Therapeutic Outfitting: Enhancing Conventional Adolescent Mental Health Interventions Through Innovative Collaborations With A Wilderness Experience Programme

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ABSTRACT: This paper presents an innovative approach designed to meet the needs of conventional mental health service providers in serving adolescents with a range of mental health needs. The collaborative effort between an experiential wilderness education programme and multiple adolescent community and mental health agencies is here described as therapeutic outfitting. This service delivery model addresses the need for innovative programme designs at a time when many adolescents experiencing mental health distress in Canada may not be receiving the services they need. Implications for practice and the need for research in this multi-agency, multidimensional setting will be discussed.

Key words: adolescent mental health, wilderness therapy, wilderness experience programmes, therapeutic outfitting, community collaboration, service delivery model

Introduction

The therapeutic outfitting model of mental health service delivery was designed to integrate experiential learning, challenging wilderness activities with conventional mental health practices for adolescents. In response to the growing need for adolescent mental health services this

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model was guided by theoretical, ethical, and practical developments in wilderness and adventure therapy (see Crisp, 1998; Davis-Berman & Berman, 1994; Gass, 1993; Russell, 2003a; Russell, Hendee & Cooke, 1998). It has the potential to facilitate a range of mental health interventions from treatment through early intervention to prevention.

Wilderness outfitting has a long history in Canada from the voyageurs to today's mountain and river guiding operations. Wilderness and adventure education in Canada has grown from these same roots and has focused on connection to wild places, indigenous travel practices, and the opportunity to re-connect with the land (Potter & Henderson, 2004). Critical to understanding the model presented here is the nature of wilderness outfitting for enhanced adolescent mental health intervention. This service delivery model is not described as therapy, although related wilderness-based programmes have shown considerable therapeutic potential. Through innovative collaborations with conventional mental health practitioners the therapeutic outfitting process proposes to enhance the continuum of care (i.e. from prevention to treatment) for adolescents with mental health issues.

Rationale for the development of the therapeutic outfitting model is presented within the Canadian context and followed by theoretical contributions of wilderness experience programmes, wilderness and adventure therapy, and the nature of this dynamic modality's potential as an effective adolescent mental health intervention. Key elements of the therapeutic outfitting model will be further described utilising the framework of international wilderness and adventure therapy best practices as described by Crisp (1998). Implications for practice will be discussed highlighting two significant clinical considerations and guidance for the practical application of the model.

Current need for innovation

Mental health distress and Canada's young people

It is estimated that 14% of young Canadians between four and 17 years of age experience some form of mental health distress and that less than 25% of these children and youth are currently being served with targeted treatment (Waddell, McEwan, Sheperd, Offord & Hua, 2005). An earlier report from Waddell and Shepherd (2002) showed rates of child and youth mental health disorders at 15% in British Columbia (approximately 140,000 youth). At the time of their report, the number of children and youth experiencing anxiety disorders was nearly 61,000, conduct disorders and ADHD each at almost 31,000, and depressive dis-

orders at close to 20,000 (p.3). Heavy drinking and illicit drug use are showing upward trends in Canadian adolescent populations at a time when other mental health issues, although prevalent, are generally receding (Health Canada, 1995; Statistics Canada, 2004).

These statistics support the need for increased service to address unmet child and adolescent mental health needs and do reflect the current level of effectiveness of interventions for children and adolescents diagnosed with mental health disorders. Canadian adolescents may not be receiving appropriate mental health interventions; from early identification of issues through to discharge from treatment. In addition, there has been little effort linking universal prevention initiatives and early targeted intervention. As children and adolescents with mental health issues go undiagnosed or do not receive effective professional help, subsequent difficulties arise in their educational, social, and family environments. Parents will seek alternative treatment modalities for their children when conventional practices are not available or appropriate in meeting the child's or parents' needs. It is in the arena of new innovations where federal, provincial, and regional authorities have sought to resolve mental health service delivery issues.

The pilot-project

A strategic plan was drafted to address critical mental health issues faced by children and youth in British Columbia. It called for evidence-based practice to guide the development of mental health services, standards of practice, and improvements in service delivery and treatment efficacy (British Columbia Ministry of Children and Family Development, 2004). As part of the five-year strategy to close gaps in service delivery, the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia requested proposals from service providers to demonstrate innovative and effective services for children and youth with mental health disorders with a focus on community collaborations. One organisation receiving a programme grant from "Promising Practices: Innovations in Services to Children and Youth with Mental Health Disorders" utilised the therapeutic outfitting model described in this paper to enrich their collaborating community partner's adolescent mental health interventions.

