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Wilderness Therapy Programs: *Stakeholder Perspectives in Washington*

This is the second report in a two-part series focused on wilderness therapy programs. Wilderness therapy combines therapeutic elements with outdoor activities in a natural setting to help support individuals with a range of behavioral, emotional, and substance use issues.

In 2021, the Washington State Legislature directed The Washington State Institute for Public Policy (WSIPP) to research wilderness therapy programs focused on behavioral health.[1] Our first report summarized existing research on wilderness therapy programs. The current report describes stakeholder perceptions of these programs. We interviewed a diverse group of individuals in Washington to learn about their opinions, questions, and concerns regarding wilderness therapy and identify themes from these interviews.

Section I provides an overview of our legislative assignment and the focus of this report. Section II provides background information on wilderness therapy programs. Section III details our process for conducting interviews and compiling results. Section IV summarizes the main themes from interviews, and Section V provides a discussion of key takeaways.

Summary

In 2021, the Washington State Legislature directed WSIPP to research wilderness therapy programs in the context of behavioral health treatment and prevention. This report summarizes stakeholder perceptions, questions, and concerns regarding wilderness therapy.

We were specifically assigned to assess the "interest and likelihood of support" for wilderness therapy programs among interest groups including "state prevention coalitions and tribes." We interviewed ten individuals representing a variety of stakeholder perspectives across Washington.

Generally, interview respondents view wilderness therapy programs as potentially beneficial for individuals they serve or those who live in their communities. However, we found that most respondents had concerns about the cost, safety, access, and lack of information about wilderness therapy programs. Respondents also wanted legislators to be aware of issues related to program flexibility, equitable access, and ongoing outreach if they consider policy decisions on this topic in the future.

Suggested citation: Cramer, J., & Gibson, C. (2022). *Wilderness therapy programs: stakeholder perspectives in Washington* (Document Number 22-12-1901). Olympia: Washington State Institute for Public Policy.

[1] Engrossed Substitute Senate Bill 5092, Chapter 334, Laws of 2021, amended by Engrossed Substitute Senate Bill 5693, Chapter 297, Laws of 2022.

I. WSIPP's Assignment

In 2021, the Washington State Legislature directed WSIPP to study wilderness therapy programs.[2] We were tasked with publishing two reports. The first report provided a research review and addressed components (a) and (b) of the assignment (see Exhibit 1).[3] This report summarizes stakeholders' interest and support for wilderness therapy programs (component c).

In our first report, we reviewed research evaluating wilderness therapy. Because existing studies were not sufficiently rigorous,[4] we could not determine if wilderness therapy had an impact on participant outcomes or determine if programs are cost-beneficial. Most studies reported that participants experienced improvements from pre-treatment to post-treatment on measures like self-concept, depression, and post-traumatic stress disorder (PTSD). However, because of the way the studies were designed, there was no way to know if these changes were due to wilderness therapy, other factors, or the passage of time. In report one, we summarized the literature to describe wilderness therapy models, populations served, and results for program participants.

In our review, we found that some wilderness therapy programs use proven behavioral health treatment models. In previous research, WSIPP found that treatment models like cognitive behavioral therapy improve outcomes for youth and adults with depression, anxiety, attention-deficit/hyperactivity disorder (ADHD), and PTSD. This suggests that wilderness therapy programs that include these models may be beneficial, regardless of any therapeutic effect of other program components. Still, rigorous research is needed to understand the effectiveness of wilderness therapy.

Exhibit 1

Legislative Assignment

...the Washington State Institute for Public Policy [shall] partner with a context expert to conduct a wilderness therapy research review. The University of Washington Evidence Based Practice Institute and Washington State University Impact Lab must assist the institute in identifying a content expert. For the review, the institute must:

(a) Identify wilderness therapy program models related to behavioral health which have a treatment approach which is well defined or definable and have a strong evidence base to be added to reporting guides for being identified as an evidence-based practice for mental health, including identification of target populations for these programs;

(b) Identify wilderness/adventure program models available for prevention services which are cost beneficial; and

(c) Assess the interest and likelihood of support for programs of this nature among relevant interest groups, such as state prevention coalitions and tribes, if such programs were listed as approved cost beneficial prevention programs by the division of behavioral health and recovery and the Washington State Health Care Authority.

Engrossed Substitute Senate Bill 5092

[2] Ibid.

[3] Cramer, J., & Wanner, P. (2022). *Wilderness Therapy Programs: A systematic review of research* (Doc. No. 22-06-1901). Olympia: Washington State Institute for Public Policy.

[4] Most studies did not include comparison groups or control for pre-treatment characteristics between study subjects.

Component (c) of the legislative assignment asks us to consider if wilderness therapy programs were deemed "cost beneficial prevention programs," then what kind of support and interest there would be among stakeholders in Washington.

As detailed in report one, we cannot evaluate program effectiveness or determine if wilderness therapy is cost-beneficial at this time.[5] Therefore, wilderness therapy does not currently meet the criteria to be considered for inclusion on the Evidence-Based Practice list by the Division of Behavioral Health and Recovery (DBHR).[6]

There are few wilderness therapy programs that currently operate in Washington[7] and there is no state funding or regulation for programs. However, there are many stakeholders with a possible interest in these programs. We interviewed several stakeholders in response to the legislative assignment to learn about their experiences with and perceptions of wilderness therapy programs. Their insights may be useful if legislators consider policy decisions concerning wilderness therapy (or related) programs in the future.

We invited individuals involved with treatment and prevention coalitions, tribal leaders and representatives, individuals serving Washington State veterans, and individuals providing services in rural communities to participate in interviews.

Our interview conversations focused on stakeholders' thoughts on the following:

- Familiarity with wilderness therapy programs;
- Interest in program participation in Washington;
- Important program models and components;
- Barriers to program participation;
- Licensing and regulation of programs; and
- Questions and concerns.

This report summarizes themes and key takeaways from the ten individuals we interviewed.

[5] We could potentially revisit this analysis if rigorous program evaluations with comparison groups are published.
[6] DBHR staff, along with WSIPP, University of Washington, and Washington State University researchers are members of the Evidence Based Practices Workgroup. They review prevention programs and determine inclusion on the Evidence-Based Practice list.
[7] We identified one program in Washington, called Rites of Passage, which meets our definition of wilderness therapy (i.e., combines therapy with outdoor activities).

