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Can Involuntary Youth Transport into Outdoor Behavioral Healthcare Treatment Programs (Wilderness Therapy) Ever Be Ethical?

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Abstract

This paper is a direct response to a recent article in this journal by Gass et al. (CASW 39: 291–302) in which the authors describe an "ethical" model for the involuntary transport of youth into Outdoor Behavioral Healthcare programs, often synonymously referred to as wilderness therapy in the literature. These authors suggest that international law supports involuntary transport and that their approach is research-based, trauma-informed, ethical, and does not interfere with client outcomes. We believe each of these claims to be in error: The international laws cited include strict rules about involuntary transport, professional codes of ethics forbid all but exceptional uses of force, and there is a large literature on the harms of involuntary transport and admission that appears to be ignored. We suggest that involuntary transport is almost always contraindicated for wilderness therapy and this practice is a symptom of what has been called the "troubled teen industry."

Keywords Adolescent treatment · Involuntary treatment · Transport · Behavioral Healthcare · Ethics · Wilderness therapy

Gass et al. (2021) claim to be describing an ethical framework for involuntary youth transport services (IYT) that is a

> …more effective and collaborative model…that results in less restrictive approaches, greater levels of willingness by the adolescent to enter treatment, and trauma-informed management of difficult emotional or physical behaviors. This model also guides professionals and caregivers on how to proceed when IYT services are deemed necessary. (p. 1)

We welcome this intention, though we find that the argument and model are ill-conceived. First and foremost, IYT services are never necessary for participation in wilderness programs. There are many useful purposes for therapy in the outdoors, but there is no ethical use of force to get youth to the wilderness or to force them to stay. The types of psychological conditions that require involuntary transport are not suitable for wilderness therapy, such as a person being at serious risk of harming themselves or others, severe eating disorders, suicidal ideation, and violent behaviour—criteria most OBH member programs' websites note excludes admission to wilderness therapy (see OBH Council, 2022).

Regarding our positionality, we write this paper as advocates for therapy outdoors. We are practitioners in the field and believe natural environments provide another avenue to engage those who seek mental and behavioral health support. That said, we are experienced in working in remote settings and Indigenous communities in Canada and Australia, where the impacts of removing people involuntarily from their homes has led to generational trauma and violations of human rights. As social and child and youth care workers, we use this response to provide a critical response to Gass et al.'s attempt to re-frame the ethics of IYT in the context of wilderness therapy.

The transport services and wilderness programs referred to in Gass et al. (2021) have been characterized

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as "totalistic programs" (Chatfield, 2019). One characteristic of these programs is that there appears to be a choice, but it is often not real. One can either "resist and suffer indefinitely or comply and rise up through the levels of the program toward release" (Chatfield, 2019, p. 53). Dobud (2021) and Rosen (2021) provided numerous case examples illustrating these problematic practices.

Most youth services have attempted to distance themselves from the practice of forced treatment (Whittaker et al., 2016), yet coerced transportation and coerced participation persists in many OBH programs. As a spokesperson for a transport company says to a youth in a Dr. Phil video found easily on YouTube, "If you don't comply, you're resisting, and if you are resisting, you're going to end up in restraints. Compliance is key to any successful program" (Dr. Phil, 2020). This reads not of treatment but abuse, and it is unethical. It is also poor developmental psychology, poor change theory, and poor group care. "I'm choking, bro, I'm going to die" (Dr. Phil, 2020), says the youth in the video as they pin him to the ground. There is a similar scenario presented in the Gass et al. paper where a young woman was unaware of where she was going and whether the two large men seemingly kidnapping her were going to "rape" or "kill" her—a scenario strikingly similar to other secure transport experiences, such as those described in Dobud (2021). Based on these examples, and others (see Rosen, 2021), we question whether these experiences can be trauma-informed–they may, in fact, cause it.

