OVERVIEW OF THE STRENGTHS MODEL

The goal of Strengths Model case management is to help people build or rebuild lives that by their own definition have meaning, purpose, and valued identity. When the model was initially developed in the 1980s by Charles Rapp and colleagues at the University of Kansas Center for Mental Health Research and Innovation, it represented a significant paradigm shift for mental health, social work, and other helping professions. People with mental illnesses have historically been oppressed by the societies in which they live, and this has often been reinforced (albeit unintentionally) by professionals responsible for helping them. When the Strengths Model was developed, traditional case management approaches often focused on pathology and diagnosis, held low expectations for what people with mental illness could achieve in their life and frequently used stabilization and maintenance as measures of success. The Strengths Model arose in response to this, viewing people not only as capable and possessing a unique array of personal and environmental strengths, but also challenging and equipping professionals to focus their efforts and support toward helping people achieve life goals and roles that anyone else in the community might pursue.

Though the model arose out of a specific context to focus on individuals who had been diagnosed with a serious mental illness, the model has always been focused on what we share in common as people, rather than what separates us along lines of disability. The belief behind the Strengths Model is that we all desire to feel connected, accepted, loved, heard, respected, and safe. We all desire to contribute, to learn, to be a part of something greater than ourselves, and feel that our lives mean something. And while we share a common array of desires and aspirations as humans, there are often wide disparities between what each of us wants in life and what we actually experience. Many of the people we serve have experienced, and often continue to experience, economic inequality, oppression, stigma, discrimination, marginalization, trauma, and social injustice. While the Strengths Model is not a panacea for these societal conditions, the model challenges us to do more with the resources we have to help people build and rebuild lives despite these conditions.

The Strengths Model is both a philosophy of practice and a set of tools and methods designed to help people (1) identify and achieve meaningful and important life goals; and (2) increase the person’s ability to exercise power related to both how they view themselves and how they interact with their environment.
A key component of Strengths Model practice is helping people make movement on two critical levels that impact a person’s recovery and wellbeing: 1) movement from entrapping environmental niches to empowering environmental niches; and 2) movement from entrapping intrapersonal narratives to empowering intrapersonal narratives. Entrapping niches are those in which there is little movement or choice for the person (homelessness, poverty, abusive relationships, unemployment, social isolation, unsafe housing). These niches are often stigmatized and create additional barriers for people achieving valued goals and roles in their life. Strengths Model case management provides intensive community-based support to help create opportunities for people to move toward empowering niches (employment, educational diplomas, certificates, or degrees; supportive relationships; meaningful involvement in the community; a place that feels life home) by marshalling and building upon useable strengths that the person already possesses.

The Strengths Model recognizes that helping people recover is not just about helping people access housing, employment, educational opportunities, and community resources. Often entrapping intrapersonal narratives can also be a barrier to a person’s recovery. These intrapersonal narratives such as “I can’t do this because of the anxiety or voices,” “I don’t deserve anything better,” “I have nothing to contribute to others or my community,” “I am just
a_____” can constrain people as much as entrapping environmental niches. Strengths Model tools and methods help people open narratives of hope, wellness, and recovery.

The Strengths Model rests on six core principles:

• **Principle #1:** People with mental illnesses can recover, reclaim, and transform their lives.

  The Strengths Model emphasizes that the capacity for growth and recovery already exists within the individual or family. Our job as helping professionals is to help create conditions in which growth and recovery are most likely to occur. It is important to recognize that we do not possess the power to control or predict how one’s recovery journey will unfold.

• **Principle #2:** The focus is on an individual’s strengths rather than deficits.

  Recovery is not fueled merely by overcoming problems, barriers, and challenges. In fact, many people recover despite the problems, barriers, and challenges faced in their lives. People tend to flourish based on their individual interests, aspirations, and strengths. At best, solving problems brings the person to equilibrium, but exploiting strengths and opportunities promotes growth.

• **Principle #3:** The community is viewed as an oasis of resources.

  This principle is a corollary of the previous one. Strengths Model practice focuses not only on the strengths of the individual but also the strengths of the environment. Most obvious to helping professionals are what communities lack and the difficulties encountered accessing the few resources available. From a strengths perspective, we must find pockets of strengths in our communities—the employers, property managers, teachers, neighbors, family, friends, and other community members who could be mobilized to help people achieve specific goals. While the community can contribute to the distress in a person’s life, the community also provides the opportunities and resources needed for people to thrive. The concept of finding empowering niches is important here.

