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Continuing the Discussion: A Commentary on "Wilderness Therapy: Ethical Considerations for Mental Health Professionals"

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Abstract Wilderness therapy programs continue to be a possible treatment modality for at-risk youth who require out-of-home care. Issues associated with wilderness therapy also continue to be a spirited topic with professionals in the field and the general public. This commentary will add additional considerations, and continue the discussion concerning wilderness therapy not addressed in the Becker (Child Youth Care Forum, doi. 10.1007/s10566-009-9085-7, 2010 this issue) article. Issues related to cost, safety of clients, effectiveness of programs and proper training of staff will be discussed. Ethical issues faced by mental health providers working with wilderness therapy programs, as discussed in Becker's article, will also be reviewed.

Keywords At-risk youth · Wilderness therapy · Wilderness camps

Wilderness Therapy

Like any theoretical orientation in therapy, each has its strengths and weaknesses that guide the therapeutic process. Wilderness therapy programs are one option on the continuum of care for at-risk youth whose behavior and/or needs may be too great for in-home care. Wilderness camp programs are an alternative medium for therapy to be delivered. These programs have various names such as wilderness camps, boot camps, outdoor behavioral healthcare and wilderness therapy programs. Research is beginning to surface on the effectiveness of established Wilderness Therapy programs (Russell 2005). However, wilderness camps have been under the microscope in the past few years for accusations of the treatment of the residents in the camps (Behar et al. 2007). More specifically are the accusations of abuse and neglect leading to deaths of more than 10 adolescents since 1990 and scores of reports of abuse and neglect.

This article will not cover the broad spectrum of the strengths and weaknesses of wilderness therapy, but will explore in depth, areas of Wilderness Therapy programs that

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have raised ethical and legal concerns as mentioned in Becker (2010 this issue). Some of the main issues that are being discussed throughout the country are cost, adequate training for employees, safety, and the question of whether wilderness programs should be considered as a possible treatment option for at-risk youth. We will address these issues along with related others.

Program Cost

Any discussion concerning residential treatment for at-risk youth will usually contain issues related to cost. There is a moderate to high financial cost associated with residential treatment. However, what is clear is that intensive in-home and some residential programs are much more cost effective than sending youth to detention and correctional facilities. Mendel (2009) reports that the average cost for a juvenile to reside in a detention facility is approximately $48,000 a year. The average cost of a wilderness camp per day is approximately $300 (Klein 2007). The cost includes boarding, food, and the cost of therapy (camping equipment costs extra). Programs can last between 30 and 90 days, depending on the type of program being offered. In total, Wilderness therapy can cost anywhere between $12,000 to $30,000 and up to $100,000 if the youth is in placement for 1 year. Due to the high cost of Wilderness therapy programs, this therapy is not available to a wide population of people. Wilderness therapy can be best afforded by families with higher socioeconomic status, while middle class would have to take out loans in order to pay for their children's outdoor wilderness therapy. Lower socio-economic parents and adolescents may be completely excluded from this form of therapy. In a study conducted by Behar et al. (2007) in which wilderness camp participants were surveyed, they reported that half of the families had an income of $100,000 or more. Currently, most insurance companies will not pay for wilderness therapy or only pay a small portion. Counselors and other professionals making referrals to treatment programs must contemplate the ethical considerations of a therapy that is potentially only available to the higher socioeconomic clientele.

Continuum of Care and Aftercare

Another ethical dilemma facing parents is deciding the best treatment options for their child. When conceptualizing where an adolescent should be placed for their psychological treatment there are factors that need to be considered before placement. Many times this is the parent's first encounter with out-of-home treatment programs. Parents are looking for professional assistance and programs that they can trust to take care of their child. Current research suggests to keep the youth close to home to enable parental involvement, increase treatment success and reduce the disruption of removing a child from their community (Bettmann and Jasperson 2009; Mendel 2000). If local support has been exhausted and/or is not a productive means of treatment, the next higher level of intensity would be residential facilities (Reamer and Siegel 2009; Scott and Lorenc 2007). Other times, parents and professionals are looking for a step-down program from detention centers and training schools. Wilderness therapy programs could be considered a treatment option on this continuum of care for at-risk youth. This article does not attempt to continue the debate surrounding the continuum of care paradigm, but to only state that the term is still widely used and embraced by many in the mental health field. It may be in the best interest of

wilderness therapy programs to remain in the discussion and continue to be seen as an option for residential treatment.

