** traditional family therapy and multi-family groups, plus family ropes course.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): multi-modal group and family therapy supplemented by ad hoc individual therapy.

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** weekly case review, progress notes, therapy

session hand-over documentation.

### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** eclectic, experiential, humanistic; creation of an initiating experience which provides a tangible therapeutic metaphor.

**THEORETICAL MODELS:** eclectic

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** full range, multi-modal group approaches

**SPECIFIC THERAPEUTIC FACTORS:** tangible nature of experience which creates disequilibrium, risk, danger, 'newness', focus on issues, questioning, achievement.

### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** full range of diagnostic and psychological assessments from interview, group, psychometric, etc. Full-time psychometrist screens all clients upon admission on range of clinical and diagnostic measures.

**NON-CLINICAL:** living skill and physical ability

### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** ??? counsellor shifts?

**POST-PROGRAM TRANSFER METHODS:** transitional housing program aimed at application of life skills

**FOLLOW-UP METHODS & TIME FRAME:** open, on needs basis through out-patient services

### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** N/A

**MEASURES USED:** client satisfaction ???

**FOLLOW-UP EVALUATION:** ???

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** full-time psychometrist screens all clients in clinical and diagnostic areas.

**CLINICAL UTILITY OF DATA:** psychometric screening guides treatment planning.

**ANALYSIS OF DATA:** only on individual basis

### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** graduate research projects on ad hoc basis

### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** maximum of 10 adolescents in any group, maximum ratio is 1:6, usual group is 6 adolescents to 1 staff. During adventure therapy 3-4:12 (maximum), typically 3:8

**LEVELS OF STAFFING:** Assistant counsellor -> direct care counsellor -> therapist -> treatment co-ordinator -> program co-ordinator.

**STAFF QUALIFICATIONS:** Direct care counsellor: at least Bachelors degree, therapist/treatment co-ordinator: Masters degree.

**STAFF TRAINING IN THERAPY:** varied

**SUPERVISION STRUCTURES:** initial staff role involves direct supervision for stipulated number of hours, here specific skills are developed and on-going skill development program tailored for individual staff.

**INTERNAL STAFF TRAINING PROGRAMS:** 2 full-time staff development officers; in-house wilderness first-aid, crisis intervention, experiential therapy training for all staff (inc. Ropes course, climbing, etc.), anger management, risk management. Monthly skills training in group process.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** eclecticism

### KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** committed to Association of Experiential Education standards, profession needs firmer program accreditation standards.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** minimal understanding of clinical assessment, teams need to have an appropriate range of therapy skills.

**OTHER:** profession needs greater unification, mandatory supervised experience in basic skills eg. Group facilitation which leads to certification of practitioners.

### KEY STRENGTHS OF PROGRAM

- full range of all levels of mental health treatment with good follow-up resources
- high standards of clinical consultation and supervision, and practice
- clear, uniform therapeutic paradigm
- excellent resources and facilities appears to cover all clinical needs
- flexible and broad range of wilderness therapy intervention options

### PROGRAM LIMITATIONS

- currently there is a need to strengthen experiential therapy approach across all areas of all programs
- older staff need re-orienting and re-motivation (made difficult by size of service/staff), difficulty in empowering direct care staff

### KEY PROGRAM FEATURES

- broad range of therapeutic programs for both children and adolescents

### CONCLUSIONS

- underscores the importance of maintaining contact with the community for integration
- week-end programs in the community would continue change, ie. Support groups. Community service projects are invaluable in transferring therapeutic changes.

### PROGRAM 9

**PROGRAM NAME: Three Springs Residential Treatment Program**

CONTACT PERSON: Jim Chrietzberg / Robyn Warner

ADDRESS & CONTACT DETAILS: PO Box 20, Trenton, Alabama 35774, USA

Phone: 704-883-8889 Fax: 205-880-9569

AUSPICE ORGANISATION: Three Springs Inc.

FUNDING&/OR FEE STATUS: private, for profit, full fee paying: 10% of clients covered by insurance, 9 clients state sponsored

## SUMMARY DESCRIPTION

**Medium sized, semi-isolated, long-term therapeutic wilderness camping, state licenced treatment program for male and female (separate) adolescents and pre-adolescents which combines conventional individual and group therapy with adventure therapy and wilderness expedition based therapy. Parents are involved through weekend parent wilderness therapy expeditions and monthly family case conferences.**

## PROGRAM PARAMETERS

**PROGRAM AIMS:** To provide effective treatment for adolescents with treatment resistant Severe Emotional Disturbance (SED) using adventure, wilderness and experiential therapies integrated with conventional psychological/psychiatric treatments.

**PROGRAM PHILOSOPHY:** Mission Statement: "The mission of this company is the healing and restoration of children and their families. Every resource at our disposal, be it financial, human, or operational shall be directed towards this purpose. Our efforts will always be governed by the principles of honour, respect, teamwork, responsibility, accountability and honesty."

**DESCRIPTION OF TYPE(S) OF PROGRAM:** long-term (usually 12-15 month) residential program: 7 days per week, 12 months per year.

**NUMBER OF CLIENTS:** 72 male, 48 female, for 12-15 months

**COST PER CLIENT PER DAY:** US\$120-140 per day (residential)

**STAFF NUMBERS/QUAL.S/EXPERIENCE/BACKGROUNDS:** all staff have a minimum of bachelor degree in social sciences plus qualifications in technical, first-aid and safety skills.

**NUMBER OF DAYS PER PROGRAM:** 24 hours, 7 days per week, 12 months per year (usually 12-15 months admission)

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** daily: 3 hours of school, 2 hours of adventure therapy (usually ropes/initiatives, also caving, climbing/abseiling), weekly adjunct group therapy (eg. Sex issues/abuse, drugs), occasional vocational group, domestic/daily living tasks. Wilderness expeditions; 3-4 (orientation) & 6-8 days (moving to 20 day trips twice yearly) of hiking, canoeing, cycle touring, combined with educational program. Short trip destinations are chosen and planned by clients

**OTHER THERAPY TYPES:** individual counselling as needed (avoided if possible) on issues such as anger management, trust, abuse or family issues; family therapy and parent support on needs basis, programed parent activities for 30-45 days per year.

## CLIENT & SYSTEM CHARACTERISTICS

**REFERRAL SOURCES:** mostly parent referred, word of mouth, private educational consultants (>half), private practising professionals, other treatment programs.

