

How Therapeutic Horticulture Is Advancing Around the World

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Horticultural therapy and therapeutic horticulture are entering healthcare, rehabilitation and community care systems through very different routes from one country to another. Some have concentrated on professional credentials and educational standards; others have advanced through social prescribing, allied health training, government-funded therapeutic landscapes, care farming, rehabilitation research or sector-wide quality systems.

No single country appears to have assembled every element required for widespread healthcare integration. Instead, different countries offer pieces of the larger picture, and important opportunities to learn from one another.

This article provides a high-level international scan rather than a comprehensive review. Terminology, credentials, professional roles and healthcare systems vary considerably. Important developments may also be taking place locally or may not yet be available through English-language and publicly accessible sources.

What does healthcare integration actually require?

It is tempting to view professional recognition as the central challenge facing horticultural therapy. Clear professional standards are certainly important, but they are only one part of the system required to make services widely available.

Healthcare integration can involve several distinct elements:

- credible education and practitioner standards;
- clear scopes of practice and competency levels;
- training for allied health and community care professionals;
- referral pathways;
- organizational safety and quality standards;

- evidence aligned with healthcare priorities;
- approved procurement and contracting routes; and
- sustainable public, private or insurance-based funding.

Progress in one area does not automatically create progress in another.

A credential can help define who is qualified without creating reimbursement or employment opportunities. A referral pathway (a formal or established process through which healthcare and community care professionals connect appropriate participants with therapeutic horticulture services) can generate interest without giving providers an effective way to contract with healthcare organizations. A strong evidence base may not lead to implementation if services cannot meet procurement, staffing or quality assurance requirements.

The international picture is therefore best understood as a collection of different approaches to the same interconnected challenges.

Strengthening professional standards

United States: board certification and accredited education

The United States offers one of the field's most developed professional credentialing structures. The American Horticultural Therapy Association (AHTA) is currently making a significant transition from its Horticultural Therapist Registered (HTR) designation to the examination-based Horticultural Therapist–Board Certified (HT-BC) credential.^{1,2}

AHTA stopped accepting new HTR applications on July 1, 2026, and began accepting applications for HT-BC on the same date. Its first examination window is scheduled for October 31 to November 14, 2026. The examination is based on six professional domains identified through a large-scale job-task analysis: horticulture; treatment planning; program planning and activity design; managing human resources; business practices, safety and ethics; and professionalism and scholarship. AHTA's separate Therapeutic Horticulture Practitioner (THP) designation remains in place.^{1,2,3}

This transition is important because it moves the profession toward a standardized assessment of individual competence, rather than relying only on the completion and review of education and experience requirements.²

AHTA's education standards are also extending internationally. Its current list of accredited certificate programs includes the National Pingtung University of Science and Technology in Taiwan, alongside programs at American universities and educational institutions. This demonstrates that professional education standards developed in one country can be adopted across borders, although it does not yet amount to a shared international credentialing system.⁴

The United States also illustrates an important limitation: professional certification does not, by itself, create licensure, healthcare billing mechanisms or institutional purchasing pathways. Credentialing can strengthen professional identity and employer confidence, but broader healthcare integration requires additional policy, funding and implementation work.

Canada: voluntary registration and organizational capacity

Canada has an established professional structure, but fewer visible connections to national healthcare systems. The Canadian Horticultural Therapy Association (CHTA) offers voluntary registration at two levels: Horticultural Therapist Technician (HTT) and Horticultural Therapist Registered (HTR). It also maintains a professional code of ethics that applies to people practising horticultural therapy or applying therapeutic horticulture methods in Canada.⁵

CHTA paused the accreditation of horticultural therapy education programs in 2013 while reviewing its policies and volunteer capacity. It now offers an Education Points Clarification Process that reviews course alignment, educator qualifications, learning formats and contact hours. CHTA clearly states that this process does not constitute the deeper review, approval or accreditation of coursework that its previous system provided.⁶

Canada's experience points to a challenge affecting many smaller professional fields: developing standards is demanding, but maintaining accreditation, government advocacy, public education and healthcare partnerships requires sustained institutional capacity. Professional associations need workable models for funding and administering these functions over time.

From recognition to referral and procurement

The United Kingdom provides useful examples of coalition building, professional standard-setting, referral development, procurement, practitioner education and advocacy, although approaches differ across its devolved healthcare and education systems.

United Kingdom: professional standards, referral development and procurement

Trellis and Thrive are working with the wider practitioner community through the Association for Social and Therapeutic Horticulture (ASTH) to develop a professional framework for STH practice across the UK. Work to date includes shared practice standards, practitioner competencies, a code of ethics and defined routes to practitioner

registration, developed with input from a practitioner forum of more than 200 people. The planned register is intended to provide commissioners, referrers and the public with clearer benchmarks for practitioner competence, safety and professional accountability.

