The Outdoors for Wellbeing: A Practitioner's View on Policy and Practice

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Contents

Abstract

Bringing people into the outdoors to improve mental health and wellbeing as a practice has deep roots and is now developing rapidly in the UK. This is partly in response to the current mental health crisis and a development from ecopsychological roots that seek to address split between humans and nature. The range of evidence has been growing, as have the range of practices, both of which are described here. There has also been a shift in focus in NHS England, to embrace social, community and environmental determinants of health and move towards social prescribing. This has created both opportunities and pressures for practitioners offering wellbeing outdoors, which are explored. To enhance understanding, a case study is offered.

Introduction

It seems perfectly natural to many people that spending time in nature will be good for human wellbeing and mental health, as exhorted by naturalist and writer John Muir more than a hundred years ago:

"*Camp out among the grass of glacier meadows. Climb the mountains and get their good tidings. Nature's peace will flow into you as the sunshine flows into trees. The winds will blow their own freshness into you, and the storms their energy, while cares drop off like autumn leaves.*" John Muir (1901)

In the 21st century, this intuitive knowing has become evidence-based, with a wealth of research about how nature-connectedness fosters human wellbeing and happiness (Adams et al., 2014; Capaldi A. et al., 2014; Husk et al., 2016; Lovell, 2016; Mayer et al., 2009). As this evidence base has grown, there has been a new and increasing focus on how this emerging knowledge can be put to work to in or through the health sector (NHS England - Personalised Care & Social Prescribing, n.d.), with special interest in mental health outcomes (NASP, 2022). The term green social prescribing has emerged (NHS, 2021), as part of a move towards wider social prescribing, within the universal personalised care model (*The NHS Long Term Plan*, 2019). This should mean that people can be referred to outdoor wellbeing activities by social prescribing link workers, via their GP or other trusted person or health professional.

In the United Kingdom there are a fast-growing number of practitioners and projects that facilitate nature-based wellbeing activities, supported both by evidence and

experience (Hine et al., 2013; Wilson et al., 2011). In 2020, the UK Institute for Outdoor Learning issued a statement of good practice for outdoor mental health interventions, noting an “exponential growth in types of outdoor programmes and initiatives being developed and utilised for mental health and psychological wellbeing. (Richards et al., 2020b, p. 1)

This rapidly developing ‘sector’ of outdoors-wellbeing activity has complex roots intertwined through diverse disciplines; environment, ecology, conservation, psychology psychotherapy, counselling, environmental education, outdoor learning and health care. This means it is challenging to describe and differing practitioner perspectives abound. The emergence of ecopsychology in the latter half of the 20th century has created a philosophical, theoretical and critical base, which continues to mature (Fisher, 2013a; Roszak et al., 1995)and ecotherapy is often described as the practice, i.e. applied ecopsychology. For this paper, the practitioner’s roots are acknowledged as being primarily in ecopsychology, ecotherapy, outdoor learning and forest school.

The current green social prescribing focus on scaleability and expansion (Dayson, 2022) to address the demanding mental health needs could be problematic for practitioners, as this desire can be at odds can be with the principle of “we too are nature” and lead inadvertently to further exploitation of nature. It could also see more efforts created without accompanying expertise in practice, or an understanding of the new and sometimes complex social prescribing ecosystem.

This paper explores the origins and current context of this rapidly growing sector from a practitioner's perspective and offers as a case study the author's own practice that has grown from ten years of experience. The focus is on working with adults, whilst acknowledging there is also a breadth of activity emerging centred on children and young people. It examines the current push to bring these practices into the health system and make them scalable, exploring the philosophical and practical challenges as they are seen through the lens of being a practitioner.

Historical Context

Ecopsychology

Growing from roots in ecology, psychology and the more radical fields of ecofeminism and ecopoetics, ecopsychology views the relationships between people and nature as broader and deeper than than those generally held in ecology or psychology (Davis, 1998; Fisher, 2013b). Ecopsychologists recognise a deeply reciprocal bond between humans and nature, and propose that the denial and breaking of this bond creates human and ecological suffering (Roszak, 1995) The connection between mental illness and human detachment from the natural world was a significant part of the early discussion and informed the development of the field (Shepherd, 1982)and continues to inform research. The pivotal work of Roszak, Gomes and Kanner (Roszak et al., 1995) brought together a series of essays that helped ecopsychology find a place in academic discussion, giving voice to critical explorations of the human-nature split and offering ways to think, speak and be that

could promote both Earth and human healing. Ecopsychology asserts that who we are, how we suffer and how we heal as humans are inseparable from our relationship with nature (Davis, 1998).

