QC24 Working with Strengths in Recovery

Participant Workbook

Version control

Version	Date released	Changes	Authorised by
1	7 July 2016	First release of new development.	Dr Wendy Ducat
1.1	31 August 2016	Adjustments completed after dry run sessions.	Mr Jade Booth
1.2	15 November 2016	Adjustments completed after pilot sessions.	Mr Jade Booth
1.3	20 July 2017 (*Transitional version*)	Updated according to sentinel events review – *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services.*	Mr Jade Booth
1.4	2 March 2018	Final version of sentinel events review update.	Laura Chandler
1.5	4 January 2019	CIR minor amendments.	Laura Chandler
1.6	16 November 2020	CIR minor amendments.	Laura Chandler
1.7	18 August 2021	CIR minor amendments.	Laura Chandler

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Contents

Icon guide

Activity	**Assessment**	**Audio**	**Checkpoint**
Discussion	**Film**	**Handout**	**Key point**
My thoughts	**Online learning**	**Prop**	**Question**
Reference material	**Reminder**	**Timing**	**Visual aid**

Icon’s designed by Popcorns Arts and Vectors Market from Flaticon.
http://www.flaticon.com/

1. Course introduction

Aim

The aim of this course is to provide an approach to working with consumers in continuing care that is underpinned by a recovery oriented partnership.

Rationale

The Strengths Model provides both a practice philosophy and a process for working with consumers in a recovery oriented way. It allows the clinician and the consumer to see possibilities rather than problems, options rather than constraints and wellness rather than sickness.

Target audience

The program is designed for mental health practitioners currently working with consumers in Queensland Health or in other mental health service organisations.

The program is targeted to those clinicians who engage with consumers in continuing care rather than a clinician who may only see the same consumer once or twice.

Course structure

This course is made up of two mandatory components:

- eLearning component (this introduces the core concepts of the practice philosophy and also introduces the five methods for implementing the Strengths Model)
- one day face-to-face training (this training uses simulation to allow clinicians to safely practice applying the strengths based philosophy and methodology in their practice).

The learning activities in this training have been designed to initiate reflection and also to engage participants actively in examining the concepts as a group, sharing their experiences and also learning vicariously from others.

Anticipated learning outcomes

1. Use person centred interpersonal skills that support a strengths based practitioner/consumer working relationship
2. Identify a consumer's strengths and how these strengths can be used to support a meaningful life as defined by the consumer
3. Use the Strengths Assessment to assist the consumer to identify their goals
4. Assist the consumer to break down their goals into measurable and achievable short term goals and plan tasks and activities using the recovery plan
5. Use the strengths model process and the practice values underpinning the strengths model when the recovery process is interrupted
6. Apply a strengths-based approach to risk and crisis situations.

Pre-requisite knowledge and experience

QC23 Forming the Therapeutic Alliance is the recommended pre-requisite program for this training or an equivalent program that provides participants with core counselling skills.

To be adequately supported in the workplace, participants should seek support and feedback from their local Mental Health Educator or a clinical supervisor when applying the Strengths Model.

Scope of practice

Scope of practice is a term that refers to the legal and/or professional limits of duties you are expected to perform in your role. Each professional discipline and role will have a different scope of practice. This is determined by legislation, professional bodies and/or your organisation (Queensland Health). Most roles require that you hold certain qualifications that demonstrate your level and type of expertise and the scope of your practice. It is your responsibility to understand and work within your scope of practice.

For instance, if you are a nurse then you should be aware of the Scope of Practice Framework for Nurses and Midwives (Queensland Nursing Council, 2005). This document clearly articulates the limits of practice for the different classifications of nurses. For example, **only** Registered Nurses are able to comprehensively assess individuals/groups; interpret assessment data; formulate and document a plan of care; evaluate client responses/information for the purposes of making changes to a care plan; and delegate activities from the care plan (Queensland Nursing Council, 2005).

Within your work environment you may become exposed to a variety of knowledge and skills. The application of some of these may be outside of your scope of practice. It is imperative that you are able to identify when such knowledge/skills fall outside of your scope of practice and that you only perform duties that are within your area of professional expertise, organisational role and/or legal limits.

Acting outside of your scope of practice will breach your duty of care, professional and organisational requirements, and may place your consumers and colleagues at risk. There are serious repercussions for acting outside of your scope of practice and these can include disciplinary measures in your workplace, ineligibility to be registered with your professional body and/or legal action.

If you have any doubt about whether a duty you are about to perform is within your scope of practice, then you should discuss this with your line manager, supervisor or professional representative before proceeding.

2. Course content

Slide 5: Introductions

Introductions

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Notes:

Slide 6: Program

Program

8:15am	Welcome and introduction
9:30am	Exploring the Strengths Model Engagement Meeting Kim
10:20am	**Morning tea**
10:35am	Strengths Assessment Personal Recovery Plan Simulation sessions 1 and 2
12:15pm	**Lunch**
12:45pm	Exploring Personal Recovery Plan Simulation sessions 3 and 4 Resource acquisition Graduated disengagement
2:15pm	**Afternoon tea**
2:30pm	When Recovery is interrupted Graduated disengagement
4:30pm	Summary, de-brief and evaluations

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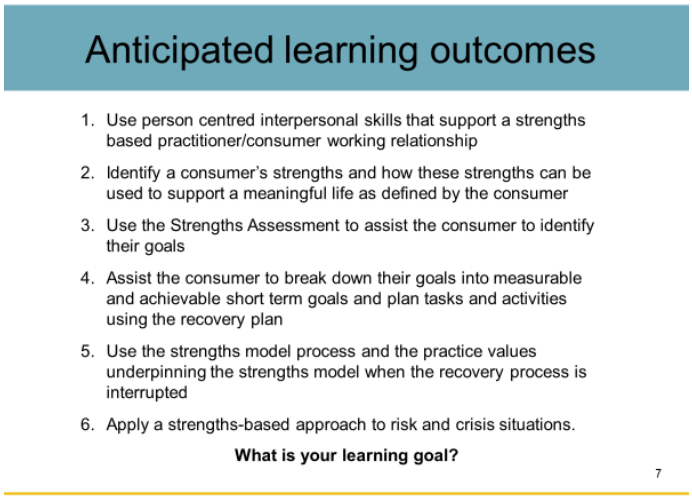
Notes:

Slide 7: Anticipated learning outcomes



Notes:

Slide 8: Guidelines for engagement

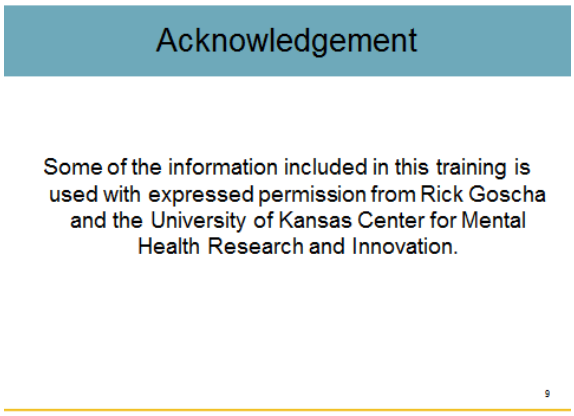
The purpose of this activity is to create safe guidelines for today's session.

Activity instructions

1. Break into small groups.
2. Within your group answer the following question.
   'How are we going to stay safe today?'
3. Write your answer/s on the butcher's paper provided.

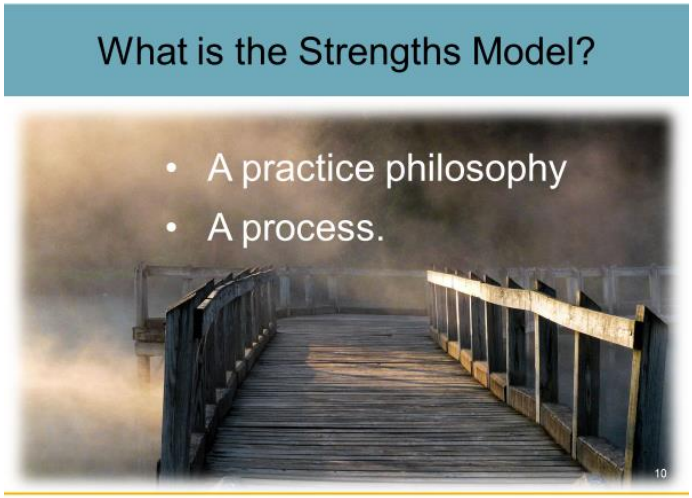
Notes:

Slide 9: Acknowledgement



Notes:

Slide 10: What is the Strengths Model?



Notes:

Slide 11: Small group activity

Activity instructions

1. Break into four groups.
2. One of these concepts will be assigned to your group:
   - hope
   - resilience
   - empowerment
   - recovery goals.
3. In your group draw images and/or write words on butchers' paper that represent what this concept means in relation to the strengths model.
4. Share your ideas with the large group.

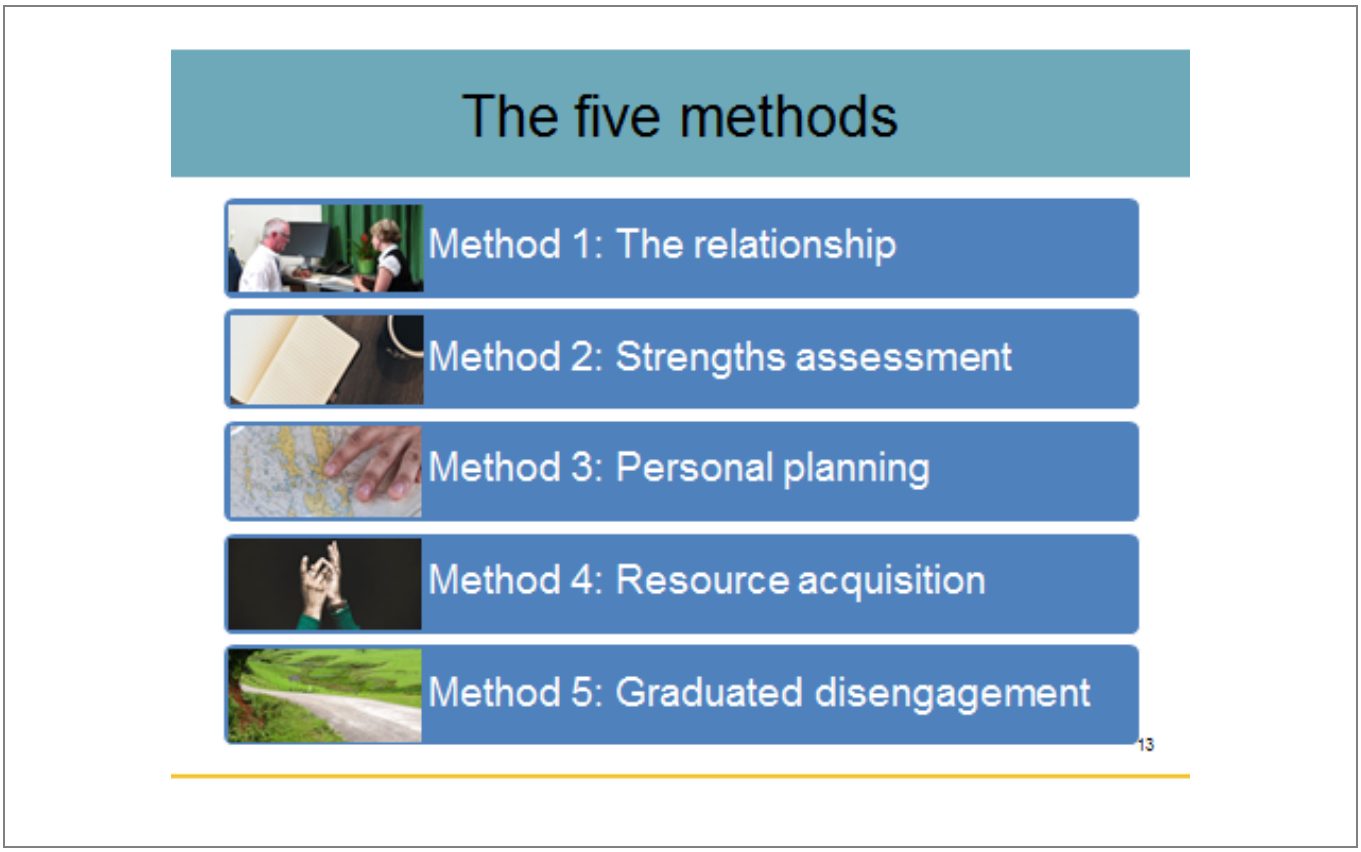
Notes:

Slide 12: Do you think the Strengths Model can be used in all situations?

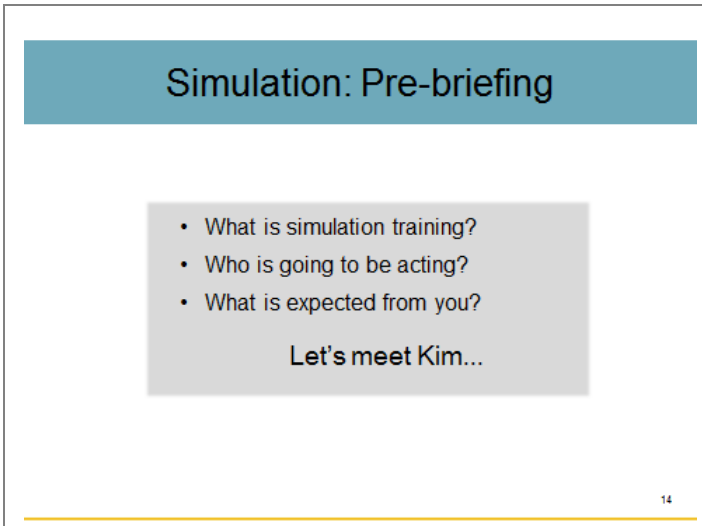
Activity objective: By testing a model in a variety of situations and contexts, we are better able to understand the limitations of the model and where it is most usefully applied. We are going to test the Strengths Model against a variety of different contexts and situations.

1. Stand and push your chair behind you/move to the front of the room.
2. Imagine there is a line down the middle of the room, this is the fence.
3. After hearing the question, place yourselves on the imaginary line between agree and disagree and describe the reason for your choice.

Slide 13: The five methods

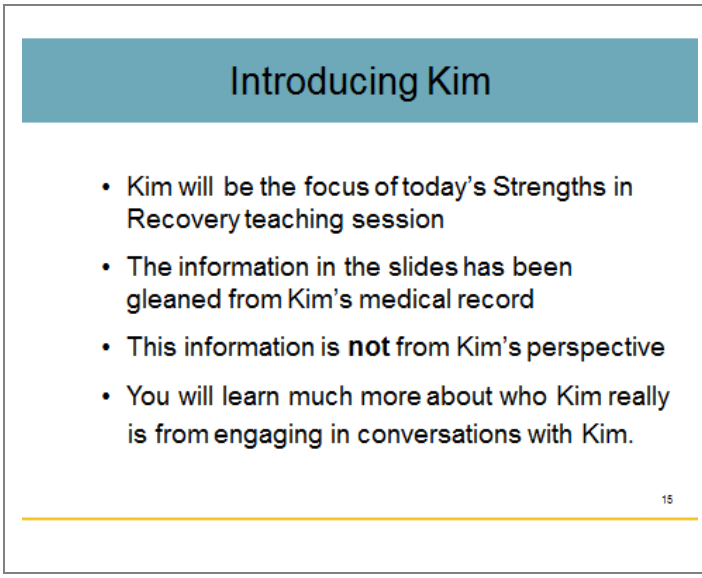


Slide 14: Simulation - Pre-briefing



Notes:

Slide 15: Introducing Kim



Notes:

Slides 16 and 17: Kim's profile

Kim's diagnosis	• Age 32 • F 20.9 paranoid schizophrenia • F 12.10 cannabis use, uncomplicated • F 17.21 nicotine dependence, unspecified • Lived with schizophrenia for 12 years.
Social history	• Kim is the eldest of three children (siblings are female) • Kim's parents separated due to substance and domestic violence issues, when he/she was 15 • Kim went to live with his/her father, the other siblings stayed with the mother • Kim had partners but never married.
Living situation	• Kim and siblings were born and raised in Brisbane • Kim chose to live with his/her father following the separation • Kim's mother and siblings moved to Toowoomba when Kim was 22 • Kim moved to Toowoomba at 27, where Kim briefly lived together with the family until Kim found alternative accommodation.
Psychiatric history	• entered the mental health system at 15 following parental break up • requested counselling but didn't attend sessions • first hospitalised at 21 with first episodes of psychosis • Kim had several hospital admissions when not taking medication • when well Kim was a computer technician • maintained good friendships.
Vocational/educational history	• gifted student throughout primary school • achieved better than average grades in high school until 15 • showed interest in computers and gained employment in this area • attended university, however, didn't complete 1st year.
Financial support	• receives disability support payments of $750.00 fortnightly • manages money reasonably well, at times struggles to pay bills linked to increased drug use • Kim's father supplements income.

Slide 19: Method 1 - The relationship (engagement)

Method 1:
The relationship (engagement)

- The stronger the relationship is, the more effective the working alliance will be
- A process of engagement and re-engagement
- A *natural* setting is important to building the relationship (versus a mental health setting)
- The primary method for increasing confidence, identifying desires, aspirations, talents and strengths.

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Notes:

Slide 20: Simulation session 1

Simulation session 1

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Notes:

Slide 21: Briefing

Briefing

Goal for this session:

- establish rapport
- make yourself useful to Kim
- find out about current situation
- start to build a picture of Kim - strengths and available resources.