II. Background

There is no single definition of what constitutes wilderness therapy. Further, there is wide variation in program models, their goals, and the populations they serve.

Our legislative assignment refers specifically to "wilderness therapy program models related to behavioral health."[8] As a result, we focus on programs that combine a range of therapeutic practices like cognitive behavioral therapy or self-reflection with outdoor activities like camping and backpacking. These programs typically serve individuals with behavioral health, mental health, and substance use issues.[9]

The theory of change for wilderness therapy typically includes having an individual leave their home environment and enter a new setting where they can focus and receive therapy. Individuals learn new skills like setting up camp, building fires, making food, and participating in physical activities like hiking and backpacking. This combination of therapy and outdoor activities aims to build confidence, independence, problem-solving skills, and a sense of belonging, which participants are meant to draw on when they exit programs.

Current perceptions of wilderness therapy may be influenced by a complicated history. During the 1980s, 1990s, and 2000s, programs with outdoor components focused less on therapy and were often structured as boot camps for parents to enroll their teenagers into (often without consent)[10] for behavioral and substance use reasons. There were reports of abuse and death from some participants and their families, and as concerns mounted, Congress investigated the youth residential treatment industry, including wilderness therapy.[11]

Over the last decade, there have been efforts to professionalize outdoor behavioral health and residential treatment programs, increase oversight, and make programs safer. For example, trade groups like the Outdoor Behavioral Healthcare Council (OBHC) and the Association of Experiential Education (AEE) have worked to establish standards and best practices for wilderness therapy providers and have created program accreditation processes.

Additionally, some states like Utah, Oregon, and Georgia have started to license and regulate wilderness therapy and related outdoor programs. See Appendix III for examples of state licensing standards.

While oversight has improved, and it is more common for wilderness therapy programs to include prevention best practices and formal therapy than in the past, it is still unclear how many programs offer high-quality treatment. As a result, concerns remain about program safety, costs, and evidence regarding efficacy.

For more information on wilderness therapy programs, see our first report.[12]

[8] ESSB 5092.

[9] The stakeholders we interviewed defined wilderness therapy in broader terms than this and some individuals said that programs do not need formal therapy to be beneficial.

[10] While not as prevalent today as in the past, there are still programs that exist in which youth and adolescents are involuntarily enrolled.

[11] Kutz, G., & O'Connell, A. (2007). *Residential treatment programs: Concerns regarding abuse and death in certain programs for troubled youth.* Government Accountability Office.

[12] Cramer & Wanner (2022).

III. Interview Process

We conducted interviews with stakeholders in Washington to understand their interest in and support for wilderness therapy. We summarize their comments, which may be useful if legislators consider policy decisions related to wilderness therapy in the future. This section details our interview approach.

Interview Sample

The legislative assignment specifically directed us to reach out to "state prevention coalitions and tribes."[13] We conducted outreach to statewide coalitions focused on behavioral health, mental health, and substance use prevention and treatment services; tribal leaders, representatives, and community members; associations representing mental health counselors; veteran service organizations; prevention coordinators serving rural communities; and youth prevention coordinators affiliated with Educational Service Districts (ESDs). We contacted people to ask about participating in our interviews through direct email and a newsletter administered by the Washington Health Care Authority (HCA).[14]

Ten people responded to our request to be interviewed. Between August and October of 2022, we spoke to individuals who serve or are members of the following communities:

- Children and adolescent communities,
- Tribal communities,
- Veteran communities, and
- Rural communities.

Four of the ten individuals we spoke to work as prevention service coordinators serving youth and adult populations across nine counties in Washington.[15] Two individuals we spoke to work for the Department of Education for the Muckleshoot Indian Tribe and the Social and Community Services Department for the Jamestown S'Klallam Tribe, respectively.

We also spoke to two individuals who work for veteran's service organizations in the state. Another individual we talked to is an elected official in Jefferson County and another coordinates academic support services for high school students in the Renton School District.

See Appendix I for information about our interview approach and list of interviewees.

Interview Instrument

We used a standardized, open-ended interview instrument to ask the same set of questions to all interviewees and identify themes across their responses. This approach also enabled us to ask follow-up questions as needed throughout the interview. Two WSIPP researchers participated in each interview, which was conducted using Zoom. We asked each interviewee's permission to record so we could review interview content later to check for accuracy in our reporting.

See Appendix II for our interview instrument.

[13] ESSB 5092.

[14] We emailed 43 individuals directly. HCA's Athena Newsletter reaches approximately 2,600 subscribers.

[15] Counties include Clark, Cowlitz, Jefferson, Klickitat, Pacific, San Juan, Skagit, Skamania, and Wahkiakum.

Limitations

It is important to keep in mind several limitations regarding our interview sample and findings.

First, our sample of ten people is small and not representative. As a result, interview findings cannot be generalized to all potential stakeholders who may be interested in wilderness therapy in Washington. Also, because we were asked to assess interest among prevention coalitions, tribes, and other stakeholders, we may not have contacted all relevant interest groups and therefore may be missing certain perspectives.

Finally, we spoke to a cross-section of individuals who are either members of or serve youth, tribal, veteran, and rural communities in Washington. Their opinions are their own and should not be interpreted as the views of everyone in the communities in which they live or serve. Furthermore, their comments do not necessarily reflect the views of the organizations, tribes, or agencies they represent.

IV. Interview Findings

In this section, we describe key interview takeaways and provide additional context using direct quotes from stakeholders. We summarize the following:

- Stakeholders' familiarity and experiences with wilderness therapy;
- Stakeholders' perceptions of whether wilderness therapy programs are relevant to the individuals they serve or living in their communities;
- Stakeholders' perceptions of what program details may be important to the individuals they serve or living in their communities;
- Stakeholders' concerns regarding wilderness therapy;
- Stakeholders' opinions about licensing wilderness therapy programs;
- Stakeholders' concerns about licensure; and
- Stakeholders' suggestions for legislators who may consider policy decisions in the future.

How Familiar are Stakeholders with Wilderness Therapy Programs?

All individuals we spoke to were familiar with wilderness therapy and some had participated in programs in the past.

Exhibit 2

Examples of Programs Operated by Stakeholders

Veterans Conservation Corp: Provides training and opportunities for Washington State veterans in the areas of conservation and sustainable agriculture in order to establish healthy relationships with nature, one's self, and the broader community.