Fisher describes a developmental path for ecopsychology, building through a first stage in the Roszak era which began to articulate the field, a second wave which was more focused on establishing itself and fitting into the mainstream, including the descriptions of ecotherapies, and creating journals, and now a third wave which could be described as working in and with the system whilst challenging the status quo. (Fisher 2021, unpublished course documents).

Ecotherapy

Ecotherapy as first defined by therapist Clinebell (1996)is about how human healing and growth is nurtured by a healthy interaction with Earth. He suggested that the "work encompasses the total mind-body-spirit-relationship organism, not just the psyche"(Clinebell, 1996, p. xx1). Later, Buzzell and Chalquist (Buzzell & Chalquist, 2009)describe the term ecotherapy as an applied form of ecopsychology, and thus a new form of psychotherapy, and their anthology introduces ways of addressing human difficulties including nature-reconnection, working with plants and animals, environmental activism and wilderness quests. More recently Doherty (2016) widens ecotherapy and describes it as "psychotherapeutic activities counselling, psychotherapy, social work, self-help, prevention, public health activities) undertaken with an ecological consciousness or intent" (p114).

Ecotherapy is a contested term, and in researching practical applications, Burls describes a very different definition for ‘contemporary ecotherapy’, seeing it as about people engaged in active care of urban or rural green spaces who labour to “provide a healthy green space for the use of their community as a result of their activities at the micro level.” (2008 p229). In line with this, Perluss(2015) suggests that ecotherapy is not a set of techniques, and more about an “an attitude of reciprocity and interdependence.” (p4)

Working with Nature

Greenway, an early pioneer of bringing wilderness adventure and ecopsychology together, articulated the view that a “wilderness that *must* heal us is surely a commodity” (1995, p. 135 authors italics). Buzzell and Chalquist proposed that nature used simply as a tool for human healing reinforces the human-nature divide expressed through ecopsychology. Buzzell (2016) elucidates this further in her definition of two different levels of ecotherapy practices: Level 1 are types of human-centred nature therapy, which whilst effective for humans, come from a viewpoint of seeing nature as a resource to be used and will add to the burden that wider nature carries; Level 2 focus on reciprocal healing, meaning that people discover or work from the base that we are all part of nature. These two descriptive levels describe a practical paradox of how to work therapeutically with nature; human healing is inextricably linked to planetary healing *and* nature used for healing reinforces the problem.

Outdoor Learning and Forest School

The field of outdoor learning includes a broad range of activities and experiences, such as sports, adventure, field studies, forest school, green crafts and conservation,

that facilitate wellbeing as well as learning (Anderson, 2021). A discussion of health and wellbeing within the Routledge International Handbook of Outdoor Studies (Carpenter & Harper, 2016)explored how outdoor programmes can engage people with activities that enable wellbeing to emerge, including psychological wellbeing (such as purposefulness and self acceptance) physical activity (because being outdoors requires activity) and social connectedness (making relationships with others). Within this broader agenda, there are forms that consider wellbeing as a specific or core outcome, for example adventure therapy (Meltzer et al., 2018; Richards, 2016) and forest school (McCree et al., 2018; Tiplady & Menter, 2021). Writing about forest school for all ages, Sara Knight (2016) gives examples of projects from 'Goods from Woods' that use the forest school approach and evidence improvements in mental health. One of these works with adults learning disabilities (Ramsden & Tomlinson, n.d.).

As interest in the links between outdoor learning and wellbeing expand, professionals are responding with new areas of discussion. A recent BERA Blog special issue (T. Hayes et al., 2021)explored how the five ways to wellbeing (Aked et al., 2008) (plus an extra one of slowing down) can inspire new practices and deeper discussions, whilst the Journal of Adventure Education and Outdoor Learning is planning a special issue 2023 investigating the potential benefits of outdoor and adventure for human health and wellbeing (Brymer et al., 2022)