**REFERRAL MECHANISMS:** assessments are undertaken if there are no recent psychological tests, up to a 90 day assessment period at commencement of the program.

**RESTRICTIONS TO ACCESS:** Severe violence, IQ<85, acute psychiatric disturbance, active eating disorder, extreme substance abuse. Will take borderline personality disorder.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none

**CLIENT AGE RANGE:** 10-17, 15 typical, males tend to be younger than females. Male groups are usually clustered 10-14, 13-15, 16-18 years of age, female groups are mixed in age.

**DIAGNOSTIC TYPES:** sexual abuse, substance abuse, SED, generally treatment resistant clients

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** dependent on level of functioning of the group, good outcomes with borderline personality disorder, conduct disorder/oppositional defiant disorder (if spread out in groups) responds very well but require longer treatment, low motivated/low self-esteem clients do particularly well, sociopathic clients take significantly longer and require regular individual and parent therapy.

#### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** Week-day program involves routine groups, week-end periods are less structured and are devoted to domestic needs and wilderness camping to increase outdoor skills, wilderness expeditions are planned on a needs basis.

**INDIVIDUAL vs GROUP APPROACHES:** Emphasis is on peer group learning as much as possible.

**FAMILY / PARENT THERAPY:** Parent counselling/family therapy monthly, 2 family wilderness therapy expeditions.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): concurrent individual counselling on needs basis, parent/family monthly

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** Treatment team case review weekly.

#### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** - see 'Creed' -

**THEORETICAL MODELS:** W. Glasser's Reality Therapy, Cognitive-behavioural theory, Adventure Based Counselling processing methods (small group de-briefing).

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** Adventure and Wilderness Therapy, milieu therapy, equestrian therapy, life skills groups (including sexuality issues, drug & alcohol issues),

**SPECIFIC THERAPEUTIC FACTORS:** Fun/excitement/enthusiasm, teaching of creativity, structure, confrontation with accountability, conflict resolution, acknowledgement of achievement by ceremony, family work. Adventure and Wilderness Therapy is most powerful in utilising these factors.

#### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** Routine psychiatric, psycho-social, psychometric, family, medical assessment upon admission and during assessment phase (up to 90 days)

**NON-CLINICAL:** Educational assessment upon admission.

#### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** Same counsellor for 3-4 days straight, meeting with family worker weekly. Treatment team meets weekly for case review.

**POST-PROGRAM TRANSFER METHODS:** After-care program, phone contact with significant professionals; family education re: program strategies and processes (eg. Nightly meetings, 'huddles') monthly over week-ends (1-2 nights). Optional return to program for up to 2 week interval if needed.

**FOLLOW-UP METHODS & TIME FRAME:** Out-patient counselling: individual and family on needs basis.

#### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** intake: full clinical assessment; discharge conference: review treatment plan and progress made.

**MEASURES USED:** Psychometric testing if appropriate or not previously done.

**FOLLOW-UP EVALUATION:** phone call survey, including parent satisfaction

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** clinical use only

**CLINICAL UTILITY OF DATA:** excellent

**ANALYSIS OF DATA:** none

## RESEARCH ACTIVITIES

**ADDITIONAL RESEARCH ACTIVITIES:** open to external (eg. University) research projects

## STAFFING & TRAINING NEEDS / ISSUES

**STAFF TO CLIENT RATIOS:** usually 2:10 depending on need, One Primary counsellor and one assistant per group.

**LEVELS OF STAFFING:** Counsellor 1 (bachelor degree), Counsellor 2 (primary, bachelor degree), Counsellor 3 (roving assistant), Counsellor 4 (supervises several lower level counsellors), Supervisor 1 (supervises all counsellor of that program, Supervisor 2 (evaluation, planning, program development, admissions).

**STAFF QUALIFICATIONS:** Minimum: bachelor degree (recreation, BA, BSci. etc.) Basic training: 4 day Project Adventure equivalent training, ropes course competency, ropes internship, counselling training, in-house Wilderness First-aid, aggression management.

**STAFF TRAINING IN THERAPY:** 30 day orientation with options eg. Creative group therapy, stress management, etc.

**SUPERVISION STRUCTURES:** 30 days directly supervised orientation, treatment team meetings.

**INTERNAL STAFF TRAINING PROGRAMS:** Adventure therapy training is all in-house (Jim Chrietzberg)

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** experience with group dynamics, how to process (debrief) and guide groups.

## KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** greater networking need.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** Difference in therapeutic paradigm with consultant psychiatrist.

**OTHER:** Staff at all levels need to have a career path structure and career development support. Significant benefit in promoting senior supervisors and managers from the counsellor level.

## KEY STRENGTHS OF PROGRAM

- holism, eclecticism and comprehensiveness of treatment approach which is well integrated through sound practice structures.
- ability to be replicated elsewhere
- high quality staff, high staff morale, with senior staff having experience at lower levels
- having resources to provide flexibility in program.

## PROGRAM LIMITATIONS

- risk of 'burnout' and consequent staff attrition. High case load on family workers, adventure therapy staff have high demand (need more staff).
- physical resources could be improved (eg camp sites)
- stronger in-house training
- lack of formal evaluation

## KEY PROGRAM FEATURES

- Strong and well structured program which is highly consistent at both the client level and staff supervision/management level.
- well integrated educational, life/living skill and therapeutic program which comprehensively attends to a broad range of client needs at all stages

- holistic approach and place of wilderness and adventure therapy components form the base of therapeutic model

## CONCLUSIONS

- staff leadership in groups is of great importance to ensure a therapeutic milieu and importantly high morale
- program philosophy needs to be consistently upheld throughout all levels of staffing.

## PROGRAM 10

### **PROGRAM NAME: Colorado Outward Bound School - Survivors of Violence (SOV)**

#### **Program**

CONTACT PERSON: Sian Hauver

ADDRESS & CONTACT DETAILS: 945 Pennsylvania St., Denver, Colorado 80203 USA

Phone: 303-831-6975 Fax: 303-831-6987 Email: citin@ud.edu

AUSPICE ORGANISATION: Colorado Outward Bound School

FUNDING&/OR FEE STATUS: private fees, fee assistance available

## SUMMARY DESCRIPTION

**Adjunctive wilderness-adventure therapy for the enhancement of the treatment of survivors of violence including sexual assault. Programs are tailored for referring agencies based around a short-term format formula. In addition, Colorado Outward Bound School offers a range of tailored mental health programs for drug and alcohol dependence, cancer survivors, & clients with physical disabilities including multiple sclerosis and brain injury.**

## PROGRAM PARAMETERS

**PROGRAM AIMS:** To address issues surrounding violence and sexual assault such as managing fear, developing trust and using peer support as a means of accelerating treatment and promoting recovery. This is achieved by experiential methods which allow clients to consolidate strategies for coping with fear and related problems.