Community capacity and Canadian context

Therapeutic outfitting adopts strong theoretical and practical understandings from wilderness therapy (described below). As a treatment

modality, wilderness therapy is receiving growing attention for promising outcomes with high-risk/high-needs adolescents. There are now more than 100 programmes operating in the United States, providing mental health treatment to over 10,000 youth annually (Russell, 2003). Many of the American wilderness therapy programmes developed in response to a shift from institutionalised to community-based treatment of mental health and substance abuse disorders to better meet the needs of consumers over the last four decades (Lyons, 1997).

In the Canadian context, most wilderness-based adolescent mental health programmes delivering contracted services for provincial and federal sources are serving youth justice or social service clients of provincial ministries. This distinction is critical in understanding the development and delivery of the therapeutic outfitting model in that direct wilderness therapy treatment is not readily available to adolescents with mental health issues. Similar wilderness programmes operate in Canada through foundations, private, and non-profit organisations for diverse populations including people with disabilities, people with life-threatening illness, and occasionally alternate education programmes.

From recreational, educational, and therapeutic perspectives, numerous programmes and summer camps provide a wide range of wilderness-based opportunities for children and youth in Canada, including individuals with disabilities or dysfunction (Potter & Cuthbertson, 2002). Their mental health benefits have not yet been a focus of research. Parents, mental health service providers, and provincial and federal ministries need to understand the potential benefits of wilderness-based treatment modalities to more effectively serve adolescents with emotional and behavioural difficulties. Wilderness-based interventions will be further explored through descriptions of related programme designs leading toward, and providing rationale for, the therapeutic outfitting model.

Wilderness as therapeutic milieu

Wilderness experience programmes

Although not specifically designed for therapeutic purposes, wilderness experience programmes have been utilised in recreational, educational, therapeutic, and even corporate development environments (Gass, 1993) and adapted to meet a variety of objectives for a range of clients (Friese, Hendee & Kinziger, 1998). Wilderness programmes may not be obviously differentiated but may have clearly-defined objectives and be

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facilitated in ways to best produce desired effects. Russell *et al.* (1998), for example, described the successful blending of a wilderness experience programme with the United States Job Corp in reaching young adult participant's educational and life skill goals. Gillis and Gass (2004) described the use of challenging experiential outdoor activities as a primary intervention in marriage and family therapy.

Wilderness programming offers participants unique learning experiences. The long-standing Outward Bound programme model is still the foundation of many wilderness-based educational and therapeutic programmes. The approach places participants in unfamiliar environments, facing them with new and challenging experiential activities, living communally with peers, and participating in briefing and debriefing sessions to assist in the transfer of learning back into their day-to-day lives (Walsh & Golins, 1976).

Wilderness therapy

Wilderness therapy is located in a larger collective of therapies generally referred to as Adventure Therapy (Bandoroff & Newes, 2004; Gass, 1993; Gillen, 2003). A key feature distinguishing wilderness therapy from other adventure therapies is the primary use of wilderness or similar natural environments, while still sharing experiential teaching and learning methodology, risk-related adventure activities, and individual and group therapy and counselling techniques. Combined with conventional therapeutic interventions this approach has emerged as an effective alternative to adolescent mental health interventions (Russell, 2003b).

Adolescent wilderness and adventure-based programmes have shown reasonably consistent outcomes in self-efficacy, independence, confidence, self-understanding, internal locus of control and decision-making (Hattie, Marsh, Neill & Richards, 1997). Programmes may be designed to meet educational, recreational or therapeutic goals (Gass, 1993). Key to preventative and early mental health interventions, wilderness and adventure-based programmes also contribute positively to participants' mental health through physical exercise (Read & Brown, 2003), healthy nutrition (Center for Disease Control, 2005), positive social skill development through group processes (Schwartz, 1994; Walsh & Golins, 1976), stress reduction and the restoration of attention (Kaplan, 1995) from spending time in natural environments.