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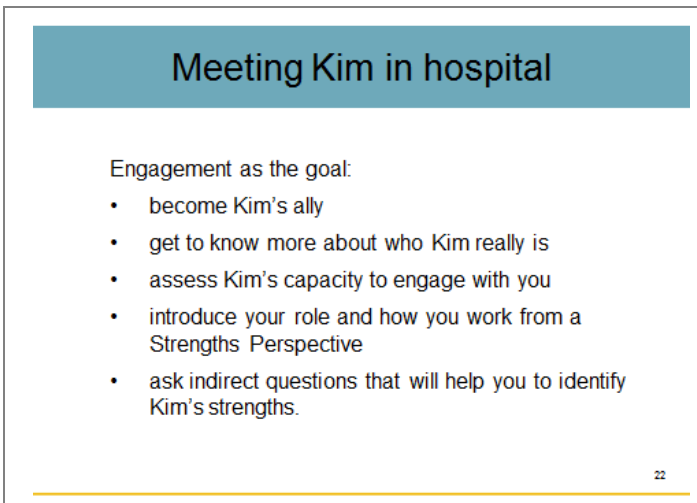
Notes:

Slide 22: Meeting Kim in hospital



Notes:

Simulation session 1: Meeting Kim in hospital

Timing: 15 minutes briefing, 20 minutes simulation, 10 minutes debrief.

Activity instructions: Your tasks during the simulation are to.

1. Become Kim's 'ally' (make suggestions for what you can do for Kim).
2. Communicate your alliance with his/her immediate needs and goals, if your needs are different to his/hers put yours aside.
3. Get to know Kim by being curious about his/her situation and immediate needs.
4. While you are getting to know Kim, assess Kim's capacity to engage with you.
5. Introduce Kim to your role and how you work from a strength's perspective.
6. As part of the rapport building process, ask indirect questions that will help you identify his/her strengths and make some notes about them as you talk with Kim.
7. Respond to Kim according to your clinical role and scope of practice.

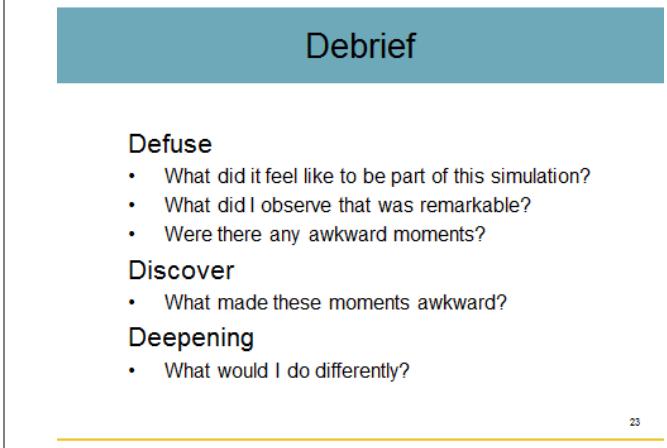
Observers

Activity instructions: Your tasks if observing the simulation are to.

1. Observe the session and interactions between Kim and the participants, while listening for questions that demonstrate how these tasks were being met.
2. Take note of what you saw being demonstrated and the questions you heard, to enable feedback and reflection after the session.

Record any notes from this simulation in the space allocated on the next page.

Slide 23: Debrief



Notes:

Reflect on your experience during the simulation using.

Defuse

- What did it feel like to be part of this simulation?
- What did you observe that was remarkable?
- Were there any awkward moments?

Discover

- What made those moments awkward?

Deepening

- What would you do differently?
- What have you learned that will influence your practice?

Meta-reflection: *What have you learned about the application of the strengths tool? Has this raised any questions? How does it compare to how you have identified a consumer's strengths in the past?*

Notes:

Slide 24: Method 2 - Strengths Assessment

Method 2: Strengths Assessment

- Collecting information on **personal** and **environmental** strengths as a basis for working together
- Helps the clinician stay purposeful in focusing on recovery
- Identifies understanding and meaning from the person's point of view
- Written in the consumer's own words (and preferably by the consumer)
- A living, dynamic, evolving tool.

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Notes:

Slide 25: Simulation session 2

Simulation session 2

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Notes:

Slide 26: Briefing

Briefing

Goals for session:

- strengthening the alliance by planning tasks and doing activities together
- introduce the Strengths Assessment (SA) tool and invite Kim to fill it in
- find out more about Kim and document this information in the SA (pages 21-23).

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Notes:

Slide 27: Kim's weekend leave

Notes:

Simulation session 2: Kim's weekend leave.

Timing: 10 minutes briefing, 20 minutes simulation, 10 minutes debrief.

Activity instructions: Your tasks during the simulation are to.

1. Identify if there are any duty of care issues.
2. Be practical and revisit tasks from the previous session.
3. Introduce Kim to the strengths assessment tool and invite him/her to fill it in.
4. Mention some of the strengths you noticed during your first meeting and ask him/her if it's okay to include them in the strengths tool.
5. Fill in the gaps in the strengths assessment tool by finding out more about Kim.
6. Begin to identify Kim's priorities and write these down (discover what is important to him/her).
7. Respond to Kim according to your clinical role and scope of practice.
8. For this session record what you learn of Kim's strengths using the Strengths Assessment Tool on pages 21-23.

Strengths questions to get you started

Home/daily living

- What is good about where you live?
- How do you get around?
- Where have you lived in the past?

Assets – financial insurance

- What is important to you regarding your current finances?

Employment/education/specialised knowledge

- What do you do as a current job or activities and what is important about this?
- What are your interests and skills?

Supportive relationships

- Whom do you spend time with?
- Have there been important people in your life?

Wellness/health

- How would you describe your health and wellness?
- What happens when you do not feel well?
- What strategies do you find useful to look after yourself?

Leisure/recreation

- Is it important to you to have leisure/recreation activities?
- What activities do you like to do?

