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Northeast Passage PATH™ Program

A Strengths-Based and Recovery-Oriented Approach for Veterans Who Experience Mental Health Disorders

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Abstract: The recreation therapy profession stands in a position to be a powerful agent of change from a strengths-based perspective (Anderson & Heyne, 2012). This article merges ongoing discussions regarding the need for development of effective evidenced-based treatment options for Veterans with mental health disorders, current dialogue regarding the changing focus in healthcare, and the role of strengths-based approaches to healthcare. It also offers a detailed example of the Northeast Passage PATH™ program (Promoting Access, Transition, and Health) as a strengths-based, recovery-oriented recreation therapy program implemented in a home/community-based setting (Craig, Wilder, Sable, & Gravink, 2013). Case examples are interwoven within the article to accent the discussion regarding strengths-based practices and illustrate how the PATH™ program implements interventions with Veterans with mental health disorders through all phases of treatment including assessment, planning, intervention, and evaluation.

Keywords: *Strengths-based practice, community-based therapeutic recreation, veterans, well-being, ICF, mental health; recovery*

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"May your choices reflect your hopes, not your fears."

—Nelson Mandela

Nelson Mandela's wish for the well-being of another embodies a concept evident at the core of strengths-based healthcare practices. It shares an assumption that all individuals desire to live lives of meaning and purpose, to actualize their dreams and goals, and to become the best versions of themselves (Heyne & Anderson, 2012; Seligman, 2002; 2011). Layered on this assumption is the wish that each individual be able to access the skills and resources that enable him or her to make choices and take action toward dreams and goals despite the existence of fears or obstacles.

Strengths-based, recovery-oriented strategies are identified as the current standard of care for treatment of individuals with mental health disorders (National Alliance on Mental Illness [NAMI], n.d.; Seligman, 2002; 2011; US Department of Health and Human Services [DHHS], 2006; World Health organization [WHO], 2001; 2013). A strengths-based treatment model recognizes an individual's personal talents, skills, interests, and assets and uses them as the starting point to create desired changes in health and well-being as part of the recovery process (Anderson & Heyne, 2012; Heyne & Anderson, 2012; Seligman, 2011).

The national and global messages regarding mental health disorders are those of hope and recovery (NAMI, n.d.; National Council for Behavioral Health, 2014; WHO 2001; 2013). Recovery has come to have two conceptual meanings relevant to treatment of mental health disorders. The first is a "recovery from" concept, meaning a reduction or amelioration of symptoms associated with mental health disorders. The other meaning includes a "recovery in" concept, embracing an individual's right to "a safe, dignified, personally meaningful and gratifying life in the community, while continuing to have a mental [health disorder]" (Davidson & Roe, 2007, p. 464; DHHS, 2006; WHO, 2001; 2013). Hope underscores the concept that recovery is possible (Iwasaki, Coyle, & Shank, 2010; NAMI, n.d.; WHO, 2001).

Despite this, there are an overwhelming number of veterans who do not feel hopeful, who do not access available mental health care, and who are not able to embody the powerful wish for well-being in the opening quotation (Irving, Telfer, & Blake, 1997; Kemp & Bossarte, 2013; Zinzow, Britt, McFadden, Burnette, & Gillispie, 2012). For many veterans who experience mental health disorders, their daily lives are often represented by choices made to reduce or simply endure symptoms instead of choices that support health and well-being (Price, Lundberg, Zabriskie, & Barney, 2015).

From a strictly deficits perspective, the statistics present a clear picture of the need for improvement in available services for veterans. Since September 11, 2001, the United States has deployed over 2.2 million troops in the Global War on Terror (Zinzow et al., 2012). Of these 2.2 million, an estimated 30% to 40% will experience a mental health disorder requiring treatment, such as depression, anxiety, or posttraumatic stress (PTS; National Council for Behavioral Health, 2012, 2014; Zinzow et al., 2012). These most recent troops add their numbers to the ranks of roughly 21 million U.S. Veterans (U.S. Department of Veterans Affairs, 2014). Untreated mental health disorders have lasting impact on every generation of Veterans and our country

as a whole (Magruder & Yeager, 2009; National Council for Behavioral Health, 2014).