• **Principle #4:** The client is the director of the helping process.

  Helping professionals bring expertise and information about various strategies, resources, options, and methods for achieving specific client goals; however, it is important to recognize that people receiving services are the experts concerning their own values, preferences, desires, and experiences. Opportunities to reinforce the person as the director of the helping situation must be found, created, and promoted. The benefit of this approach is to keep workers centered on what is meaningful and important to the person rather than what professionals or others within the system deem “best” for the person. Strengths Model practitioners should do nothing without the person’s approval and should involve the person in decisions during every step of the process.
• **Principle #5:** The relationship is primary and essential.

The relationship is primary and essential because without it, a person’s strengths, talents, skills, desires, and aspirations often lie dormant and are not mobilized toward goal achievement. It takes a strong and trusting relationship to discover a rich and detailed view of a person’s strengths and capabilities and to create an environment where a person is willing to share what is most meaningful and important to them. A Strengths Model-based relationship can be viewed as being a travelling companion with people along their recovery journey rather than acting as a travel agent. Strengths Model practice is predicated on the worker having a sincere and genuine investment in helping the person achieve important life goals while respecting autonomy and self-determination.

• **Principle #6:** The primary setting for our work is in the community.

Given the stated principles of self-determination and a focus on naturally occurring resources within the environment, it should be clear that office-based interventions are contra-indicated in the Strengths Model. People do not recover inside the walls of behavioral health clinics; they recover in the community. A community outreach mode of service delivery offers rich opportunities for assessing a person’s strengths and helping a person make use of these strengths to positively impact their life. Some people need help to navigate the complex social interactions necessary to achieve the goals they desire, which may include working with property managers, employers, teachers, family members, community agencies, and other individuals and organizations. Working with a person in the community settings where these interactions occur helps to avoid overgeneralization of problems and keeps the work focused in ways that are most relevant and useful to the person.

These principles provide both a philosophical base as well as day-to-day guidance for tasks and goals. Further, the Strengths Model employs two primary tools:

1. **The Strengths Assessment**

The Strengths Assessment is started during the engagement phase of the helping relationship but is frequently updated as the practitioner learns more about a person’s talents, skills, environmental strengths, interests, and aspirations. Initially the Strengths Assessment is used to establish goals that are meaningful and important to the person, but ultimately becomes a portrait of the “whole” person, embellishing those aspects of the person that currently contribute or have previously contributed to the person’s wellness. Good Strengths Assessments are developed through a conversational approach, with the practitioner demonstrating a sincere interest in wanting to know more about the person. The Strengths Assessment is used over time to help the person develop strategies toward goal achievement and to help them find personally empowering places and roles (“niches”) where they can demonstrate competence and
confidence. The Strengths Assessment can assist the worker to create a person-centered treatment plan that ensures that services are provided in the context of something that is meaningful and important to the person.

2. The Personal Recovery Plan

The Personal Recovery Plan is the base from which movement begins once a meaningful and important goal has been identified. While problems, barriers, and challenges a person may face are not ignored within the Strengths Model, they are always viewed within the context of how they impact something the person desires to achieve in their life. Examples include: “I want to better manage symptoms of depression so I can care for my son,” or “I want to be free of drugs and alcohol so I have more money for my own place to live,” or “I want to learn strategies to deal with distressing voices so I can feel comfortable going out in public” (e.g., go to the grocery store, go to church, take a walk in the park, spend more time with family). The Personal Recovery Plan becomes an active “to do” list within the helping relationship and is used during nearly every contact with the person. While there may be other goals from the person’s treatment plan that are being worked on, the Personal Recovery Plan ensures that the primary goal identified by the person is always given attention and never lost, even in the presence of an occasional crisis or short-term concern.

The Strengths Model tools work together to help people move beyond the formal mental health system and find niches in their communities where they can thrive. This is accomplished by identifying and using highly individualized strengths they already possess and then building upon those. Strengths are also used to help people overcome problems and barriers that interfere with their life goals. The Strengths Model works hard to strengthen people’s natural supports whenever possible, to help people develop anchors within the community rather than the mental health system.