A Developing Sector

In its practices, this outdoor wellbeing sector has grown through the more traditional routes like adventure therapy, therapeutic horticulture and outdoor counselling, and

now encompasses newer applications like forest bathing, forest schools, green gyms and surf therapy (Barton & Pretty, 2010; Goodenough & Waite, 2020; Harper & Dobud, 2021). Practitioners start from differing places and are often developing their own activities through matching their experience with local needs. As things are growing quickly, there is a somewhat confusing array of descriptions and umbrella terms, making it hard to understand and define (ref Lovell?). Through this writing I use the term "wellbeing outdoors" to encapsulate the range of approaches that are emerging. Other authors speak of nature-based interventions (Pretty & Barton, 2020; Richards et al., 2020a), nature on prescription (Fullam et al., 2021), outdoor mental health interventions (Pryor et al., 2021; Richards et al., 2020b) and green care (Bragg & Leck, 2017).

Wellbeing, Mental Health and Social Prescribing

Wellbeing

In the UK the focus is shifting from a medical model of health to a social model that includes social, community and environmental determinants of health (Buzelli et al., 2022)and leading to the new integrated care systems (*The NHS Long Term Plan*, 2019). Wellbeing is a multifaceted concept, often debated (Forgeard et al., 2011) and broadly about quality of life and what matters to people (What Works Wellbeing, n.d.). For evidence-based research it is usually considered in two components; subjective such as life satisfaction, positive emotion and feeling life is meaningful; and objective measure such as adequate nutrition, physical health, mental health education and safety (de Feo et al., 2014). In the UK personal subjective wellbeing is measured by the Office for National Statistics using four measures: life satisfaction,

feeling that the things done in life are worthwhile, happiness yesterday and anxiety yesterday (B. Hayes et al., 2022).

A different perspective on health and wellbeing comes from an indigenous lens. Here, it is broader than mere physical health or absence of disease and can emphasise the balance in four areas of life "the physical, emotional, mental, and spiritual which are intricately woven together and interact to support health and well-being" (Hatala et al., 2020, p. 14). It is also rooted in the nature, places and more-than-human that are being called upon to offer up their gifts so that human wellbeing can emerge and all life can thrive. (McCabe & Saltmarshe, 2022). For some, this is a story beyond a focus on creating human wellbeing and towards creating a thriving and co-evolution of life, where humans are engaged in caring for land and the land/country/place reciprocates by creating human (and other beings) health, a perspective that is voiced strongly in indigenous research ("Yotti" Kingsley et al., 2009). For many indigenous peoples the confiscation of land, genocide, lack of access to their stories, spirituality and genealogy have created a direct and long-lasting impact on their health and wellbeing (Brown, 2021; Keaulana et al., 2021; McCabe & Saltmarshe, 2022).

Mental Health

Mental health services in the UK are struggling to keep up with demand, rates of mental illness are steadily rising and the numbers of people seeking treatment has risen by two thirds since 2000 (BMA Medical Team, 2022). In England rates of mental ill-health have been steadily rising, even before the COVID-19 pandemic and antidepressant drug items prescribed have increased for the last six years (Gray,

2022). There is a concerning lack of capacity within mental health services and medical professionals are worried about the further impacts of the current cost-of-living crisis on both adult and children's mental health (Royal College of Psychiatrists, 2022).

Social Prescribing

In tandem with this developing crisis, the NHS Long Term Plan (*The NHS Long Term Plan*, 2019) moved the system towards a population health focus, including a comprehensive model for personalised care which began delivery in 2019. The creation of social prescribing and social prescribing links workers is fundamental to this new model, and represents a cultural shift in healthcare, helping embed de-medicalistion and focus on community assets. The prescribing of community based activities and resources to support health and wellbeing is becoming increasingly common in England (Featherstone et al., 2022). Initially designed to support those with complex needs in areas of multiple deprivation, social prescribing is now an essential component of the current NHS universal personalised care model (Lane, 2021). Social prescribing aims to find out what matters to people and help them decide on care and support needs (Sanderson et al., 2019). It also aims to legitimise the use of community-based resources and activities as alongside medical treatment (Gitsham, 2021). Husk et al say that "social prescribing not as an intervention, but …a system." This means it can be difficult for people to grasp, and flows through it are important to track. (2020, p. 7)

Social prescribing link workers are at the heart of this model, providing the link between primary care and other local agencies (such as police, social services and

voluntary sector) and the assistance or service that a person needs to improve their health and wellbeing. Some link workers are based within primary care networks and others within voluntary or community-sector organisations (Hazeldine et al., 2021). The NHS Long Term plan is ambitious, initially committed to having more than 1,000 trained social prescribing link workers in place by the end of 2020/21 and there is a commitment that every GP practice will have access to a link worker by 2023 .