PTS symptoms such as intrusive memories, emotional numbing, and avoidance, influence levels of functioning across physical, cognitive, and social domains (Maguen & Burkman, 2013; Price, 2013; Schnurr, Lunney, Bovin, & Marx, 2009). The resulting impact on individuals, families, and society is multidimensional (Schnurr et al., 2009). For example, 68% to 84% of veterans who experience PTS will likely also experience a life-long alcohol abuse disorder, are three times more likely to engage in interpersonal violence than the general public, and have more marital/family problems often connected to instances of domestic violence (Coll, Weiss, & Yarvis, 2011). Unemployment rates among Veterans of Iraq and Afghanistan Wars are 40% higher than the national average; one in every three homeless men is a veteran, and approximately 22 veterans commit suicide everyday (National Council for Behavioral Health, 2014). This view presented by statistics, albeit based in deficit, illustrates the need for positive growth in the healthcare system for Veterans who experience a mental health disorder.

Health and Well-Being

The World Health Organization (WHO) defined health as "the state of complete mental, physical, and social well-being vs. simply the absence of disease" (WHO, 1946, p. 100). The WHO attempts to operationalize these concepts of well-being through the International Classification of Functioning, Disability, and Health (ICF), that evaluates individuals not only in terms of body function and structure (the more traditional view of health), but also functioning in regards to participation in life and community activities within the context of personal and environmental factors (WHO, 2002). The field of positive psychology embraces this concept of health, participation, and well-being. Positive psychology discusses well-being as a construct comprised of things such as experiencing positive emotion, positive relationships with others, engagement in activities chosen for their own sake, achievement, and meaning defined as "belonging to and serving something that you believe is bigger than the self" (Seligman, 2011, p. 17).

Within both the ICF framework and positive psychology definitions, the concept of functioning reflects the interaction between the individual's functional skills, access to internal and external resources that support successful development of positive relationships, engaging in community events and leisure activities, experiences of positive emotions, and living a life of meaning and purpose (Seligman, 2011; WHO, 2002).

The WHO identifies these aspects of well-being as a human right in the 2013 Mental Health Action Plan, and identifies the facilitation of access and engagement as the responsibility of health care providers (WHO, 2013). This facilitation is at the core of strengths-based approaches to care; and, is consistent with current recommendations for treatment modalities for Veterans who experience mental health disorders.

Recommendations for Veteran Care

Results of veteran-specific studies indicate treatment approaches with outcomes related to those indicators of well-being identified by ICF and the field of positive psychology previously discussed. Suggestions include development of modalities that utilize both cognitive and experiential means to increase personal belief in ability to cope, transform stress into personal strength, assign meaning

to experience and life, foster the development of social networks, increase the experience of positive emotions, and redefine self and the world (Hawkins, McGuire, Britt, & Linder, 2015; Litz et al., 2009; Pietrzak, Russo, Ling, & Southwick, 2011; Steenkamp et al., 2011). Within this context, experiential means including participation/engagement in a variety of personally and culturally relevant recreation activities that support health, social connections, and reinforce positive aspects of self/values (Iwasaki et al., 2010; Iwasaki, Mackay, Mactavish, Ristock & Bartlett, 2006; Maguen & Burkman).

The recreation therapy profession has great potential to fill this call for treatment modalities to support the recovery of veterans and members of the armed forces who experience mental health disorders related to their military service. Recreation therapists use purposeful and carefully facilitated recreation engagement and experiences as the context to enable increased access to community resources and individual strengths and skills that support well-being across multiple health domains (Anderson & Heyne, 2012; Carruthers & Hood 2007; Heyne & Anderson, 2012; Hood & Carruthers, 2007).

PATH™ Program (Promoting Access, Transition, and Health)

The Northeast Passage PATH™ program is a strengths-based recovery-oriented therapeutic recreation intervention that actively engages veterans with disabilities in recreation and leisure experiences in their home communities (Wilder et al., 2011). This program has a strong history of outcomes that include increasing access to resources, developing social connections, redefining self, and creating lives of meaning and purpose through recreation engagement for individuals who experience disability (Craig, Wilder, Sable, & Gravink, 2013; Sable & Gravink, 2005; Wilder et al., 2011).

PATH™ recreation therapists meet with veterans in their homes to conduct a comprehensive bio-psycho-social assessment that includes identification of individual strengths, recreation interests, and personal history. Through a collaborative process, individual goals related to health and well-being are identified and a goal-based plan guides subsequent visits. PATH™ therapists meet with veterans four to 12 times over the course of six months to a year to work toward their identified goals (Wilder et al., 2011). Interventions take place within the community and utilize recreation interests to build further strengths. Sustainable engagement in recreation becomes a pathway for redefining one's self within the context of his/her environment, builds relationships, and improves health (Craig et al., 2013; Sable & Gravink, 2005; Wilder et al., 2011).