After children have finished the wilderness program it is recommended they enter into aftercare, which falls into the continuum of care paradigm. Some different types of aftercare include outpatient (individual counseling), residential care (therapeutic boarding school), inpatient hospitalization, Residential Treatment Centers (rehabilitation facilities), and Alcoholics Anonymous (Russell 2005). Typical aftercare is the step-down to an outpatient setting. This helps ease the transition back into their normal environment and helps maintain the positive changes which occurred during their wilderness therapy experience (Hill 2007). In a study conducted by Russell (2005) of 88 participants in wilderness camps, only 27.1% participated in outpatient therapy in a 2 years follow up. Of note, is that 85% did participate in some type of aftercare treatment. In the survey conducted in Russell's study, parents described Wilderness therapy as being the first step to a long process of change. Russell described aftercare as the next step after participating in a wilderness therapy program. It is critical that counselors and referring professionals know the various aftercare treatment options for their clients.

Effectiveness of Wilderness Therapy Programs

There is clearly a limited amount of research on the effectiveness of wilderness therapy programs (Kutz and O'Connell 2007). Becker (2010) mentions the establishment of the Outdoor Behavioral Healthcare Industry Council (OBHIC 2009) as an organization that is conducting most of the wilderness therapy program research and promotes best standards in outdoor behavioral healthcare. At the time of press, OBHIC only has 15 member programs. This is only a small fraction of the amount of wilderness programs throughout the country. Also of note, is that OBHIC seems to be reporting the research of only one principal investigator. The goal is not to evaluate this person's research, but to encourage others to conduct effectiveness studies focused on wilderness therapy programs. These additional research contributions, both positive and negative, will strengthen the OBHIC's place in providing a balanced view of the effectiveness of wilderness therapy programs.

There is support for Becker's (2010) suggestion that parents and clients be provided with as much information about specific programs as possible before making any decision. The concern is that many times, the only information available for parents is the promotional material (print and internet) provided by the wilderness program (Behar et al. 2007). Typically the promotional material does not contain evidence-based research reporting the effectiveness of the program. In addition, before making referrals, the referring professionals are encouraged to evaluate the wilderness therapy programs based on state licensure, any national accreditation by a mental health accrediting agency and any past reports of abuse or neglect. Professional reviewing the results of any effectiveness research that is being conducted by the program would also be beneficial.

Safety and Staff Training Concerns in Wilderness Therapy Programs

Becker's (2010) article briefly discussed some of the ethical issues associated with wilderness therapist boundaries and staff training. We suggest that perhaps the most disconcerting controversies with Wilderness therapy programs are the reports of abuse, neglect and even death's of clients while participating in wilderness therapy. In 2007, Kutz

and O'Connell testified before the House of Representatives' Committee on Education and Labor several cases describing abuse and death in residential programs, including wilderness therapy camps, since 1990. According to this United States Government Accountability Office (GAO 2007) report, the researchers primarily examined wilderness camps, boot camps and boarding schools. Many of the programs were unregulated by their state. The report suggested that there were thousands of reports of abuse in these programs across the country from 1990 to 2007. The report also indicated that in 2005 alone, there were 1,619 reports of staff members who were involved in incidents of abuse in residential settings. Kutz and O'Connell go on to state the troubling issue of not finding accurate data since the data is not being collected by one specific national agency. This leads to the question of how many more incidents go unreported? The GAO report describes incidents of trained staff unable to recognize signs of dehydration and other physical ailments, which ultimately put the safety of the adolescent in critical danger. In addition there is also documentation of untrained staff, lack of nourishment, and leading campers to land that had not been scouted in advance. The most recent reported death was on August 28, 2009. A teen from Portland, Oregon collapsed during a hike while staying at a wilderness therapy camp. The cause of death was reported to be hyperthermia and malnutrition (Golden 2009).

Behar et al. (2007) reported information from 230 previous wilderness program participants (that supported the GAO report) indicated numerous issues related to safety and staff issues. The respondents had all participated in unregulated and unlicensed programs. The survey results suggested a clear misuse of seclusion, numerous reports of abuse and neglect and violations of patient's rights. The report also stressed the need for these programs to be licensed by their states and/or accredited by a national accrediting agency. There are several ethical considerations for licensed mental health professionals who are working for these unregulated wilderness therapy programs. Licensed professional counselors are mandated by their code of ethics (American Counseling Association 2005) to report possible abuse and neglect (even if it is their own organization), use evidenced-based therapy techniques and nonmaleficence.

