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Canadian Adventure Therapy

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Adventure therapy (AT) has been difficult to define in the literature. While general agreement exists that AT is commonly practiced in therapeutic camping, wilderness therapy, or activity-based psychotherapy settings (Alvarez & Stauffer, 2001; Bandoroff & Newes, 2004; Gass, 1993; Gass et al., 2012), a formally agreed upon definition of AT has proven problematic due to the diversity of practices internationally. In fact, the international AT community has resisted a singular definition in order to remain widely inclusive and choosing only to note two core components: engagement in challenging activities with therapeutic intent (International Adventure Therapy, 2022).

Birthed in the United States, AT has been defined broadly as "any intentional, facilitated use of adventure tools and techniques to guide personal change towards desired therapeutic goals" (Alvarez & Stauffer, 2001 p. 87) and narrowly as "the prescriptive use of adventure experiences provided by mental health professionals, often conducted in natural settings that kinesthetically engage clients on cognitive, affective, and behavioral levels" (Gass et al., 2020, p. 1). In Europe, AT has been identified as "a combination of experiential learning and personal or individually different therapeutic approaches" employing challenge, nature, and reflection (Vossen et al., 2017, p. 2). In Australia, AT combines nature, small groups, "adventure and outdoor environments with the intention to achieve therapeutic outcomes" (Australian Association for Bush Adventure Therapy, 2008) and includes "healing, journeys, and relationships in attempting to articulate the means, methods and aims of practice" (Carpenter & Pryor, 2004, p. 237).

In Canada, AT uses experiential challenge activities, usually conducted in small groups, to engage with the therapist, for the varied purposes of empowering, building resilience, lowering stress, developing coping strategies, improving pro-social skills, resolving trauma, transforming

behavior, reducing resistance to change (Priest, 2021) and enhancing overall ecohealth (Ritchie et al, 2022). Globally, AT is differentiated from other adventure fields by the use of the usual outdoor challenges in nature, but by adding "advanced facilitation techniques that offer beneficial alternative behaviors or augment what is already done well" so as to reduce client resistance to healthy change (Priest & Gass, 2018, p. 418).

Therapy or Therapeutic?

Central to these definitional arguments is the attempt to delineate between the concepts of "therapy" and "therapeutic." Early on in the historical evolution of AT, Gass (1993) suggested that adventure programming exists across a continuum of depth of intervention, with recreational programming occupying the shallow end of the spectrum, educational programs somewhere in the middle, and adjunctive (developmental) and primary (therapy) treatment interventions considered "deep". This continuum is further developed in the opening definitional chapter of this textbook (Priest, 2023a).

In order to delineate between developmental (therapeutic or adjunctive) programs and therapy (primary treatment) programs, Williams (2004) proposed a six factor model. This model required that in order for an intervention to be considered therapy it must include:

1. a diagnosed presenting problem,
2. specific treatment goals,
3. a targeted intervention specific to the presenting problem,
4. theory-informed program planning,
5. systematic research and evaluation of process and outcomes, and
6. facilitation by trained clinicians (Williams, 2004).

Therapeutic programming may still have beneficial client outcomes, but not necessarily include the core components of therapy or the presence of a practitioner with a clinical license (Williams, 2004). In summary, AT typically involves several elements: a small **group** of clients, with **individual** needs, engaged in **challenges** involving risk, conflict or exercise, with **nature** immersion followed by **reflection** under the **facilitation** of an outdoor **leader** in a **psychotherapeutic process** guided by a supervising **therapist** (Priest, 2023b). The last two elements delineate therapy from therapeutic programming.

Adventure Therapy in Canada

Significant AT growth has occurred during the last 25 years, especially in the United States, Australasia, the United Kingdom, and Europe (Norton et al., 2015). However, growth in Canada has been much slower (Ritchie et al., 2016). Starting in the 1970's, therapeutic adventure programs designed as diversion interventions for youth at risk of engagement with the juvenile justice system became common in British Columbia, reaching a peak of 26 funded programs. Yet, by 2014, only 2 programs remained active (Barnett & Howell, 2014), and, by 2019, these two had closed. These two programs did not include mental health services from licensed clinicians and were more accurately described as developmental programs than therapy. These BC programs aimed to support skill development that increased the quality of participants' daily lives rather than address resistance to change or processing of trauma (Priest & Gass, 2018). While these developmental programs did not meet the previously described definition of AT, wilderness programming affiliated with juvenile justice was quite common across Canada, and served as a stepping stone towards AT programming. One such program was Project Dare which started as an open custody wilderness-based program in 1971. Wendigo Lake Expeditions took control of the program after the government privatized it, providing services from 2000-2021. Wendigo Lake Expeditions differed from its Western counterparts in that their program included licensed mental health professionals (Russell, 2006).

