



United Behavioral Health

Behavioral Clinical Policy: Wilderness Therapy

Document Number: BH727BCPWT_032020

Effective Date: March 16, 2020

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INTRODUCTION

Behavioral Clinical Policies are a set of objective and evidence-based behavioral health criteria used by medical necessity plans to standardize coverage determinations, promote evidence-based practices, and support members' recovery, resiliency, and wellbeing for behavioral health benefit plans that are managed by Optum®¹.

INSTRUCTIONS FOR USE

This guideline is used to make coverage determinations as well as to inform discussions about evidence-based practices and discharge planning for behavioral health benefit plans managed by Optum. When deciding coverage, the member's specific benefits must be referenced.

All reviewers must first identify member eligibility, the member-specific benefit plan coverage, and any federal or state regulatory requirements that supersede the member's benefits prior to using this guideline. In the event that the requested service or procedure is limited or excluded from the benefit, is defined differently or there is otherwise a conflict between this guideline and the member's specific benefit, the member's specific benefit supersedes this guideline. Other clinical criteria may apply. Optum reserves the right, in its sole discretion, to modify its clinical criteria as necessary using the process described in *Clinical Criteria*.

This guideline is provided for informational purposes. It does not constitute medical advice.

Optum may also use tools developed by third parties that are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Optum may develop clinical criteria or adopt externally-developed clinical criteria that supersede this guideline when required to do so by contract or regulation.

BENEFIT CONSIDERATIONS

Before using this policy, please check the member-specific benefit plan document and any federal or state mandates, if applicable.

¹ Optum is a brand used by United Behavioral Health and its affiliates.

DESCRIPTION OF SERVICE

Wilderness Therapy

Wilderness Therapy is a behavioral health intervention targeted at children and adolescents with emotional, addiction, and/or psychological problems. The intervention typically involves being immersed in the wilderness or a wilderness-like setting, group-living with peers, administration of individual and group therapy sessions, and educational/therapeutic curricula including back country travel and wilderness living skill development. This therapy aims to remove children and adolescents from the negative influences and destructive patterns in their lives by placing them into a more therapeutic environment (Roberts et al., 2017). These programs include wilderness boot camps, though many have attempted to differentiate themselves from such types of treatment, which rely heavily on punishment, confrontation and deprivation in order to gain compliance and obedience. Some wilderness programs may be nationally certified by agencies such as the Council of Accreditation and the Joint Commission on Accreditation of Health Organizations and/or licensed by state agencies.

Wilderness Therapy may be identified by other terms in the research literature, including: "Wilderness Treatment", "Behavior Management Through Adventure", "Residential Wilderness", "Adventure Therapy", "Nature-Assisted Therapy", "Nature-Based Therapy", "Adventure-Based Counseling", "Wilderness Adventure Therapy", and "Outdoor Behavioral Healthcare".

COVERAGE RATIONALE

Wilderness therapy is unproven and not medically necessary for the treatment of emotional, addiction, and/or psychological problems including, but not limited to:

- Adjustment Disorders
- Mood Disorders
- Anxiety Disorders
- Conduct Disorders
- Impulse Disorders
- Social Functioning Disorders
- Substance Related Disorders
- Attention-Deficit Hyperactivity Disorder

There is inadequate evidence of the safety and efficacy of wilderness therapy for treating these mental health and substance-related conditions. Inadequate study designs, safety concerns, inadequately trained staff, and questions of long-term benefit are key limitations.

The requested service or procedure must be reviewed against the language in the member's benefit document. When the requested service or procedure is limited or excluded from the member's benefit document, or is otherwise defined differently, it is the terms of the member's benefit document that prevails.

Per the specific requirements of the plan, health care services or supplies may not be covered when inconsistent with Level of Care Guidelines and/or evidence-based clinical guidelines.

All services must be provided by or under the direction of a properly qualified behavioral health provider.

CLINICAL EVIDENCE

Summary of Clinical Evidence

The wilderness therapy literature contains a number of studies that suggest participants show some level of improvement on behavioral health outcomes and/or recidivism rates for juvenile offenses. However, these results are not conclusive, and there are considerable limitations in the research methodology used to examine many of these programs. Most notably, there is a lack of randomized controlled trials or well-designed cohort studies that would allow causal conclusions about the impact of wilderness therapy to be drawn. There is also a lack of demonstrated durability of effect; few of the reviewed studies included follow-up measures, none of which included follow-up of a comparison group. There is extensive variability in the length, design, and fidelity of the programs themselves as noted by many of the authors of the reviewed research studies. The reviewed studies and guidelines

did not reveal that wilderness therapy was equivalent to or better than procedures currently in use. Wilderness therapy research currently lacks post-discharge and follow-up data, large representative samples, and superior research design (Hoag et al., 2016).

Overall, authors note that the practice of wilderness therapy has increased over the past decade. As this therapy has evolved, the importance of measuring the efficacy and outcomes has become clear (Hoag et al., 2016).