In 2014, Northeast Passage received a Veterans Administration (VA) Adaptive Sports grant that extended the PATH™ program to veterans and members of the armed forces who experience mental health disorders as the primary reason for referral (Northeast Passage, n.d.). The VA Adaptive Sports Grant recognizes the importance of recreation participation as a way to support the recovery of veterans who experience mental health disorders. This is reflective of both global and national trends in best practices for mental healthcare and consistent with calls for alternative treatment modalities identified earlier (DHHS, 2006; Iwasaki et al., 2010; WHO 2002; 2004; 2013).

Integrating Theory with Practice

There are multiple theories that support recreation therapy as a strengths-based practice (Heyne & Anderson, 2012). Figure 1 is a condensed version of Heyne and Anderson's internal and exter-

nal strengths model (2012, p. 108). This model presents strengths as both internal (skills, knowledge, character traits, etc.) and external (environment including other social supports, built and natural resources, and available opportunities). The dotted line between these internal and external strengths represents the fluid nature and relationship of these two worlds. Recreation is both an internal and external strength, as well as a means for developing strengths. Recreation therapists utilize recreation as a tool to facilitate this process of increased strengths (Anderson & Heyne 2012; Heyne & Anderson, 2012). This dynamic exchange represented by the dotted line can also be understood to be where facilitation of increased strengths within a recreation therapy intervention takes place (see Figure 1).

Figure 2 expands this original model at the dotted line to illustrate the integration of multiple, but related, constructs of health presented by the ICF and positive psychology into practical application by the Northeast Passage PATH™ program. In this model, the dotted line is expanded to represent areas of facilitation by the PATH™ program (represented in grey) that comprise the concept of function. ICF evaluation of functioning includes participation (engagement) as well as environmental factors (their relative accessibility). The internal self/strengths engages the world by participation/engagement and is represented by an arrow leading outward. The external world/strengths touch the individual through their relative accessibility or availability and is represented by an arrow leading toward the self. At a core level, recreation therapists use existing strengths to facilitate further skill development, experience positive emotion, relationships, achievement and meaning. The resulting increases in individual strengths and ability to function contribute to an individual's overall subjective well-being (Anderson & Heyne, 2012; Seligman, 2011).

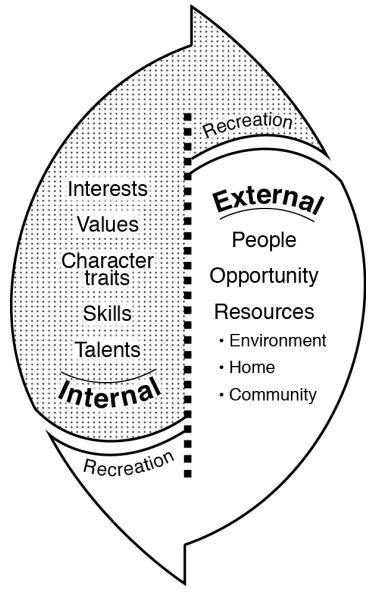

Figure 1. Internal and External Srengths

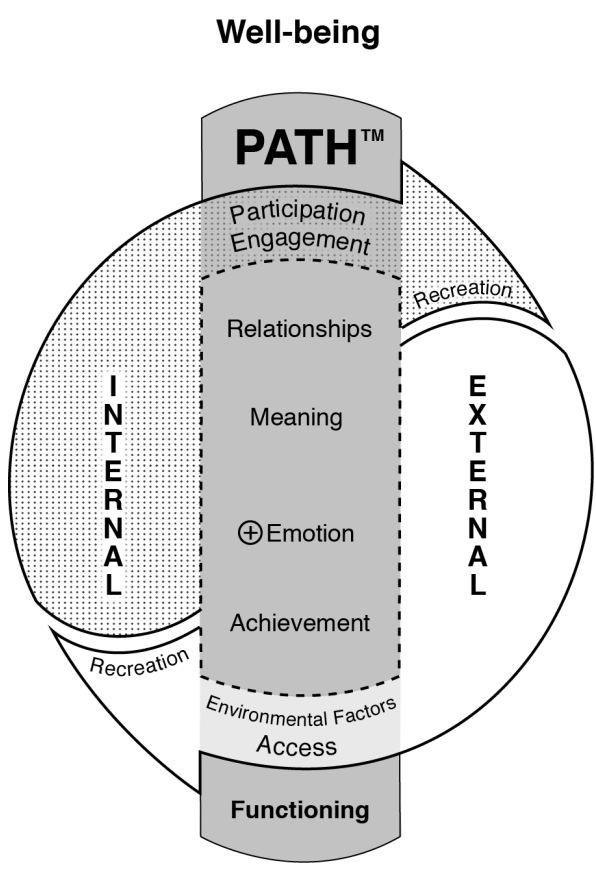

Figure 2. PATH™ Program Model

Over the past 11 years, Northeast Passage has provided a continuum of services to veterans in their community that support health at their level of readiness to engage. Northeast Passages' continuum of services range from ongoing event style adaptive sports and recreation programs, veterans specific recreation programs, one-on-one in office consultation regarding adaptive equipment and equipment rental, to its most intensive one on one in home/community-based therapeutic recreation services (i.e., PATH™). The PATH™ program is designed to reach those individuals who, based on their current experience of disability and their unique individual circumstances, are less likely to access available resources or engage in activities that support health. This approach to meaningful and relevant health-related goals, embedded in the context of the daily life, was identified by participants as the primary aspects of the program that created change (Craig et al., 2013).