Spirituality/culture

- Is there anything in your life that brings you a sense of comfort, purpose or meaning?
- What gives you strength to carry on in times of difficulty?
- Do you enjoy any customs or celebrations?
- What are the beliefs that you were raised with?

Observers

Activity instructions: Your tasks if observing the simulation are to.

1. Observe the session and interactions between Kim and the participants, while listening for questions that demonstrate how these tasks were being met.

2. Take note of what you saw being demonstrated and the questions you heard, to enable feedback and reflection after the session.

   Record any notes from this simulation in the space allocated on the next pages.

Strengths Assessment for:

Current strengths: *What are my current strengths? (e.g. talents, skills, personal and environmental strengths)*	**Individual desires and aspirations:** *What do I want?*	**Past resources (personal, social, environmental):** *What strengths have I used in the past?*
Home/daily living		
Assets: Financial/insurance		
Employment/education/specialised knowledge		

Current strengths: *What are my current strengths? (e.g. talents, skills, personal and environmental strengths)*	**Individual desires and aspirations:** *What do I want?*	**Past resources (personal, social, environmental):** *What strengths have I used in the past?*
Supportive relationships		
Wellness/health		
Leisure/recreational		

Current strengths: *What are my current strengths? (e.g. talents, skills, personal and environmental strengths)*	**Individual desires and aspirations:** *What do I want?*	**Past resources (personal, social, environmental):** *What strengths have I used in the past?*
Spirituality/culture		

What are my priorities?

1.

2.

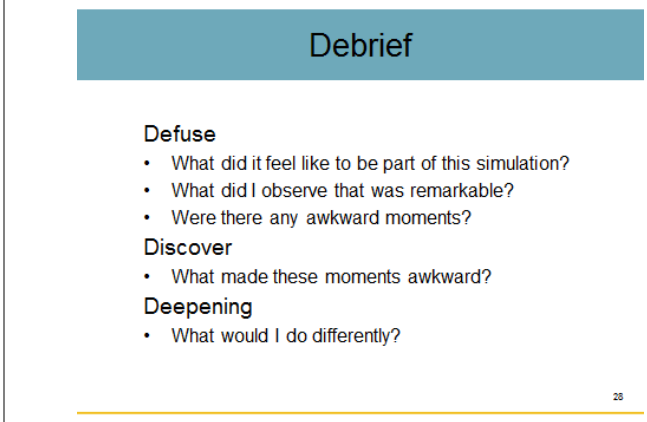
3.

4.

Additional comments or important things to know about me:

This is an accurate portrait of the strengths we have identified so far in my life. We will continue to add to these over time in order to help me achieve the goals that are most important to my recovery. My signature: _____ Date: _____	*I agree to help this person use the strengths identified to achieve goals that are important and meaningful in their life. I will continue to help this person identify additional strengths as I learn more about what is important to their recovery.* Clinicians signature: _____ Date: _____

Slide 28: Debrief



Notes:

Reflect on your experience during the simulation using.

Defuse

- What did it feel like to be part of this simulation?
- What did you observe that was remarkable?
- Were there any awkward moments?

Discover

- What made those moments awkward?

Deepening

- What would you do differently?
- What have you learned that will influence your practice?

Meta-reflection: *What have you learned about the application of the strengths tool? Has this raised any questions? How does it compare to how you have identified a consumer's strengths in the past?*

Notes:

Slide 29: Method 3 - Personal Recovery Plan

Method 3: Personal Recovery Plan

- Creating a **mutual agenda** to achieve the goals that the person has set and to define the purpose of each goal
- Strengths lend ideas and motivation towards goals
- The more creative you are, the easier it is to develop goals and find resources
- **Prioritising** goals - provides direction, measures progress
- Goals don't have to be 'easy' – more effort and commitment is needed when a goal is difficult.

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Notes:

Slide 30: Hidden goals – finding values

Hidden goals – finding values

A stated goal may be a clue to the underlying values of the person, for example.

'I want to have ten children' may indicate a core value of:

- caring for others
- wanting a relationship
- nostalgia for growing up in a large family.

How do you tap into these 'key passion statements'?

How might tapping into values be useful?

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Notes:

Slide 32: Simulation session 3

Simulation session 3

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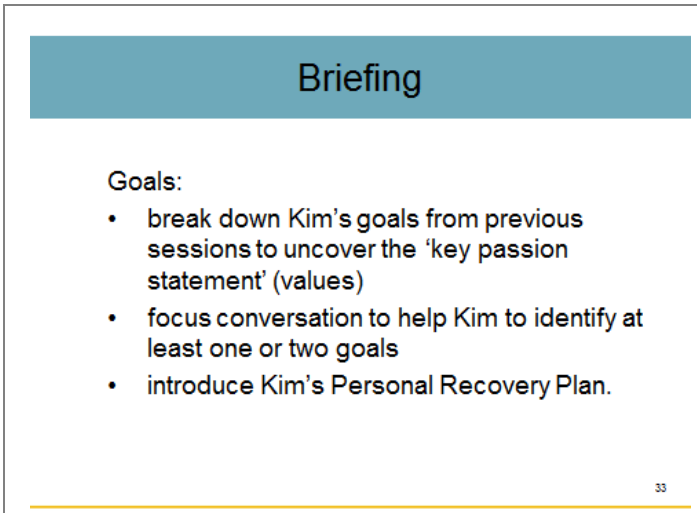
Notes:

Slide 33: Briefing



Notes:

Simulation session 3: Exploring Kim's personal goals

Timing: 10 minutes briefing, 20 minutes simulation, 10 minutes debrief.

Activity instructions: Your tasks during the simulation are to:

1. Show Kim the strengths assessment that you have started to fill out last week together.
2. Clarify Kim's priorities and write them in her strength's assessment.
3. Ask more about his/her goals (what's important to him/her about them, be curious and inquisitive showing genuine interest).
4. When Kim asks you what you are going to do with this information, tell her about the personal recovery plan and explain the difference between personal goals and the goals in a treatment plan.
5. Respond to Kim according to your clinical role and scope of practice.
6. For this session, you can continue to record what you learn of Kim's strengths using the Strengths Assessment Tool on pages 21-23.