If a young person's problems have progressed to the point at which the parents, a social worker, psychologist, or judge thinks that involuntary confinement is necessary, there are safer alternatives than involuntary transport of youth to treatment programs; specifically, places where the next step can be negotiated with parents and youth. Examples of circumstances that may require involuntary confinement include repeated suicide attempts, anorexia to the point of endangering their own health, or drug overdose. A wilderness experience is not prescribed for any of these. There are circumstances for which a wilderness program can be helpful, but youth should enter these programs voluntarily and have their agency and autonomy preserved (see Pringle et al., 2021).

We write this response as advocates for child and youth care, the human rights of recipients of mental and behavioral healthcare, and we are guided by social work and clinical counseling ethics. Our concern is not with therapy outdoors but the ongoing lack of clarity about the ethics of practice. Here we raise our concerns about associating experiential, adventure-based, outdoor therapies with coercive practices. First, we describe briefly the history of OBH and IYT, review some of the ethical principles described by Gass et al. (2021) and describe flaws in their ethical reasoning.

Background

Our earlier work documented some of these problems with OBH programs and the IYT services on which they rely (Harper, 2017; Harper et al., 2021; Harper & Fernee, 2022). OBH refers to a group of wilderness therapy programs in the United States that work in concert with transport services. Gass et al. (2021) describe an ethical framework for transport services as a distinct practice from OBH, but the OBH programs receiving transported youth share responsibility with transport services for admitting youth who are too often "kidnapped" (Hardy, 2011). The problems of these youth do not justify zip ties, restraints, handcuffs, midnight removal from their beds and homes, or highway transfers from family cars to window-tinted SUVs. None of these practices can be ethically justified, even by claiming, as Tucker et al. (2015, 2018) did, by saying that their treatment outcomes are equivalent to non-transported youth.

In 2007, the United States Government Accountability Office (GAO) reported that private, for-profit residential youth treatment programs, including wilderness therapy programs, were operating in an extra-legal environment in which young people were often harmed in the name of "treatment," in part because some of these youth were taken against their will and transported to the program site and not permitted to leave or contact their parents or lawyer once admitted. These programs recruited young people referred by their parents, and treatment consisted of an intense regime of rigorous social and physical activity in remote environments far removed from their community (Chatfield, 2019).

The industry acknowledged the GAO report, and some but not all of the worst programs seemed to disappear. Private pay wilderness therapy programs have continued (Norton et al., 2014), often out of sight of regulatory agencies, in service to wealthy families who can afford the high fees (i.e., approx. $500–600 USD per day for an average of 90 days, according to Gass et al., 2019). OBH programs and transport companies appear to depend on each other for a steady supply of clients. The programs, referral services, transport services, and researchers who study them have a mutual financial incentive to approve their own practices, and the desperate parents who contract with them may not know enough about other options. In fact, grassroots movements, such as #BreakingCodeSilence, and the recent efforts of Paris Hilton (2021) and Rosen (2021) have demonstrated that this industry did not disappear in the early 2000s; instead, it has thrived. About 50% of youth receiving OBH

are delivered to these programs by transport services, very often from family homes to programs across multiple state lines (Tucker et al., 2015, 2018).

A potential participant–involuntary or not–ought to be provided realistic details about the type of care and treatment before they are admitted, including the typical length of stay, where they will be staying, a description of the living conditions, and the qualifications and experiences of staff with whom they will interact. They should have the right to leave the program at any time, and they cannot be denied access to their parents, their lawyer, or a child advocate (Ellis, 2013). Youth should not be abducted from their family home and informed afterward what will happen to them. .

Second, some of these programs are using physical activity, like backpacking, as a program activity. Physical activity as a meaningful, purposeful experience, as a contributor to fitness, and carrying gear as one's contribution to a group experience is part of the charm of a wilderness experience. It can also be coercive, forcing youth to hike long distances against their will or used as a threat to leave them behind in the wilderness if they do not want to participate. The literature has examples of how this is done coercively and used as punishment by some OBH programs (Chatfield, 2019). As one participant put it, "I never really bought into the idea that hiking was going to make me contemplate my sins" (Dobud, 2021).