More relevant to therapeutic outfitting are the prescriptively therapeutic programmes which have demonstrated clinical improvement in social and psychological well-being of adolescents (see Clark, Marmol,

Cooley & Gathercoal, 2004; Crisp & Hinch, 2004; Russell, 2003). Definitions of practice (Russell & Hendee, 2000), evaluation of outcomes (Russell, 2003, 2005), and the detailed monitoring of risk-related incidents (Russell & Harper, 2006) demonstrate the level of professionalism and therapeutic intent of these licensed and accredited mental health organisations.

Clark *et al.* (2004) have completed the most clinically significant research in wilderness therapy to date. Their multi-dimensional study addressed three of the five axes of the Diagnostic Statistics Manual (DSM IV) used in psychological, psychiatric, and mental health fields to identify and guide treatment of personal dysfunction. One hundred and nine adolescents participating in 21-day wilderness therapy programmes were included in this study. Significant positive outcomes were reported for many mental disorders with special attention being given to characterological change as it is rarely affected by short-term interventions. The authors suggest this finding will have long-reaching implications considering the negative impact personality disorders have on individuals, families and society. Although lacking control or comparison groups, this study provides another formal step towards recognition of wilderness therapy in psychological and psychiatric research fields.

Mediating or confounding variables in wilderness therapy

A number of factors may be causal or mediating the positive outcomes reported in related wilderness therapy programmes. Challenging physical activities, inclement weather, and subsequent effort of outdoor living demands individual and group vigilance for the health and well-being of each wilderness therapy participant. Participants in outdoor programmes generally eat healthy diets, complete daily physical activity, have lowered distractions and stress from their regular daily living, and subsequently provide their bodies with an opportunity to cleanse and heal. Detoxification from alcohol, drugs, tobacco, and even sugar and caffeine occurs during wilderness therapy programmes; abstinence is the norm. The effect of these factors is possibly the most intriguing aspect of wilderness-based educational and therapeutic programmes. It is not yet fully understood what occurs during the wilderness therapy process that causes or supports its effectiveness as an adolescent mental health intervention.

Exercise and nutrition

Clinical psychologists Read and Brown (2003) reviewed current research literature supporting the role of physical exercise in improving mental health outcomes. Physical exercise was described as a promising and viable substance abuse intervention and was suggested for clinical application. Wilderness therapy staff encourage daily exercise for adolescents in treatment as they travel in outdoor environments. It could be argued that simply living outdoors demands substantial physical effort (e.g. rolling up your bed, backpacking, collecting firewood etc). A moderate level of physical activity has been suggested as the most effective approach to reach and maintain physical health (Dubbert, 1992; Hansen, Stevens & Coast, 2001), which in turn is reasoned to positively influence mental health.

The role of nutrition in individual wellness has been widely expressed as a determinant of physical, mental, and cognitive health (Center for Disease Control, 2005). The link between nutrition and the treatment of psychological disorders, however, is relatively limited in understanding. In a random survey of 232 psychologists registered with the American Psychological Association, the majority of respondents acknowledged diet and exercise as key contributors to mental health, although frequency of their prescription was low (Burks & Keeley, 1989).

In the wilderness therapy context, beneficial nutrition is accounted for in standard meal planning, food pack-out and preparation due to the isolated nature of the programmes and the intensive micro-community atmosphere. Short-term educational and counselling interventions have shown significant changes in diet and exercise patterns of adolescents four months post-intervention (Patrick *et al.*, 2001). Wilderness therapy programmes have intensive counsellor-client contact, nutrition is maintained by the programme staff, and food preparation is most often a key curricular element of each programme. Based on literature, it could be reasoned that adolescents may develop healthy eating and exercise patterns, maintain those habits in their lives post-discharge from treatment, and receive subsequent mental health benefits.

Attention restoration theory

Supportive research has demonstrated relationships between natural environments and individual and group well-being ranging in theoretical frameworks from the fields of psychology to urban planning (see Hartig,

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Kaiser & Bowler, 2001; Kuo & Faber Taylor, 2004; Stokols, 1992). Kaplan and Kaplan (2002, 2003) described the general preferences people have for natural, healthy, and supportive environments. The related theory of 'attention restoration' stems from the early work of psychologist William James and has been described as integral in mental health promotion in wilderness therapy literature (see Davis-Berman & Berman, 1994; Russell, 1999). Wilderness experiences provide a retreat from daily living that necessitates sustained intentional attention (directed) and facilitates rejuvenating or restorative attention (involuntary) (Davis-Berman & Berman, 1994; Kaplan, 1995).