Enviros Wilderness Camp Association, currently based in Calgary, AB, started as a single wilderness program developed by social workers in 1976 and has grown to a large wrap around agency that provides a variety of mental health,

addiction, and social services (About Enviros, 2023). Enviros' Shunda Creek wilderness-based addictions treatment program partnered with Gillis and Russell (2017) in 2010 to create an outcomes monitoring program with a specific focus on assessing the added value of including AT components in substance use treatment, eventually leading to the development of the Adventure Therapy Experience Scale (ATES). Shunda Creek continues to operate its 90-day treatment program under supervision of licensed mental health professionals near Kananaskis, AB.

Canadians have attended all nine International Adventure Therapy Conferences (IATC), and the Third IATC was hosted in Victoria, British Columbia, in 2003. At the Fourth IATC in Rototura, Aotearoa/New Zealand in 2006, a group of Canadians met to discuss the current state and development of AT in Canada, leading to a series of the Canadian Adventure Therapy Symposia or CATS (Ritchie et al., 2016). Since the first 2009 CATS, held in Victoria, BC, seven more CATS have convened in Canadian locations including Quebec, Ontario, Alberta, Nova Scotia, and the Yukon (Cornell, 2019). CATS events were intentionally held in distinct regions of the country to encourage participation from a breadth of educators, clinicians, researchers, students, Indigenous communities, and program providers across the nation; about 50 percent of CATS event participants identified as providing therapy or therapeutic services, while the remainder identified with other primary service domains (Cornell, 2019). This diversity in attendance has resulted in focusing conference conversations on the potential benefits of AT and AT-related practices across multiple sectors.

Many Indigenous communities across Canada have long histories of land-based healing practices to support health, well-being, and culture. While a full description of land-based healing practices is beyond the scope of this chapter, land-based healing practices in Canada have been described as

> *…a health or healing program or service that takes place in a non-urban, rural or remote location on a land base that has been intentionally spiritually cultivated to ensure the land is honoured and respected. The land is understood to be an active host and partner to the people engaged in the healing process. The cultivation of a land base under the stewardship of First Nation people is usually done through the development of an intimate spirit-based relationship through ceremony, offerings, expression of gratitude and requests for permission from the land to enter and use it for healing purposes. (Hanson, 2012, p. 2)*

On the surface, there may be some similarities between traditional land-based healing practices and AT; both practices aim to support mental health and well-being and occur outdoors. Despite these similarities, it is important the two practices are not conflated. Canadian adventure therapists should be careful to avoid cultural appropriation of traditional practices in their work, but there is value in western and Indigenous practitioners coming together to share, learn, and support each other in a good way. An example of such collaboration occurred at CATS 7 in Whitehorse, YT. Grand Chief Peter Johnston gave a keynote about the value of engaging with land for health, wellbeing, and moving forward as a society, as well as Yukon First Nations treaties and self-governance (Cornell, 2019). Future meetings of Canadian AT professionals should continue to invite Indigenous voices to the table to deepen conversations about how all parties can support each other's healing work outdoors.

A recent census of Canadian AT providers found that while there are a few larger programs offering AT services across the country (e.g. Enviros in Alberta, Pine River Institute in Ontario, Le Grand Chemin in Quebec), the majority of AT providers across the country offer services through smaller private practices (Priest & Javorski, 2021). AT programming tended to be adjunctive to more traditional mental health services, and includes shorter nature-based counselling in local natural spaces, day trips involving facilitated rock climbing, canoeing, kayaking, hiking, or sailing, and shorter-term (2-10 day) wilderness expeditions

(Priest & Javorski, 2021). While formal training or post-secondary education in AT is sparse in Canada (Ritchie et al., 2016), a Master's degree in AT was recently launched at the University of Quebec at Chicoutimi. AT services are also expanding in agency-based services in Newfoundland. While there does not seem to be the market to support longer-term AT programming, popular in the United States and European nations, interest is growing in and for the need of AT-based mental health support across Canada.