The emerging registration framework also recognizes different routes into practice. These include specialist education in social and therapeutic horticulture, as well as routes for established health and care professionals who add appropriate horticultural and STH education or experience. This approach acknowledges the interdisciplinary nature of the field while establishing shared expectations for professional practice.

England: coalition building, social prescribing and procurement

In England, the Therapeutic Horticulture Stakeholder Group was established by Natural England in 2022 with support from the National Academy of Social Prescribing. It is now convened by Thrive with support from Natural England and includes representation from NHS England, academics, healthcare professionals, Trellis and other organizations involved in social and therapeutic horticulture.⁷

The group's vision is for social and therapeutic horticulture to become a core part of the national healthcare offer, supported by appropriate referral processes, professional development and delivery across clinical, community and educational settings.⁷

England's wider social prescribing system has helped establish a recognized route through which healthcare professionals and link workers can connect people with non-clinical community services, including gardening and other nature-based activities.⁸

However, recognition does not necessarily mean widespread access. UK government research published in 2023 and focused on England found that 7% of surveyed individuals had ever received a referral to a nature-based activity. Among those who had received a referral, 78% participated. This suggests that referrals can successfully support participation, but nature-based referrals were still reaching a relatively small proportion of the surveyed population.⁸

In March 2026, Thrive became an awarded supplier on the East of England NHS Collaborative Procurement Hub's national Social Impact framework, creating a compliant route through which NHS organizations can engage the organization without beginning a separate full tender process in every case.⁹ This is significant because procurement pathways can reduce administrative barriers to commissioning, although they do not by themselves guarantee demand, funding or contracts.

Scotland: network development, nationally recognised training and advocacy

Scotland offers a complementary model focused on network development, recognised education and advocacy. Trellis supports a national network of more than 500 therapeutic gardening projects operating in settings that include hospitals, care homes, schools, prisons, hospices and community spaces, collectively reaching more than 15,000 people each week.¹⁰ Trellis also founded the Association for Social and Therapeutic Horticulture, whose UK-wide professional framework is now being developed jointly with Thrive.

Trellis has developed a Professional Development Award in Developing Professional Practice in Therapeutic Horticulture at SCQF Level 7. The award has been approved by Qualifications Scotland and is expected to become available in Scotland from 2026. It is one of the educational routes to registration identified within the developing UK practitioner-registration framework.¹¹ Trellis has also represented therapeutic horticulture in NHS Scotland discussions, including at the 2025 NHS Scotland Event,¹² as well as in discussions with government ministers and presentations to clinicians, practitioners and students.

Trellis extends its advocacy internationally through World Therapeutic Horticulture Day, which it launched in 2023 and now marks annually on May 18, with participation extending to more than 48 countries.¹³

Taken together, these developments raise practical questions for therapeutic horticulture providers that extend beyond professional recognition: Are organizations ready to respond to tenders? Can they demonstrate governance, safeguarding, quality assurance and measurable outcomes? Can small providers collaborate to fulfil contracts that would be difficult to deliver independently?

Building the workforce through education and professional pathways

Countries are building the therapeutic horticulture workforce through several routes: training existing health and care professionals, creating flexible entry pathways, developing post-professional and university education, and establishing professional networks, standards and qualifications.

Singapore: public infrastructure and workforce development

Singapore offers one of the clearest examples of coordinated public sector involvement. The National Parks Board launched its Parks for Health Framework in June 2025. The framework combines access to green space, therapeutic landscape design, partnerships with healthcare institutions and targeted therapeutic horticulture programming.¹⁴

NParks has committed to working with healthcare partners to introduce therapeutic horticulture programs in areas with larger senior populations. It is collaborating with the National Healthcare Group to introduce programming through Communities of Care and with SingHealth to develop courses and training opportunities for healthcare professionals and community care organizations. Singapore has also integrated therapeutic landscapes into hospitals and other healthcare developments.^{14,15}

Workforce development is supported through several levels of training. Kwong Wai Shiu Hospital's Community Training Institute offers a two-day train-the-trainer course for community-care staff covering basic plant care and the planning and adaptation of social and therapeutic horticulture activities for different clients.¹⁶ Other short professional training includes a two-day therapeutic horticulture workshop offered through Singapore's Community of Practice in Social Prescribing and facilitated by NParks and SingHealth Community Hospitals' occupational therapy team.¹⁷

A more extensive Certificate in Therapeutic Horticulture is offered through Ngee Ann Polytechnic's Continuing Education and Training Academy. First introduced by NParks' Centre for Urban Greenery and Ecology (CUGE) in 2016 and subsequently transferred to Ngee Ann Polytechnic, the program brings together horticulture, therapeutic horticulture and health-related content for people interested in applying therapeutic horticulture in healthcare, social care and other settings. CUGE continues to offer shorter professional-development courses related to therapeutic horticulture and therapeutic garden design.^{18,19}

The strength of Singapore's model lies in the combination: public landscapes, healthcare partnerships, occupational therapy involvement and multiple levels of workforce development.