Kaplan (1995) integrated theoretical understandings of stress with research demonstrating the restorative properties of natural environments and suggested stress can be prevented or reduced through the restoration of directed attention. This theory has widespread application to wilderness-based programmes, especially those providing mental health services to clients with emotional and behavioural dysfunction.

A large scale study of children with attention-deficit hyperactivity disorder (ADHD) used 'green' or natural environments to show considerable reductions in symptoms and positive aftereffects when compared with comparable activities in different settings (Kuo & Faber Taylor, 2004). Although early in its development, this type of research may provide empirical support for the inherent therapeutic value of natural environments in wilderness therapy.

Group dynamics, challenge and risk

Some theorists believe that group size and common objectives contribute to the success of the whole (see Schwartz, 1994). Following the advice of early group dynamics research Outward Bound courses utilised a ten-man-group (Walsh & Golins, 1976) and that is still the norm; however, more clinically-oriented wilderness programmes utilise slightly smaller groups. While treatment considerations and case plans are designed according to individual client needs in wilderness therapy programmes (Russell, 2000), clients are continually assessed for individual change while subsequently participating in an intensive group programme using individual and group therapy and counselling practices.

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One intentional feature of wilderness and adventure-based therapy programmes is the use of risk, challenge and group initiatives (Bandoroff & Newes, 2004). Adolescents may experience risk through participation in activities like canoeing, climbing or skiing. Considerable

social and psychological risk may be experienced during challenging interpersonal group process or during the isolation of a multi-day solo experience. This facilitated stress is intended to increase perceptions of risk, difficulty, and the likelihood that individuals will have the opportunity to work through and overcome difficult situations. Walsh and Golins (1976) described 'adaptive dissonance' as a cognitive state created by stress-related activities. Dissonance (or disconnect) occurs when an experience does not match an individual's perception, belief, or knowledge of a given situation. Cognitive dissonance experienced in groups sets the stage for restorative processes to return order or balance to the group (Matz & Wood, 2005). The strength of cohesion a group possesses and the individual attachment members have for the group and each other will moderate the effects of cognitive dissonance. Although not fully understood, exceptional opportunities for growth and learning for participants can be facilitated during this process.

Therapeutic outfitting

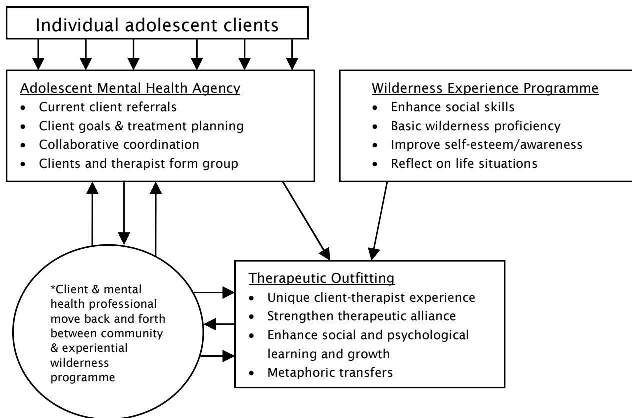

Figure 1: A collaborative service delivery model

A brief description of the pilot-project activities and logistics will be set out to provide context for the therapeutic outfitting model depicted in Figure 1. The model will then be described following a framework for

best practices suggested by Crisp (1998).[1] In his international study of critical issues in wilderness and adventure therapy practice, 14 programmes were assessed and key authors and practitioners were interviewed. It is the only published attempt to set a template for standards of practice in the field of wilderness and adventure therapy. The framework for best practices, including the following key elements, will be discussed as related to the therapeutic outfitting model: theoretical paradigm, systemic framework, assessment process, treatment planning, flexibility, therapist skills, client outcomes, risk management, ethical issues, training, and research.

The pilot-project utilising the therapeutic outfitting model consisted of 15 days of intervention over six and a half months. It included two days of team building with experiential activities and outdoor skills training (primarily sea kayaking), shortly followed by a five-day sea kayak and hiking expedition, and concluded with bi-monthly one-day programmes for six months following the wilderness expedition. Youth practised basic wilderness skills, problem solving, decision-making, positive risk-taking, conflict resolution, group work, and developed emotional competence through individual and group counselling processes.