**PROGRAM PHILOSOPHY:** Outward Bound Philosophy: "To Serve, to Strive and Not to Yield". Mission of OB: to enhance individual character, promote self-discovery and challenge students to cultivate self-reliance, leadership, fitness and compassion and service through wilderness education.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** A range of tailored programs for mental health agencies utilising a combination of basecamp and adventure therapy interventions with short or longer term wilderness expeditions.

**NUMBER OF CLIENTS:** dependent on referring agency.



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**COST PER CLIENT PER DAY:** ~US\$150 (residential)

**STAFF NUMBERS/QUAL.S/EXPERIENCE/BACKGROUNDS:** Outward Bound instructors with additional qualifications in social sciences (bachelors degree) or mental health (pursuing masters degree)

**NUMBER OF DAYS PER PROGRAM:** variable, typically 3 over a week-end (for accessibility)

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** group initiatives, ropes/challenge course, climbing/abseiling, peak ascent, solo.

**OTHER THERAPY TYPES:** usually provided by referring mental health agency

**CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** Usually sexual assault and related counselling services (public and private)

**REFERRAL MECHANISMS:** Agency staff negotiate course type and aims and engage clients.

**RESTRICTIONS TO ACCESS:** Generally, clients have had significant counselling prior to attending and are in the final stages of treatment. Clients will not be accepted if they have a low functioning borderline personality disorder, actively psychotic or suicidal, have major unaddressed/unresolved issues, are not willing for OB staff to discuss their case with their therapist.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none

**CLIENT AGE RANGE:** any age, typically young adult, not usually less than 16

**DIAGNOSTIC TYPES:** primarily survivor of sexual or physical assault; PTSD, personality disorder, depression, suicidal ideation, substance abuse.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** - see above -

**PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** 3-5 days: group initiatives, ropes and challenge course, peak ascent, Sunday: solo and high ropes course

**INDIVIDUAL vs GROUP APPROACHES:** primarily group

**FAMILY / PARENT THERAPY:** none unless dictated and offered by referring agency.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): typically significant previous individual and/or group counselling and subsequent counselling through referring agency.

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** Agency therapy staff attends entire OB course and provides follow-up counselling based on outcomes of program, or hands-over information to other respective counsellors.

**THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** Experiencing fear in vivo with the opportunity to work through, cope and succeed in spite of it in a supportive social milieu provides a major essential therapeutic step and a powerful reference contradicting previous response patterns.

**THEORETICAL MODELS:** Experiential education

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** Adventure and wilderness activities.

**SPECIFIC THERAPEUTIC FACTORS:** Exposure to fear in a supportive group with the opportunity to develop and consolidate a functional pattern of responses.

**DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** Done by referring agency, including medicals, if open enrolment, interview is done by OB staff and information is collected from primary therapist.

**NON-CLINICAL:** Individual coping and fear responses in addition to social skills are assessed throughout all activities and used to guide interventions and feedback to agency.

**INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** Briefing and de-briefing sessions used to process each

activity.

**POST-PROGRAM TRANSFER METHODS:** Agency staff who attends program counsel clients post program or handover information to clients' counsellor.

**FOLLOW-UP METHODS & TIME FRAME:** immediate, up to several weeks dependent on agency.

### EVALUATION METHODS

**EVALUATION TIME FRAME DESIGN:** none

**MEASURES USED:** none

**FOLLOW-UP EVALUATION:** none, except as per agency protocols

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** n/a

**CLINICAL UTILITY OF DATA:** n/a

**ANALYSIS OF DATA:** n/a

### RESEARCH ACTIVITIES

**ADDITIONAL RESEARCH ACTIVITIES:** several finished and on-going research projects

### STAFFING & TRAINING NEEDS / ISSUES

**STAFF TO CLIENT RATIOS:** 2 OB staff and 1-2 agency staff per group (up to 8-12 clients)

**LEVELS OF STAFFING:** Direct care: Program Director, Program Instructor, Agency Therapist

**STAFF QUALIFICATIONS:** Standard OB technical, first-aid and risk management, usually most staff pursue post-graduate mental health degrees.

**STAFF TRAINING IN THERAPY:** Generic training as part of post-graduate degree

**SUPERVISION STRUCTURES:** Program Director directly supervises program instructor in the field and debriefs post-program.

**INTERNAL STAFF TRAINING PROGRAMS:** Wilderness Therapy Practicum for mental health professionals is a 10 day (residential) experiential program covering wilderness and adventure therapy activities and processing methods.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** Group facilitation skills.

### KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** Professional networking needs significant improvement, but certification of practitioners may not enhance standards of practice (due to lack of strict entrance criteria), and may limit the unique contribution that experiential therapies can offer by limiting who can practise. Supervision of the highest level and accreditation of programs is most likely to ensure highest standards and development of the profession.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** Ideally would be an integrated or joint graduate training as part of university degree.

**OTHER:** Cross-training is ideal that includes holistic models that incorporate notions of psycho-pathology with a sound understanding of group processes and milieu.

### KEY STRENGTHS OF PROGRAM

- linked to long established outdoor education school
- one of the earliest pioneer in contemporary wilderness-adventure therapy programs
- flexibility to employ experienced therapeutic staff sessionally thus retaining skills
- role in overall treatment process is realistic and complimentary to other adjunctive therapies, integration with other treating agencies is well developed through comprehensive protocols.

## PROGRAM LIMITATIONS

- follow-up and post-program integration is dependent on agencies commitment and understanding of the transfer process and capacity to implement it.
- program is limited in scope (primarily through economic and therefore time restrictions) to remain an adjunctive intervention.

## KEY PROGRAM FEATURES

- pioneering and innovative service which can draw on a larger generalist outdoor education paradigm developed, and open to the public Wilderness Therapy Practicum training

## CONCLUSIONS

- courses developed around specific client types can offer highly effective complimentary adjunctive therapy.