Warriors Path: a program facilitated by the Muckleshoot Indian Tribe that aims to prevent substance use and abuse by connecting middle-and high-school students with the land and teaches culturally relevant activities like gathering and harvesting.

Route Step Outdoors: An outdoor adventure program operated by Nineline Veteran Services that is periodically provided to veterans and their families.

It is important to note that most respondents we talked to define wilderness therapy more broadly than we do. In our research, we have defined wilderness therapy as programs that combine therapy elements with outdoor activities and serve individuals with behavioral health, mental health, or substance use issues. Some individuals we spoke to said that programs did not need formal therapy to be beneficial and that being in nature with peers is therapeutic in and of itself.

While most individuals we spoke to did not operate wilderness therapy programs, four of ten respondents described similar outdoor-based programs they (or the organizations they work for) administered. Exhibit 2 describes a few of these programs.

Additionally, six of ten respondents had previously worked or enrolled in wilderness therapy or related outdoor adventure programs. For example, one individual was previously employed as a program manager for a wilderness therapy program in Alaska that guided youth on kayaking excursions and connected them with licensed therapists. Another respondent had participated in the Outward Bound for Veterans program in Colorado.

Is There Interest in Participating in Wilderness Therapy Programs?

Most of the individuals we interviewed (seven) said the communities they serve or live in would likely be interested in participating in wilderness therapy programs. Some indicated that being in nature with people from similar backgrounds can be healing, particularly for those who have experienced trauma.

Others reported that programs may be an impactful intervention for middle-and high-school students since connecting to nature and peers can be particularly valuable during this transitional period in life.

Respondents living in rural communities indicated that wilderness therapy may be perceived as a more acceptable approach than traditional therapy and could also fill a gap in mental healthcare access in the area.

Several individuals indicated that interest would depend on how programs are advertised and that some, particularly families with children, may have concerns about safety and accessibility that would need to be addressed first. See Exhibit 3 for examples of responses to this question.

Exhibit 3

Interview Responses – Is There Interest in Participating in Wilderness Therapy Programs

Stakeholder who serves children and adolescents

- *"It would depend on the context in which they were presented. If* [programs] *were illustrated as an incentive for youth to participate in some sort of summer programming to keep them engaged, especially in middle school years when the tendency is to start using substances, then that would work."*

Stakeholders who serve tribal communities

- *"Definitely. To me, wilderness therapy or land-based therapy is a more culturally centered and responsive intervention for indigenous communities. I think if they were more broadly offered, we'd have a lot more people engaging in both preventative and intervention work."*
- *"Yes. You're comfortable, you're out of an office area,* [everyone] *is equal, it's just a really beautiful way of being able to do therapy and to connect."*

Stakeholders who serve veterans

- *"Yes. It just feels good to be out in nature and to be with a cohort of folks with a strong identity such as having served in the armed forces…"*
- *"It would be a benefit not only to veterans but to individuals suffering with any kind of trauma…"*

Stakeholder who serves rural communities

- *"Yes. It dovetails nicely with the local values that often in our rural environment stigmatizes mental health and behavioral health and substance use issues but put a lot of value on outdoor recreation. It may actually be more effective in some rural areas than other treatment options."*

What Wilderness Therapy Program Components are Important to Stakeholders' Communities?

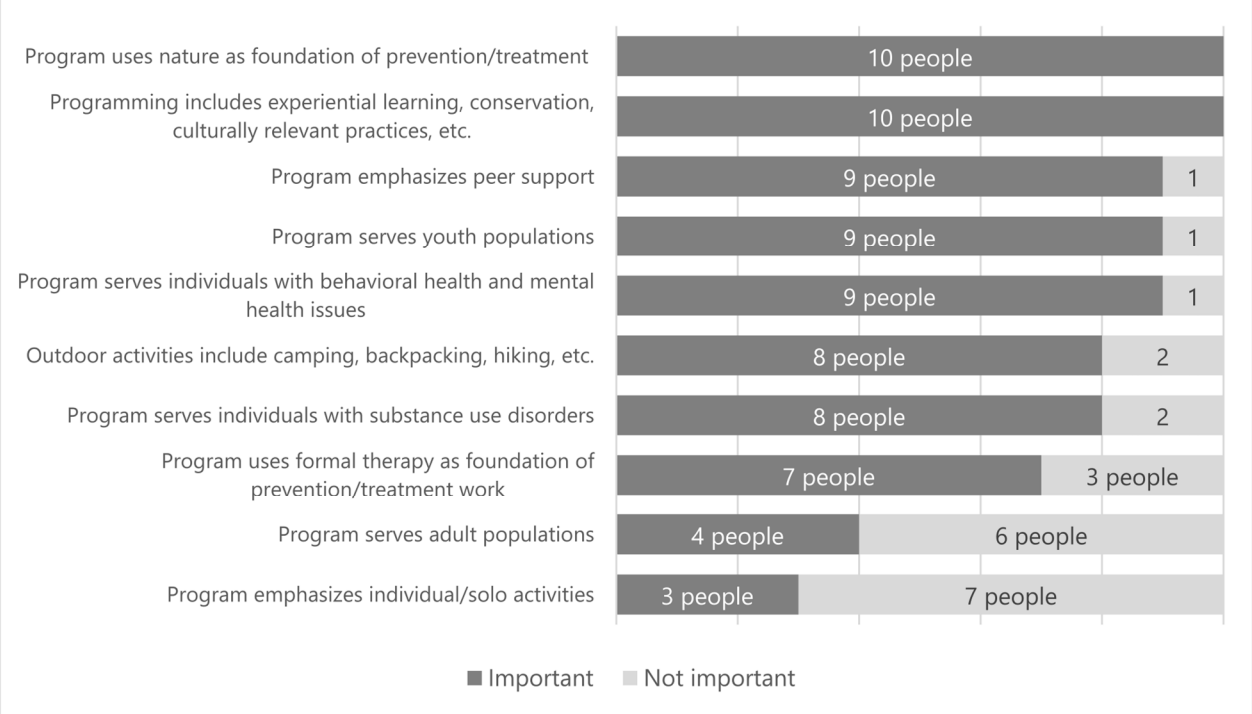
All respondents agreed that wilderness therapy programs should use nature and outdoor activities as the foundation for treatment and that programs should include experiential learning, conservation, and culturally relevant practices. Most respondents (seven) indicated that programs should include formal clinical therapy models. Respondents serving veteran, tribal, and rural communities stated that alternative modalities can also be effective and even programs without formal therapy elements can be beneficial.