The Essential Elements of Adventure Therapy

AT engages clients in challenges (experiences with unknown outcomes) to provide opportunities for the client to experiment with different thoughts, feelings, and behaviors (Priest & Gass, 2018). The challenges include taking risks, resolving conflicts, enduring difficult exercise, and immersing in nature. Interactively, these provide intrapersonal, interpersonal, physical and mental health benefits (Priest, 2023b; Ritchie et al., 2022). These challenges are normally facilitated using reflection techniques adapted from Kolb's (1984) experiential learning cycle; and adventure therapists present an activity designed to require clients to employ thoughts, feelings, or behaviors in line with a therapeutic goal, help clients reflect on the experience, and ask clients to consider how they can transfer learnings from the experience back to their everyday life (Priest & Gass, 2018). Beyond this general framework of challenges and reflection, and regardless of activities undertaken, the essential elements of AT can be best expressed using the alliterative acronym SUPRA: saturated solutions, unique universe, purposeful programming, reduced resistance, and authentic adventure.

S = Saturated Solutions. In contrast to traditional talk therapies, which employ predominantly cognitive-based pathways to work toward therapeutic goals, AT interventions actively engage clients through cognitive, behavioral, and affective pathways (Gass et al., 2020). AT interventions are immersive; whether they be short AT sessions, half day or full day experiences, or longer wilderness-based AT programs that keep clients engaged in therapy 24 hours/7days a week for several weeks (Gass et al., 2020). Adventure therapists employ advanced facilitation skills including isomorphic framing, frontloading, and funneling to develop transformative activities supportive of client growth toward therapeutic goals (Priest and Gass, 2018).

In the North American context, the AT process has been described as therapists and clients co-creating a goal, participating in an adventure experience alongside the therapist, and then processing the experience to help the client transfer the skills, knowledge, and/or insights gained from the adventure experience to their daily lives (Alvarez et al., 2020; Gass et al., 2020). While Dobud and Natynczuk (2022) argued that learning goals should not be introduced before the adventure experience (specifically nature-based experiences), the rest of their solution-focused model for outdoor therapies followed a similar process. Gass et al. (2020) also argued for a solution-focused component to AT interventions, where AT practitioners help clients identify strengths highlighted in adventure experiences. A similarity across all models is the belief that adventure experiences provide a safe environment for clients to experiment with different ways of being in the world; this allows participants to test out novel solutions to challenges they face in their daily lives in the context of an adventure activity, explore the pros and cons of each solution with the AT practitioner and the rest of the group, and think about which option may serve them best beyond the container of the AT program (Alvarez et al., 2020; Dobud & Natynczuk, 2022; Gass et al., 2020).

U = Unique Universe. Drawing on the work of Satir (1972), Walsh and Gollins (1976), and (Whitaker, 1978), AT interventions typically involve groups that are large enough to allow for reciprocity, diversity, and conflict, yet small enough for members to unite around an objective, avoid the formation of cliques, and manage conflict in a healthy way. The active nature of AT interventions supports physical health by providing clients healthy eating, regular sleep routines, and frequent exercise. AT interventions, regard-

less of context, are screen-free, and provide clients the opportunity to develop trusting relationships with peers, clinicians, and themselves free from negative health outcomes (poorer physical health, quality of life, and family relationships) associated with screen-based media consumption (Iannotti et al., 2009).

The use of unique environments has been central to the AT process through over five decades of literature (Alvarez et al., 2020; Carpenter, 2008; Deane & Harré, 2014; Gass et al., 2020; Jansen & Pawson, 2012; Nadler, 1993; Priest & Gass, 1997; Schoel et al., 1988; Walsh & Gollins, 1976). Novelty, through either setting (e.g. nature) or activity choice, provides enhanced assessment opportunities. Client projections onto both the novel environment and novel activity provide adventure therapists with deeper opportunities to observe client behaviours than would be typical during a talk therapy session in an office (Priest & Gass, 2018). In addition, the use of unfamiliar prescribed physical environments (often in nature/wilderness) that contrast with clients' daily lives helps: 1) enable clients to gain a new perspective on their usual behaviors (Gass et al., 2020); and 2) create adaptive dissonance (Walsh & Gollins, 1976) that can motivate clients to explore healthier ways of being within the unfamiliar environment through the support of their peers and the facilitator (Gass et al., 2020). The use of contrasting, unfamiliar environments is supportive of client autonomy; the drive to become more comfortable in the novel setting requires participants to develop internal motivation to think about change (Gass et al., 2020) .