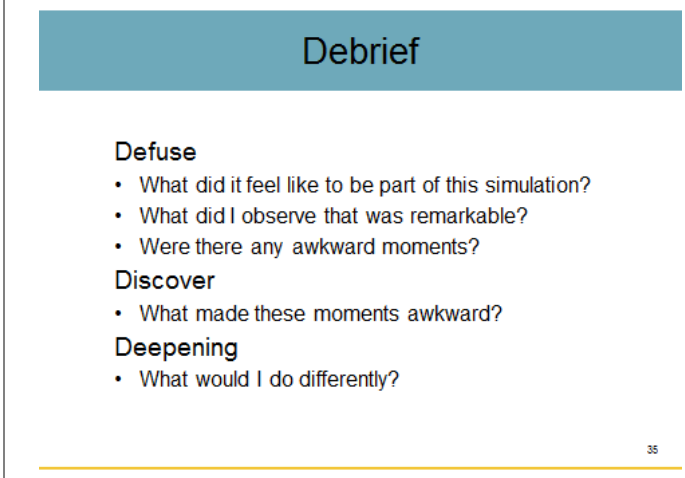
Observers

Activity instructions: Your tasks if observing the simulation are to:

1. Observe the session and interactions between Kim and the participants, while listening for questions that demonstrate how these tasks were being met.
2. Take note of what you saw being demonstrated and the questions you heard, to enable feedback and reflection after the session.

Record any notes from this simulation in the space allocated on the next page.

Slide 35: Debrief



Notes:

Reflect on your experience during the simulation using.

Defuse

- What did it feel like to be part of this simulation?
- What did you observe that was remarkable?
- Were there any awkward moments?

Discover

- What made those moments awkward?

Deepening

- What would you do differently?
- What have you learned that will influence your practice?

Meta-reflection: *What were the challenges in working with Kim's priorities while keeping the values and principles underpinning the Strengths Model?*

Notes:

Slide 36: Method 4 - Resource acquisition

Method 4: Resource acquisition

The community is rich with opportunities, resources and enriching, genuine and supportive relationships.

The four dimensions of resources that require attention are:

- **availability**
- **accessibility (including affordability)**
- **accommodation; and**
- **adequacy.**

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Notes:

Slide 37: Simulation session 4

Simulation session 4

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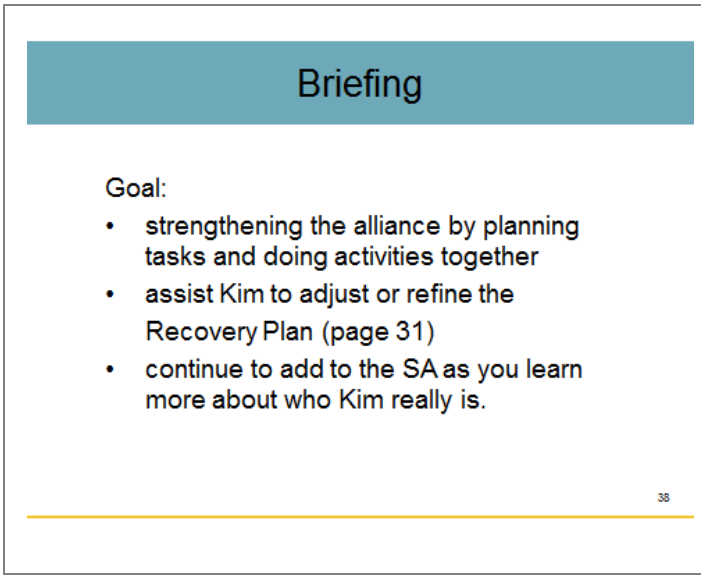
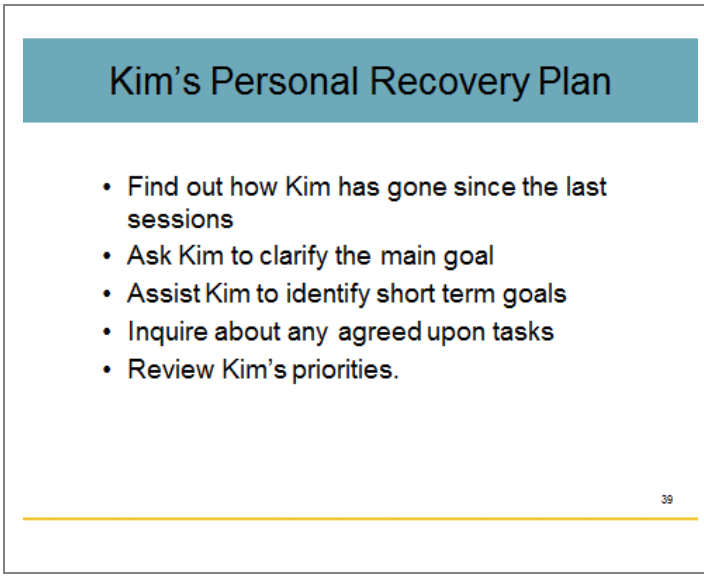
Notes:

Slide 38: Briefing



Notes:

Slide 39: Kim's personal Recovery Plan



Notes:

Simulation session 4: Kim's personal Recovery Plan

Timing: 5 minutes briefing, 20 minutes simulation, 10 minutes debrief.

Activity instructions: Your tasks during the simulation are to.

1. Identify if there are any duty of care issues.
2. Find out how Kim has gone since the last session.
3. If there were tasks that you agreed on ask about how they have gone.
4. Review Kim's priorities as written in the strength's assessment.
5. Introduce the personal recovery plan by sharing what you have written with him/her.
6. Ask Kim to identify his/her main goal (what is he/she passionate about).
7. Respond to Kim according to your clinical role and scope of practice.
8. For this session record Kim's recovery plan on page 31.

Observers

Activity instructions: Your tasks if observing the simulation are to.