Clinical Trials & Studies

Roberts and colleagues (2017) conducted a 3-year longitudinal assessment of outcomes in outdoor behavioral health (OBH) care. The study involved a convenience sample of 186 volunteer participants (age 18-32), drawn from clients of an OBH program in the southwestern United States. Participants were eligible if they completed the program's 35-day minimum length of stay requirement. Length of stay decisions (ranging from 5-22 weeks) were made on the basis of client progress and establishment of a discharge plan. Participants mostly had a primary diagnosis of either a mood disorder, substance use disorder, or anxiety disorder. All participants completed the Outcome Questionnaire (OQ® 45.2) six times, between week 1 and 18-months post-discharge follow-up. Treatment was provided weekly in individual and group therapy sessions facilitated by a therapist. The therapist oversaw the clinical assessment, treatment planning, and service delivery. The weekly treatment plan provided structure and guidance for the wilderness staff and clients in how to merge therapeutic and relational goals into the daily wilderness therapy. Results found participants to show statistically and clinically significant change in their time in OBH care, and gains were maintained up to 18 months post-discharge. These gains appeared to be maintained as participants integrated back into the community. The authors note that the use of self-report data and only one outcome measure limit the findings of the study. Additionally, the study used a convenience sample and a within-subjects design without a control group, allowing potential threats to internal validity.

Bowen and colleagues (2016) evaluated Wilderness Adventure Therapy (WAT) outcomes based on participants' pre-and post-program and follow-up responses to self-report questionnaires. A sample of 36 adolescents, ages 12-18 years old with mental health issues all completed a 10-week manualized WAT intervention. The WAT intervention is described as a 10-week, part-time program, which is facilitated by three WAT practitioners for six to eight participants. WAT has four components that includes week 1 of screening, assessment, engagement, orientation, and discussion of client goals. Treatment weeks 2-9 involves seven day-based adventure activities (e.g., bushwalking, rock climbing, cross country skiing, and white water rafting), plus two-day and five-day training excursions. Parents, teachers, and support workers also participate in up to eight weekly indoor adventurous problem-solving activities integrated into group therapy. Termination at week 10 includes a review of met and unmet goals, identification of post-treatment goals and strategies, and identifying psychosocial supports. Results found the short-term standardized mean effect size to be small, positive, and statistically significant. Additionally, moderate, statistically significant improvements were seen in psychological resilience and social self-esteem. Short-term changes were largely retained at the three-month follow-up period. The authors conclude that while these findings indicate WAT to be effective for clinically symptomatic people, future research utilizing a comparison or wait-list control group and a larger sample size would be necessary to demonstrate the effectiveness of WAT interventions. Additional limitations noted include the evaluation design, reliance on self-reported data, regression to the mean, missing data, and use of non-validated questionnaires.

Hoag et al. (2016) conducted a study over 3 years to measure the efficacy of wilderness therapy and identify the associated mechanisms of change. Between 2007 and 2010, 332 adolescents between the ages of 13-17 years participated in at least 5 weeks of a wilderness program. Included in the 332, a total of 118 adolescents and their parents participated. The most common category of primary diagnoses of participants was mood, behavior, substance-related, and anxiety. The Youth Outcome Questionnaire Self-Report 2.0® (Y-OQ®SR 2.0), Life Effectiveness Questionnaire (LEQ), the Hope Scale (HS), and the Treatment Expectancy/Credibility Questionnaire (CEQ) were used for adolescent outcomes, while the Y-OQ® 2.01 was used for parent outcome results. Significant improvement ($P < .001$) was noted on the self-assessments from intake to discharge for HS, LEQ, and CEQ. The parent scores on the Y-OQ®2.01 from intake to discharge was clinically and statistically remarkable ($P < .001$). The authors' note that the outcome differences for their sample between males and females

was near significant and requires further research. The authors report low post-discharge follow-up rates and no statistical analyses could be completed. The limitations of the study were identified as overall low parent participation and post-discharge follow-up rates.

Zachor and colleagues (2016) examined the effectiveness of an outdoor adventure program in children with autism spectrum disorders (ASD). The study included 51 participants (age 3-7) who were currently enrolled in ASD special education programs. All individuals used the same educational protocols, and the intervention group ($n = 30$) also participated in the outdoor adventure program for 13 weeks. The control group was not significantly different in age, sex, cognitive or adaptive behavior measures. Each session lasted 30 minutes and occurred in community parks near the participants' schools. Four devices were used in each session: two-way climbing rope ladder, rope elevator, rope bridge, and a hammock and rope swing. Each session began with an opening song, followed by the children using the rope devices, moving from one to another throughout the session. These activities required communication between the child, instructor, and peers. At the end of the session, everyone gathered for a short closing meeting, in which the children were asked, 'how was it' and, 'what activities did you enjoy doing'. Lastly, the group sang a closing song together. The results found the outdoor adventure program intervention to have a significant impact on ASD symptom severity, as measured by subdomains of the Social Responsiveness Scale. The authors conclude that the outdoor adventure program may be an effective intervention in addition to traditional treatments in young children with ASD. They encourage future studies to examine the outcome of such programs delivered for longer periods of time and maintenance of the achievements over time.