Australia: recognizing interdisciplinary routes into practice

Therapeutic Horticulture Australia (THA) takes a flexible approach to professional membership.

Its full-membership criteria recognize three pathways: qualifications in both horticulture and allied health or social services; a qualification in either area combined with 120 hours of validated therapeutic horticulture experience; or 400 hours of validated experience without the specified qualifications.²⁰

This model acknowledges a central reality of therapeutic horticulture: effective practitioners may arrive from horticulture, recreational or occupational therapy, nursing, social work, disability support, education or other related fields. Each brings valuable expertise, but may also need additional learning outside their original discipline.

Australia's approach raises a question that is relevant internationally: rather than expecting every practitioner to follow one identical pathway, can the field define the competencies people need based on their previous education, professional scope and intended level of practice?

Austria and Switzerland: therapeutic horticulture as post-professional education

Austria offers a more formal post-professional model. Its university continuing education program in garden therapy is designed for people with backgrounds in medicine, physiotherapy, occupational therapy, nursing, psychology, social work, education, horticulture and related disciplines.²¹

The program explicitly describes its garden therapy qualifications as continuing education within an existing primary profession, not as independent therapeutic training or authorization to practise another healthcare profession.²¹

This distinction provides a potentially useful model for allied health education. Professionals can develop substantive competencies in therapeutic horticulture while remaining accountable to the standards and scope of their original profession.

It also helps employers and participants understand the limits of the training: education in therapeutic horticulture can strengthen how a qualified professional works, but it does not give someone the authority to practise in a regulated clinical role unless they already hold the required professional credentials.

Switzerland offers a comparable university continuing-education pathway through the Zurich University of Applied Sciences. Its 15-ECTS Certificate of Advanced Studies in Garden Therapy is designed primarily for professionals in healthcare and social service fields, including occupational therapy, physiotherapy, nursing, psychology and social work. Participants learn to develop, implement and evaluate garden therapy activities within their own professional settings and to select plants for therapeutic use based on participant needs.²²

Germany: connecting professional standards, care settings and insurer support

Germany offers an example of horticultural therapy developing through a combination of professional networks, longstanding rehabilitation practice and structured support from statutory health and long-term-care insurers.

The Gesellschaft für Gartenbau und Therapie (GGuT) traces its origins to the Arbeitskreis Gartenbau und Therapie, established in 1989, and brings together professionals from horticulture, therapy, medicine, nursing, education and related fields.²³ In 2009, GGuT and other organizations helped establish the Internationale Gesellschaft GartenTherapie (IGGT) to coordinate efforts around professional recognition and quality development in the German-speaking field.²⁴ IGGT maintains a professional registration system in which applicants document relevant education and qualifications against established criteria, with registration renewable through continuing professional development.²⁵ IGGT brings together organizations from Germany, Austria and Switzerland and works with other European associations.²⁶

Horticultural therapy also has a longstanding presence within specialist rehabilitation. At VITREA Klinik Hattingen, a neurological and neurosurgical rehabilitation hospital, therapeutic gardens and a horticultural-therapy program have been developed over more than three decades. The clinic describes its 150,000-square-metre grounds as including dedicated therapeutic areas designed to support patients in regaining abilities while also providing opportunities for relaxation and contact with nature.²⁷

More recently, statutory insurers have supported research and implementation within residential long-term care. IKK classic funded the DuWigata research project examining horticultural therapy with people living with dementia in care homes, followed by a prevention initiative that had reached 24 facilities across eight German federal states by 2023. Its implementation model trains care staff as horticultural-therapy assistants with instruction and support from qualified horticultural therapists. The work also informed an IKK classic Good-Practice guide addressing organizational requirements, staffing, safety, practitioner qualifications, program design and evaluation. A related IKK Südwest initiative expanded from five participating care facilities in 2025 to ten in 2026, suggesting that this implementation model continues to develop.^{28,29,30} To date, this program—organized by the GÄRTEN HELFEN LEBEN Institute—has introduced garden therapy in approximately 100 facilities.²⁶

These initiatives do not indicate that horticultural therapy is independently reimbursed as a standard medical treatment throughout the German healthcare system, even though it is now once again listed as a treatment method in the German Pension Insurance (DRV) catalogue of therapeutic services.²⁶ They demonstrate a different route to integration:

combining specialist horticultural-therapy expertise with established rehabilitation and long term care structures, while involving statutory insurers in research, workforce development and implementation. Germany therefore offers a useful example of how therapeutic horticulture can become embedded within existing systems even before a distinct profession-wide reimbursement pathway exists.