1. Observe the session and interactions between Kim and the participants, while listening for questions that demonstrate how these tasks were being met.
2. Take note of what you saw being demonstrated and the questions you heard, to enable feedback and reflection after the session.

Personal Recovery Plan for:

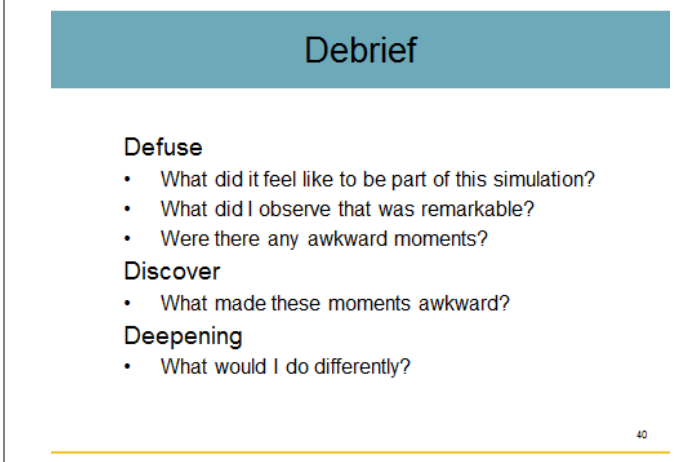
My goal (this is something meaningful and important that I achieve as part of my recovery):

Why is this important to me:

What will we do today? (Measurable, short term action steps toward achievement)	Who is responsible?	Date to be accomplished	Date accomplished	Comments

The goal listed above is something important for me to achieve as part of my recovery. My signature: _____ Date: _____	I acknowledge that the goal listed above is important to this person. Each time we meet, I will be willing to help this person make progress towards this goal. Service providers signature: _____ Date: _____

Slide 40: Debrief



Notes:

Reflect on your experience during the simulation using.

Defuse

- What did it feel like to be part of this simulation?
- What did you observe that was remarkable?
- Were there any awkward moments?

Discover

- What made those moments awkward?

Deepening

- What would you do differently?
- What have you learned that will influence your practice?

Meta-reflection: *What do you need to keep in mind when filling in the Recovery Plan?*

Notes:

Slide 41: Method 5 - Graduated disengagement

Method 5: Graduated disengagement

- Being empowered to disengage from a service is a big step, your role is to support this empowerment
- Using the Strengths Model reduces the cycle of despair, alienation and isolation that exacerbate a person's symptoms
- The Strengths Assessment and Personal Recovery Plan can help to sustain goals and self-management techniques.

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Notes:

Slide 43: Multidisciplinary brainstorming

Multidisciplinary brainstorming

Purpose of brainstorming:

1. support and affirmation
2. generating creative ideas
3. learning.

How might you use the Strengths Assessment and/or the Personal Recovery Plan within a multidisciplinary team?

See flowchart on page 34 of participant's workbook.

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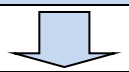
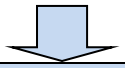
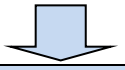
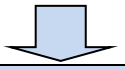
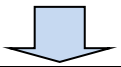
Notes:

Multidisciplinary team brainstorming process

The brainstorming process that is completed with the MDT or in clinical (group) supervision.
Step 1: Hand out strengths' assessment.

Step 2: Identify what is the client goal(s) and what help I, as a Case Manager specifically need from the group.

Step 3: Describe what is the current situation and what had already been tried.

Step 4: Questions on what the team needs clarified from the strength's assessment.

Step 5: Brainstorming ideas from the group for enhancing how the Case Manager works with the client goals (10-15 minutes).

Step 6: Determine what will be my plan based upon the suggestions made to take back to the client.

(Taken from the article by Melissa Petrakis in further reading).

Slide 45: When the recovery plan takes a detour

When the recovery plan takes a detour

- 'What if' situations.
- What issues do they raise for you?
- How does the Strengths Model and tools fit with these 'what ifs' (risk and crisis).
- How would you use Strengths Brainstorming Sessions?
- How might you use the Strengths Model to help manage risk?

45

Notes:

Slide 46: Team brainstorming

Team brainstorming

Goal:

- explore unexpected events
- use the strengths tool to work with risk and crisis.

46

Notes:

Slide 47: Kim's unexpected event

Activity instructions: This is a group activity; you will use the Strengths Model to address **Kim's unexpected event.**

I know you talked to my sister when she called you. You don't have permission to talk to my family!

I know what Sandra told you

'I have been drinking heavily for the last week and have been smoking pot more than usual.'

Sandra thinks that I haven't been taking my medications either because I'm starting to 'talk nonsense' when I'm on Facebook. I've been saying that I'm going to track down my ex-partner and 'make them pay'. I have been posting photos holding a hammer or making a hand gesture like a pistol.

I have been phoning mum telling her that she should get back together with dad. This is something apparently I do just before I go off the rails.

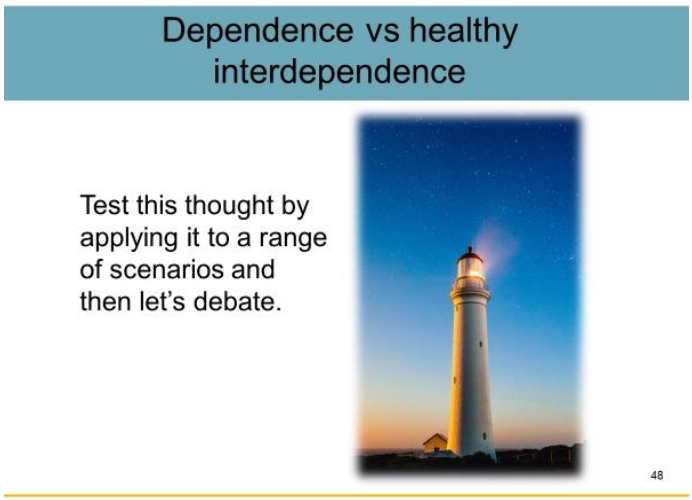
Sandra reckons the place is a mess and I'm not talking sense again.