Third, some authors (Tucker et al., 2015, 2018) have justified involuntary confinement and treatment in OBH on instrumental terms, that is, by claiming that the programs are effective so that how they arrived does not matter. Others have argued OBH programs are safe (Javorsky & Gass, 2013) although psychological and emotional safety were not addressed. Rather the focus was on incidents of injury, illness and behavioral controls, such as therapeutic holds and restraint which are, as the authors state "often associated with behavioral healthcare programs" (p. 113). We have described the problems with this data elsewhere (Harper, 2017; Harper & Dobud, 2020), including programs that require youth to report on improvement before being released and misleading collection and analyses of data. We are troubled by the claim that the end justifies the means.

Of course, this too means that involuntary–forced–admission to wilderness programs is never acceptable. There are reasons for securely confining people, but the reasons provided by OBH programs are not those. As a result, transport services and OBH programs who accept involuntary youth violate professional ethical codes. For example, the National Association of Social Workers (U.S.) argues against practices that limit self-determination, autonomy, and client choice. The methods used by transport services are derived from police and security services tactics–not social work, child and youth care, or any other modern human service protocols. No ethical professional suggests compliance is the goal of treatment. Long ago Mitten (1994) presented similar criticisms of oppressive, paternalistic outdoor therapy programming, suggesting compliance makes for "easy to work with clients" - not sustainable therapeutic outcomes.

The Legal Requirements for Involuntary Placement

Two claims made by Gass et al. (2021) about the legality of involuntary transport are incorrect. First, the authors state that "In most countries youth can be legally transported involuntarily… into a treatment program when certain conditions exist under the authority of their legal caregivers" (p. 2). They provide citations for this claim from Australia, Canada, India, Finland, and the United Kingdom. However, these papers do not address involuntary transport. For example, the two citations from Canada (Clark et al., 2019; Hamilton et al., 2020) emerged from a debate about the appropriateness of *secure care*, that is, involuntary care, and not to be conflated with *treatment* or with *transport.* Involuntary treatment is one type of secure care, but it is not assumed and needs its own justification. Further, neither citation says anything about authorizing the *transport* of young people involuntarily, and they do not approve of kidnapping. In British Columbia there are strict conditions to ensure secure care is rarely used and only under strict conditions:

> A person 16 years of age or older may be involuntarily admitted to a mental health facility if a physician who has examined the person issues a medical certificate certifying that all four criteria for certification are met:
>
> - the person has a mental disorder for specified reasons,
> - requires treatment by a designated facility,
> - requires care to prevent the person's mental or physical deterioration or for the protection of the person or others, and,
> - cannot suitably be admitted as a voluntary patient. (Mental Health Act, 2021 34, 34.2).

Further, the Mental Health Act also says:

> In addition to restrictions built into the detention periods noted above, when someone is involuntarily admitted, they are entitled to (a) written and oral notice of the name and location of the facility where they are detained, (b) notification of their circumstance to near relatives, (c) notification of their right to talk to a lawyer under s. 10 of the *Charter*, (d) the right to be promptly provided with reasons for the detention, (e) the right to have the deten-

> tion reviewed by an independent review panel or court, and (f) the right to request a second medical opinion on the appropriateness of the treatment authorized by the designated director. (Mental Health Act, 2021 34, 34.2)

The initial secure care may persist only up to a maximum of 48 hours, and continued evidence is required if longer periods of time are warranted.

Similarly, the Australian reference shared by Gass et al. (2021) relates to the use of a *Community Treatment Order* in the state of South Australia, a legal process including the client's right to appeal (McMillan et al., 2019). Involuntary transport, as described in the OBH literature (Hardy, 2011; Tucker et al., 2015, 2018) does not include these safeguards to protect the autonomy, agency, and human rights of the young person, even though informed consent, autonomy, and choice are described by Gass et al. (2021) as central to effective practice. Neither the Canadian or the Australian references are relevant or justify current OBH practices.