## PROGRAM 11

### **PROGRAM NAME: Santa Fe Mountain Centre**

CONTACT PERSON: Jim Beer, Executive Director

ADDRESS & CONTACT DETAILS: Route 4 Box 34C, Santa Fe New Mexico 87501 USA

Phone: 505-983-6158 Fax: 505-983-0460

AUSPICE ORGANISATION: none

FUNDING&/OR FEE STATUS: non-profit, typically contract to agency

## SUMMARY DESCRIPTION

**Service which offers a range of tailored experiential programs utilizing conventional wilderness and adventure activities and community oriented activities to empower and assist socially disadvantaged and mental health clients. The Centre has a strong community emphasis and offers many innovative programs focusing on multi-culturalism and social diversity.**

## PROGRAM PARAMETERS

**PROGRAM AIMS:** Experiential programming for personal development and community building.

**PROGRAM PHILOSOPHY:** To provide activity to clients to have new experiences of themselves and others through 'play' and challenge. This is done with clients' families and significant others (including workers) in a fashion that is tailored to client need. It is assumed that it is vital that clients have an audience to affirm their new self.

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**DESCRIPTION OF TYPE(S) OF PROGRAM:** Programs are tailored through negotiation with agencies around experiential activities.

**NUMBER OF CLIENTS:** variable, maximum 100, annually 1500-2000 clients (10 programs)

**COST PER CLIENT PER DAY:** US\$15 per day, US\$140 per day for overnight activities.

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** 12 full-time, ~ 10-20 seasonal, qualifications: varied, typically bachelor degrees, minimum technical/safety/first-aid. Staff are assessed for employment on an individual basis with an emphasis on the value of ethnic and community background and experience.

**NUMBER OF DAYS PER PROGRAM:** variable

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** length from 1-17 days, some one day per week followed by long expedition. Activities include initiatives, ropes, climbing (day activities); back-packing, canyon descents, peak ascents, white-water rafting, community service, indigenous ceremonies, art and music.

**OTHER THERAPY TYPES:** informal group sessions, informal 1:1 goal setting.

### **CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** Health Management Organisations (HMOs), state agencies: adjudicated youth (institutionalised youth agencies), native American agencies (youth), department of health: homosexual males, and females at risk of HIV & AIDS, schools, survivors of abuse (funding by crime victims agencies)

**REFERRAL MECHANISMS:** clients recruited by via agency, schools, drug & alcohol treatment centres, word-of-mouth.

**RESTRICTIONS TO ACCESS:** Severe anger/violence problems, physical restriction, acute psychiatric disturbance, all assessed on a case by case basis.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none

**CLIENT AGE RANGE:** 7 to geriatric, average 15-16.

**CLIENT / DIAGNOSTIC TYPES:** any, dependent upon agency client target groups, include: native Americans, HIV/AIDS, repeat offending drunk-drivers, community building, youth corrections, victims of crime.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** diverse, participation needs to be voluntary, adolescents respond well, reserved individuals respond quickly (dependent on therapist?) but may take longer to engage initially.

### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** mixture of one day sessions, extended wilderness expeditions and community activities as designed by clients and agency.

**INDIVIDUAL vs GROUP APPROACHES:** individual goal setting, group emphasised as a mini-community, supplementary individual input.

**FAMILY / PARENT THERAPY:** adjunctive as pre and post program and provided by agency.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): as per agency, strongly encouraged by agencies.

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** Staff and family involvement post-program, letter writing to self in future, long-term follow-up sessions months and years later, community development activities and goal setting.

### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** Empowerment of the individual and community through community orientated programs, using the affirmation and support of community and significant others to strengthen and validate therapeutic outcomes.

**THEORETICAL MODELS:** Systems theory, Michael White, narrative, Stephen Glenn (humanistic psychology), Adventure Based Counselling, multi-cultural education, indigenous experiential traditions.

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** contemporary processing techniques according to individual practitioner.

**SPECIFIC THERAPEUTIC FACTORS:** Novel context, playfulness and challenge, openness to difference, group and community context, inter-dependence of relationships for group and individual success, spiritual connection with wilderness (ie. Transcendence), freedom from distraction.

#### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** Discussion of clients with referring agencies.

**NON-CLINICAL:** Screening checklist by the Centre, 3 days of day experiential activities to determine group/individual functioning.

#### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** briefing/de-briefing, same staff throughout program.

**POST-PROGRAM TRANSFER METHODS:** community development activities planned during program followed by a post-program activity held in the community which links back to original goal(s) for the program.

**FOLLOW-UP METHODS & TIME FRAME:** months and years follow-up contact.

#### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** post-program

**MEASURES USED:** none

**FOLLOW-UP EVALUATION:** agencies are surveyed post-program, clients who have done program 3 or more times are also surveyed on issues of personal change, life circumstances, consumer satisfaction, etc.

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** consumer satisfaction, social and self changes

**CLINICAL UTILITY OF DATA:** none

**ANALYSIS OF DATA:** none

#### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** external university research projects

#### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 1:4-6, groups typically 8-12 clients with 2-3 staff dependent on activity

**LEVELS OF STAFFING:** instructors/counsellors, project managers

**STAFF QUALIFICATIONS:** proficiency system in technical skills, ad hoc assessment of each staff team to ensure appropriate range of therapeutic skills

**STAFF TRAINING IN THERAPY:** dependent on individual practitioner

**SUPERVISION STRUCTURES:** peer supervision feedback, individual supervision for first 2-3 months, post-program peer evaluation.

**INTERNAL STAFF TRAINING PROGRAMS:** regular schedule of in-house training based on greatest perceived need.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** group dynamics, integrating technical activity in a therapeutic way, ability to work with different cultures, facilitation skills.

#### **KEY PROFESSIONAL ISSUES**

**STANDARDS & ACCREDITATION:** accreditation of programs allows greater flexibility, licencing of practitioners can exclude a range of valuable/skilled practitioners. Composition of skills/qualifications within the staff team is critical - having the correct range of skills.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** need to be open to different professional backgrounds and experiences as being very relevant, eg. Multi-cultural skills.

**OTHER:** need to expand the definition of "experiential" to involve different cultural definitions. Development of the profession would be best achieved through: better professional networks, professional

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identity (broad rather than narrow), better develop an understanding of experiential learning, ie. Reduce the division between notions of 'healer' and 'healed' .