Theoretical paradigm and systemic framework

Therapeutic outfitting is the utilisation of experiential education and wilderness expedition programming in collaboration with community and institutional mental health service providers to enhance therapeutic interventions for adolescent clients. Potential benefits range across the spectrum of mental health needs from therapy to therapeutic relationships to prevention and life skills development. This service delivery model recognises the need for levels of involvement from a variety of community and family players. Individual and group interventions occur during therapeutic outfitting for each adolescent and may include the engagement of family, school, peers, and extra-familial people when possible and appropriate. Literature in multi-dimensional and multi-systemic therapies have shown significantly improved results in adolescent treatment (e.g. Liddle *et al.*, 2001).

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[1] Canada was not included in Crisp's 1997 report of international best practices in adventure therapy practices. The author visited 11 programmes in the United States, two in the United Kingdom, and one in New Zealand. Criteria for inclusion in this inquiry were not disclosed but programmes appear to reflect a clinical model in which a licensed therapist – Masters or PhD level trained – was responsible for client treatment planning and oversight of mental health interventions.

Wilderness therapy is the closest theoretical model of service delivery in the literature (see Russell, 2001). Wilderness and adventure therapy (often described together) have been described as most closely fitting the therapeutic modality of cognitive behavioural therapy (Gillen, 2003) although numerous therapeutic modalities have been utilised. Experiential learning and the hardship of daily outdoor living have provided external stimuli to support the suggestion of wilderness therapy being primarily cognitive behavioural therapy. Most licensed wilderness therapy programmes (in the United States) are delivered by wilderness field staff, therapists, and are often supervised by a clinical psychotherapist (Russell, 2001).

Therapeutic outfitting is different, however, from wilderness therapy in four significant ways: 1) some clients are already engaged in a therapeutic mental health intervention and extend that engagement through attending an experiential wilderness programme with their therapist, 2) therapeutic outfitting provides multiple interventions over a half-year rather than the intensive residential duration of wilderness therapy programmes, 3) therapeutic outfitting is clearly adjunctive to therapy and not a primary therapy intervention, and 4) therapeutic outfitting may provide opportunities for prevention and early intervention for adolescents who are at risk of mental health difficulties but not yet in treatment.

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For adolescents in treatment, each collaborating mental health agency provides a minimum of one therapist or counsellor to accompany existing clients. The adolescent's continuum of care is maintained, expanded and supported through the therapeutic outfitting intervention and through the transfer of learning of new skills and knowledge from the experiential wilderness programme back into the adolescent's day-to-day life. Bacon (1983) described this learning as being metaphorically framed with real-life situations to assist participants in applying new interpersonal and intrapersonal skills.

Assessment process, treatment planning, and flexibility

A significant aspect of the therapeutic outfitting model is that the depth of social and psychological intervention will be determined, and subsequently facilitated, between mental health professionals and wilderness leadership staff. A clear understanding of the role of the experiential wilderness programme in the therapeutic process needs to exist. It is a vessel designed to allow collaborating mental health workers to increase the therapeutic potential of their interventions through intensive communal living and participation in experiential learning and

physically challenging wilderness activities with their clients. Similarly youth workers who accompany at-risk adolescents on wilderness experiences can maintain and develop their therapeutic relationships as part of an overall strategy of prevention and skills development.

Existing client-therapist relationships provide a unique opportunity for further development of therapeutic goals and objectives. Through experiencing challenging activities, counsellors or therapists can maintain or re-assess their client goals with the experiential wilderness programme staff. Collaboratively, the staff determines reasonable goals to be further discussed with individual clients (i.e. client goals) and collectively as a group (i.e. group goals). Whether clients have worked with their primary therapist individually or not, group counselling processes during the experiential wilderness programme provide additional opportunities for therapist assessment and intervention.

Nature is often unpredictable and presents wilderness leaders with the challenge of providing alternative experiential programming and activities when faced with inclement weather. Adolescent needs can also change (especially under the additional stress of challenging risk-related activities and inclement weather) and require flexibility in programming to be met. It is not uncommon for a collaborative staff decision to discontinue travel activities when adolescent groups need time to sort out issues and stabilise.