Who is the Strengths Model for, and Where Does It Fit Within the Organization?

Target population

The Strengths Model was initially developed for adults with serious mental illnesses. The research base showing the effectiveness of the model has focused primarily on this population. The majority of teams that have implemented the model to high fidelity work within community support service programs based in community behavioral health organizations.
serving people with serious mental illnesses and extensive hospitalization histories. That being said, teams have also been effective using the Strengths Model with transitional-aged youth (ages 16–25), youth with severe emotional disorders (12–16), older adults (65+), and individuals with co-occurring substance use disorders.

**Which staff are targeted**

The Strengths Model works best when it is part of a larger organizational shift and commitment to providing recovery-oriented services. While the Strengths Model tools are used primarily by a specific set of staff who interact with clients on a regular basis within the community, helping people build and/or rebuild lives beyond the mental health system with meaning and purpose requires all staff to take responsibility for creating an environment where people are able to thrive.

The staff who primarily use the Strengths Model tools are any staff who provide case management services. This could be a full-time community-based, direct service worker who has the title of care manager, case manager, or community support worker. It could also be a clinician who provides case management as well as therapy. People who bring the lived experience of mental illness to these roles are uniquely positioned to support people in their recovery using the Strengths Model tools and methods.

We also have anecdotal evidence that the Strengths Model fits within teams that provide peer support, supported employment, supported education, and supported housing. While the model has not been studied within these types of teams, the philosophies, values, and approaches of these services are highly consistent with a Strengths Model approach.

There is also practical application of the model for outpatient clinicians, crisis services, and residential services. While factors such as high caseloads (outpatient therapy), time constraints (crisis services), and limitations of time spent in the community (residential services) may prevent full implementation of the model, there have been reports that people working in these services have had success using tools from the Strengths Model in individual cases.

**Strengths Model Studies**

Ten studies have tested the effectiveness of the Strengths Model with people who have serious mental illnesses. Four of the studies employed experimental or quasi-experimental designs (Stanard, 1999; Macias et al., 1997; Macias et al., 1994; Modrcin et al., 1988), and six used non-experimental methods (Fukui et al., 2012; Barry et al., 2003; Ryan, Sherman, and Judd, 1994; Kisthardt, 1993; Rapp and Wintersteen, 1989; Rapp and Chamberlain, 1985). These studies produced positive outcomes in the areas of hospitalizations, housing, employment, reduced symptoms, leisure time, social support, and family burden.
In the four experimental studies, positive outcomes significantly outweighed outcomes in which no significant difference was reported. In none of the studies did clients receiving Strengths Model case management do worse. The results have also been remarkably consistent across settings and within studies. Three of the studies had multiple sites with different case managers, supervisors, and affiliations, with a total of 15 different agencies.

The two outcome areas in which results have been consistently positive are reduction in symptoms and enhanced quality of community life. All three studies assessing symptom outcomes reported statistically significant differences favoring the Strengths Model. This included findings that people receiving Strengths Model case management reported fewer problems with mood and thoughts, and greater stress tolerance and psychological well-being than the control groups. In one study that compared Assertive Community Treatment (ACT) and the Strengths Model, no differences were found in hospitalization and social functioning, but differences in reduction of symptoms were statistically significant, favoring the Strengths Model (Barry, Zeber, et al., 2003).

Although the studies used a variety of measures (e.g., increased leisure time in the community, enhanced skills for successful community living, increased social supports, decreased social isolation, and increased quality of life), people receiving Strengths Model case management had enhanced levels of competence and involvement in community living. Eight of the nine studies using these types of measures reported statistically significant positive outcomes.

Other outcomes that seem to be strong indicators of the effectiveness of Strengths Model case management include reduced hospitalization (four out of seven studies showing significant positive outcomes), employment (three out of three showing significant positive outcomes), and independent living (three out of three showing positive outcomes).