P = Purposeful Programming. AT practitioners work alongside clients to develop treatment goals and plans, generally participating in the adventure experiences with clients (Alvarez et al., 2020; Gass et al., 2020). This places the therapist in a unique position to work towards goal consensus, collaboration, and alliance factors intensely over a shorter period of time than talk therapies through shared mutual experience. An early meta-analysis of psychotherapy outcomes including 375 evaluations of psychotherapy against no treatment control groups found that while on average, therapy clients were better off than 75 percent of untreated individuals, there were negligible treatment differences based on psychotherapeutic modality (Smith & Glass, 1977). Instead, the quality of the therapeutic alliance had the largest effect on positive client change through treatment (Smith & Glass, 1977). More recent meta-analyses on treatment outcomes for youth specifically found similarly negligible differences in treatment effect sizes by modality (Weisz et al., 2017; Weisz et al., 2019). Wampold and Imel's (2015) book presented a contextual model for therapy based on a comparison of the effect sizes for positive client change found in a literature search for psychotherapy outcome trials. The authors found that while treatment differences were the most commonly studied factor across the psychotherapy literature, psychotherapeutic modality was associated with a small effect size overall (Wampold and Imel, 2015). Their findings further supported Smith and Glass's (1977) conclusion that therapeutic alliance was more strongly associated with positive outcomes; empathy, alliance, positive regard/affirmation, and congruence/genuineness all showed medium effect sizes for positive client change through psychotherapy (Wampold and Imel, 2015). Most interestingly, Wampold and Imel (2015) found that goal consensus and collaboration between the therapist and the client, though studied the least, demonstrated the strongest effect sizes for positive client change through treatment.

AT interventions offer prescriptive challenges designed so that in order for a client to be successful, they must generate and apply adaptive thoughts, behaviors, and/or feelings targeted as goals in their treatment plans (Alvarez et al., 2020; Gass et al., 2020). Activities often require that clients engage through affective, behavioral, cognitive, social, or kinesthetic domain to navigate challenges in the present moment, and experience eustress, the conscious application of personal competence to overcome perceived risks (Priest & Gass, 2018). Whether adventure activities are designed to allow clients to address specific treatment goals (Alvarez et al., 2020; Gass et al., 2020), or nature-based experienc-

es are used to allow more emergent outcomes (Dobud & Natynczuk, 2022), AT practitioners strive to help clients transfer learning focused around co-created goals from the adventure experience to their daily lives.

R = Reduced Resistance. AT interventions engage clients through processes associated with the experiential learning cycle (Kolb, 1984). These processes support clients through activities, reflection on these experiences, integration or identifying learnings from experiences, and continuation or commitment to applying those learnings in the future through specific changes in thinking and behavior. Adventure therapists often practice from a solution focused orientation, helping clients to "do more" of what is working for them and "do less" of what is not (Gass et al., 2012). Activities are selected to engage with and build upon client strengths and interests, further reducing the likelihood of client resistance to treatment (Bandoroff & Newes, 2004). Furthermore, AT interventions are designed to support client autonomy, competence, and relatedness, the three basic psychological needs described by self-determination theory (Ryan & Deci, 2000). Ryan and Deci (2000) believed that when these needs were met, clients were more likely to develop intrinsic motivation to change, thus reducing resistance to therapy. The deliberate use of reciprocity (Walsh & Gollins, 1976) in AT interventions also serves to reduce client resistance.

Participating in group experiences that require attention and effort from all members in order to meet an objective can engage those clients who may be otherwise resistant to learning and growth (Bruner, 1966). Fetterman et al. (2016) found that cueing study participants to write about negative life experiences and depressive symptoms in metaphorical terms led to greater reductions in negative affect and depressive symptoms over time compare to participants who were cued to write in literal terms. Furthermore, they found that metaphorical processing could be taught to participants who were more pre-disposed to thinking literally (Fetterman et al., 2016).