Ongoing contact with programme staff during the post-expedition phase of the intervention is critical for the successful transfer of learning. Aftercare has been described in a recent study as a crucial step in the change process following therapeutic wilderness interventions (Russell, 2005) and yet is relatively unavailable in current adolescent mental health or justice related wilderness-based programmes in Canada. The therapeutic outfitting model provides the collaborating mental health practitioner **with** intermittent opportunities to bring the group back together for single-day experiential and adventure activities (e.g. rock climbing or challenge course). Client assessment and goal setting processes are naturally aligned with the facilitation of these single-day interventions and can further enhance the efforts of the mental health agency therapist, counsellor, or youth worker.

Therapist skills and client outcomes

The theory and methods employed by the wilderness leaders and mental health agency staff in a therapeutic outfitting intervention may vary with client group and mandate of the mental health agency. It is critical that the range of clinical and practical skills necessary to ensure client

physical and psychological safety are present (Davis-Berman & Berman, 1994). Crisp (1998) recommended cross-training of wilderness and adventure leadership and clinical skills as an ideal for practitioners; however, it is the author's opinion that very few have achieved a desirable proficiency in both domains. It is clear that having all requisite skills and knowledge present does not ensure that client needs will be met. The level of communication and collaboration required for successful therapeutic outfitting is substantial and requires the fullest commitment from partnering agencies to be completed effectively.

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Client outcomes will range according to the nature of their therapeutic engagement. The programme utilising the therapeutic outfitting intervention described in this paper worked collaboratively with mental health agencies serving adolescent populations with the following issues: 1) substance abuse, 2) eating disorders, 3) identified as at-risk in the school system, 4) recognised as at-risk in First Nation communities, 5) adolescents with hearing impairments, and 6) adolescents with life threatening or terminal illnesses. The first four groups were identified in British Columbia's Child and Youth Mental Health Plan (2004) as needing improvements in service and were referrals to the pilot-project. The last two groups, although not included in the mental health pilot-project, participated in the therapeutic outfitting process and demonstrate the diversity of clients and flexibility of the model in delivering service. Client goals for the therapeutic outfitting intervention were developed collaboratively involving the client, mental health professional or youth worker, wilderness leaders, and often the client's parents. Again, if therapy was to be conducted, it was undertaken by the mental health professional and relative to their level of training, client goals, and the objectives of their employment.

Risk management and ethical issues

Wilderness activities have inherent risks and need considerable attention to manage both physical and emotional risks when included in the treatment of clients with emotional and behavioural issues (Davis-Berman & Berman, 1994). The activities undertaken require leadership with considerable levels of maturity, knowledge, technical skill, and awareness to be delivered safely. As the therapeutic outfitting model is designed to include a minimum of one **member of** therapeutic staff, the need for therapeutic client assessment and intervention is primarily overseen by the mental health agency worker. This does not abdicate responsibility for adolescent supervision from the wilderness staff. In fact, the role of the wilderness staff in this multi-agency service delivery

model becomes even more crucial in delivering the intervention. Wilderness leaders need to be able to direct experiential activities, manage safe group travel, coordinate group living needs, all the while communicating and collaborating in the therapeutic process unfolding under the supervision of the therapist. Wilderness leader competencies in the pilot-project included Sea Kayak Guide certification, Advanced Wilderness First Aid, **and** outdoor living and camp craft skills, as well as various levels of work experience and in-house training related to at-risk adolescents.

Training and research

The mental health agency staff may or may not be familiar or competent in wilderness travel or outdoor living. This may place additional burden on the wilderness leader but also demonstrates the collective experience of the clients and their therapists (i.e. they are in this together). Cross training opportunities are significant for collaborating agency staff. The experiential teaching and learning methodologies employed by wilderness leaders along with outdoor living and travel skills are available to the therapists while wilderness staff can further develop their counselling or mentoring abilities. It is recognised, however, that therapeutic wilderness programmes are not ideal for entry-level staff, but rather an opportunity for experienced staff to diversify skills and further develop professionally through 'cross-training'.