What is Wellbeing Outdoors?
Definitions and Frameworks

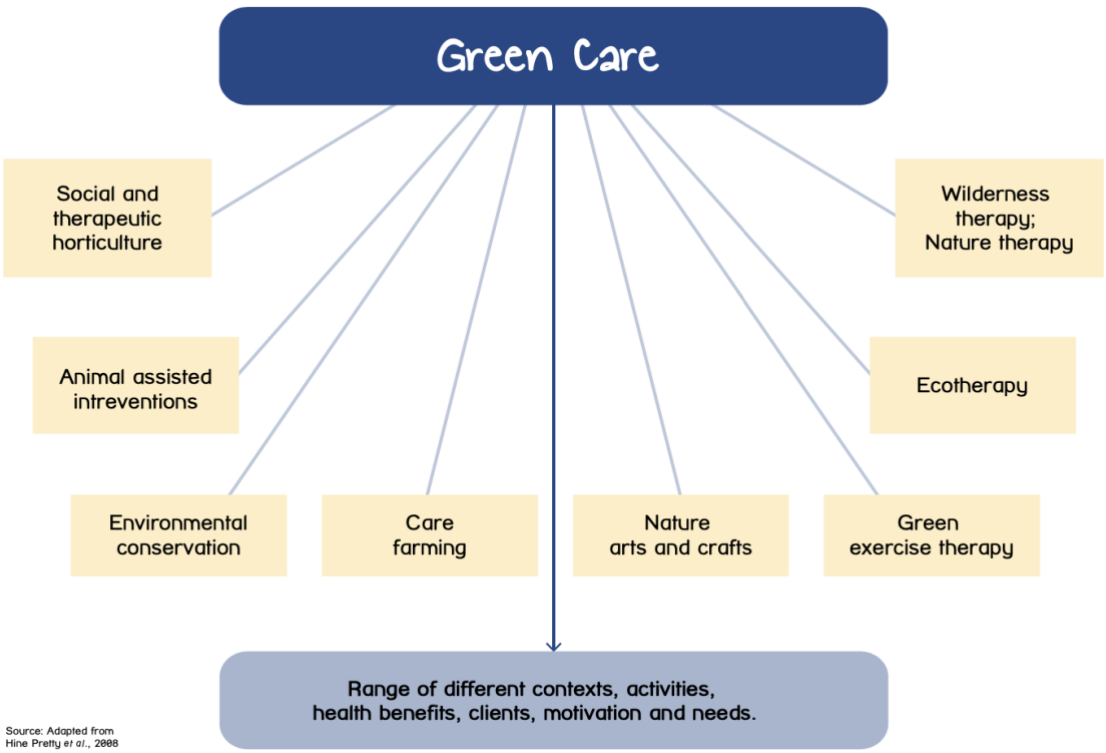
To describe what wellbeing outdoors can encompass, recent research, reviews and evaluations are considered. In their paper for Natural England looking at the role of 'nature based interventions' for mental health, Bragg & Leck (Bragg & Leck, 2017, p. 13) describe "the nature, health and wellbeing sector" and define two distinct areas of work: green care and nature-based interventions (where this is a nature-based therapy or treatment intervention) and nature-based health promotion activities, which includes community gardens and conservation volunteering.

Before this, the evaluation of the Ecominds initiative (Hine et al., 2013) - the first large UK initiative to explore and evaluate nature-based approaches to mental health - used the umbrella term Green Care, and described the range of categories of activities shown in Figure 1. Green care has been defined as "nature-based therapy or treatment interventions specifically designed, structured and facilitated for

individuals with a defined need" (Green Care Coalition, quoted in Sempik & Bragg, 2016, p. 100).