Italy: regional recognition and professional education

Italy offers an example of professional development advancing through both university education and regional government recognition. The University of Bologna offers a postgraduate Master's programme in Therapeutic Horticulture, while Tuscany has recently taken a further step toward formal professional recognition.^{31,32}

In July 2026, the Region of Tuscany approved a professional profile for the Therapeutic Horticulture Practitioner. The profile was developed with reference to the American Therapeutic Horticulture Practitioner framework, while adapting its competencies and training requirements to the Italian regulatory context. Work is now underway with the Tuscany Region to develop training for the first practitioners, with regional funding expected to support the initiative.^{32,33}

Italy therefore provides an example of professional recognition developing at the regional rather than national level, alongside university-based education. Tuscany's experience may be particularly relevant in jurisdictions where professional recognition and workforce development can advance regionally before a national framework is established.

India: university-based postgraduate education

India offers another example of formal education developing through an agricultural institution. Kerala Agricultural University's College of Agriculture at Vellayani offers a postgraduate diploma in horticultural therapy for graduates from a range of agricultural, health, rehabilitation, education and social service disciplines.³⁴ Its inclusion in this scan illustrates the diversity of institutions contributing to therapeutic horticulture education, although further information would be helpful about how the program connects with professional practice and healthcare employment.

Beyond university-based education, professional associations are also helping to build the shared language, networks and educational infrastructure needed for workforce development.

Spain: developing shared language and interdisciplinary education

The Asociación Española de Horticultura y Jardinería Social y Terapéutica (AEHJST) was established in 2018 to support professionals and organizations working in social and therapeutic horticulture in Spain. Its activities include professional education, research promotion, networking, project support and collaboration with public administrations, universities and private organizations.^{35,36}

AEHJST's education is directed toward professionals and students from healthcare, social services, education, horticulture, agriculture and environmental fields. Over the past several years, it has worked with universities including the Universidad Autónoma de Barcelona, the University of Zaragoza and the University of Santiago de Compostela to deliver introductory and specialized training, including university microcredentials in social and therapeutic horticulture and therapeutic-garden design.³⁷

One of AEHJST's most significant international contributions has been its collaboration with the Peru-based APHTS to develop shared Spanish-language definitions for horticultural therapy, therapeutic horticulture, horticultural therapists and therapeutic gardens. This responds to more than a translation challenge: terms such as "therapy" and "therapist" carry different professional and legal implications across countries. Shared terminology can support greater consistency in education, practice, research and communication across the Spanish-speaking field.³⁸

AEHJST is also contributing to wider European professional development through research and standards initiatives, including the EU-funded GreenME project and collaboration on shared therapeutic-horticulture competencies across Europe. It has also developed a therapeutic-garden certification system intended to promote quality in garden design, management and use.^{39,40}

Spain's experience demonstrates the value of building an interdisciplinary professional community while developing the shared language, education and quality frameworks needed to make an emerging field understandable to established health, social care and educational sectors.

Lessons from adjacent Green Care and care farming models

Some useful healthcare-integration lessons come from care farming and Green Care. These practices are not synonymous with horticultural therapy and may involve agriculture, animals, forestry, employment and social care as well as plants. Their

organizational and funding structures nevertheless offer relevant lessons for therapeutic horticulture.

In the Netherlands, regional provider organizations and a national quality system have helped care farms demonstrate standards around safety, participant involvement and staff education while negotiating access to healthcare and municipal funding. Norway's *Inn på turet* model similarly combines national quality standards with a farmer-owned cooperative that enables individual providers to pursue contracts and projects beyond the capacity of one farm.^{41,42}

Austria's Green Care system provides another example of agriculture, health and social care working across sectors. Certified farms may provide services including horticultural therapy alongside other Green Care interventions, supported by farm certification and specialized education.⁴³

Together, these models suggest that healthcare integration may depend not only on practitioner qualifications, but also on organizational quality systems, shared infrastructure and mechanisms that allow smaller providers to participate in larger contracts.