The second claim, implied, is that the OBH wilderness therapy programs admit youth with similar issues and circumstances as youth in these international jurisdictions under secure care and community treatment orders. This is also incorrect. Many of the youth OBH programs admit are referred by "educational consultants" whose job it is to recruit participants into the program (Younis, 2021). Likewise, many are referred to the program directly by anxious and desperate parents who locate OBH programs on the internet (Harper, 2007; Tucker et al., 2015, 2018). A young person can enter an OBH program voluntarily or involuntarily without the involvement of any judicial system, physician, judge, or other unbiased third party with regulatory oversight related to the protection of child rights.

It would have been more appropriate to examine state laws relevant to each OBH program or, more importantly, where the young person resides. For example, the state of Utah's Department of Human Services (2021) defines a civil commitment as a "legal process through which an individual with symptoms of severe mental illness is court-ordered into treatment" (para 1). In Colorado, a licensed clinical social worker concerned with a client's safety may initiate a 72-hour mental health hold. However, that worker "may not resolve such a hold; that is may not remove the hold or begin the commitment process" (NASW Colorado Chapter, n.d., para 4). The commitment process may only be conducted by an external professional, such as a doctor or psychologist. Regarding children and adolescents, a different process involves a neutral and detached designated examiner who is not involved in the young person's treatment.

How Not to Do Ethics

When the keywords "involuntary youth transport" are entered into a journal search engine, the only article that comes up is Gass et al. (2021). However, "involuntary transport" brings up numerous articles. For example, Bradbury et al. (2014) studied the challenges of involuntary transport in New South Wales, Australia, and two years later Bradbury et al. (2016) reported on the lived experience of people who were transported by the police for mental health reasons. Their research found the police response often appeared too intense given the circumstances, especially non-violent callouts. Similarly, Jones et al. (2021) studied the negative experiences of youth and young adults who were restrained during involuntary transport. Samso et al. (2020) studied the involuntary transport of participants who were schizophrenic, some of whom required restraint. Cheung et al. (2018) discusses the "medical incapacity hold," involuntary medical hospitalization of patients who lack decisional capacity. Wilson et al. (2021) asked whether nurses working in acute settings can really be trauma-informed. Chatfield et al. (2019) reported that the degree of totalistic qualities is negatively correlated with quality of experience. Stuart et al. (2020) studied the experience of carers of patients admitted involuntarily. Stander et al. (2021) reported findings from a study of care providers' experience during a behavioral emergency. All of these have lessons for a discussion of the ethics of involuntary admission and transport, and we have not mentioned the many articles on involuntary admission to treatment for medical, mental health, or psychiatric reasons. None of these were cited by Gass and colleagues.

Instead of discussing the literature, Gass and colleagues describe several series of ideas, including a three-step "framework around the principles of least coercion," a "five-step ethical framework," five categories of ethical principles, seven ethical guidelines for the use of involuntary youth transport, and another five steps for "applying ethical guidelines for IYT." Each has problems, including misinterpretation of the source materials and not taking into account the body of literature on involuntary transport described above. They provide two transport scenarios but do not provide any interpretation and no application of the variety of "frameworks" in their paper to these scenarios.

For example, in the paper by O'Brien and Golding (2003) cited as including a three-step "framework around the principles of least coercion," Gass et al. (2021) misunderstand what O'Brien and Golding are doing; they are describing different types of coercion in human service practice that ought to be avoided, not justifying coercion. O'Brien and Golding have an exhaustive list of coercive practices, including:

> … forcing someone to do something against their wishes. However, we want to also include manipulating someone's wishes as coercion. Examples of the first type of coercive practice in the mental health setting would include: physical force, non-recognition of refusal of treatment, compulsory treatment or hospitalization, restraint and seclusion. Examples of the second type of coercive practice would include: manipulation through half-truths or not telling the truth, under-disclosure, and restricting possible choices. Convincing a person to alter their choices through persuasive argument can be considered coercive if the persuasion involves deception or the use of threats. This means that overriding someone's decision-making by letting them choose for themselves but restricting their access to information counts as coercion, as does providing false information to manipulate their decision towards something they would not normally want. Physically preventing someone from doing what they wish or choose to do is also coercive. Thus we have defined coercion to include not only force, but also acts of manipulation and persuasion that do not involve overt force. (pp. 168–169)