Figure 1

Green Care Model



Note: This figure is taken from Ecominds Evaluation (Pretty et al 2013)

In a more recent study of potential health cost savings and improving human happiness, Pretty & Barton (2020) [1]describe a range of nature based interventions and mind-body interventions (NBIs and MBIs). Within this they include forest and woodland schools; wilderness and adventure therapies; ecotherapies and green care; social farms and gardens; and dementia prevention and support. The term

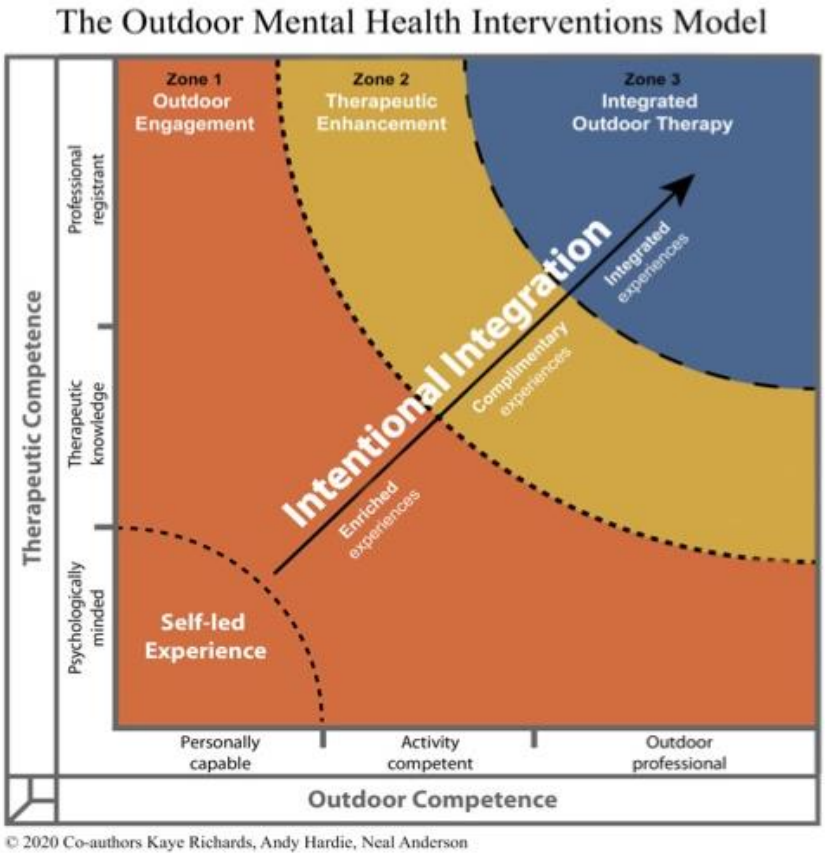
ecotherapy remains contentious, with some describing is as a subset of outdoors wellbeing practices and and others seeing it as umbrella term (Ambrose-Oji, 2014; Hine et al., 2013).

As the green social prescribing agenda is taking hold, the terms nature based interventions and nature on prescription (Bragg & Atkins, 2016; Garside et al., 2020; Marx & More, 2022) are becoming commonly used by professionals, and the release of the Nature on Prescription Handbook (Fullam et al., 2021)aimed to guide organisations and practitioners in how to navigate the field. It is likely that not having a common language or descriptions are getting in the way of people fully understanding is on offer and what benefits they can get

The Institute for Outdoor Learning have created a model from an outdoor learning perspective, which can enable people at all levels of participation with outdoor wellbeing to understand this complex field, and work out here in the map they or their service can fit (Richards et al., 2020c). They describe this as an “Outdoor Mental Health Interventions Model” with three zones that reflect the types of work being undertaken; outdoor engagement, therapeutic enhancement and integrated outdoor therapy. The horizontal axis has three indicators of competence; personally capable, activity competent and outdoor professional, whilst the vertical axis has three indicators of therapeutic competence; psychologically minded, therapeutic knowledge and professional registrant.

Figure 2

Outdoor Mental Health Interventions Model



Note: This figure is taken from Outdoor Mental Health Interventions & Outdoor Therapy: Institute for Outdoor Learning Statement of Good Practice. (Richards et al 2020)

Examples of Practice

Practice is influenced by the aim, skill, and experience of the practitioners; their relationship with their target group and those who refer them; the context in which they operate including their organisation and how work is financed; and last but not least, the places where they practice. In the space available here, a few relevant examples are given for further exploration. The IOL also provide generic examples within their paper and locate them within their model(Richards et al., 2020b).

The Exeter Drugs Project “Flourish in Nature” (Exeter Drugs Project, 2022)supported people in recovery from substance abuse to become volunteer outdoor activity

leaders, and have produced a toolkit for others use. Forestry Commission Scotland "Branching Out" (Wilson et al., 2011)worked with mental health service users in Glasgow to get them outdoors for regular sessions, and produced a report and useful description of their activities. Plymouth Argyle Community Trust (Kerswell & Rowles, 2022)produced an evaluation and report of recent green social prescribing pilot, which included activities in the local park and more traditional green volunteering.