Research-led development and implementation

Sweden: research linked to regional service delivery

Sweden offers an important example of research informing regional service delivery. The Alnarp Rehabilitation Garden brought together horticulture, environmental psychology, medicine and rehabilitation within a specially designed therapeutic environment. Research from the program has informed services elsewhere, and Region Skåne has procured nature-based rehabilitation from rural providers using approaches influenced by the Alnarp model.⁴⁴

One matched cohort study examined a nature-assisted rehabilitation program for people experiencing severe stress reactions or depression using healthcare consumption and social insurance data. Participants showed reductions in some forms of healthcare use, particularly primary care visits and inpatient psychiatric care, although the study found no significant difference in sick leave status and identified important limitations.⁴⁵

This type of research is particularly relevant to healthcare decision-makers because it examines not only participant wellbeing, but also outcomes such as service use, sick leave and potential cost implications. The field would benefit from more studies addressing these system-level outcomes alongside quality of life, social connection and occupational engagement.

Denmark: therapeutic environment design

Denmark complements Sweden's rehabilitation research with a strong focus on therapeutic environment design. The University of Copenhagen's Nature, Health and Design research group combines research, teaching and applied development in evidence-based health design and nature-based treatment. Its work demonstrates how garden and landscape design can be developed alongside therapeutic programming rather than treated as a separate consideration.⁴⁶

China: research growth and emerging professional infrastructure

China presents a research-led pattern that is increasingly developing professional and institutional infrastructure. A 2026 scoping review of horticultural therapy for depression searched eight Chinese and international databases and included 18 studies, 15 of which were conducted in mainland China. Most used randomized controlled designs, with interventions delivered in hospitals, nursing homes, universities and community settings. The review also found considerable variation in intervention design and facilitator qualifications.⁴⁷ Research into Chinese hospital landscapes has similarly identified horticultural therapy as a growing focus within three decades of rehabilitation landscape research.⁴⁸

The modern development of horticultural therapy in China can be traced to a 2000 publication that introduced international horticultural therapy practice to Chinese audiences. Professional organization followed: a horticultural therapy department within the Chinese Social Workers Association was established in 2014, and in 2020 a professional committee was established within the Chinese Society of Landscape Architecture. The national body is now known as the Committee of Landscape for Wellbeing and Horticultural Therapy of the Chinese Society of Landscape Architecture.^{49,50} In 2022, Forest and Garden Health Care Therapist, encompassing forest and garden health-care practice, was included in China's national occupational classification. The related training and certification system has not yet been fully implemented.^{49,50}

Universities have played an important role in advancing horticultural therapy research and practice in China. International professional pathways have also begun to emerge: in 2020, the first two AHTA-registered horticultural therapists in mainland China completed AHTA's education and supervised-internship requirements, including 480 hours of clinical practice.⁴⁹ Research at Harbin Institute of Technology has since expanded toward a broader framework for nature-based interventions and public health, connecting horticultural therapy with related approaches and international research. The International Symposium on Nature-based Interventions and Public Health has now been held twice, and in 2026 the International Research Center for Nature-based Interventions and Public Health was established at Harbin Institute of Technology with international academic participation. The 2026 symposium brought together researchers from China and other

countries to explore research, practice, education and digital development across nature-based interventions.^{50,51}

China therefore illustrates a field moving from substantial research activity toward more formal professional recognition, international collaboration and broader nature-based health infrastructure. At the same time, nationally standardized horticultural-therapy-specific education, certification and workforce pathways remain under development.

Professional and policy pathways in East Asia

South Korea: national qualifications in healing agriculture

South Korea has developed significant government infrastructure around healing agriculture, an adjacent field that should not be treated as interchangeable with horticultural therapy. Its national framework is grounded in the Act on Research, Development and Promotion of Agro-healing, which provides a statutory basis for research, professional training and the development of healing agriculture services.⁵²

South Korea's official healing agriculture system requires candidates to complete education through designated training institutions and pass qualification examinations. Although the qualification system provides for both Level 1 and Level 2 practitioners, implementation initially focused on Level 2. In 2026, the government announced the first Level 1 national professional qualification examination, bringing the higher tier of the two-level system into operation.^{53,54}

Training is delivered primarily by government-designated regional agricultural extension agencies, universities and university-affiliated institutes. As of 2026, four institutions were designated to provide the 124-hour Level 1 program, while 24 institutions were designated to provide the 142-hour Level 2 program.⁵⁵

This is a notable example of the government using legislation, approved educational institutions and national qualifications to build an emerging workforce. It also demonstrates why terminology matters: healing agriculture may overlap with horticultural therapy in its use of plants and farming environments, but it has its own policy origins, credentialing structure and professional identity.