O'Brien and Golding conclude that a good theory of coercion helps identify ethically compromised everyday practices. They also provide a ranking of coercive practices to help practitioners thoughtfully select the least coercive option. Physically restraining and transporting youth against their will does not do well in their list. Gass et al. (2021) begin with the most coercive possibility and look for justifications for that choice, and their reorganization of O'Brien and Golding's conditions into steps makes it easier to justify that choice. Other OBH research (e.g., Tucker et al., 2015) claim that the results of their treatment justify that coercion, a shocking authoritarian and paternalistic claim.

Further, there are several unexplained statements. For example, the authors write, "In determining an ethical decision about IYT, the loss of client autonomy alone is enough to necessitate moving directly from Step 1 to Step 2" (Gass et al., 2021). Why? Because it violates "ordinary moral sense" or because it does not? They say that a potential benefit of IYT is "reducing safety risks during transport," as if voluntary transport is more of a risk than IYT. They argue that a potential consequence of IYT is "the violation of human rights and self-determination" but provide no insight about when violating these are justified–or when it is not. The authors provide a long list of interested associations whose ethical codes might say something about IYT and conclude that none of them mention involuntary youth transport, yet there are ethical guidelines surrounding forced treatment and guidelines about secure care, including clear statements in the ethical codes of those associations, including the National Association of Social Workers' (2021) *Code of Ethics.* Standard 1.03(d) states "social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service." While clinical judgment comes into account when a social worker decides to limit a client's self-determination if they are at increased risk of harming themselves or others in the foreseeable future, transported youth are unaware of their admission to OBH, the length of their stay, or their right to refuse treatment (Dobud, 2020).

Gass et al. (2021) state, "Since the ethical dilemma is resolved in step four, the process does not proceed to step 5" (Gass et al., 2021). We ask, which ethical dilemma? They have not identified the ethical dilemma this intends to address, and they have already stated that this fifth step does not apply, so apparently, only three steps exist. It baffles the reader and provides little direction to the practitioner or parent.

Next, they list "five categories" of ethical principles:

(1) Autonomy—the right to freedom of action and choice as long as the client's behavior does not pose a serious risk to self or others.

(2) Nonmaleficence—above all else, no harm is done to people.

(3) Beneficence—do "the greatest good" to contribute to the health and welfare of others.

(4) Fidelity—be faithful, keep promises, and be loyal and respectful of people's rights.

(5) Justice—individuals are treated equally and fairly.

These principles are common to social work and child and youth care practice, though problematic in relation to IYT. The authors' state, "In this vein, IYT may be considered an ethical option when these principles are satisfied in the IYT decision-making process" (p. 5). Yet we find no explanation about how autonomy can be satisfied and still commit someone to secure treatment, except the claim about "a serious risk to self or others" which, as we stated previously, should be determined by an independent third party. We are left with many questions. How does one parse the serious risk? How does one decide when "no harm" is done, when one is doing "the greatest good," or is being faithful and just? It seems this responsibility is left solely to the parent and to the financially compromised educational consultant, transport service, and OBH program.

Next, Gass et al. describe their seven "ethical guidelines for the use of IYT" (p. 6). In other words, they conflated the process of assessment and determining the best care and treatment for youth and their families to the process of justifying IYT. These confusions are exemplified by Step

1: "Consent to treatment." They already know more than half of youth will not consent (Harper et al., 2021), yet they persist. Step 7 is the "Use of IYT procedures maximizing autonomy, respect, and dignity for youth throughout the entire treatment process." How can involuntary transport maximize autonomy? Again, in the "Model for Applying Ethical Guidelines for IYT, the authors say, "Once the decision for IYT has been made, it is essential to ensure that the procedures used maximize autonomy, respect, and dignity for the youth throughout the entire process" (p. 7). More obfuscation follows: "Strong efforts must be made by IYT providers to include the youth… in evaluating the use of an IYT…. IYT providers (and other professionals such as therapists, educational consultants, etc.) should actively pursue assent by the adolescent to initiate the treatment process, even after determining that IYT is appropriate." What Gass et al. describe becomes a caricature of informed consent.