Tucker and colleagues (2015) examined changes in body composition and mental health outcomes among adolescents who participated in a wilderness therapy program. A total of 516 adolescent clients (age 13-18; mean age 16.2) enrolled in wilderness therapy between 2011 and 2013 were included. These individuals had been diagnosed with a behavior disorder, including major depression, oppositional defiant disorder, learning disorder, impulse control disorder, and substance related disorders. The average length of stay for participants was 79.8 days. All participants in the program received individual and group psychotherapy, wilderness-living, psycho-education groups, adventure therapy activities, value-based academic curriculum, and a healthy lifestyle (i.e., healthy diet, sleep habits, work, and exercise). Family therapy was provided weekly using narrative therapy. Participants went on hike/backpack expeditions 4 to 5 times a week for 3 to 10 miles each. Primary measures for the study included BMI and the Youth-Outcome Questionnaire Self Report Version 2.0 (Y-OQ SR 2.0); these were gathered at both admission and discharge. Noteworthy improvements in mental health functioning were reported, particularly among obese and female participants. The authors acknowledge the lack of a comparable comparison group of youth, and that mental health functioning data was limited to self-report only. They note that future research is needed on the long-term impact of WT programs for both physical and mental health outcomes among youth.

Systematic Reviews & Meta-Analyses

According to Weeland et al. (2019), particularly in children, increased exposure to nature appears to have positive benefits to cognitive, affective, and behavioral self-regulation. Two meta-analyses were conducted on the effect of exposure to nature on self-regulation of schoolchildren (Mean age=7.84 years; $SD=2.46$). The studies included reviewed the association between exposure to nature and cognitive and affective self-regulation, or behavioral manifestations, the children in the studies were ages 4-12 years old, and the studies were peer-reviewed journals written in English. The 3-level meta-analyses showed small, but significant positive overall relationships of nature with self-regulation in both correlational (15 studies, $r = .10$; $p < .001$) and (quasi-) experimental (16 studies, $d=.15$; $p < .01$) studies. Moderation analyses revealed no differential associations based on most sample or study characteristics. However, in correlational studies the type of instrument used to measure exposure to nature (index score of nature vs. parent-reported exposure) significantly moderated the association between nature and self-regulation. Stronger associations were identified when exposure to nature was assessed via parent-reports than via an index such as by a normalized difference vegetation index (NDVI). The results reveal that nature may be a promising tool in stimulating children's self-regulation, and perhaps preventing child psychopathology. The authors emphasize that nature interventions can easily be implemented in a variety of settings and exposure to nature is affordable and safe. The authors acknowledge that limitations exist with a need for more rigorous experimental studies, using theoretically based conceptualizations of nature, and validated measures of nature and its recognized outcomes.

Fleischer and colleagues (2017) completed a meta-analysis which includes 30 studies; 53 effect sizes, 1802 subjects, 39 adventure therapy samples and 21 control samples. Participants had a mean age of 18 years and 69% were male. Participants were either at risk or in treatment for behavioral or mental health issues. This meta-analysis examines adventure therapy programs on three components regarding self-concept: locus of control, self-efficacy, and self-esteem. The results revealed that short-term effect sizes of the impact of adventure therapy on self-concept were moderate for both uncontrolled effects ($g = 0.51$) and controlled effects ($g = 0.56$). There was no evidence for a difference between the effects on locus of control, self-efficacy or self-esteem. The identified high heterogeneity of effect sizes could not be explained by any of the examined moderating variables. The follow-up effects confirmed long-term self-concept changes. Fleisher et al., conclude that psychological processes involved in adventure therapy should be the emphasis on future research, in addition to a goal of high methodological quality.

Guidelines & Consensus Statements

American Academy of Child and Adolescent Psychiatry (AACAP): The AACAP published principles of care for treatment of children and adolescents with mental illness in residential treatment centers (Houston et al., 2010). The AACAP notes that some state statutes define “boot camps” or “wilderness therapy programs” as residential treatment centers. These programs, however, frequently do not provide the range or intensity of services that would meet the definition of a clinical residential treatment center. Additionally, many of these programs do not engage in the use of a multidisciplinary team including psychologists, psychiatrists, pediatricians, and licensed therapists who are constantly involved in the treatment plan of the individual.

U.S. FOOD AND DRUG ADMINISTRATION

Wilderness therapy programs are not subject to regulation by the FDA.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) for wilderness therapy programs could not be identified.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member-specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other clinical criteria may apply.

Procedure Codes	Description
	There is no specific CPT code for Wilderness Therapy
T2036	Therapeutic camping, overnight, waiver; each session
T2037	Therapeutic camping, day, waiver; each session

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REVISION HISTORY

Date	Action/Description
04/11/2017	Version 1
04/11/2018	Annual Update: Updated formatting, references. Approved by UMC.
06/17/2019	Annual Update: Updated formatting & checked references.
03/16/2020	Annual update