To connect veterans with the PATH™ program, Northeast Passage utilizes relationships with veterans' service providers. Northeast Passage has worked with the VA national office to create a form that service providers can utilize when working with a veteran. After receiving

the form, a PATH™ therapist follows up with a phone call to the veteran to initiate participation in the program. Northeast Passage has done extensive outreach to VA providers in departments of primary care, pain management, mental health, social work, peer-to-peer counselors, and Veteran centers staff/therapists. This provides multiple avenues for Veterans to connect with the Northeast Passage PATH™ program and benefit from the program.

Examples of PATH™ Program Veterans

Northeast Passage serves veterans across all areas of service that experience mental health disorders directly related to their military experience. The PATH™ program also acknowledges the entirety of individual experience that contributes to his or her health status, including personal biology, individual history prior to military service, as well as current life circumstances. Below are three case examples of veterans who have accessed the Northeast Passage PATH™ program. These case examples illustrate the diversity of veterans across service eras and the importance of being prepared to respond to the complexity of the veteran's experiences and situations. These initial case descriptions are typical of information received from a referral based in a medical model.

Case example #1: William. William is 32 years old with 12 years of service in the Marine Corps. He was deployed five times to Afghanistan and Iraq. William is an example of the younger generation of veterans accessing the PATH™ program. He experiences TBI, depression, and PTS with persistent pain and decreased range of motion in his back due to injuries sustained during combat. He is married and has two children. He has a history of alcohol abuse, developed as an attempt to manage emerging symptoms of TBI and mental health disorders. He recognized the impact on his family relationships and has been sober for eight months. He and his family just moved to the area. He is employed and currently taking classes at the local community college, however, he has difficulty relating to peers. He stated, "I don't know who I am any more," and verbalizes both a lack of confidence and motivation to engage in leisure activities or his community. He was connected to the Northeast Passage PATH™ program through his mental health care provider at the VA.

Case example #2: Mary. Mary is 70 years old. She served 20 years in the Navy as a nurse and was deployed to a trauma hospital in Japan during the Vietnam War. Mary is an example of a veteran who has aged both with and into disability. Mary was medically discharged due to a neurological condition that impacts her mobility. She has several mental health diagnoses including depression, PTS, and bipolar disorder that she has been able to manage for many years through appropriate medication. As she has aged, she has developed other chronic health conditions, including chronic obstructive pulmonary disease, cardiac disease, and arthritis. Over the last six months, she has developed herniated discs and back pain further decreasing her mobility. She is able to ambulate short distances unassisted and uses a walker for longer distances when needed. She has recently gained custody of her two grandchildren after the loss of their mother. Increased stress levels attributed to changes in her mobility, multiple health conditions, and responsibility for her grandchildren have manifested in an increase in symptoms related to her mental health disorders. She was connected to the Northeast Pas-

sage PATH™ program through a support group for women survivors of military sexual assault.

Case Example #3: Mark. Mark is 55 years old. He served in the Army for six years and was stationed in Germany and Europe during the end of the Cold War era. Mark is an example of a veteran whose military service took place during peacetime. He identifies himself as an alcoholic, and at the initial assessment, was still actively drinking. In addition to alcohol and substance use disorders, he experiences anxiety, depression, and PTS. He indicated life-long struggles with depression and substance abuse that were exacerbated by his military service. He has experienced periods of homelessness, but lives in an apartment through the Veteran's Affairs Supported Housing (VASH) program. He does not drive and relies on public transportation, walking, or riding his bike. He is currently employed, however, but he has a history of job loss and unemployment related to alcohol abuse. He was connected to the Northeast Passage PATH™ program by his social worker.