Most individuals indicated that it is important for programs to serve youth populations, provide behavioral health, mental health, and substance use support, and emphasize peer-to-peer connections. Further, most respondents (seven) stated that solo activities are not as important as other components, voicing concerns about safety and the risk of social isolation, especially for vulnerable participants.

See Exhibit 4 for a list of program details and level of support.

Exhibit 4

Poll Responses – What Wilderness Therapy Program Details May Be Important to Your Community



Note:
N = 10 interview respondents.

In addition to the poll answers above, several respondents highlighted additional points (see Exhibit 5 for selected responses). Some respondents expressed a need for culturally relevant practices and lessons on outdoor safety.

The most common concern was that programs should be accessible to all participants, regardless of financial costs, transportation, and equipment.

Exhibit 5

Additional Poll Responses – What Wilderness Therapy Program Details May Be Important to Your Community

Stakeholders who serve children and adolescents

- Include financial incentives for youth and adult participants to address discrepancies in access for marginalized communities
- Include lessons on how to safely recreate outdoors
- Provide equipment and transportation
- Ensure that programs are accessible to youth in which English is a second language

Stakeholders who serve tribal communities

- Include culturally relevant practices
- Include family therapy elements

Stakeholder who serves veterans

- Include military cultural engagement training for program staff and participants

Stakeholder who serves rural communities

- Improve accessibility, especially regarding cost and transportation

Notes:
Text is paraphrased comments from interviews.
Stakeholders' opinions are their own and do not reflect the opinions of everyone in the communities they live in or serve.

What Barriers Might Keep Individuals From Participating in Wilderness Therapy?

Most respondents (seven) said that program costs would be a barrier to participating in wilderness therapy.[16] Other barriers were related to transportation to and from programs, and the potential stigma that individuals in veteran, tribal, and rural communities may face if wilderness therapy programs include formal therapy practices.

Respondents said that lack of access to programs in rural communities, for people of color, and individuals with disabilities are also barriers. Others noted that lack of evidence about program effectiveness and insurance coverage may discourage participation too.

Several respondents noted barriers for program providers, including the challenge of starting new programs. Several individuals suggested that new programs should partner with trusted community institutions like churches and schools. See Exhibit 6 for selected responses.

Exhibit 6

Interview Responses – Potential Barriers to Accessing Wilderness Therapy Programs

Stakeholders who serve children and adolescents

- *"I work with programs for young adults with disabilities. I think having any sort of physical impairment is a huge challenge. I don't know what that would look like as far as developing a program."*
- There is a disconnect between youth and nature these days. Because they have less experience in the outdoors they may not even think about these programs as a possible space for healing.

Stakeholders who serve tribal communities

- *"For some populations, access to appropriate gear, especially if you're thinking about weeklong trips, could be a barrier"* (regarding barriers to participants).
- *"I think the* [lack of] *billable service* [issue] *is a barrier, it's really tricky, just in general to bill for preventative services. I think that's a substantial barrier"* (regarding barriers to program providers).

Stakeholder who serves veterans

- *"I can't speak for every military service member…but there is this sense of I am self-sustaining, I am independent, and I shall not ask for help. I can handle this on my own"* (regarding stigma as a barrier).

Stakeholders who serve rural communities

- *"With any sort of program that is getting rolled out, it needs to be in conjunction with at least one trusted partner that the community knows. The churches tend to be a trusted provider of services."*
- *"I think, if there was a cost associated with it, that would be a huge barrier, especially if someone is being asked to take time away from work to attend."*

Notes:
Italicized text are quotes from interviews.
Unitalicized text and text in brackets [ ] are paraphrased comments from interviews.
Stakeholders' opinions are their own and do not reflect the opinions of everyone in the communities they live in or serve.

[16] In our first report, we noted that a month-long program could cost approximately $20,000. Cramer & Wanner (2022).

What Questions or Concerns Do Stakeholders Have About Wilderness Therapy Programs?

Most respondents focused on concerns, so we highlight those in this section. Half of the individuals we spoke to stated safety concerns and emphasized the need for policies and standards that protect participants enrolled in programs. They also identified the need for staff to be trained to effectively respond to emergencies and care for individuals with mental health or substance use diagnoses.

Some individuals (four) also raised concerns about equitable access to programs, particularly for populations that may not have previous experience in the outdoors or have not felt comfortable or welcome in nature in the past.

One respondent also mentioned that—because of the inherent risk involved with outdoor activities—lack of insurance coverage can be seen as a liability for potential providers. See Exhibit 7 for selected responses to this question.

Exhibit 7

Interview Responses – Concerns About Wilderness Therapy Programs

Stakeholder who serves children and adolescents

- *"Making sure there are more requirements and expectations for wilderness therapy companies for their staff trainings, led by licensed mental health professionals. I think heavy screening* [among participants] *too before someone goes out into the wilderness* [is needed]."

Stakeholder who serves tribal communities

- *"Having regulations around this is actually important and necessary due to* [troubling history of programs]…[but this work must include] *cultural considerations of different communities."*

Stakeholder who serves veterans

- *"How does everyone have equitable access to these services and how are we breaking down those barriers for individuals in marginalized neighborhoods* [including] *individuals of color, women, children, domestic violence victims, military veterans, and trauma survivors?"*

Stakeholder who serves rural communities

- *"If you can't measure it, you can't manage it. Coming up with metrics to analyze and build the evidence to support this* [with the goal of] *developing it into an evidence-based practice that we can actually use with more ease."*

Notes:
Italicized text are quotes from interviews.
Unitalicized text and text in brackets [ ] are paraphrased comments from interviews.
Stakeholders' opinions are their own and do not reflect the opinions of everyone in the communities they live in or serve.

Do Stakeholders Think Wilderness Therapy Programs Should be Licensed and Regulated in Washington?

Two respondents supported the idea of potentially licensing wilderness therapy programs in Washington, stating it is necessary to ensure program safety. One respondent said that licensing is not necessary, but that there should be requirements in place that ensure program staff are adequately trained. The remaining respondents did not oppose licensing but suggested that regulations should not dictate the use of specific therapeutic models and should allow providers the flexibility to design programs.

Several individuals also said that they would support licensing efforts if it meant that state funding sources would become available to support program providers.

Multiple respondents (four) also noted that if regulations set rigid staffing requirements, this could limit program providers' ability to hire individuals that have wilderness experience but do not have the "right" set of credentials.