**KEY STRENGTHS OF PROGRAM**

- non-profit, free-standing, thus increasing flexibility in service models and clients served
- long history of innovation (since 1971)
- geographical proximity to the diversity of culture within the community
- able to address issues of culture and class at the community level
- diversity of program types

**PROGRAM LIMITATIONS**

- being tied to shrinking funding that is constraining, eg. Preference to work with youth communities rather than 'problem youth'
- rather work for programs driven by community rather than based on activity.
- difficulty in planning long-term because of funding uncertainties

**KEY PROGRAM FEATURES**

- community building focus, adaptability to local ethnic and cultural needs, flexible and collaborative

**CONCLUSIONS**

- importance of community development and adaptation of programs to community need, community integration.
- prevailing political context is highly interventionist and prescriptive, ie. a culture of 'helping' which can dis-empower clients

**PROGRAM 12**

**PROGRAM NAME: Anasazi Foundation**

CONTACT PERSON: Larry Olsen, Ezekiel Sanchez, Paul Newman

ADDRESS & CONTACT DETAILS: 1424 S. Stapley Rd, Mesa, Arizona 85204, USA

Phone: 1800-678-3445 / 602-892-7403 Fax: 602-892-6701

AUSPICE ORGANISATION: none

FUNDING&/OR FEE STATUS: non-profit, health insurance rebatable, licenced mental health service.

Scholarships are available for economically disadvantaged clients.

**SUMMARY DESCRIPTION**

**An independent, 60 day wilderness expedition based treatment program for adolescents with mental health and family problems based around native American wilderness survival**

skills training (based on a book by Larry Olsen 1967), native American traditions and spiritual teachings of the Church of Later Day Saints (Mormon Church). Emphasis is given to the family and family relationships as primary in the treatment process, hence concurrent family/parent work culminates in a 3 day family wilderness solo and long-term family based follow-up.

#### **PROGRAM PARAMETERS**

**PROGRAM AIMS:** To improve adolescents' lives by working with adolescent and family, not to be outcome orientated, and use wilderness expeditions to provide learning opportunities.

**PROGRAM PHILOSOPHY:** To provide natural peer experiences, where the wilderness sets the agenda, not therapy, hence the approach is theoretical.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** 8 weeks (56 days) mobile wilderness expeditions of 7 days interval which allows re-supply and staff change over.

**NUMBER OF CLIENTS:** maximum 50

**COST PER CLIENT PER DAY:** US\$15,000 per client = US\$270 per day (residential). Scholarship covers ~20%, insurance usually 50%

**STAFF NUMBERS/QUAL.S/EXPERIENCE/BACKGROUNDS:** 20 staff, direct care staff usually completing undergraduate degree, case managers usually masters level in counselling or related field.

**NUMBER OF DAYS PER PROGRAM:** 56 full-time residential

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** de-emphasize an agenda, unstructured 8 week long wilderness expeditions. Survival training (eg. Native tool making is used as a problem solving experience and to improve comfort and adaptability to the environment.

**OTHER THERAPY TYPES:** 1:1 counselling once weekly including weekly case conference and family feedback

#### **CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** word of mouth from previous clients/family is largest source, secondarily other professionals.

**REFERRAL MECHANISMS:** ~60% through Mormon Church connections, phone screening, family visit, adolescent interview, admission.

**RESTRICTIONS TO ACCESS:** geographic distance, history of violence(ie. using weapons, assaultive behaviour)

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** Church of Later Day Saints Social Services assist individual clients with financial aid.

**CLIENT AGE RANGE:** 12-18, typically 15-17, some over 18 self-referred. No co-ed. groups but ~60% males and 40% females. Groups are streamed according to age bracket where possible.

**DIAGNOSTIC TYPES:** any behavioural diagnosis, including depressed & suicidal, oppositional-defiant (majority of clients), eating disorders, substance abuse, some court ordered delinquent, some with adoption issues.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** older (17+) respond quicker, females respond quicker, families that are intact with a spiritual faith, short-term substance abuse (long term history more difficult)

#### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** week by week mobile expedition. Weekly cycles include staff change-over.

**INDIVIDUAL vs GROUP APPROACHES:** mostly group focus, 1:1 session with case manager each week, limited 1:1 counselling encouraged with direct care staff.

**FAMILY / PARENT THERAPY:** seminars for parents (philosophy of parenting; ref. 'Arbinger', Terry

Warner) on weekly basis, weekly phone contact with parents by case manager, last 3 days of program is a family solo with the whole family on the trail.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): occasional subsequent 1:1 counselling on needs basis

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** not applicable

### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** the value of being self-sufficient is used to help clients to differentiate 'needs' from 'wants', empower individuals to help themselves through a simple and therapeutic experience of wilderness living at a stone age level. Values of personal agency, honesty and integrity are found through a re-ordering of priorities derived from wilderness experiences.

**THEORETICAL MODELS:** survival training through native American wilderness skills.

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** not applicable

**SPECIFIC THERAPEUTIC FACTORS:** wilderness environment, peer group, peer comparison in a neutral setting, discovery of competency through skills.

### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** none

**NON-CLINICAL:** none

Therapeutic history is not usually made available to direct care staff to avoid prejudice, case manager is only person to have previous mental health history.

### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** daily progress notes (structured), 1 day per week change over day of staff where issues are handed over, 2-3 times per week "fire-side" discussion based on a theme such as honesty, spiritual issues, etc.

**POST-PROGRAM TRANSFER METHODS:** case manager calls once per week post-program for 3 months

**FOLLOW-UP METHODS & TIME FRAME:** first 3 months is a critical period. Over the first 6 months each client and family receives a news package with resources (eg newsletters), and a phone call once per month for 12 months.

### **EVALUATION METHODS**

**EVALUATION TIME FRAME DESIGN:** pre-admission data and post-discharge questionnaire of the parents' perception of their children

**MEASURES USED:** questionnaire/survey

**FOLLOW-UP EVALUATION:** 300 out of 800 past participating families returned questionnaires (1990-1995)

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** outcome based behaviour status according to the parents' perceptions.

**CLINICAL UTILITY OF DATA:** ?

**ANALYSIS OF DATA:** descriptive: 40% return to previous behaviours, 30% show no recurring problems, 25% have minor problems.

### **RESEARCH ACTIVITIES**

**ADDITIONAL RESEARCH ACTIVITIES:** none

### **STAFFING & TRAINING NEEDS / ISSUES**

**STAFF TO CLIENT RATIOS:** 3:7-10, prefer smaller ratios because of staff-client splitting, prefer 1:3 as a single unit.