There is serious pain resulting from the lack of dignity and autonomy in involuntary transport and treatment (Dobud, 2021). In jurisdictions where involuntary confinement of youth is legal, these decisions come after demonstrably exhausting all other options. Because involuntary confinement is always accompanied by the use of force by adults and, sometimes, resistance by youth, dignity is hard to achieve, and there is no autonomy.

Gass et al. (2021) state that transport services ought to model themselves after OBH programs: "After suffering several traumatic professional events in the 1990s, the field underwent a deep self-examination process to create the progressive field it currently experiences today." This appears to be false. Many OBH programs depend on transport services for a steady supply of youth, over 50% of which are involuntarily transported (e.g., 64.5% in Tucker et al., 2018). They may have different management structures, but the conflict of interest has changed little since the GAO's (2007) report. They were caught by publicity and legal authorities and forced to reform. Yet they have not yet appropriately distanced themselves from the *troubled teen industry* (Rosen, 2021), and this Gass et al. paper is one more example of their refusal to take this seriously. For 30 years now, past OBH clients describe themselves as survivors. Social workers, counselors, marriage and family therapists, psychologists etc., especially those licensed and delivering these services, are likely violating the Code of Ethics of their professional associations (e.g., National Association of Social Workers). They are accountable to their clients and profession first, and only then to their employers and program standards. In this situation, the Association of Experiential Education is also implicated in this critique as they provide accreditation for OBH outdoor program's "standards of program quality, professional behavior, and appropriate risk management" (See https://www.aee.org/accreditation).

The Iatrogenic Effects of OBH

To be ethical, Gass et al. suggest practices should be verified with research. We agree, yet we have doubts about the body of OBH research. First, there is no OBH literature on iatrogenic effects, though others have documented the harms. Every type of treatment may do harm, and established treatments acknowledge and study those. In other fields there is more rigorous study. For example, Jones et al. (2021) found that:

> Three quarters of the youth reported negative impacts of [Involuntary Hospitalization] on trust, including unwillingness to disclose suicidal feelings or intentions. Selective non-disclosure of suicidal feelings was reported even in instances in which the participant continued to meet with providers following discharge. Factors identified as contributing to distrust included perceptions of inpatient treatment as more punitive than therapeutic, staff as more judgmental than empathetic, and hospitalization overall failing to meet therapeutic needs. (p. 2017)

McGowan and Wagner (2005) found "(a) group composition, (b) member-reinforced disruptive behavior in groups, and (c) leadership behavior may have independent [negative] effects on outcomes for substance abusing adolescents who participate in group treatment" (p. 2). Werch & Owen (2002) identified increases in drug consumption among some youth who participated in treatment. Ward-Ciesielski and Rizvi (2020) found heightened suicide risk among youth who were hospitalized for the very risk of suicide. Yampolskaya et al. (2014) analyzed the characteristics of youth in residential programs, suggesting that those most at risk of involuntary treatment suffered from multiple problems, including child maltreatment.

These are admirable studies of the risks of involuntary treatment; once we know about them, they can be part of the evidence–and part of the risk–we consider when deciding whether it is necessary for any particular youth. This suggests that involuntary approaches ignoring the maltreatment portion of the equation might be troublesome, even unethical. Failure to account for the best available evidence is at odds with nearly all definitions of evidence-based practice, which also include privileging client preferences.

Despite this, paper after paper by OBH researchers finds only overwhelmingly positive outcomes. Further, OBH Research Scientists (https://www.obhcenter.org/research-scientists/) seldom identify any conflict of interest or financial compensation for their work (Gass et al., 2021), despite the direct funding by the industry and the reliance of that funding on supportive outcomes research.