Evidence Base

Evidence for Wellbeing benefits

The evidence base for the benefits of wellbeing outdoors - for all ages and specifically for mental health issues and social isolation - has been growing rapidly in recent years (Husser et al., 2020; Lovell, 2016; Mayer et al., 2009; Polley et al., 2020; Pretty et al., 2005; Richardson et al., 2021). Wellbeing outdoors works because people are connected to nature (Capaldi A. et al., 2014)their mood improves (Kondo et al., 2020), cognition improves (Mayer et al., 2009) they feel better and people are more likely to be active (Smyth et al., 2022) .

Barton and Pretty (2020) showed that those with mental illness benefited the most from exercising in nature, and that large benefits accrued for even short bursts of exercise. The Ecominds (Hine et al., 2013) evaluation reported that 'ecotherapy' can improve wellbeing outcomes across ages, even when the projects evaluated did not include formal therapy. Recent research with the Conservation Volunteers Green Gym (now trademarked!) showed that those with the lowest levels of wellbeing made

significant increases from regular practical activity outdoors (Smyth et al., 2022), and that people who visit local green spaces and four times more likely to achieve recommended physical activity levels. There is also growing data around physiological benefits. For example the Japanese practice of forest bathing (shinrin-yoku), has created an evidence base for health benefits of spending time in forests(Li, 2022), Shinrin-yoku , showing that phytoncide compounds released by plants and trees impact positively on immune function.

Green Social Prescribing

Green social prescribing is not well defined. NHS England website says simply “The COVID-19 pandemic has highlighted the importance of being outdoors to people’s mental and physical health, as well as the inequality of access to green space. ” (NHS England - Personalised Care & Social Prescribing, n.d.). The University of Derby blog adds “The aim is to help people overcome the barriers they face to accessing green space and making the most of nature whilst safeguarding the natural environment”(Cairns, 2022). It is however, an important part of the social prescribing offer with a particular focus on approaches that support mental health and wellbeing, backed up with a range of evidence. (Garside et al., 2020; Gitsham, 2021). Activities can range from local walking scheme and community garden projects to green gyms, forest bathing and arts activities which take place outdoors, and include green and blue environments.(NASP, 2022)

At the time of writing, a two-year cross-governmental £5.8M funded project is supporting seven test and learn green social prescribing sites across England(Alford,

2021). The specific aim is to trial how embedding green social prescribing (GSP) can improve mental health outcomes, reduce health inequalities, reduce demand on the health and social care system and develop best practice (NHS, 2021) .

Early report data is showing that in terms of sustainability, GSP providers are heavily reliant on volunteers to deliver, that funding is unpredictable and short-term and that social prescribers do not fully understand what is on offer (Garside & Dayson, 2022). The social prescribing system itself is complex and varies from place to place, and providers are not generally funded to offer nature-based services. With community assets being at the core of the green social prescribing offer, rather than being seen as a resource, they should be a key collaborator in building healthier communities (Garside 2020). This is echoed by Polley et al, who say that the care sector should be investing in the small VCSE who deliver services accessed under GSP referrals. (Kimberlee R et al., 2021).

Evidence about participants shows that those with mental health needs may need a lot of reassurance and practical support to arrive at a service, some don't feel they can easily access the outdoors for wellbeing, and that there is areal appetite for more support. Those with mental health issues, with disabilities, women, lack of income or time (Kearney, 2022). Reaching those in the most need, whose social disadvantage, health conditions and health crises limit access to nature, and who can potentially benefit the most, is a complex challenge (Fixsen & Barrett, 2022).

A Case Study

A person walks slowly along a grassy ride through an old English forest. They are part of a group who come to these woods regularly to support their wellbeing. This is a place of oak, ash, beech, holly, larch, and occasional Scots pine, with an under-storey of hazel and rampaging bramble, now clothed in the yellow-green-brown leaves of autumn. A gentle light reflects from water droplets hanging on the nearby leaves after recent rain. With the group, they move off the wide track, onto a narrow path deeper amongst the fading foliage. The person's senses are kindled by the aroma of damp leaves underfoot, soft afternoon light, sounds of robin-song and cool air. As their feet move along the path, they find a place to sit and settle, to consciously focus on the beauty of the sights and sounds around them.