Marchand et al. (2009) conducted a study to examine the high turnover rate of instructors, also referred to as Outdoor Behavioral Healthcare field instructors. This study surveyed instructors on the difficulties inside the work setting with a 9:1 ratio of negative aspects of being an instructor over the benefits. The instructors reported issues such as unsafe physical environment, pressure to perform, lack of outlet to share intense experiences, and sleep deprivation. This is compared to the benefits for instructors at wilderness camps which they describe as living in the wilderness, break from daily home pressures and concerns, personal growth, clarification of personal values, and no technology or media (Marchand et al. 2009). However, it is not stated in the study how the burnout rate of instructors may affect the counselor/counselee relationship. While this research is a positive step in examining the issues concerning Outdoor Behavior Healthcare field instructors, a concern is the dearth of published articles in this area.

Advancements

Another focus of concern about Wilderness Therapy programs is the lack of program regulation and supervision. Such program structure would create a standard for which camps must adhere to in order to keep their residents safe. As of November 2009, only a handful of programs are licensed by their respective states or a member of official standardizing organizations such as the Joint Commission, Council on Accreditation and others. A bill

sponsored by Representative Miller (2009), directly addresses the issue of abuse to teens in behavioral modification facilities. The bill specifically mentions wilderness programs, boot camps, boarding school and behavior modification programs that are not licensed and regulated by their respective States. The bill is called HR 911 or the Stop Child Abuse in Residential Programs for Teens Act of 2009. The purpose of this bill is to create a standard in which residential treatment facilities must follow. Specifically this bill states wilderness camps may not use abuse or neglect to discipline a child as well as prohibiting the withholding essential supplies for survival such as food, water, shelter, clothing or medical attention needed for the safety of the child. Other issues addressed in the bill are to ban restraining and secluding children, prohibit physical or mental abuse aimed at diminishing the child's self-respect, and to give residents access to telephones. The bill also addresses that qualified staff must attend training that addresses what constitutes child abuse and how to report it, familiarize with symptoms of heatstroke, dehydration, and hypothermia, along with having a criminal history background check performed on each employee (Miller 2009). Residential programs that are found in violation of the Stop Child Abuse in Residential Programs for Teens Act of 2009 will be fined up to $50,000 per violation. In addition a hotline will be set up where people may call to report abuse at residential care facilities.

Other sections of the US government have also taken initiative to help in the regulation of Outdoor Behavioral Healthcare. Roberson (2008), the assistant director of the Bureau of Land Management, released a memo addressing what wilderness therapy camps must do in order to obtain permits from each state's individualized requirements to obtain licensure. Each camp is required to obtain a permit if they use public land, if they do not already have a permit they must be in good standing with the state requirements, provide records and references of prior experiences and similar operations. If programs fail to comply with any of the above stipulations, fail periodic inspections, are not in a state that has a licensing board, or a camp has been proven to subject a youth to abuse the camp will be denied a permit (Roberson). This memo was issued soon after the release of the GAO (2007) report and was to take effect immediately.

Conclusion

This article has demonstrated the importance in the development of cost efficient programs, understanding continuum of care, the need for on-going services post wilderness camp, and the use of national standards that can and must be followed by wilderness therapy programs. Standardization has been an on-going battle since the mid 1990s, where 35 wilderness camps joined together in a collaborative effort to create guidelines (Gleick and Donohoe 1995). However, until there is a nation wide standard that would help improve the safety of the children, a debate will continue as to how much there is a need and how effective wilderness camps may be for at-risk youth and their families.

The intent of this article is not to demonize the efforts of wilderness camps or belittle the efforts of trained and conscientious staff that help at-risk adolescents. One goal was to continue the much needed discussion concerning wilderness therapy programs. We do commend Becker (2010) for his work and hope that this commentary added to the discussion and expanded on some of the issues touched on in his article. We also acknowledge that there are many licensed/accredited wilderness therapy programs that have well-trained staff and provide quality services. However, it is important to educate the reader about on-going controversies in this field to help make an informed decision. Advancements have been made and numerous groups are putting forth effort to make wilderness therapy camps

safer for their clientele. The current Stop Child Abuse in Residential Programs for Teens Act of 2009 and organizations such as The Alliance for the Safe, Therapeutic and Appropriate use of Residential Treatment (A START 2009) are continuing to help parents and mental health professionals understand residential treatment modalities such as wilderness therapy programs. They are helping these individuals make the ethical decisions concerning placement of at-risk youth in residential programs. As professionals in the field of mental health, it is our duty to educate our clients on all aspects of therapeutic options so that they may receive the most appropriate care possible.

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