Japan: regional certification and evolving professional pathways

Japan presents a distinctive pathway in which horticultural therapy initially spread through civic initiatives and practitioner networks before more formal education and certification systems developed. Modern horticultural therapy was introduced from the United States in the early 1990s, contributing to a range of practices from professionally delivered horticultural therapy to community-based therapeutic horticulture.⁵⁶

Formal training expanded in the 2000s. Hyogo Prefecture established a horticultural therapy course at the Hyogo Prefectural Awaji Landscape Planning & Horticulture Academy in 2002, combining horticultural, medical and welfare education with substantial supervised clinical training. Graduates received a prefectural horticultural therapist qualification. Professional certification also developed through national associations. A certification system introduced in 2004 was later taken over by the Japanese Horticultural Therapy Association (JHTA), while other organizations have continued to offer their own qualifications, resulting in multiple certification pathways rather than a single nationally regulated credential.^{56,57}

In April 2024, JHTA revised its certification system, broadening eligibility for its certification examinations to include graduates of four-year universities and holders of relevant professional qualifications who meet prescribed practical-training and examination requirements. JHTA currently offers two levels of certification: Horticultural Therapist and Advanced Horticultural Therapist.⁵⁸ Despite these developments, research has identified relatively few dedicated horticultural-therapy positions, with many practitioners combining the work with existing roles in nursing, occupational therapy, care work and other fields. Horticultural therapy has also not been reimbursed as a distinct service through Japan's national medical fee system. Japan therefore illustrates how education and professional certification can advance even when employment structures, national recognition and reimbursement remain less developed.^{56,57}

Hong Kong: tiered certification and externally recognized education

Hong Kong offers a different model: a structured professional system led by an association.

The Hong Kong Association of Therapeutic Horticulture (HKATH) is the sole organization providing professional horticultural therapy certification in Hong Kong. Its four-level system includes Horticultural Therapy Facilitator, Assistant Horticultural Therapist, Registered Horticultural Therapist and Registered Horticultural Therapist Supervisor. Registered Horticultural Therapists must hold a recognized bachelor's degree or equivalent, complete accredited coursework and accumulate 400 internship hours, including the planning and delivery of professionally supervised horticultural therapy groups for specific populations. Hong Kong's dense urban environment also creates practical challenges for outdoor growing, requiring practitioners and interns to adapt horticultural therapy to space-constrained settings. HKATH is also conducting research on the role and value of supervised internship, with results expected in 2027.^{59,60,61}

Hong Kong has also developed externally recognized educational pathways from introductory to more advanced levels. Its Certificate Course in Therapeutic Horticulture

Programme Assistant was accredited by the Hong Kong Council for Accreditation of Academic and Vocational Qualifications (HKCAAVQ) in 2021, followed by accreditation of the higher-level Certificate in Therapeutic Horticulture Programme Planning in 2025. Both are eligible for financial support through the Hong Kong Government's Continuing Education Fund.^{62,63} In 2026, the Horticultural Therapy and Life Education: Train-the-Trainer Certificate Course was also accredited by Training Qualifications UK (TQUK), becoming the first HKATH course recognized by an international awarding organization.⁶⁴

Hong Kong's experience demonstrates how an association can create differentiated practitioner levels, connect education with substantial supervised practice and obtain external recognition for training. It also reinforces a recurring lesson: association-led credentialing and educational recognition can strengthen professional development even when statutory recognition, healthcare reimbursement and purchasing pathways remain separate or less developed.

Latin America: regional coordination and healthcare-based practice

Latin America is less visible in the English-language literature on horticultural therapy, but it should not be absent from the international picture.

In Peru, Instituto Verdecir has helped expand access to horticultural therapy education in Spanish. Its comprehensive training program combines theoretical education with supervised practice and has trained more than 100 professionals from fields including psychology, occupational and physical therapy, education and mental health, contributing to a growing regional practitioner network. The organization has also supported the development and translation of Spanish-language professional resources.⁶⁵

The Asociación Panamericana de Horticultura Terapéutica y Social (APHTS), also based in Peru, supports professional development through education, certification, a professional directory, resources and regional networking. APHTS is a partner in NATURELAB, a European Union-funded project examining nature-based interventions for health and wellbeing across Europe and Latin America, where it contributes to therapeutic-program design, practitioner training and standardized intervention guidance. APHTS has also worked with Spain's AEHJST to develop more consistent Spanish-language terminology for horticultural therapy and related practice.^{38,65,66}

Connections with public health are also beginning to develop. APHTS and Instituto Verdecir have contributed to an Art & Nature for Health initiative organized by Peru's National Institute of Health, including presentations on horticultural therapy and a small pilot program for public healthcare employees experiencing burnout.^{65,67} Elsewhere in

South America, public hospitals in Chile have incorporated therapeutic gardens into palliative care, child neuropsychiatry, mental-health treatment and rehabilitation. Therapeutic horticulture has also been used with renal patients in Bogotá and with hospital inpatients in Pará, Brazil.^{68–72}

These examples demonstrate regional professional development, emerging public-health partnerships and active healthcare-based practice. Latin America may therefore be especially valuable to study for how a field builds professional identity, shared language, workforce capacity and health-sector relationships while formal infrastructure is still developing.