AT interventions are often designed to be isomorphically connected to the clients' treatment goals; the activity itself is a metaphor for an issue the client is seeking to resolve, and successful resolution of the activity becomes a parallel process to achieving a treatment goal in real life. Addressing a client issue through the structured metaphor of an activity is often met with less resistance than occurs while speaking about the issue directly (Priest & Gass, 2018). The process for creating isomorphically framed AT interventions and facilitating direct or indirect transfer of learning from the adventure experience to clients' daily lives has been well described in the literature (Bacon, 1983; Gass, 1993; Gass et al., 2012; Gass et al., 2020). Therapeutic metaphors can act to reduce client resistance to functional change and enhance the efficacy of therapeutic interventions (Erikson, 1980) as they can often communicate complex or abstract concepts in a more understandable way (Hayes et al., 1999). Metaphors require clients to conduct a transderivational search of all of their past experiences, values, and beliefs in order to make sense of the current metaphorical experience (Bacon, 1983). This unconscious process bypasses the conscious resistance to change clients may have and allows the client to create their own meaning (Gass, 1993). Gass (1993) further explained that properly formed metaphors in AT build upon their application in traditional therapies due to: 1) clients' tendency to exhibit self-motivating responses to properly formed AT interventions; and 2) the orientation of AT interventions towards successful resolution.

A = Authentic Adventure. North American literature over the last five decades has shifted considerably in how ethical and effective AT is practiced, however, the core elements of AT interventions have always included concrete physical experience. Walsh and Golins (1976) described the essential role of a characteristic set of physical problem-solving tasks as core to the AT change process. Schoel et al. (1988) provided a framework to use experiential group problem-solving challenges and challenge course activities (e.g. high and low ropes courses) to facilitate social, emotional, and behavioral change, while Nadler

(1993) detailed how kinesthetic engagement in challenging activities could cause disequilibrium in clients leading to behavioral change. Norton (2010) found that physical challenge was essential to positive change in wilderness therapy clients, and Bowen and Neill's (2013) meta-analysis found learning through meaningful physical engagement in adventure activities and the associated positive use of stress (eustress) was essential to the change process.

AT interventions are concrete, straightforward, and produce feelings of choice for clients (Priest & Gass, 2018). AT experiences involve real or perceived risks appropriately matched to the clients' competence in a given area, and clients must use their existing skill sets or develop new ways of being to successfully complete the activity. They are organized with the intent of collectively achieving clients' treatment goals and structured in a manageable way such that client confidence is built through solving incrementally more challenging problems (Priest & Gass, 2018). The activities are consequential; clients receive natural feedback on their mental, emotional, social, and physical performance, and adventure therapists help clients reflect on this feedback to identify ways to improve (Gass et al., 2020). AT interventions foster reciprocity between members, such that client groups must make use of the varied strengths of each member to overcome challenges that would be impossible to achieve as an individual (Gass et al., 2020).

Becoming an Adventure Therapist

Adventure therapy interventions require practitioners to have expertise in a variety of domains: outdoor activities and leadership, facilitation and therapy, knowledge of clientele and culture, and personal qualities and qualifications (Priest & Gillis, 2023). Acquiring these skills requires an individual to train themselves in two or more professions: as a licensed mental health clinician and a credentialed instructor for any outdoor activity they wanted to lead as part of their AT practice. This involves earning a masters' degree in a mental health field (e.g., counselling psychology, social work, marriage and family therapy, and child and youth care), earning a clinical license in the province they want to work in, maintaining wilderness first responder qualification, and earning and maintaining an instructor credential for any applicable outdoor activities (e.g., canoeing, kayaking, rock climbing, cycling, etc). Earning and maintaining these credentials as an individual requires a significant investment of time and resources. As noted by Priest and Gillis (2023), it is also possible to create facilitation teams with multiple practitioners, each bringing a unique skill set to ensure the leadership team has expertise in all domains required to provide ethical and effective AT programming.

Several recent publications have detailed the essential elements of good AT practice (Borroel et al., 2020; Borroel et al., 2021; Priest & Gillis, 2023). While they are not identical, the fundamentals of AT described in each overlap closely (see table 1), and they serve well as a guide for new practitioners interested in developing the skills required to facilitate AT programming as an individual or as part of a team. In 2018, 24 AT practitioners from 11 nations met for three days in the Blue Mountains to the west of Sydney, Australia, to discuss the essential elements of adventure therapy and practice in an international context (Borroel et al., 2020). One of the outcomes of the meeting was a list of 16 essential elements of safe and effective AT practice, displayed in the "Think Tank" column of table 1. The Association for Experiential Education (AEE) began offering the Certified Clinical Adventure Therapist (CCAT) credential in 2021 (Borroel et al., 2021). The CCAT credential is US-Based and requires expertise in 10 competency categories. More recently, Priest and Gillis (2023) presented the tri-competent adventure therapist, describing four domains of expertise essential to AT practice in North America.