Research and evaluation in wilderness therapy and other adventure-based programming has been consistently challenged for numerous reasons: high diversity of programming (Hattie *et al*., 1997), not addressing specificity in variables (Hans, 2000), over-emphasis on outcomes without specifying processes (Baldwin, Persing & Magnuson, 2004), lack of valid methods of comparison (Neill, 2003), lack of control groups and limited follow-up or long term research (Bandoroff & Scherer, 1994). Research has been described repeatedly as inherently difficult in wilderness programming. Logistics, cost, and small group numbers tend to limit the number of studies that report statistically significant or methodologically sound findings. In addition when working with a number of institutional and community-based partners in short-term programme delivery there are a number **of** logistical challenges for researchers in establishing relationships with families, therapists and participants. The potential sample sizes are small and the time required for appropriate research protocols (ethical approval, multiple informed consent procedures, access permission) **is** prohibitive.

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Implications for mental health practice

Clinical considerations

Two primary clinical considerations guide the wilderness staff during the therapeutic outfitting process: 1) to increase the potential therapeutic alliance between client and mental health agency staff, and 2) to maintain professional therapeutic boundaries through recognition of what constitutes therapy; that is, to not overstep the role of experiential wilderness programme facilitator.

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Catalyst for increased therapeutic alliance

The group climate has been often identified as a key helping factor in child group psychotherapy (Shechtman & Gluk, 2005), youth development programming (Boccaro & Witt, 2003), and in counselling and personal growth groups (Johnson, Burlingame, Olsen, Davies & Gleave, 2005). Research in group climate or group alliance is limited in wilderness therapy literature but can be professed anecdotally as a key element of the process by many practitioners.

Clinical research of therapeutic alliance has shown it to be a modest yet consistent predictor of outcomes (Horvath, 2001; Martin, Garske & Davis, 2000) and its strength has only recently been evaluated in wilderness camp settings (Bickman *et al.*, 2004). The therapeutic outfitting model supports pre-existing therapeutic, supportive, or educational relationships between adolescent clients and their therapist or counsellor. The nature of each relationship is relative to the form of treatment the client is receiving and reflects the mandate of the collaborating mental health agency. In this regard, therapeutic outfitting would be described in adventure therapy literature as 'adjunctive' to the primary mental health intervention of the collaborating agency (Gass, 1993; Ringer, 1995). As individual or group case plans of the mental health agency are supported, participants receive primary treatment from their therapist or counsellor, while also benefiting from the growth and learning experienced in the wilderness programme. As adolescents and their primary mental health worker co-participate in the therapeutic outfitting programme, it is proposed that the intervention will strengthen the client-therapist alliance. The strengthening of therapeutic relationships extends to the early intervention and prevention potential of these programmes for at-risk youth who are not in treatment but may respond positively to wilderness programme experiences and reduce their risk of needing clinical intervention or treatment.

Therapy vs. therapeutic

Wilderness and adventure-based activities, whether in isolated wilderness environments or on a high-ropes challenge course, are often a catalyst for strong emotions. The expertise of the facilitator and the professional mandate of collaborating agencies need to be considered in maintaining the continuity of programming, and protecting the physical and emotional safety of the individual while not overstepping predetermined roles or client goals (Ringer & Gillis, 1995). A spectrum or 'depth' of intervention described in wilderness and adventure therapy literature is relevant to the following discussion between what is therapy, and what is therapeutic.

While a broad application of recreational activities in outdoor and wilderness settings can be seen in summer camps and community recreation departments throughout the country, it is the intended outcomes and the rationale for service that will generally distinguish each programme as recreational, educational/enrichment, or therapy (Crisp, 1998; Ringer & Gillis, 1995). For example, the demonstration of intentional therapeutic programming has been at the forefront of wilderness therapy programmes' effort to build credibility and distinguish themselves from traditional wilderness experience programmes (i.e. not intentionally conducting therapy). They explicitly utilise conventional psychotherapy practices, are accredited and licensed as such, and intentionally address dysfunctional behaviours of their clients. In contrast, a summer camp may offer wilderness expeditions for the purpose of recreation, or possibly environmental education. Outcomes from the summer camp wilderness experience may be therapeutic for an individual but may not have been intentionally facilitated by the staff.

The therapeutic outfitting model would be defined by current adventure therapy literature as therapeutic enrichment and not therapy, unless the collaborating partner's primary modality is defined as therapy (i.e. clinical treatment of an underlying dysfunction). In this regard, the therapist or counsellor of the collaborating agency determines the level and nature of intervention based on their agency mandate and the needs of their clients.