**LEVELS OF STAFFING:** college students, week on, week off roster, case managers are masters trained (usually MSW)

**STAFF QUALIFICATIONS:** trail staff: undergrad students, case managers MSW

**STAFF TRAINING IN THERAPY:** internal training for direct care, internships for undergraduates as for their course requirements, case managers: generic professional training

**SUPERVISION STRUCTURES:** 1 per week interview with case manager

**INTERNAL STAFF TRAINING PROGRAMS:** ethics, program philosophy, wilderness technical, all staff attend 'Arbinger' parent seminars

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** orientation to modelling appropriate relationships (as per 'Arbinger').

### KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** support certification and training

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** ?

**OTHER:** need to develop better tools for healing, need to gain greater universality ie. Insurance support

### KEY STRENGTHS OF PROGRAM

- well resourced due to level of fees charged
- on-going wilderness program where clients remain in wilderness for extended period
- continuity of staffing (weekly roster)
- long operating history
- high level of parental involvement including family integrated component (3 day family solo)
- clear structure and unified approach
- long-term contact support with previous clients
- high profile founder (Larry Olsen, Ezekiel Sanchez)

### PROGRAM LIMITATIONS

- need to compromise some areas for economic and licencing reasons, eg. Compromise a pure wilderness experience (staff have to supervise clients all night, etc.), need full-time nurse on staff
- would like to have less of a therapeutic agenda. Potential conflict regarding therapeutic versus spiritual approach
- not so suitable for non-intact families, or where parents are minimally involved

### KEY PROGRAM FEATURES

- extensive, long-term wilderness expedition format
- well developed, systems and staffing structures
- client 'paced' treatment approach with family integration being overall objective

### CONCLUSIONS

- wilderness expedition based treatment can be a viable mental health service with apparently good outcomes
- better outcomes with intact families and high level of parental involvement

**PROGRAM 13**

**PROGRAM NAME: Aspen Youth Alternatives**

CONTACT PERSON: Scott Shell / Karen Albrecht

ADDRESS & CONTACT DETAILS: PO Box 400, Loa, Utah, 84747, USA

Phone: 801-836-2090 Fax: 801-836-2040

AUSPICE ORGANISATION: Californian Health Systems, Aspen Achievement Academy

FUNDING&/OR FEE STATUS: for profit, negotiated Youth Corrections contract (from various states).

**SUMMARY DESCRIPTION**

**An independent, 60 plus day wilderness expedition based program for adjudicated (court-sentenced) male and female adolescents, which uses a cyclical program based around native American wilderness living skills. Emphasis is given to developing pro-social skills and modifying behavioural problems such as anger and poor impulse control. Adaptation to wilderness living and survival skills forms the basis for therapeutic metaphor which is integrated with school curriculum.**

**PROGRAM PARAMETERS**

**PROGRAM AIMS:** treatment of young offenders / adjudicated youth

**PROGRAM PHILOSOPHY:** To facilitate opportunities for growth and change for clients through discipline with love.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** Aspen youth alternatives has been running for 2 years and offers a cyclic program which is entirely wilderness based as an alternative to incarceration for adolescents who have been court sentenced. School curriculum is highly integrated with the learning of survival skills and environmental knowledge which forms the basis of therapeutic metaphor. Week long cycles focus on different modes of transportation such as hand carts, while a level system of privileges reinforce pro-social behaviour change. Groups are of mixed sex.

**NUMBER OF CLIENTS:** ~32: 4 groups of 8

**CLIENT AGE RANGE:** 14-18, typically 15-16

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** total staff ~120 (40-50 EFT) field staff typically part way through undergraduate social/behavioural sciences degree who also hold wilderness technical skills.

**NUMBER OF DAYS PER PROGRAM:** dependent on client progress, typically 60

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** backpacking with improvised pack and conventional pack, some ropes course and abseiling (summer), hand-cart pushing.

**OTHER THERAPY TYPES:** not applicable

**CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** court sentenced, youth detention centres from various state youth corrections services.

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**REFERRAL MECHANISMS:** court service worker assigns client to a waiting list, Aspen selects appropriate client upon vacancy, screening interview arranged

**RESTRICTIONS TO ACCESS:** prefer behavioural problems, decline primary personality disorder, eating disorder, sociopathic traits

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** none

**COST PER CLIENT PER DAY:** US\$120 per day (residential)

**DIAGNOSTIC TYPES:** Primarily behavioural: ADHD, conduct disorder, sex offenders, antisocial behaviour, etc.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** better outcomes from older (16-18) males, those with family support and/or have their own children, those who have educational success.

### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** typically 60 days in 1 week cycles (with staff change-over). Four different stages in an open group: 1) orientation/observation (~2 days), 2) survival skills phase, 3) team functioning, using hand-carts emphasising co-operation, 4) leadership phase including navigation, privileges, being a mentor for newer clients. Progression through each phase is dependent on co-operation and assistance from others in lower phases. Inter-dependence between phases was reported to be better using a closed group format.

**INDIVIDUAL vs GROUP APPROACHES:** group emphasis, importance on positive peer culture

**FAMILY / PARENT THERAPY:** weekly involvement with parents via telephone, workbook on parenting skills, parents attend graduation and 1-2 day debrief following a one overnight camp-out with adolescent.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): none

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** not applicable

### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** logical and natural consequences, the individual is innately healthy but needs to have positive behavioural encouragement, emphasis is on 'here-and-now' experiences rather than past experiences.

**THEORETICAL MODELS:** metaphor developed through survival skills which is also linked to school curricula, cognitive-behavioural concepts and skills, reframing of behaviour.

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** individualised treatment plan reviewed regularly: level system of privileges based around skill acquisition and school curricula, generic group counselling and group processing.

**SPECIFIC THERAPEUTIC FACTORS:** positive peer culture, examples of defined roles in a healthy ecosystem, rites of passage of the wilderness experience, life history, success and completion, adaptation and harmony to and with the environment.

### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** use of court reports and history in screening process

**NON-CLINICAL:** as evidenced through the course of the program in relation to behavioural problems, social skills, etc.

### **INTEGRATION / TRANSFER / FOLLOW-UP**

**INTRA-PROGRAM INTEGRATION METHODS:** weekly phone call to parents on progress from the case manager, individualised treatment plan, field staff report daily to supervisor

**POST-PROGRAM TRANSFER METHODS:** supported placement upon return to school, liaise with parents and hand-over to referring case worker.