Assessment and Treatment Planning From a Strengths-Based Perspective

For recreation therapists who engage veterans in a variety of activities, recognition and understanding of disability in conjunction with assets and strengths is integral to creating safe solutions for participation in activities that support health/well-being. Many health professionals are familiar with assessment strategies from a problems-based perspective; however, the process of being solution focused begins with either an understanding of what the individual envisions as a possible future or evaluation of what factors have contributed to greater well-being in the past (Graybeal, 2001). Resources and options used toward this envisioned future of improved health/well-being require a contextual understanding of an individual across health domains. PATH™ therapists use observational and active listening skills to gather information about individual strengths. These are reflected back to the individual within the context of discussion to generate further identification of individual internal strengths such as values, motivations, character strengths, and recreation interests; and are used to generate a plan of action to increase health and well-being.

The initial assessment interview is a collaborative process between the veteran and the PATH™ therapist to increase the understanding of the unique situation of each veteran, his or her strengths and desired health changes and to create personally relevant goals and plans. PATH™ therapists begin with the important assumption about inherent health and resiliency of Veterans, and an understanding that combat provides opportunity for growth (Bryan & Morrow, 2011). Northeast Passage PATH™ therapists utilize a combination of standardized assessment tools, as well as a conversational style interview as part of the comprehensive initial assessment (Craig et al., 2013; Sable & Gravink, 2005; Wilder et al., 2011).

Strengths-based interview strategies. PATH™ therapists meet with the Veteran in a location of his or her choosing, but preferably in the home. The context of this environment provides the PATH™ therapist an opportunity to observe the physical space where the Veteran lives, to meet the people and/or animals integral to daily life, and see the evidence of personal interests and strengths of the individual.

For example, when interviewing Mary, opening dialogue about her home

included the questions of "How long have you lived here?" and "How accessible is the space for you?" Her response yielded a tour of her home that revealed handmade quilts, handmade raised garden boxes in need of repair, and several children's toys in the back yard. Follow-up questions such as, "Wow, did you make these?," "What do you like to grow?," "What games do you like to play with your grandkids?," and "Are there special places you like to go as a family?" validate Mary's individual interests in quilting and gardening and generate discussion surrounding her motivation to find recreation and spaces to play with her grandchildren, as well as her personal desire to maintain an active presence in their lives.

Observation of Mary as she moves through her home on the tour, allows for practical assessment of functional abilities. Even though Mary has multiple health conditions impacting her mobility from a strength and endurance perspective, she has good symmetry of movement, good body and environmental awareness, and relatively good balance. Conversation about these strengths combined with an understanding of the impact of her health conditions on her ability to keep up with her grandchildren, lead to her envisioned solution of going for a family bike ride where she would use a foot-powered trike to engage with her grandchildren safely while cycling.

PATH™ therapists reflect back to the individual, not only observations made regarding the physical environment, but also observations about the individual's character strengths or personal skills within the context of the interview. For example, during William's initial assessment interview, his son, who has a developmental disability, was present. The PATH™ therapist was able to observe the gentle and loving way he interacted with his son. This strength, reflected back to him in the form of a compliment, yielded discussion around his motivations for being sober, and his desire to be a present father and husband. He envisioned he would use the PATH™ program as a means of continuing to build and strengthen family connections and new community connections through recreation. A compliment about his use of humor throughout the interview and a question about the role this plays in his life, led to a discussion about how highly he values humor and is impressed by those who can use humor to tell a story. Upon further discussion, this appreciation of expression through humor was also reflected in his interest in acting and the expressed desire to use these talents to connect with others.

Standardized assessment tools. The standardized assessment tools chosen for the PATH™ program evaluate the overarching concept of well-being in relation to the ICF definition of health, positive psychology, and strengths-based practices. The tools have also displayed good psychometric properties across disability and culture, an important consideration given the multiple disabilities/health conditions experienced by veterans who access the PATH™ program. The assessment tools include the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) that evaluates functioning (Üstün et al., 2010), the WHO Quality of Life-BREF (WHOQOL-BREF) that measures perceived quality of life (Skevinton, Lofty, & O'Connell, 2004), and the Subjective Happiness scale that is a global assessment of one's belief about whether they are a happy or unhappy person (Lyubomirsky & Lepper, 1999).

The PATH™ therapists utilize standardized assessment tools within the initial assessment interview to create a

complete contextual understanding of an individual. PATH™ therapists utilize these tools as a springboard for further discussion to guide and validate the focus of the veterans' goals for participation in the PATH™ program. For example, Mark identified in the Subjective Happiness scale that he considers himself to be an unhappy person. The PATH™ therapist asked him if he was able to identify a time when he was happier and what he envisions would create a difference in his experience of happiness. Mark articulated that during the four years he maintained sobriety he was much happier. Further discussion revealed that while he is currently not ready to commit to sobriety, he does think that increasing his ability to schedule time for himself and engage in activities that interest him would help him manage stress and allow him to decrease the frequency of his binges.