See Exhibit 8 for additional responses to this question.

Exhibit 8

Interview Responses – Should Wilderness Therapy Programs be Licensed and Regulated

Stakeholder who serves children and adolescents

- *"Part of what I think can be a challenge with certifications and standardizations is where you gain in efficiency you lose in value outside of those boundaries.* [For example] *people who are perfectly capable of serving someone else* [but may not have required certifications could be excluded]."

Stakeholder who serves tribal communities

- *"Yes,* [land-based programs] *can be beautiful and powerful and incredibly healing opportunities but, put in the wrong hands, could be an opportunity to do harm if there aren't regulations in place."*

Stakeholder who serves veterans

- Regulations can limit how you structure your program and what staff qualifications you require, which limits how you serve people. For example, there may be people who are perfectly capable of serving veterans, but because they don't have certain credentials they may be left out.

Stakeholders who serve rural communities

- *"I think* [regulations] *make it harder and easier at the same time. Having a framework allows a lot of programs to start up but it can have a chilling effect too."*
- If licensing opens up access to more programs and funding then yes, but there should be clear reasons for why it's needed. It shouldn't be rules simply for the sake of rules.
- "*I wouldn't regulate it to the point of being prescriptive with the therapy portion. I'd be a little worried about what it would look like."*

Notes:
Italicized text are quotes from interviews.
Unitalicized text and text in brackets [ ] indicate paraphrased comments from interviews.
Stakeholders' opinions are their own and do not reflect the opinions of everyone in the communities they live in or serve.

What Potential Licensing Requirements Should be Included or Excluded?

We asked stakeholders what licensing requirements should be included or excluded if legislators consider regulations in the future. Most respondents agreed that requirements should promote safety. All respondents supported the inclusion of emergency protocols and most supported regulations that mandate sanitation, hygiene, and nutrition standards.

Most respondents supported standards for minimum staff qualifications. Several clarified that qualifications should focus on basic safety skills rather than educational or professional credentials.

A concern is that experienced individuals without these credentials may be excluded from hiring opportunities.

Respondents expressed uncertainty about requirements for reporting, client admissions, and therapeutic practices. Some respondents preferred that program providers set eligibility criteria and reporting standards themselves. Some individuals felt that providers should determine what therapeutic practices to employ and that a variety of program models should be encouraged in order to serve diverse populations and needs. See Exhibit 9 for licensing details and levels of support.

Exhibit 9

Poll Responses – What Licensing Requirements Should be Included or Excluded

Notes:
N= 10 interview respondents.
Poll options are based on Utah's licensing standards. We used Utah as a model because we wanted to present an array of options for interviewees to select from.

Several respondents expanded on their poll answers to provide more context. One theme we found is that individuals see value in regulations that ensure wilderness therapy staff are trained to respond to emergencies. Respondents also noted the importance of having licensed clinicians on staff to work with individuals struggling with mental health and substance use issues.

As reflected in responses to other questions, individuals said requirements should not limit program providers' ability to hire the staff they deem most qualified to support participants in outdoor settings.

See Exhibit 10 for additional responses to this poll question.

Exhibit 10

Additional Poll Responses – What Licensing Requirements Should be Included or Excluded

Stakeholder who serves children and adolescents

- *I said yes on minimum qualifications because I was thinking first aid and CPR, those types of minimum qualifications, not degreed positions. I think there should be flexibility there. I think there should be training for sure, but the moment you start requiring* [degrees] *beyond high school you're going to exclude so many wonderful people who have a heart for community engagement and love of nature"*

Stakeholders who serve tribal communities

- *"Minimum qualifications in terms of physical safety and being able to navigate the outdoors yes, minimum qualifications in terms of people engaging around really sensitive mental health conversations and providing therapeutic interventions yes, but I don't think everyone on staff would need that same level of qualification to participate. A lot of our elders, community members, and knowledge keepers might not have those types of credentials* [but] *would play a critical role in being able to provide a program like that"*
- *"I think there should be a definition* [of wilderness therapy programs] *but I think it should be fairly broad and inclusive to include both prevention and intervention"*

Stakeholder who serves veterans

- Include a requirement for each program provider to have an individual who is responsible for data collection and reporting standards.

Stakeholder who serves rural communities

- If developing program eligibility requirements, these should include the lowest threshold for exclusion. For example, requirements should outline basic mental and physical health criteria, but otherwise leave eligibility requirements up to the program providers to decide.

Notes:
Italicized text are quotes from interviews.
Unitalicized text indicates respondents' comments submitted in a "fill-in" portion of the poll.
Stakeholders' opinions are their own and do not reflect the opinions of everyone in the communities they live in or serve.

What Questions and Concerns Do Stakeholders Have About Licensing Wilderness Therapy Programs?

Most respondents wanted to know what the goal of licensing would be, how it could impact program accessibility, and who would be involved in setting requirements. Regarding concerns, six of ten respondents worried that licensing would restrict program providers' ability to hire qualified staff and limit their ability to implement the therapy models they deem appropriate.

Further, three respondents were concerned about the potential burden of data collection and reporting requirements. A few people indicated that more research should be done before licensure is considered in Washington. See Exhibit 11 for additional responses to this question.

Exhibit 11

Interview Responses – Do You Have Concerns About Potential Licensure and Regulations

Stakeholders who serve children and adolescents

- *"Reporting requirements are incredibly time consuming. You're filling out all of this data without understanding how* [it's] *going to affect programming and there's not a lot of space for the people doing work on the ground to report in a way that feels most reflective of their outcomes."*
- *"There are different* [non-conventional] *therapies* [like EMDR or native ceremonial healing practices] *and when you start to regulate there's a strict structure of what's allowed and not allowed."*

Stakeholders who serve tribal communities

- *"Make sure* [data collection requirements are] *inclusive of the ways we see effectiveness and how we - from oral traditions - share and communicate effectiveness."*
- *"I would want anyone working with my community to go through something that would provide them context and understanding around what it means to work with indigenous communities and what kind of therapeutic modalities are most culturally relevant and responsive."*

Stakeholder who serves veterans

- *"This is a practice that hasn't had all of the pieces worked out yet. Therefore, trying to standardize some components of it, I feel, is not quite there."*

Stakeholder who serves rural communities

- The behavioral healthcare workforce is limited already so there are concerns that regulations could make this worse. I've seen valuable programs with and without licensed mental health professionals so any regulations shouldn't keep individuals who lack "the right credentials" from participating.