**FOLLOW-UP METHODS & TIME FRAME:** after care is a major priority

## EVALUATION METHODS

**EVALUATION TIME FRAME DESIGN:** pre and post-program

**MEASURES USED:** measure of locus of control and self-concept, workers judgment of level of responsibility

**FOLLOW-UP EVALUATION:** 'trackers' follow client for up to 12 months assessing recidivism.

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** quality assurance, overall efficacy of program

**CLINICAL UTILITY OF DATA:** only massed statistical analyses

**ANALYSIS OF DATA:** statistical pre-post analyses

## RESEARCH ACTIVITIES

**ADDITIONAL RESEARCH ACTIVITIES:** none

## STAFFING & TRAINING NEEDS / ISSUES

**STAFF TO CLIENT RATIOS:** 2-3: 8

**LEVELS OF STAFFING:** 4 field staff levels plus internships (21 days) based on various criteria including an evaluation, field team manager (usually master level counsellor) who liaises with parents and case managers, visits group twice per week, field director oversees all groups.

**STAFF QUALIFICATIONS:** see above

**STAFF TRAINING IN THERAPY:** educational professional development 2 hours per week in-house

**SUPERVISION STRUCTURES:** twice daily radio check-in, weekly group supervision for field staff.

**INTERNAL STAFF TRAINING PROGRAMS:** induction training (1 week) focus on phases of program, technical & first-aid, crisis and aggression management program.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** 1) crisis management, 2) processing, 3) behaviour management in groups and wilderness environment.

## KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** ?

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** ?

**OTHER:** ?

## KEY STRENGTHS OF PROGRAM

- clear, graduated structure which neatly integrates therapeutic, school and survival skills
- clear hierarchical supervision structures,
- creative use of environment eg. using hand-carts, improvised packs, etc.
- ability to select clients who will benefit and decline those less likely to.

## PROGRAM LIMITATIONS

- constrained in being able to teach moral values (ie. religious ideas) which would enhance outcomes
- reliant on referring case worker to conduct follow-up and ensure transfer of outcomes
- minimal contact and involvement with families and parents.

## KEY PROGRAM FEATURES

- integrated school curriculum with wilderness skills, therapeutic metaphor and behavioural skills
- on-going wilderness expedition model maintains an impetus for change
- mixing both male and female offenders allows inter-gender issues to be addressed

## CONCLUSIONS

- preferred sex ratio in groups is 3 females to 5 males, so females can role model appropriate behaviour
- mobile wilderness program appears to be a highly cost effective alternative to incarceration which may have significant rehabilitative benefits once returned to the community.

## PROGRAM 14

### **PROGRAM NAME: Adventure Development**

CONTACT PERSON: Colin Goldthorpe

ADDRESS & CONTACT DETAILS: Specialist Education Service, Public Trust Building, 442 Moray Place, Dunedin.

PO Box 5147, Dunedin, New Zealand. Phone: 03-477-8610 Fax: 03-479-0541

AUSPICE ORGANISATION: Special Education Service Otago

FUNDING&/OR FEE STATUS: non-profit, funded through regional health authority and the ministry of education to service 'youth at risk': those with drug & alcohol issues and their families.

## SUMMARY DESCRIPTION

**A multi-modal wilderness and adventure therapy program which combines individual and family therapy before and after a 9 day wilderness and adventure therapy group intervention. A high degree of flexibility in approach is tailored to individual need due to small group size and broad therapeutic training of staff.**

## PROGRAM PARAMETERS

**PROGRAM AIMS:** to assist clients to develop more control over their lives, over themselves (ie. autonomy), and to take increasing responsibility for self.

**PROGRAM PHILOSOPHY:** much reality is socially constructed, clients can develop ways of thinking which enable them to take over that process, become more intentional about constructing their reality.

**DESCRIPTION OF TYPE(S) OF PROGRAM:** 4 months of individual and family therapy followed by 9 day group wilderness and adventure therapy with 3 month individual and family follow-up.

**NUMBER OF CLIENTS:** 10-12 per group, minimum of 4 programs per day, maximum of 8 per year

**COST PER CLIENT PER DAY:** ????

**STAFF NUMBERS/QUALS/EXPERIENCE/BACKGROUNDS:** 10 staff, 5 staff on average per area. On during wilderness therapy 3 staff plus admin staff. Therapeutic staff are registered psychologists (educational or clinical) or masters level in counselling,

**NUMBER OF DAYS PER PROGRAM:** 2-3 months out-patient therapy, 9 days base camping/expeditioning, 3 months out-patient follow-up

**TYPES OF ACTIVITIES UNDERTAKEN & DAYS FOR EACH:** within 9 day Basecamp: combination of Project Adventure, high and low ropes course, group therapy, "reflection" (solo).

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Typically 3-4 day expedition, 5-6 day base camp.

**OTHER THERAPY TYPES:** individual therapy (narrative/brief, just therapy, motivational interviewing, coping/CBT strategies, linguistic, possibility therapy) 10-15 sessions in total, 6-8 pre-trip. Family therapy 2-3 sessions pre-trip, 2-3 post-trip, including narrative, systems, just therapy.

### **CLIENT & SYSTEM CHARACTERISTICS**

**REFERRAL SOURCES:** self and family referral, schools, youth justice, social welfare.

**REFERRAL MECHANISMS:** information sent to parents, written application, 2 way selection process.

**RESTRICTIONS TO ACCESS:** funding criteria: must have significant drug/alcohol use and/or other risk factors. Will take all forms of violence, moderate (contained) suicidal clients.

**SUPPORT &/OR AUTHORITY ORGANISATIONS:** Specialist Education Service

**CLIENT AGE RANGE:** 13-20, typically 13-18, average 14.8.

**DIAGNOSTIC TYPES:** Drug & alcohol, depression & suicidal, poor physical self-concept, sociopathic, ADHD, conduct disorder, family dysfunction, abuse (physical/sexual/emotional), learning disorders, impulse control problems, external locus of control.

**DIAGNOSTIC OUTCOME DIFFERENTIALS:** very good outcomes where clients behaviour, thoughts and emotions are related to their past and present environments, more difficult with those who have an underlying psychopathology unrelated to what has happened to them. ADHD, conduct disorder, family dysfunction are harder to achieve good outcomes, suicidal and depressed responds very well.