Within the context of the health history questions, Mark identified that he has some arthritis in his knees, but otherwise does not experience significant mobility impairment. Mark also spontaneously identified how thankful he was for his mobility. This strength of reflecting on a positive with gratitude amidst other difficulties was reflected back to Mark by the PATH™ therapist in the form of a compliment. This prompted Mark to further expound on his vision of scheduling small breaks in the week to engage in activities that interested him and were meaningful. He identified recreation interests based in connecting with nature, specifically animals. He also identified being skilled in understanding, creating, and repairing machines; and, enjoyment of learning about history through museums and documentaries.

Finally, results of the standardized assessment tools are also used to summarize the content of the initial assessment. Content of conversation and subsequent goals/plan are paired with assessment results to provide opportunity for the Veteran and PATH™ therapist to confirm that the assessment was comprehensive and addressed health and functional domains relevant and important to the Veteran.

Intervention and Evaluation–Facilitating Functioning

PATH™ program interventions occur in the veterans' homes and communities (Wilder et al., 2011). PATH™ participants have identified the collaborative approach to personally meaningful goals, within the context of their community, as the aspects of the PATH™ program that create the most positive change (Wilder et al., 2011). PATH™ therapists facilitate functioning through increased access and participation/engagement in recreation and community. Within the context of participation/engagement in recreation activities PATH™ therapists leverage existing individual strengths, support the development of related strengths, and facilitate aspects of well-being such as the experience of positive emotions, relationships, sense of meaning, and achievement (Anderson & Heyne, 2012; Craig et al., 2013; Sable & Gravink, 2005; Seligman, 2011; Wilder et al., 2011).

Access and engagement/participation. Veterans are included in the planning of each session to increase engagement in activity as well as to facilitate access to community resources. For example, Mary prioritized recreation experiences with her grandchildren and identified fishing and cycling as two activities of interest. The PATH™ therapist was able to identify accessible locations for each of these activities within her community. In addition, the PATH™ therapist provided education and the opportunity to try a recumbent trike, tie on and bait a hook, and cast a line. Within the context of these interventions, Mary was able to explore

these community access points, gain education and skill development for each of these activities, and successfully engage in both cycling and fishing with her grandchildren. With the positive experience of these activities and increased confidence, she was able to replicate them independently. This was an example of facilitated access to, and engagement in, community resources that developed the functional skills of planning and implementing recreation engagement within the community. For Mary, increases in functioning within her community supported both internal and external strengths utilized in her role as caregiver. Mary's PATH™ process illustrated how increased functioning in turn creates greater individual strength (See grey section of Figure 2).

Facilitation of access and participation can be related to creating comfort and access to social spaces. William identified that he was interested in pursuing acting, although he was anxious about his abilities and engaging with civilians around this interest. The PATH™ therapist worked with William to utilize his social strengths of kindness and humor to create connections with a local theater company. The PATH™ therapist initiated connections within the theater company to identify a mentor who would meet with William in an informal setting. Prior to meeting the mentor, the PATH™ therapist scheduled an evening to go see the current production with his wife and other veterans. This created more familiarity with the theater space and the cast from an observer's perspective, while at the same time drawing on and strengthening the relationship with his wife through a shared experience. William ultimately chose to pursue different interests. However, further choices continued to be motivated by a focus on positive relationship building based on his successful participation and shared positive emotion with his wife. In this example, facilitated experience in meaningful activity generated functional skill development around community access and strengthening relationships (as illustrated in the shaded grey section of Figure 2.)

Development of strengths. The planning process of each intervention can also be utilized to leverage a person's interests to build further strengths such as self-advocacy, recreation planning skills, and sense of achievement. For example, Mark decided that he would be interested in planning a trip to an art museum to practice scheduling time away from work and engaging in recreation interests. The PATH™ therapist provided information about local bus options for transportation and the opportunity to get free museum passes from the local library. After this conversation, Mark was able to access his local library to inquire about free passes as part of the overall planning process for the intervention. He felt positive about being able to achieve these steps independently and practiced skills of self-advocacy discussed as part of the planning process.

Other components of well-being. Facilitation of other components of well-being such as positive emotions, relationships, meaning, and achievement involve the entirety of the therapeutic recreation process. Ongoing formative evaluation within the context of the experience allows for adjustment and facilitation strategies that support success and learning.

