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Beyond Surveillance toward Prevention of Injury and Illness at Camps

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Organized camps for children celebrated 150 years of existence two years ago. The first camp for boys can be traced back to the US Civil War.¹ Many overnight camps came in existence during the latter half of the 19th century, including private independent, agency, faith-based, and camps for girls. In the 1930s a study of camps showed that sometimes these environments were detrimental to children's health. To counter the situation, physicians, nurses, and dietitians were hired as staff members to institute healthful practices in camps. In addition, standards of performance were adopted by the American Camping Association in 1935 to address health and safety.² These standards and the accreditation of camps evolved over the years to encompass other operational and program management policies, procedures, and practices.

As noted by Garst, Erceg, and Walton, injuries and illness pose a risk whenever people gather for any activity. Reducing the frequency as well as the severity of these risks is the omnipresent duty of all individuals working in youth organizations. Childhood injury and illness has been reduced nationally because of efforts that have focused on surveillance, intervention, and prevention. The American Camp Association (ACA) is to be applauded for conducting a study to benchmark illness and injuries in resident overnight camps and day camps. The collection of data on staff members who are in late adolescence and frequently referred to as emerging adults³ is essential and was not addressed in earlier studies. Further, applying these findings to reduce injuries and illness through intervention and prevention is essential.

This study was well-designed with useful data pertaining to frequencies and probabilities concerning the *who*, *when/where*, and *what/why* of injuries and illnesses. Although few serious illness or injuries including death occur at camp, the severity of illness and injuries and the impact on camp experiences might also be important to consider. In developing risk management plans, the focus is on probability and impact. Being restricted from participation for one hour (day camps) or four hours (resident) may be quite different from hospitalizing or sending a camper/staff member home.^{4, 5}

This benchmark study provides new data and also reconfirms *common knowledge*. For example, one might expect that day campers would become ill less often than resident campers and be less likely to be injured because they spend fewer hours onsite. Counterintuitively, I might have expected more injuries to occur during campers' free time than in structured activities. From a positive side, structured activities should be easier to supervise than free time activities. However, as the authors note,

supervision of free-time activities may be an area that should receive more attention in camps.

I applaud the ACA for using the data to develop training modules. Assuming all the individuals on a camp staff viewed the training modules, camp directors perceived some improvement. I do not know how the training was developed, but I wonder if campers could also be recipients of some of these training modules. A more focused experiment with the outcomes associated with training modules is necessary to assess whether this training made a difference in actual injury or illness reduction, although camp directors' perceptions are important relative to policies and procedures. Additional modules could be developed for specific camp activities to demonstrate safety. The ACA Accreditation Standards call for written policies and procedures regarding safety in activities, but visual modules might be useful for all staff, especially regarding free-time supervision.

This study has other important implications for camp professionals. As noted by Garst, et al., camps are ultimately responsible for their own self-regulation and self-assessment surrounding injuries and illnesses. The success of prevention and intervention in the future will require that individual camps use their specific surveillance data to make appropriate changes yearly. Having population benchmark data can help directors assess where their camp contexts in comparison to other camps. However, having individual trend data each year would be the ideal situation for designing staff training programs aimed at illness and injury prevention. This study provides a framework for identifying the context of illness and injury incidences from a population standpoint. A useful next step might be to develop some type of app reflecting the model from CampRIO.TM Camp health records are required in accredited camps and they provide a basis for monitoring. However, reducing risks requires an analysis of the monitoring and what it tells camp directors, as well as what it portends for yearly interventions. Many camps analyze their health records regularly and respond accordingly, but making this process as easy as possible through development of an app could be a useful next step.

Although the data were not reported, I would be interested in whether any gender illness or injury as well as age differences existed related to injuries and illnesses. Key⁶ found no differences in gender at camps, but Wojcio⁵ uncovered that male campers comprised a larger percentage of reported injuries, while female campers accounted for a higher percentage of reported illnesses. Since the data showed that staff members also became ill and injured at camp, age may make no

difference. Further, this study was open to all camps, so both ACA accredited and non-accredited camps were involved in the data collection. I wonder if any differences exist on a population basis regarding the impact of accreditation.

Another possible project related to health in the future might be developing a surveillance system to monitor mental health issues in camp. Health professionals as well as all camp staff frequently deal with the mental/emotional health of campers and peers. Most of these problems do not start at camp, but may be manifested while at camp^{7, 8}. Such problems might be homesickness, bullying, eating disorders, physical/sexual abuse, behavioral episodes, or substance abuse. These mental health issues do not necessarily preclude participation in camp activities for a period of time, but they could be salient in how camp is experienced. Camp staff are not prepared to be professional counselors, but understanding the mental as well as physical health issues of campers may be paramount to making camp a place that is as free as possible of adverse risk factors and facilitating camp as the optimal place for children, adolescence, and emerging adults to grow.

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