Notes:
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Unitalicized text and text in brackets [ ] are paraphrased comments from interviews.
Stakeholders' opinions are their own and do not reflect the opinions of everyone in the communities they live in or serve.

At the end of our interviews, we asked if stakeholders had additional information they wanted to share. Based on their response to this question and other questions throughout the interview, we identified several points stakeholders said they want legislators to be aware of if considering policy decisions related to wilderness therapy in the future. Exhibit 12 details these comments, which were shared by at least two stakeholders throughout the interviews.

Exhibit 12

Stakeholders' Recommended Considerations for Legislators

Any potential regulations should not mandate the use of specific therapy models

Stakeholders felt that wilderness therapy providers should have flexibility to determine what therapy models are appropriate for the individuals they want to serve. Several stakeholders reported that even if programs do not implement clinical therapy models like cognitive behavioral therapy, connecting with peers and working on personal growth in nature can be therapeutic in and of itself. Further, some stakeholders felt there may be a stigma associated with traditional therapy and said that individuals may be more comfortable participating in a program that uses alternative prevention or treatment approaches. For some stakeholders, it is important that program providers can decide what practices and clinical models are best suited to the populations they wish to serve.

Potential staffing requirements should not limit employment opportunities

Most individuals said they felt it is important to have licensed clinicians on staff who are trained to serve individuals with mental health and substance use disorders, as well as vulnerable populations that have experienced trauma. Respondents also said that regulations should ensure that staff are trained in areas like first aid, CPR, outdoor medical treatment procedures, and fire safety. However, some stakeholders said that requirements should not restrict providers' flexibility to employ those they deem qualified to deliver programming. For example, some respondents mentioned there are individuals in their communities with relevant outdoor recreation experiences who would be valuable mentors and guides in wilderness therapy programs. Respondents worried that these individuals may be excluded from employment opportunities if regulations mandated specific educational and professional credential criteria.

Potential policy decisions must respect cultural differences and traditions

Several individuals reported that if legislators decide to make policy decisions on wilderness therapy in the future, they need to do more outreach with stakeholders, so policies are informed by their perspectives. For example, we heard that wilderness therapy programs are uniquely beneficial to indigenous communities because programming connects individuals with the land and their cultural traditions. One respondent recommended that legislators work with tribal leaders and representatives to ensure that any future decisions respect the values and practices of tribes in Washington. We heard similar comments from stakeholders who serve rural and veteran communities too.

Potential policy decisions should promote equitable access to programs

Stakeholders want legislators to understand there are many populations that could benefit from wilderness therapy, but for many reasons, have not been able to attend programs in the past. For example, some individuals said that women or people of color have not been populations traditionally served in the past and therefore they may feel unwelcome or uncomfortable in these settings. Others expressed concerns about safety and access for individuals with physical or cognitive disabilities. Further, some individuals mentioned that low-income populations have been unable to enroll in programs because of exorbitant program costs. Legislators should keep in mind how potential policy decisions may increase or limit these groups' access to wilderness therapy programs.

V. Discussion

In this section, we summarize the key findings that emerged from interviews, outline limitations that influence the interpretation of results, and describe the overall takeaways from our two reports on wilderness therapy.

Summary of Findings

To learn about stakeholder perceptions of wilderness therapy, we interviewed individuals who coordinate prevention services, are tribal community members, serve veterans, and support middle-and high-school students.

All of the stakeholders we interviewed were familiar with wilderness therapy, but most defined these programs in a broader sense than we have in our research.

Seven out of ten individuals reported that the communities they serve or live in would be interested in wilderness therapy programs if more were available in Washington. They mentioned that programs could support students transitioning from middle school to high school, provide culturally relevant programming for indigenous youth, offer an alternative to traditional therapy, and could fill a need for more mental healthcare services in rural communities in the state.

When asked about important program details, all respondents agreed that wilderness therapy programs should use outdoor activities and nature as the foundation of treatment. Most also indicated that programs should use formal therapy too, but not everyone agreed that these practices were necessary.

Most individuals we spoke to suggested programs should target youth with behavioral health and substance use issues.

Most respondents (seven) said that program costs are a major barrier to participation. We also heard that transportation, availability, and the lack of information, in general, could be barriers to individuals who may want to participate.

The most common concerns stakeholders expressed about wilderness therapy were related to safety and equitable access. Respondents described the need for program staff to be trained to respond to emergencies and care for individuals struggling with mental health and substance use challenges. They also spoke about the need for programs to be more widely available to people of color, women, individuals with physical and cognitive disabilities, and individuals from low-income backgrounds. Program costs and the lack of evidence around program efficacy were also common concerns.

Support for the potential licensing of programs was mixed. Two individuals supported licensure for the sake of ensuring program safety and several others supported the idea if it leads to state funding sources. However, others were concerned that regulations could restrict program providers' ability to implement flexible models and limit their ability to hire qualified staff. Several individuals said that more information about program effectiveness is needed before legislators consider regulating programs altogether.

Overall, respondents noted that if legislators consider policy decisions in the future, they should balance the need for program safety with the need for providers to be able to develop programs that are appropriate for the populations they want to serve. Further, respondents said legislators should prioritize policies that increase equitable access to programs in the state and should include stakeholders in policy development.

Limitations

There are several limitations to our results. First, while we attempted to interview a broad group of stakeholders, we had a limited number of individuals who agreed to speak to us. Because of this small sample size, interview responses are not generalizable and do not represent the views of all stakeholders in the state.

Further, while the stakeholders we spoke to include a cross-section of individuals representing youth, tribal, veteran, and rural communities, their opinions do not reflect the views of everyone in those communities. There are likely diverse opinions regarding wilderness therapy in these communities that we cannot speak to.

Finally, because we focused outreach to prevention coalitions, tribes, and individuals working in the mental healthcare profession, our sample may be comprised of individuals with more or less favorable opinions of wilderness therapy than others. We specifically asked stakeholders to share their concerns about wilderness therapy programs. However, interview results likely do not capture the full extent of critiques or concerns that people in Washington have about these programs.