PATH™ therapists may utilize reframing strategies regarding interpretation of situations and events surrounding recreation participation such as individual performance and thoughts about the perceptions and opinions of others, or meanings attached to current or previous social and recreation experiences. For ex-

ample, Mark identified his love of animals in his initial assessment interview and his desire to be engaged in meaningful acts of caring for animals. He envisioned volunteering at a local wildlife rescue to combine these strengths. The PATH™ therapist researched and contacted the local wildlife rescue to determine responsibilities, essential eligibility requirements, and commitments of volunteers to care for these injured animals. Based on the information gained, the PATH™ therapist discussed with Mark that his alcohol use would not allow him to obtain the volunteer position at the wildlife rescue and suggested several alternatives based on other recreation interests. At first, Mark was upset and wanted to discontinue participation in the program, stating, "There's probably not much that can be done to help me," and "I'm probably a waste of your time." The PATH™ therapist utilized strategies for reframing this "all-or-nothing" type of thinking and negative self-messaging to reaffirm his individual value and re-motivate creative thinking around his goals of scheduling leisure engagement in his daily routine to acknowledge the positive and reduce stress. It was at this time that Mark agreed to visit the art museum.

Other strategies include engaging veterans in reflection related to the experience as part of integrating new skills and achievements into the definition of self and the world, and their personal strengths. For example, while at the museum, the PATH™ therapist initiated discussion that invited Mark to observe his own reaction to the day's events including spending time acknowledging beauty and the process of engaging in this recreation interest. He identified that he felt surprised by how easy it was to get to the museum and that being focused in the moment looking at the artwork was relaxing and enjoyable. The PATH™ therapist engaged Mark in a discussion about options to recreate this on a daily basis, even if on a smaller scale in nature around his home. This spontaneous discussion led to photography as an activity that might capitalize on his love of machines while in nature. Mark indicated that he was interested in trying photography.

Ongoing formative evaluation within the context of interventions includes not only observation skills, but also discussion with the veteran around his or her experiences. This contributes to a continued collaborative approach to achieve desired changes. For example, on the return trip from the museum, the PATH™ therapist asked Mark about his experience of not drinking throughout the day's outing. This led to Mark discussing with the PATH™ therapist the logistics of how long he is able to currently go without drinking prior to experiencing symptoms of withdrawal. Due to the positive emotions experienced that day, Mark was motivated to attend other recreation opportunities through Northeast Passage. He reflected that he would need to plan around his alcohol use and safety related to withdrawal as an issue for prolonged or multi-day opportunities. Shortly thereafter, Mark actually decided he was ready to commit to being sober and checked himself into a VA hospital for a two-month inpatient rehabilitation program. While still in the hospital, the PATH™ therapist discussed transition/discharge plans with Mark in preparation for supporting his success once he came home. The PATH™ therapist located a camera for him to engage in photography on a daily basis and remained in contact as he prepared for discharge to home. Once home, the PATH™ therapist facilitated participation in photography and fostered a sense of achievement by providing initial basic

instruction, finding beginning photography assignments, working with Mark to identify and visit local green spaces to take pictures, and organizing a meeting with a photographer for a lesson/mentorship.

After several months of sobriety, Mark was now ready to re-engage with the idea of volunteering for the wildlife rescue. His motivations for engaging included not only stress management but also structuring free time in support of sobriety, increasing his social network in sober contexts, and making a meaningful contribution to the world around him. As his photography skills improve, Mark intends to contribute not only his time, but also the images he captures while at the wildlife refuge as part of ongoing fundraising campaigns for the organization.

Throughout Mark's PATH™ process, the recreation therapist used the APIE process to engage him in facilitated recreation experiences that utilized and developed his individual strengths, functioning, and well-being. The facilitated experiences created positive emotions, developed relationships, and created a sense of meaning and purpose (Grey section of Figure 2). As a strengths-based approach, the PATH™ recreation therapist capitalized on the reciprocal relationships between individual strengths and the dynamics of facilitated engagement in recreation.

Evaluation and discharge. At the conclusion of the program, the veteran completes the standardized assessments again. Within the discharge interview, new skills, strengths, and accomplishments in relation to original goals are discussed. Pretest and posttest scores are used to confirm progress and highlight growth areas. Northeast Passage remains a resource for veteran-specific recreation opportunities and phone consultation after discharge.

Implications for Practice

Currently only 50% of veterans who meet the criteria for a mental health disorder are receiving care, and of those referred for mental health care, only 42% follow through with recommendations for treatment or follow-up care after the initial visit (Zinzow et al., 2012). In contrast, based on the initial 12 months of data tracking, for the veterans engaged in the 2015 Northeast Passage's U.S. Department of Veteran Affairs, Project Engage, there was an 85% return for a follow-up visit of veterans who complete the initial assessment with the PATH™ program. This higher rate of engagement is due to the real-time, individual focus of PATH™ program.This approach provides the Veteran with initial strong supports that bridge to more self-initiated participation (Craig, Wilder, Sable, & Gravink, 2013; Sable & Gravink, 2005; Wilder et al., 2011).