### **PROGRAM MODEL / FRAMEWORK**

**TIME FRAME DESIGN:** 2-3 months individual & family therapy - 9 day wilderness and adventure therapy (the 'Journey') - 1-2 months follow-up individual and family therapy

**INDIVIDUAL vs GROUP APPROACHES:** during wilderness and adventure therapy: 2 individual 'check-in' sessions over 9 days, group as a major emphasis and support in client change. Ad hoc individual issues are dealt with through individual therapy.

**FAMILY / PARENT THERAPY:** pre and post wilderness and adventure therapy, ranging from teaching parenting skills to comprehensive family reconciliation work.

**ADJUNCTIVE THERAPY** (previous/concurrent/subsequent): - see pre/post individual and family therapy -

**ADJUNCTIVE THERAPY INTEGRATION MECHANISMS:** 1) pre-trip frames the 'Journey' as a time to reflect, place to experiment with change, acquire new skills, opportunity for congruence and risk-taking, 2) same therapists from individual & family therapy - wilderness and adventure therapy - follow-up therapy, 3) contract with client pre-trip about requirements for 'Journey', set goals for wilderness and adventure therapy, expectations for opportunities, front-loading challenges, log book, counsellor gets information regarding each client's goals, major issues, family concerns, etc. prior to and following the 'Journey'.

### **THERAPEUTIC PARADIGM**

**THERAPEUTIC PHILOSOPHY:** change occurs when clients realise the control they have over the meanings they derive from experiences, they can take control over this meaning to choose more helpful constructions of experience. This impacts upon subsequent thoughts, feelings and behaviour.

**THEORETICAL MODELS:** Bandura Self-efficacy theory, constructivist models of social reality, action research and experiential learning. Developmental models eg. Erickson, systems theory and Eco-psychology.

**RANGE OF THERAPEUTIC INTERVENTION TYPES:** narrative, motivational, brief and just therapies selected according to client need in relation to each of their issues.

**SPECIFIC THERAPEUTIC FACTORS:** perspective of self from an interaction with the environment. Holism (individual/family/peer/school, and within the individual ie cognitive/affective/behavioural), systemic focus, cultural/ethnic/class/gender.

### **DIAGNOSTIC &/OR OTHER ASSESSMENTS**

**CLINICAL:** AUDIT questionnaire (D&A), ????

NON-CLINICAL: - see evaluation -

### INTEGRATION / TRANSFER / FOLLOW-UP

**INTRA-PROGRAM INTEGRATION METHODS:** coherent rationale integrating all program components, front-loading via problem task de-construction during activity briefing.

**POST-PROGRAM TRANSFER METHODS:** individual and family therapy use exceptions from their journey to change expectations and behavioural responses.

**FOLLOW-UP METHODS & TIME FRAME:** individual and family therapy, open contract available, 2-3 follow-up phone contacts, graduation 4-5 months post 'Journey'

### EVALUATION METHODS

**EVALUATION TIME FRAME DESIGN:** pre and post program , External evaluation 1-2 months post program.

**MEASURES USED:** AUDIT questionnaire, interview with client by therapist co-constructing therapeutic stories, and undertaking self-evaluation.

**FOLLOW-UP EVALUATION:** External evaluation: structured interview with client re: outcomes and therapeutic process, questionnaire to referring agency, structured interview by phone call to parents or caregiver.

**USE OF DATA / PURPOSE OF EVALUATION PROGRAM:** monitor drug usage pre and post, evaluate efficacy of program, consumer satisfaction.

**CLINICAL UTILITY OF DATA:** high, practical

**ANALYSIS OF DATA:** Formal reports completed on each program for funder and program development by external evaluator and director.

### RESEARCH ACTIVITIES

**ADDITIONAL RESEARCH ACTIVITIES:** previously 5-6 masters level academic project, currently selective post-graduate projects.

### STAFFING & TRAINING NEEDS / ISSUES

**STAFF TO CLIENT RATIOS:** 3:12 (1:4), usually 1:3.5

**LEVELS OF STAFFING:** Program Director, Assistant Director, counsellors; team leader and co-leaders

**STAFF QUALIFICATIONS:** registered psychologist or masters level counsellor (occasionally masters level trainee under supervision).

**STAFF TRAINING IN THERAPY:** generic training as psychologist/counsellor, peer training in co-therapy.

**SUPERVISION STRUCTURES:** once every 2-3 weeks

**INTERNAL STAFF TRAINING PROGRAMS:** technical skills, Adventure Based Counselling is done externally and internally, individual and family therapy training, co-leadership including risk-management, group processing skills, etc. is done in-house.

**MAJOR PERCEIVED STAFF TRAINING NEEDS:** continuing development in the following: co-therapy, family therapy, outdoor technical skills, risk management, group development.

### KEY PROFESSIONAL ISSUES

**STANDARDS & ACCREDITATION:** practitioners require a base mental health qualification. This ensures accountability through the base profession.

**CLINICAL BACKGROUND TRAINING / ADVENTURE THERAPY TRAINING:** essential. Quality in relationships with clients cannot be mandated - need a broad education.

**OTHER:** 1) accountability: protection of the rights of the client, need a regulating body (eg professional association, statutory board, etc.), 2) standards, training and supervision, 3) ethical issues: captive populations, use of stress, coercion to attend, 4) credibility: demonstrated outcomes via research including coherent rationales, 5) self-managing teams, co-leadership, 6) professional liability, occupational health & safety, sustainability.

### KEY STRENGTHS OF PROGRAM

- non-mystical approach - empower clients to be self-helping
- training and skills of staff: generic mental health professionals, in-house training, ie the capacity to apply flexible and analytic thinking to any situation, understanding complex issues hence flexible approach with clients
- coherent rationale integrates all elements of therapy into a whole, based on an on-going action research
- sound documentation of therapeutic processes and risk management decisions
- extensive open-ended follow-up

### PROGRAM LIMITATIONS

- need more training in substance abuse and family therapy
- selection and evaluation procedures
  - need to recruit trained and qualified female and Maori staff
  - continual developmental phase of program improvement, especially eco-psychology, team systems, family therapy

### KEY PROGRAM FEATURES

- highly trained staff
- commitment to on-going training
- documented, high level of positive outcomes
- program impacts on all domains of young person's life
- replaceability of outcomes in other regions with similar clients due to sound concepts, training and documentation

### CONCLUSIONS

- highly trained staff can offer greater flexibility, continuity of care, and high clinical standards with good outcomes through relatively short-term intervention.