Ukraine and Armenia: building local capacity in conflict-affected communities

Ukraine and Armenia demonstrate another route through which therapeutic horticulture can develop: building local capacity in communities affected by conflict, displacement and trauma. In Ukraine, international training and mentorship have supported botanical garden staff and other practitioners in developing therapeutic horticulture and related nature-based programs for people affected by war.

Early capacity-building included a Ukrainian-language therapeutic horticulture course developed with support from the North Carolina Botanical Garden, followed by further training and mentorship that helped practitioners begin establishing local programs. Ten staff members from five Ukrainian botanical gardens completed online training and mentorship during 2024–2025, began introducing pilot programs and received certificates in June 2025. In early 2026, staff from four botanical gardens then launched their own online therapeutic horticulture course for other Ukrainian practitioners, marking an important shift toward locally led education and workforce development.^{73,74}

This work is increasingly moving into rehabilitation practice. In 2025, a therapeutic garden opened in Kyiv with support from Ukraine's Ministry of Veterans Affairs, creating an accessible setting for veterans, military personnel, their families and civilians affected by war.⁷⁵ A subsequent therapeutic horticulture program for more than 50 veterans incorporated food growing, group activities and time in the garden, with activities designed to support social connection, agency and psychological recovery. In internal post-program surveys, nearly all participants reported improved overall wellbeing compared with their experience on the hospital ward, alongside strong voluntary attendance and sustained engagement.⁷⁶

The work is also continuing to expand across Ukraine. Seven major public gardens are developing projects to increase their capacity for nature education and healing programs, with accessibility for people with disabilities a shared priority.⁷⁷

In Armenia, development is at an earlier stage. Partnerships for Nature, a U.S.-based nonprofit, has supported therapeutic horticulture capacity-building alongside Armenian organizations. Local practitioners are already applying therapeutic horticulture, particularly with children, while three staff members from the Miasin International Charitable Foundation completed online therapeutic horticulture training in early 2026. Further training and locally led program development are planned.^{74,78}

Together, these examples illustrate the value of combining international knowledge exchange with local adaptation and leadership. Rather than importing a fixed model, practitioners and organizations are developing therapeutic horticulture around their own communities, cultures and needs.

Cross-border research and professional networks

Alongside country-level developments, cross-border research initiatives and professional networks are helping connect practitioners, researchers and organizations across different healthcare, education and policy systems.

GreenME is a four-year European Union-funded project running from 2023 to 2027. It sits alongside NATURELAB and RESONATE, related EU-funded research initiatives examining nature-based interventions and therapies across different health, policy and geographic contexts.^{39,66,79} GreenME's work includes developing an EU framework and country-specific approaches, building partnerships between healthcare systems and Green Care providers, and creating training for nature-based therapy providers.³⁹

This work is broader than horticultural therapy. GreenME describes a continuum extending from everyday access to green and blue spaces, through nature-based health promotion, to individually focused nature-based therapy.³⁹

Professional learning networks also contribute to international development by helping practitioners compare approaches, access education and research, and build relationships across national systems. GrowTH™ Therapeutic Horticulture Learning Network, which developed this article, connects members in more than 30 countries across every inhabited continent through professional education, shared resources, discussion and international knowledge exchange.⁸⁰ GrowTH also provides a free, open-access HT/TH Research and Readings Database containing nearly 800 tagged and summarized articles, allowing users to filter the literature and find research relevant to their work.⁸¹

What can the international field learn from these examples?

Several common lessons emerge:

1. Professional standards are necessary, but not sufficient

Credentials can establish practitioner competency and professional identity. Healthcare adoption also depends on strong referral relationships, appropriate employment structures, sustainable funding, workable procurement processes, and confidence that service providers have the policies, safety procedures, governance and quality-assurance systems needed to deliver programs responsibly.

2. Workforce development can take multiple paths

Across countries, therapeutic horticulture capacity is developing through specialist professional credentials, university and continuing education, train-the-trainer models, association-led certification and education for professionals already working in healthcare, rehabilitation, recreation, social care and community settings.

A single pathway may not be appropriate for everyone. Instead, preparation can reflect a person's existing education, professional scope and intended level of practice. This increases the importance of distinguishing among general awareness, activity facilitation, therapeutic application within an established professional scope, and specialist horticultural therapy practice.