Gass et al. (2019) stated "the lead author is paid a partial summer stipend of his university salary by the Outdoor Behavioral Council, the National Association of Therapeutic Schools and Programs" (NATSAP) (p. 1) yet in the same paper the authors declare receiving no financial support. The central goal of conflict-of-interest expression "is to protect the integrity of professional judgement" (Field & Lo, 2009, p. 4). which preserves the public trust, but can also obscure biases and vested interests if not declared (Galea & Saitz, 2017; Little, 1999).

Conclusions

Our mission is not to critique therapy outdoors, of which we are fierce advocates. There are many good outdoor therapy, outdoor youth development, and outdoor education programs, and we believe these are generally under-appreciated and under-utilized. The youth we describe in this paper may have apprehensions when asked to engage in traditional talk therapy, and most of the youth transported to OBH are suggested to have endured numerous treatment failures. In these cases, "more of the same" is seldom indicated (Duncan et al., 2007). Being a population notoriously challenging to engage in psychotherapy–often arriving with a healthy distrust of adults and authority figures–the outdoor setting provides a more levelling environment for therapy to take place. When client choice, autonomy, and self-determination are privileged above all else, outdoor therapists can tailor their outdoor services based on open and transparent discussions, providing opportunities to enhance adolescent engagement (Pringle et al., 2021). These practices are described in the literature (Fernee et al., 2019), have evidence support (Vankanegan et al., 2019), and have included numerous adventure-based activities, such as surfing, rock climbing, sailing, canoeing, backpacking, or simply a leisurely stroll through nearby park (Cooley et al., 2020; Dobud & Harper, 2018).

However, the road to greater recognition of outdoor therapies will be eclipsed by the unethical, coercive, and involuntary practices of these programs. Claiming that transport services and OBH programs are two different services with independent effects misleads the reader, because OBH programs depend on a steady supply of clients who are transported unwillingly. To help wilderness therapy gain the recognition it deserves as a bona-fide treatment for struggling youth, academics and practitioners alike have three options. First, they can continue to ignore the totalistic practices many OBH programs continue to perpetuate. Second, people can acknowledge this is only a small percentage of wilderness therapy practice internationally and hope that, without intervention, those invested in these practices will make necessary changes. Third, and the best option, everyone invested in the promise of therapy outdoors can band together to put clients' rights first and our own prestige, legacy, and recognition second. In particular, we would like OBH and similar programs to stop accepting involuntary clients, including those delivered to them by transport services. If this truly occurred, the practices we critiqued in this paper will become alarming to all—no longer eclipsed by a robust lack of transparency from those most invested in this industry.

We are concerned about the role of OBH in perpetuating the totalistic troubled teen industry, paternalistic wilderness therapy practices, and coercive transport services. The Gass et al. (2021) paper attempts to perpetuate all three, indirectly and directly. It is time for these services to be brought under the auspices of professional associations and public services that can provide them with ethical guidelines to prevent the abuses of parents and their children. These services can take advantage of parents by presenting false choices about the treatment options at a moment when the parents feel lost about what to do. They also take advantage of children and youth by violating principles of informed consent, including coercion into treatment, not telling them about the conditions of treatment, not telling them about the qualifications of treatment staff, not telling them about their right to have their own lawyer, not revealing the location of the program, preventing them from withdrawing from the program, and preventing contact between parents and children. These are basic ethical principles of youth treatment practice. In addition, they also ought to have the right to have the conditions of their forced treatment reviewed independently by at least a physician and ideally an independent panel of experts.

There are many youth who can benefit from outdoor and wilderness experiences, but youth for whom involuntary transport is necessary and ethical are not those youth. IYT in OBH programs violates the law and ethical norms of practice, and the Gass et al. (2021) paper perpetuates a harmful practice.

Declarations

Conflict of interest The authors declare that they have no conflict of interest.

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