"Each week there is a walk through the trees, looking at nature and learning new things about how things grow. At a point in this walk there is a time when you, along with those you are sharing this walk with, are asked to sit and spend five minutes in silence, sat leaning against a tree. This is my safe place. This is the most precious gift I have been given." (Rachael, 2017)

This case study explores my professional practice. I became an outdoor practitioner by accident, having had an early indoor career as an alternative health therapist, then worked in community development, training and group facilitation. I loved both blue and green spaces, windsurfed and hiked, and became aware how my own feelings of health and wellbeing were improved by spending time moving and being outdoors. Spending time on Dartmoor with a work colleague who lived there and reading about ecopsychology(Roszak et al., 1995), I began to shape ideas about both being in nature and working with people in places where they could easily feel

the nature around them. I discovered Forest School, and after year or so volunteering decided to become qualified as a leader and bushcraft practitioner. The mingling of these experiences created a unique foundation for my practice in outdoor wellbeing.

My current work is focused in Young Wood, part of the public forest estate of the northern Blackdown Hills Area of Outstanding Natural Beauty, close to Taunton, the county-town of Somerset. Here, I have co-founded a small social enterprise called Neroche Woodlanders, which began as a legacy project from mine and others' involvement in the five year lottery-funded Neroche Landscape Partnership Scheme (Carter et al., 2011). Unusually, and because of this legacy aspect, we have a management agreement with Forestry England which allows us to build structures like compost toilets, pole-barn, camp kitchen and roundhouse, and to carry out woodland management activities. All these are essential components in our outdoor wellbeing work. From the outset, our aim was to help improve the wellbeing of the place and the wellbeing of people through varied activities, a process we described as reciprocity. Over time, this became embodied in our community-built roundhouse structure, with its reciprocally framed roof.

Young Wood is varied in topography and flora, and includes ancient woodland as well as plantings of larch, Douglas fir, beech, oak and ash and is designated as minimal intervention in the current forest design plan (Robinson, 2018). It is also home to English lime, wild service trees and large understory of over-grown hazel and bramble, a great habitat for dormouse. The forest edge is bordered by conventionally farmed arable fields and at the bottom of steep slopes is an

abundantly floriferous meadow now managed as part of a wood-pasture. The proximity to Taunton creates opportunities to serve the local community, and especially those people who would not usually get access to outdoor woodland spaces. When we started we noted that areas in Taunton were ranked in some of the most deprived in England based on the Indices of Multiple Deprivation.

The start of wellbeing work with adults came in 2010 when a mental health nurse, who had carried out conservation volunteering through the local Neroche Landscape Partnership Scheme (NLPS), asked to bring a team of work colleagues for a relaxing team-building session of whittling, foraging and campfire cooking. During this event the clinical staff present realised that this type of activity could really benefit their younger patients with psychosis, so a trial was suggested. This trial ran for four sessions funded by the NLPS with mental health workers bringing their charges along, and the sessions worked well for those who could attend regularly. However, there was no funding for further sessions. As the author was in the early stage of co-founding a new social enterprise, it was suggested that getting funding and then opening sessions up to others may work. This led to a programme called Wild Learning, which ran for eight years starting in 2012, with regular funding from adult learning. During this time over 160 people with varying degrees of mental ill-health, social isolation and other complex needs came to sessions, and our team leading the sessions gradually devised a programme that provided a mix of wellbeing outcomes.

We gradually developed relationships with local agencies and organisations who could informally refer people into the programme. This started with a local homeless

charity who had several hostels in Taunton, who were keen to work collaboratively, and became a key player in the project for the first five years. As our confidence grew and people could see the benefits to those who came, other organisations and agencies got involved, including the police, mental health workers, MIND support workers, job centre staff and social workers. At the same time we also began running Forest School type programmes for local families, where families came to regular weekend sessions and focused on their wellbeing and play together. Some parents moved between programmes and came along to the Wild Learning sessions, to benefit their wellbeing, and the community built.