Takeaways From WSIPP's Two Reports

Below are the key takeaways from our two reports on wilderness therapy:

1) Although there is a lot of evidence about effective treatment for behavioral health issues,[17] the current state of research does not indicate whether wilderness therapy is an effective approach for these issues. Most studies we reviewed report improvements to participant outcomes (from pre-treatment to post-treatment), but do not demonstrate that wilderness therapy caused these changes to occur.
2) Rigorous program evaluations (with comparison groups) are needed to understand the impact of wilderness therapy. Future research should evaluate programs for a variety of populations, measure behavioral health outcomes consistently, and examine what types of clinical therapy models may be most effective in outdoor settings.
3) Among the small group of stakeholders we interviewed, there is general support for wilderness therapy programs. Stakeholders indicate that programs may be well suited to support middle- and high-school students, indigenous youth, veterans, and individuals in rural communities in Washington.
4) The individuals we spoke to recommend that legislators engage further with stakeholders to understand the potential impacts of policy decisions on program providers and participants before creating policy.

[17] See WSIPP's findings for child and adult behavioral health programs.

Appendices

Wilderness Therapy Programs: *Stakeholder Perspectives in Washington*

I. Interview Method

We conducted nine interviews with ten individuals (see Exhibit A1 for interviewees and their affiliated organizations, tribes, or agencies). Interviews lasted one hour and were facilitated by the same two WSIPP researchers (the authors of this report) using Zoom. Interviews were held between August and October 2022. We asked everyone for permission to record so that we could review interview content and accurately convey their responses in this report (nine of ten individuals permitted recording).

We used a standardized, open-ended interview instrument (see Appendix II) to ask the same set of questions across all ten stakeholders and compare their responses. We developed our outreach plan and interview questions based on several factors:

- The legislative assignment directed us to "assess the interest and likelihood of support for programs…among relevant interest groups such as state prevention coalitions and tribes."
- A literature review was conducted during our first report, and
- Based on feedback from legislative, DBHR, and the Evidence-Based Practice Institute (EBPI) staff, and feedback from researchers who specialize in studying wilderness therapy and outdoor adventure programs.

Exhibit A1

List of Stakeholders Interviewed

Name	Position	Organization, tribe, or agency
Delphina Liles	Youth Services Coordinator	Joyce L. Sobel Family Resource Center
Dustin Brenske	Deputy Director of Social and Community Services	Jamestown S'Klallam Tribe
Greg Brotherton	County Commissioner	Jefferson County
Holly Gumm	Community Health Educator	Jefferson County Public Health
Joy Lyons	Prevention and Youth Services Manager	Educational Service District 112
Karolina Szulkowski	Academic Advancement Coordinator	Renton School District
Kim Pham	Veterans Conservation Corps Manager	Washington State Department of Veteran Affairs
Lisa Wilson	Director of Curriculum and Instruction	Muckleshoot Indian Tribe
Marlena White	Program Coordinator	United General District 304
Shawn Durnen	President	NineLine Veteran Services

Note:
Comments in this report reflect the opinions of interviewees, not of the organizations, tribes, or agencies they represent.

II. Semi-Structured Interview Protocol

Introductions and Perceptions of Wilderness Therapy Programs

**Prior to the interview, we defined wilderness therapy for stakeholders to contextualize the topic for them. Some stakeholders considered programs more broadly than we define them for this assignment.*

1. Please introduce yourself and describe your role as [___].
2. Do you have familiarity or experience with wilderness therapy programs?
3. Do you think the individuals [you serve or that live in your community] would be interested in participating in wilderness therapy programs if more were available in Washington?
4. If wilderness therapy programs were available, what program details would be most important to individuals [you serve or that live in your community]? (Multiple choice, select all that apply)[18]

   - ☐ Program serves individuals with substance use disorders
   - ☐ Program serves individuals with behavioral health and mental health issues
   - ☐ Outdoor activities include camping, backpacking, hiking, etc.
   - ☐ Outdoor programming includes experiential learning, conservation, culturally relevant practices, etc.
   - ☐ Program serves youth populations
   - ☐ Program serves adult populations
   - ☐ Program emphasizes individual/solo activities
   - ☐ Program emphasizes group activities and peer support
   - ☐ Program uses outdoor activities/nature as foundation of prevention/treatment work
   - ☐ Program uses formal therapy and outdoor activities/nature as foundation of prevention/treatment work

   a. Is there anything not listed above that you want to add? (short answer)
5. Are there any barriers that might keep individuals [you serve or that live in your community] from engaging with wilderness therapy programs?
6. What questions do you have about wilderness therapy programs?
7. What concerns do you have about wilderness therapy programs?

[18] Presented as a poll question via Zoom.

Perceptions Regarding Hypothetical Licensing and Regulation of Wilderness Therapy Programs

**Prior to questions 8-11, we provided a description of licensing requirements in other states. We explained that questions are hypothetical, programs are not currently licensed in Washington, we have no knowledge of efforts by the legislature to license programs in the future, and WSIPP is neither for nor against licensure.*

8. Do you think wilderness therapy programs should be licensed in Washington?
9. If the legislature were to license wilderness therapy programs, what requirements do you think should be included or excluded?[19]

	Include	Not sure	Exclude
Program definition (what wilderness therapy is and isn't)	○	○	○
Staff-to-client ratios	○	○	○
Water, food, nutrition standards	○	○	○
Minimum qualifications and trainings for staff	○	○	○
Clients have access to mental health professionals	○	○	○
Safety and emergency standards	○	○	○
Data collection and reporting requirements	○	○	○
Sanitation and hygiene requirements	○	○	○
Required therapeutic practices	○	○	○
Client admission requirements	○	○	○

   a. Is there anything not listed above that you want to add? (short answer)
10. What questions do you have about licensure and regulations?
11. What concerns do you have about licensure and regulations?

Wrap Up

12. Is there anything we didn't ask that you think is important for us to know?
13. Are there other individuals or groups you think we should talk to for this project?

[19] Presented as a poll question via Zoom. Poll options are based on Utah's licensing standards.