**Development of the Strengths Model Fidelity Scale**

In 2004, the University of Kansas Center for Mental Health Research and Innovation developed the Strengths Model case management fidelity scale to ensure adherence to key components of the model for implementation purposes. The nine-item scale is divided into three core areas: 1) structure, 2) supervisor/supervision, and 3) practice/service. Fidelity scale items 1-2 relate to structure; fidelity items 3-4 relate to supervisor/supervision; and fidelity items 5-9 relate to practice/service area. While it is understood that teams will start the process of implementation at low fidelity, agency leadership typically make certain commitments to the project before implementation begins. While these commitments will be negotiated with each organization based on what makes sense for them as an organization, Table 1 describes these typical commitments:
<table>
<thead>
<tr>
<th>Fidelity item</th>
<th>Agency commitment</th>
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<tbody>
<tr>
<td><strong>Structure</strong></td>
<td></td>
</tr>
<tr>
<td>1. Caseload Size</td>
<td>Commitment to keep average caseload size for case managers under 25:1. This could be an individual case manager who has a caseload of 25:1 or a combination of staff (case manager/peer support worker) who can support the person in the community whose combined time equates to a caseload under 25:1.</td>
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<tr>
<td>2. Community Contact</td>
<td>Commitment to ensuring that 75% or more of case management contacts with the client occur in the person’s home or in the community (not at the offices of the agency).</td>
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<tr>
<td><strong>Supervision/Supervisor</strong></td>
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<tr>
<td>3. Group Supervision</td>
<td>Commitment to start the group supervision process within the first three months of implementation. This does not have to be a new meeting, it can be a re-organization of a current team meeting where clients are discussed.</td>
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<tr>
<td>4. Supervisor</td>
<td>Commitment to allow the supervisor time to review Strengths Model tools and give feedback to staff. In the beginning, as teams are learning Strengths Model practice, this might be two hours per week and built into coaching calls with the supervisor.</td>
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<tr>
<td><strong>Practice/Service</strong></td>
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<td>5. Strengths Assessment – Quality</td>
<td>Commitment to start using one Strengths Assessment with one client following the initial workshop. Within six months, a Strengths Assessment should be started on each client being served by the case management team.</td>
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<td>6. Strengths Assessment – Integration</td>
<td>Commitment to learn how the quality of treatment plans can be improved by using information attained through using the Strengths Assessment.</td>
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<td>7. Personal Recovery Plan</td>
<td>Commitment to start using one Personal Recovery Plan with one client within six months into implementation. Within one year, case managers should be using the Personal Recovery Plan with 75% of all clients being served by the team.</td>
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<td>Fidelity item</td>
<td>Agency commitment</td>
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<td>8. Naturally Occurring Resources</td>
<td>Commitment to using naturally-occurring resources with clients to achieve goals whenever possible.</td>
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<tr>
<td>9. Hope Inducing Practice</td>
<td>Commitment to making the effort to align with clients around goals that are meaningful and important to them and respecting choice and autonomy whenever possible.</td>
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OVERVIEW OF IMPLEMENTATION

CIBHS provides support through all phases of the implementation process, which would include:

- **Pre-implementation** – This involves activities such as determining outcome measures to evaluate effectiveness, define processes to use data to guide continual improvement efforts, determine organizational structures and supports needed to implement the practice effectively, identify members of the leadership team to oversee implementation efforts, and identify a champion(s) to keep the Strengths Model on the organizational agenda.

- **Initial two-day Strengths Model workshop** – The goal of this two-day workshop is to help staff understand how the tools, theory, methods, and practice interventions fit together. Helping staff understand the “big picture” of the work ahead will provide a context for the skill development that will occur during the implementation phase. Staff will have the opportunity to practice using the tools and ask questions in a safe, learning environment.

- **Implementation** – This involves skill-building exercises, topic-specific coaching calls for both supervisors and case managers, reviewing tools and providing feedback, process feedback through field mentoring, and support to establish strengths-based group supervision. Coaching calls and/or on-site skill building workshops would be used to help staff build skills in areas such as: engaging people around their definition of recovery; assessing strengths; understanding motivation and goal setting; understanding the “active ingredients” desired through specific goal pursuits; providing stage-appropriate treatment; use of naturally-occurring resources (including family and social supports); maximizing choice and autonomy; generating movement through an iterative process of personal goal planning; and working towards graduated disengagement. The supervisory support methods and techniques used within the Strengths Model will help ensure that staff can apply these skills in actual practice.

- **Sustainability** – This involves fidelity reviews to determine alignment with specific practice standards, detailed fidelity reports to guide improvement efforts, and access to practice consultants to answer questions. CIBHS plans to develop a website to provide resources to support sustainability efforts and develop a learning community for Strengths Model sites to interact and provide mutual support.