Organisational considerations

Two primary concerns for agencies considering the practice of the therapeutic outfitting model include: 1) the need for flexibility in many areas of programme design and service delivery, and 2) effective com-

munication of roles and responsibilities to collaboratively deliver this innovative adolescent mental health intervention.

Flexibility

Multiple agency approaches require the utmost of flexibility in the design, delivery, and administration of therapeutic outfitting. Considerations for multiple agency missions and standards of practice, logistical and financial contributions and limitations are only a few areas requiring an open and adaptable approach. Baseline standards for safety and client care need to be agreed upon first and maintained throughout the collaboration. Compensation and insurance coverage for the mental health professional participating in the wilderness programme has administrative implications for agencies and is only one of numerous conversations needed between partnering agency administrators and staff.

Effective communication

To meet the need for flexibility, significant time and energy will be needed to ensure effective communication inter-organisationally and at all administrative and service delivery levels. Discussing and understanding levels of training and agency mandates for client service, developing effective treatment plans for clients, and training collaboratively are recommended to begin the therapeutic outfitting process.

Agency administrators and frontline service delivery staff communication issues were present when initiating the pilot-project. When innovative collaborations have been formed by senior administrators of partnering organisations, understanding is documented through contractual agreements. One difficulty observed in design of this new service delivery model was the depth of communication required to ensure that, when frontline staff began to work together, they had the same understanding of objectives as the senior administrators originally agreed on and the ability to realise these objectives during service delivery. This requires exceptional effort on behalf of all parties to share knowledge and understanding through open communication and collaborative training prior to working with clients.

As roles and responsibilities are to be shared between two organisations, it is recommended that, when collaborations are being established, an effort be made to foster relationships that may grow into long-term commitments to the therapeutic outfitting model of adolescent mental health service. The pilot-project experienced greater suc-

cess in programming when working with existing partners while experiencing some growing pains with new organisational partners.

Conclusions

Therapeutic outfitting has been presented as an alternative intervention model to enhance mental health practitioners in their work with adolescent clients. A strong theoretical framework guided the development of this innovative model; however, the relative effectiveness of this collaborative approach is yet to be determined.

Positive mental health outcomes in similar therapeutic wilderness interventions have been demonstrated (e.g. Clark *et al*., 2004) and a supportive body of literature is developing while a clear understanding of the process is **as** yet unknown (Russell, 2000). Related fields have offered insight into potentially contributing therapeutic factors beyond conventional mental health practices and methodology such as exposure to 'green' environments (Kuo & Faber Taylor, 2004), physical exercise (Patrick *et al*., 2001), and nutrition (Center for Disease Control, 2005). Although simplistic in approach, it is not hard to imagine these contributing factors as critical in the restoration and maintenance of adolescent mental health as well as in early intervention and prevention of mental health disorders. Clear need exists for further research to understand the variables contributing to successful therapeutic wilderness experiences.[2]

Key components of the therapeutic outfitting model include the primary focus on enhancement of the therapist-client alliance while integrating experiential learning of new interpersonal skills and knowledge and assisting with the transfer of the newly-acquired skills into the adolescent's daily life. Strong consideration needs to be given to the realities of combining clinical mental health services with experiential wilderness programming; essential to the success of the process is a heightened level of communication and full collaboration by partnering agencies. Even when all requisite skills and knowledge are present between staff members, no guarantees of a safe and effective intervention

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[2] Research and programme evaluation of the therapeutic outfitting model were undertaken to assess effectiveness of the collaborative partnerships, treatment fidelity, and client and stakeholder satisfaction. Additionally, measures of social, behavioural, and emotional change were utilised in a repeated measures longitudinal study with a comparison group. Findings will be reported upon completion of the pilot-project in the summer of 2006.

can be made. The need for clearly-defined roles, responsibilities, and objectives cannot be overstated in this process.

Limitations of the therapeutic outfitting model include its inherent need for flexibility in meeting multiple agency and client needs through effective collaboration. Staff and administration of each partnering organisation need to ensure clarity of objectives and the realities of each agency's mandate and maintain vigilance in effectively communicating on behalf of clients and each partnering organisation.

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