A typical session includes group check-in around the campfire, grounding and mindfulness activities, exploring the woods walks where we look for whatever is in season, cooking a hearty lunch together on the campfire, green-woodworking activities, conservation tasks and small crafts and final review of what people have enjoyed and would like more of. This range and variety of activities means that participants have agency and over the months (or even years) of coming can develop skills, confidence and knowledge. There is free transport (via a contract minibus) to the woods from Taunton, waterproofs and boots we loan or give away, and lots of food to eat and take away. As a practitioner I lead the current team of staff and volunteers, and between us we have a range of skills and lived experience; as well as all staff being qualified forest school leaders, we also have years of bushcraft, green-wood, basketry, and cooking skills and lived experience of mild to severe mental issues and neurodivergency. We do not see ourselves as therapists, rather as guides to a meeting with a natural place that can help people to find their own way to healing.

At the current time, we are running a two-year Woodland Wellbeing project funded through Somerset Open Mental Health and a small local trust. We receive referrals from local social prescribers, MIND, mental health services, the police and others, as well as people coming by word of mouth. Being in place for more than ten years means that we are trusted by local agencies and local people, and it does not mean that all those who could benefit can find our services. The lack of funding for green social prescribing is problematic, as small projects like ours need to apply for grants most years, which takes time away from providing sessions. We run drop-in sessions for those who want to refer, to educate them about the way that we work, the evidence and the benefits.

Implications for Practice

The push to bring more people into wellbeing outdoors has a range of challenges and implications for practitioners. The challenge of green social prescribing, with its need to be scalable, is that it may be so mechanistic in its application that it demands that wellbeing outdoors only benefits people.

If “we are nature” then practitioners need to continue to share and design ways to make reciprocal healing with nature and between humans and nature, to openly discuss the tensions, and to resist commodification and using nature simply as a backdrop. Place-based pedagogies and respectfully learning from indigenous research may help illuminate this pathway, by encouraging a dialogue with and

about the nature-places that are the heart of this work (Fatima et al., 2022; Lynch & Mannion, 2021; Wattchow & Brown, 2011; Wooltorton et al., 2020)

The pragmatic issues to being involved in green social prescribing are manyfold; practitioners not only need to know where they sit in terms of competences, experience and qualifications, perhaps using the OHMI model from IOL (Richards et al., 2020a), they also need to understand their local manifestation of the social prescribing system (and other ways to link with potential participants), and create trusting relationships with the appropriate agencies, including local health and VCSFE organisations. They need to find ways to source finance for their work, and make sure they are accessible to those who will most need it, which has further cost implications. Once they are established, they may find that there is more need than they can address, and that they become overwhelmed, or that group sizes too big and eventually long standing members not able to come (Thompson & Husk, 2021). Having people understand what wellbeing outdoors is and how it can benefits is a practitioner challenge, and it is much wider issue for health and the outdoors sector. The proliferation of terms is unhelpful, and the model proposed by the IOL could help address that and build confidence that practitioners can be trusted and know what they are doing.

These challenges may point to a need for practitioners to link together to share practice, experience and develop a collaborative voice. There has been plenty of research carried out, and little speaks the experience of those doing the work in the wood, on the hills or in the fields.

Conclusions

The intuitive knowing of nature being good for humans is backed up evidence is now well accepted. The challenge of how to work (and live) with nature in a reciprocal way, that benefits both humans and non-humans, is brought into focus through the development of green social prescribing in the UK. Buzzell and Chalquist remind us:

"It's important to bear in mind that ecotherapuetic practices cannot be used to lasting effect from within the old colonial-consumerist mindset. Using nature as a mere tool for human healing perpetuates the very self-world splits responsible for both our ecologically resonant maladies and deteriorating biosphere. Trees, soils, streams and skies, are co-participants - subjects in their own right with their own precious needs and freedoms to preserve" (2009, p. 9)

The varied roots of this emerging outdoor wellbeing sector, whilst making it complex to understand, also mean that it has diversity and variety that can be a strength, just as within any healthy natural ecosystem. Developing and working with flexible models like that created by IOL can enhance confidence in what practitioners are doing, and encourage further diversity and development without imposing hierarchies. It would be useful to see existing practitioners using this model, and for those involved in the green social prescribing test and learn sites to map it against their practices.

Working with the complex new personalised care agendas and social prescribing is hard for practitioners for whom it is not a core skillset. The research that is coming from the Test and Learn sites, if reported well and openly, will be invaluable as a

tool. However, there will still be the thorny issue of funding, not just for providing services, but also including the time it takes to engage with the social prescribing system and wider networks.

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