III. Licensing Requirements in Utah, Oregon, and Georgia

Exhibit A2

Licensing Requirements for Outdoor Programs in Utah, Oregon, and Georgia

Standards	Utah[#]	Oregon[*]	Georgia[^]
Program definition	24-hour intermediate outdoor group living environment with regular formal therapy including group, individual, and family therapy.	Provides services outdoors to children and adolescents with behavioral problems, mental health problems, or substance use problems.	Provides room, board, and oversight with outdoor activities in wilderness or camp settings to improve the emotional and behavioral adjustment of children through age 18.
Admissions	Ages 13-17. Clients must submit health and medical history, mental health and physical exam, drug screening, pregnancy test, physical stress assessment, and admissions assessment.	Ages 10 minimum, the program can serve individuals over 18. Clients must submit admission assessment and screening which includes social, health, and psychological history. Mental health diagnosis and evaluation by a licensed mental health professional.	Ages 8-18. Clients must submit a medical exam by a licensed physician, a dental exam, and a psychological evaluation. An intake study by staff includes descriptions of family history, client, school history, and suggested treatments.
Treatment plans	---	Service plan describes the services and treatment the client will receive. The plan is reviewed and updated periodically. Includes a discharge plan.	Individual service plan includes how clients' needs will be met, length of stay, daily activities and goals, medical and counseling needs, and discharge plan.
Outdoor activities	Hiking cannot exceed the physical capability of the weakest member of the group and is prohibited in extreme temperatures. Backpacks cannot exceed a determined weight. Solo activities are voluntary, have a written plan, and are supervised by staff.	Hikes occur at the speed at which the slowest client is capable. Backpacks and equipment cannot exceed the physical abilities of clients. Solo activities must have written plans and be supervised by staff.	---

Notes:

This table is not an exhaustive list of standards governing outdoor programs in Utah, Oregon, and Georgia and only highlights notable details. For more information see codes linked below.

[#] Utah Administrative Code R501-8-1 through R501-8-17.

* Oregon Administrative Rules 413-215-0901 through 413-215-1031.

[^] Georgia Administrative Code 290-2-7-.01 through 290-2-7-.21.

Exhibit A2 (cont.)

Licensing Requirements for Outdoor Programs in Utah, Oregon, and Georgia

Standards	Utah[#]	Oregon[*]	Georgia[^]
Staff	Must have executive director, field director, senior field staff, direct care staff, and assistant staff. Staff must meet age, credential, and experience requirements. A licensed mental health professional and physician must be on staff. Ratio of 1 staff to 4 clients and groups cannot exceed 16 people.	Must have executive director, field director, senior field staff, and field staff. There must be a licensed health care professional and if necessary, a certified drug and alcohol counselor on staff. Staff must meet age, credential, and experience requirements. Ratio of 1 staff to 3 clients and groups cannot exceed 12 people.	Executive director must meet credential and experience requirements. There must be a social worker on staff. Program must arrange provision of services by physicians, dentists, psychologists, etc. Must have an adequate number of staff to care for, protect, and supervise clients.
Staff training	At least 80 hours. Trained in areas like counseling, wilderness expedition, navigation, safety, conflict resolution, behavior management, emergency response, wilderness medicine, CPR, and first aid.	Trained in areas like risk management, safety, behavior management, de-escalation, physical restraint, wilderness medicine, first aid, navigation, and critical incident prevention and response.	At least 40 hours. Trained in areas like behavior management, emergency safety interventions, children's needs in primitive environments, first aid, CPR, and outdoor safety.
Safety	First aid kit approved by medical professional and always available. Two-way radios are available during outdoor activities to connect field and base camp staff. During outdoor activities, field staff have client's contact info and medical forms, as well as maps and emergency response plans.	Programs have written policies on equipment safety, environmental hazards, risk management, health and nutrition, and physical stress management. Emergency plan assigns staff during emergencies, outlines evaluation plans and medical care arrangements and is reviewed by emergency service agencies.	Program must have disaster preparedness plans, plans for unanticipated interruption to utilities. There must be periodic disaster drills. Emergency safety intervention plan to prevent the child from harming themself or others. Plans are reviewed by emergency management agency.

Notes:

This table is not an exhaustive list of standards governing outdoor programs in Utah, Oregon, and Georgia and only highlights notable details. For more information see codes linked below.

[#] Utah Administrative Code R501-8-1 through R501-8-17.

* Oregon Administrative Rules 413-215-0901 through 413-215-1031.

[^] Georgia Administrative Code 290-2-7-.01 through 290-2-7-.21.

Exhibit A2 (cont.)

Licensing Requirements for Outdoor Programs in Utah, Oregon, and Georgia

Standards	Utah[#]	Oregon[*]	Georgia[^]
Water and nutrition	Set amount of potable water available per client per day. Amounts increase during high temperatures and hikes. Water from natural sources must be treated. Electrolytes provided. Each client receives at least 3,000 calories per day. Fresh fruit and vegetables are provided at least twice a week. Food and water cannot be withheld.	Set amount of potable water available per client per day. Amounts are increased during hikes. Water from natural sources must be treated. Electrolytes provided. Each client receives no less than 3,000 calories per day. Food and water cannot be withheld.	Clients provided food of adequate quality and quantity to supply nutrients for growth and development. Clients receive three meals per day, no more than 14 hours apart. Food cannot be withheld.
Equipment and supplies	Program provides clients with sunscreen, insect repellant, personal hygiene items, seasonally appropriate sleeping bags and ground pads, basic clothing, and protective gear. Shelter when temps are low or there's rain/snow. Items cannot be withheld.	Program provides clients with sunscreen, insect repellant, backpacks, personal hygiene items, wool blankets, tarps, ponchos, seasonally appropriate sleeping bags and ground pads, shelter from the rain, and seasonally appropriate clothing.	Program provides clients with shelter, housing, or primitive campsite with bed and bedding, and personal hygiene equipment.
Health care	First aid promptly provided. If clients need treatment beyond first aid, it is overseen by a licensed medical professional. Each client's physical condition is checked often by medical professionals. Medication is stored appropriately and provided to clients by trained staff based on prescription directions.	Clients receive immediate care for injuries, illnesses, or physical complaints and first aid promptly. Clients receive physical health assessments from medical professionals. Medications are stored appropriately and issued under prescriptive descriptions, by trained staff. Staff monitor clients' health daily.	Clients receive physical exams from licensed physicians. Medications are stored appropriately and issued under prescriptive descriptions by trained staff. First aid is provided immediately when needed. Staff monitor clients' health daily. Clients receive dental care as needed.

Notes:

This table is not an exhaustive list of standards governing outdoor programs in Utah, Oregon, and Georgia and only highlights notable details. For more information see codes linked below.

[#] Utah Administrative Code R501-8-1 through R501-8-17.

* Oregon Administrative Rules 413-215-0901 through 413-215-1031.

[^] Georgia Administrative Code 290-2-7-.01 through 290-2-7-.21.

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