The Northeast Passage PATH™ program is one example of a strengths-based recovery-oriented therapeutic recreation intervention that actively engages veterans with disabilities in recreation experiences in their home communities. (Craig, Wilder, Sable, & Gravink, 2013; Sable & Gravink, 2005; Wilder et al., 2011). This program engages the more vulnerable population of veterans who need the additional support of in-home/community intervention to create sustainable patterns of recreation and community engagement that support functioning and well-being. Therapeutic recreation services delivered in this home/community-based setting are a strong addition to the continuum of care that is consistent with current global and national shifts in healthcare. These services focus on patient-centered approaches to health management and acknowledge recommendations for the development of strengths-based treatment

programs for veterans with disabilities. The PATH™ program uses both cognitive and experiential means to develop personal belief in veterans ability to cope, recreate definitions of self and the world, and re-engage with the community (Litz et al., 2009; Maguen & Burkman, 2013; Pietrzak, Russo, Ling, & Southwick, 2011; Sable & Gravink, 2005; Steenkamp et al., 2011; Wilder et al., 2011). Other descriptions of specific protocols for the PATH™ program can be found in Sable & Gravink (2005) and Wilder et al. (2011).

Strengths-based approaches to care for veterans are relevant to the military culture, and values of self-reliance, toughness, and unit cohesion/performance when interventions are framed as opportunity for growth through the development of skills relevant to current and future situations (Bryan & Morrow, 2011). These approaches to care have the potential to work around stigma associated with accessing mental healthcare and engaging veterans (Bryan & Morrow). Through strengths-based approaches to care, the recreation therapy profession is uniquely poised to address the needs of veterans who experience mental health disorders: These approaches work within the military culture and minimize the stigma associated with seeking mental healthcare (Anderson & Heyne, 2012; Carruthers and Hood, 2007; Heyne & Anderson, 2012; Hood & Carruthers, 2007).

The PATH™ model demonstrates how the use of a strengths-based APIE process within the natural context of a person's home/community is an important addition to the continuum of recreation therapy service delivery models (Craig et al., 2013; Sable & Gravink, 2005; Wilder et al., 2011). Continued research regarding the impact of community-based recreation therapy modalities, like the PATH™ program, could provide valuable evidence for the impact of these programs on functioning and well-being as indicators of health.

Implications for recreation therapy include consideration of relevant questions regarding opportunities for growth of the profession. How will recreation therapists respond as a profession to this shift in the healthcare paradigm outlined by the WHO through the ICF framework that calls for patient-centered and community-based care (WHO, 2001; 2002)? How do we position recreation therapy as a visible and valued allied health profession that already utilizes the strengths-based approach to healthcare that is being called for by these current shifts? How can recreation therapists leverage the call for a population health model of care as an opportunity to replicate community-based recreation therapy service delivery like the PATH™ program in mainstream healthcare? The responses to these questions will impact the growth of recreation therapy in the coming years.

The Affordable Care Act (ACA) outlines a population health model of care whose aim is to keep vulnerable populations healthy vs. a medical model of care that operates on a fee basis for procedures in response to illness (Rosenbaum, 2011). The ACA encourages the formation of accountable care organizations (ACOs) that are responsible for care both in and outside the hospital (Rosenbaum, 2011). This is an opportunity for recreation therapy to be viewed as a powerful ally in health management. The Northeast Passage relationship with the VA to provide the PATH™ program for veterans is one example of a community-based recreation therapy service delivery model that has been successfully embraced as a population health model of care. The continued support of the PATH™ model through VA

contracts at a local level and through the VA Adaptive Sports Grant, attests to the potential of community-based recreation therapy to be embraced as a strengths-based approach to health management.

Long-term sustainability of community-based models of recreation therapy service delivery, like the PATH™ program, will require steps to create an infrastructure that supports the expansion of the profession in this area. Continued education, advocacy, and relationship building amongst the VA and other ACOs, who are embracing a population health model, will provide opportunity to expand the PATH™ program to other regions. This will create a potentially wider base of research regarding efficacy of strengths-based recreation therapy programs delivered in the home/community. Advanced training of recreation therapists is needed to ensure a sufficient skill base to implement the PATH™ strengths-based approach in a home/community setting. As a profession, recreation therapists would be wise to embrace current shifts in healthcare as an opportunity for growth. As a strengths-based approach to health management that can be delivered in a community setting, recreation therapy already embodies the changes being sought in healthcare.

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