While the three descriptions of essential competencies for AT programming vary slightly, the core elements are all similar. Based on these, in order to provide safe, ethical, and effective AT interventions in Canada, providers should have expertise as an individual or collective facilitation team in:

Table 1: Essential Elements of Adventure Therapy (Note: The international AT community does not require a masters' degree or clinical licensure, but training requirements vary based on local cultural context)

Certified Clinical Adventure Therapist: AEE (Borroel et al., 2020)	**Tri-Competent Adventure Therapist: c. 2000 (Priest & Gillis, 2023)**	**Think Tank IATC-8: Eighth International AT Conference (Borroel et al., 2021)**
1 **Technical Skills** 2 **Organization/Administration** MISSING: instructional and meta skills, but may already be inherent in a licensed mental health practitioner	**Experience** (Technical, Safety & Risk Management, Environmental, Planning, Meta Skills, Instructional)	**Risk Assessment** and **Crisis Management** **Technical Outdoor Skills** **Adventure** (as central to change)
3 **Facilitation & Processing** 4 **Conceptual Knowledge** 5 **Therapeutic Alliance Building** 6 **Assessment**	**Reflection** (Theoretical, Transformative, Psychotherapy, Facilitation, Metaphors, Alliance, Trauma-Informed)	**Group Work** (holistic facilitation and processing) **Nature-Based Interventions** (Nature as teacher and healer) **Trauma-Informed Practice** **Counseling Theories and Models** **Therapeutic Alliance** (relationships and communication)
7 **Interventions** (designed specifically for clients) 11 **Socio-Cultural/Environmental Considerations**	**Clientele** (Concerns, Tailoring, Indications, Contraindications, Cultural, Indigeneity, Social Justice, Empowerment, Socialization)	**Indigenous/Cultural Awareness** **Holistic Well-Being** **Interventions/Tool kit** (mindfulness, metaphors, initiatives, etc) **Client Specific Knowledge**
8 **Therapeutic Monitoring** 9 **Documentation** 10 **Professionalism** PREREQUISITES: possession of a graduate degree, verification of licensure, analysis of prior learning and experience under supervision, etc.	**Personal** (Graduate Degree, Self-Awareness, Intentionality, Overall Comfort, Professional Ethics, Prosocial Teamwork, Holistic Attitude, Pervasive Resilience, Willingness to Learn, Evaluation, Traits)	**Safe, Ethical, Effective Practice** **Personal Self-Awareness** **Professional** (reflective/reflexive practice and supervision) **Evaluating Effectiveness**

1. **activities/outdoor pursuit expertise** for all activities being offered as part of an AT intervention with instructor qualification where available and appropriate wilderness first aid training;
2. **administrative expertise** including physical, social, emotional, and behavioural risk management, insurance, waivers/assumption of risk documentation, logistics, environmentalism, outcome monitoring, and critical incident response;
3. **clientele expertise** including social justice issues, culture and Indigeneity, language, tailoring interventions for individual needs, holistic well-being, and indications/contra-indications for specific activities/interventions;
4. **counselling expertise** with a master's degree and clinical license, including knowledge of models of change, psychotherapy models, metaphors, nature-based interventions, therapeutic alliance and trauma-informed care; and
5. **facilitation expertise** in delivering activities and processing to transfer client learning from the activity to their daily lives, managing groups, and group leadership.

Conclusion

Adventure Therapy in Canada is still a developing field, but it holds great potential as an alternative form of mental health and well-being treatment. In order to provide safe, ethical, and effective care, Canadian AT providers should have the activity, administrative, clientele, counselling, and facilitation expertise necessary to offer any activities included as part of an AT program. Canadian AT providers should participate in program evaluation and client outcome research to evaluate the efficacy of AT interventions for a variety of populations; the findings of this work

could be used to advocate for additional access to AT programming through provincial health and social service networks and insurance providers. The work of CATS should be continued, with a focus on bringing together AT providers, Indigenous communities, and government stakeholders to continue conversations about the value of connecting in and with natural places, conservation, land access, knowledge sharing, and how AT programming could help to address some of the 94 calls to action from the Truth and Reconciliation Commission (TRC, 2015). Finally, the next iteration of CATS should bring together AT practitioners, past clients, developing practitioners, and academics to discuss AT training in Canada. Sharing the experience of practitioners and clients may help academics create training opportunities in the form of micro-credentials, diplomas, and/or graduate degrees to help train the next generation of Canadian AT practitioners.

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