3. Referral and purchasing pathways must develop together

The United Kingdom's experience shows the value of both social prescribing and approved procurement frameworks. People need ways to reach services, while providers need realistic ways to enter contracts and be paid.

4. Organizational standards matter

The Netherlands, Norway and Austria demonstrate that funders may assess the provider organization as well as the individual practitioner. Safety, governance, participant involvement, staff qualifications, documentation and quality improvement all affect purchaser confidence.

For therapeutic horticulture, organizational standards may also need to address plant toxicity, allergies, infection prevention, tool safety, accessibility, safeguarding, environmental conditions and emergency procedures.

5. Small providers may need shared infrastructure

Collective quality systems, cooperatives and regional contracting organizations can help smaller providers meet requirements that would otherwise exclude them from public contracts.

6. Research must address both human and system outcomes

The field should continue measuring outcomes that matter directly to participants. It should also expand research into healthcare use, costs, staff capacity, implementation, caregiver outcomes and long-term participation.

7. International collaboration can help build local capacity

The experiences of Ukraine and Armenia demonstrate how international training, mentorship and knowledge exchange can support the early development of therapeutic horticulture in new settings. Longer-term growth, however, depends on adapting that knowledge locally and developing practitioners, education and programs that can increasingly be led within their own communities.

Different strengths, shared challenges

The international examples most worth studying are not necessarily those with the largest number of horticultural therapists or the most established professional associations. In many cases, the most transferable lessons come from countries that have made progress on one particular part of healthcare integration.

The table below summarizes the examples explored in this scan, along with several closely related models that merit further study.

Country or region	What its experience can help us understand
United States	Professional standards, competency-based credentialing and accredited education
Canada	The opportunities and capacity challenges facing voluntary professional associations
United Kingdom	UK-wide professional standards and practitioner-registration pathways, alongside social prescribing and procurement in England and network development, nationally recognised training and advocacy in Scotland
Singapore	Public-sector infrastructure, healthcare partnerships and multiple levels of therapeutic horticulture workforce development
Australia	Flexible interdisciplinary entry routes and competency-based professional membership
Austria and Switzerland	Post-professional therapeutic horticulture education and integration within established health and social-care professions

Country or region	What its experience can help us understand
Germany	Professional networks, specialist rehabilitation, and insurer-supported workforce development and implementation in long-term care
Italy	Regional professional recognition, university-based education and the development of publicly supported practitioner training
India	Postgraduate horticultural therapy education through an agricultural university, with connections to professional practice and healthcare employment still to be clarified
Spain and AEHJST	Association-led education, shared professional terminology, quality standards and European competency development
Netherlands and Norway	Adjacent care-farming models illustrating provider quality systems, collective contracting and publicly funded care
Sweden and Denmark	Multidisciplinary research, rehabilitation models and therapeutic environment design
China	Research-led development, emerging professional infrastructure and national occupational recognition, with training and certification systems still developing
South Korea	Legislation, national qualifications and public investment in related therapeutic sectors
Japan	Regional certification, multiple professional pathways and the limits of professional development without national reimbursement
Hong Kong	Tiered association-led certification, substantial supervised practice and externally recognized vocational education
Latin America, particularly Peru and APHTS	Regional professional development, public-health partnerships, healthcare-based practice and participation in international research
Ukraine and Armenia	International capacity-building, locally led workforce development, rehabilitation practice and therapeutic horticulture in conflict-affected communities

No country offers a complete model that can simply be transferred elsewhere. Healthcare funding, professional regulation, education and public policy differ too greatly.

What the international landscape does show is that the field's advancement depends on several systems developing together.

The most transferable examples are therefore not simply those that have established a qualification or launched a successful program. They are those that have begun connecting multiple parts of the system: education, professional standards, organizational safeguards, public policy, referral processes, procurement and sustainable funding.

Taken together, these international examples suggest that the future growth of horticultural therapy and therapeutic horticulture will depend on more than demonstrating that plant and nature-based programs are beneficial. The field must also make it easier for healthcare organizations to understand what is being offered, who is qualified to provide it, how services can be delivered safely, which outcomes can be expected and how programs can be funded.

This scan is necessarily incomplete. We welcome corrections, current examples and perspectives from professional associations, educators, researchers, practitioners, healthcare leaders and people who have participated in therapeutic horticulture services.

This article was developed by GrowTH as part of our commitment to making research, education and international developments in the field more accessible to practitioners and organizations.

International review and contributions

We are grateful to the practitioners and field leaders who reviewed regional sections, suggested updates and contributed additional context to this international scan.

Overall expert review

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Regional review and contributions

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- **Lada Mendrukh** — Ukraine; Manager of the VDNK Therapeutic Garden, Kyiv

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