You will be asked to work on **one** of the following aspects listed below:

- relapse in drug and alcohol use
- avoiding the 'entrapping niche' of online negative influences
- addressing risk of future violence
- patching up the relationship with Kim's sister and mother.

Notes:

Slide 48: Dependence vs healthy interdependence



Notes:

Scenarios

1. Karl is interested in undertaking a TAFE course on carpentry and wants to find out more information about this but does not have internet access at home.

Possible arguments

Dependent: You go online and print out the information for him.

Healthy interdependence: You walk with Karl to his neighbourhood library, show him how to use the internet facilities and where to look for information about TAFE online.

2. Karl wants to learn how to cook a simple meal so he can make a romantic dinner for his girlfriend whom he met at TAFE.

Dependent: You look up a simple and easy recipe for Karl to cook, write a list of food to buy, go shopping with him and help him cook.

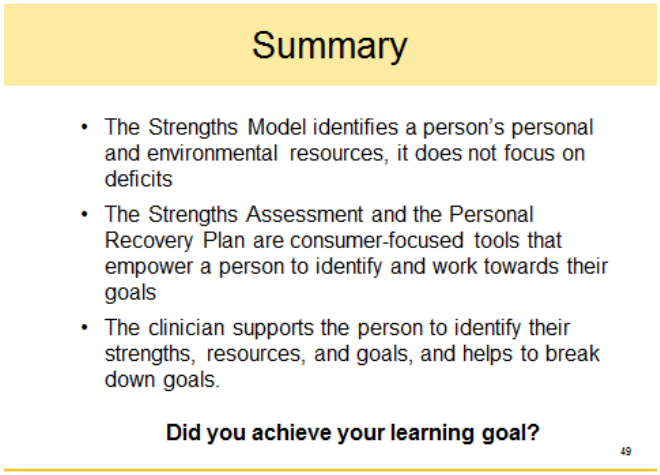
Healthy interdependence: You discuss with Karl what he would like to cook and encourage him to find the recipe on line at the neighbourhood library. You offer to help Karl with grocery shopping and cooking if he wants your support.

3. Polly is actively looking for a job and has three job interviews lined up in the next two days, however, she is unable to drive.

Dependent: You drive Polly to all her job interviews ensuring she is there on time.

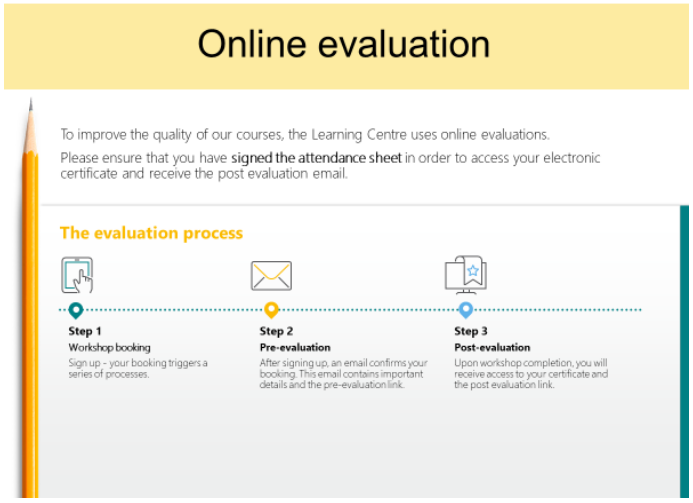
Healthy interdependence: You support Holly to plan her trips to her interviews via public transport. You offer to travel with her to her interviews and wait for her in the waiting room or outside.

Slide 49: Summary



Notes:

Slide 50: Online evaluation



Online evaluation

To improve the quality of our courses, the Learning Centre uses online evaluations. Please ensure that you have signed the attendance sheet in order to access your electronic certificate and receive the post evaluation email.

Step 1: Workshop booking, your booking triggers a series of processess.

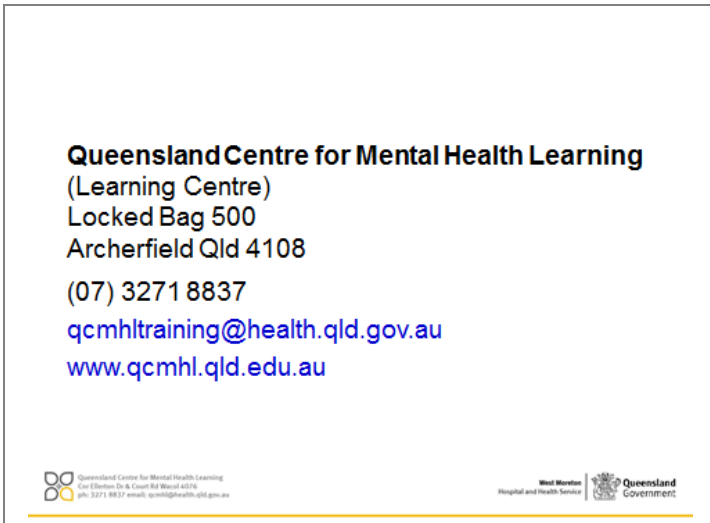
Step 2: Pre-evaluation, after signing up, en email confirms your booking. This email contains important details and the pre-evaluation link.

Step 3: Post-evaluation, upon workshop completion, you will receive access to your certificate and the post evaluation link.

Slide 51: Learning Centre website for additional training

Notes:

Slide 53: Learning Centre contact details



Notes:

3. The Strengths Assessment Tool applied to a scenario

(The following scenario has been taken directly from: The Strengths Model, a recovery oriented approach to mental health services, by Charles A. Rapp and Richard J. Goscha, 2012, 117-122)

> David was required to attend the day treatment program five days per week as a condition for residing at the program's Transitional Living Facility. Over the past two weeks he was becoming increasingly more aggressive with staff and other clients. He was suspended for one day last week for yelling at admin staff when they refused to give him bus tickets.
>
> David stated that he did not want to be at day treatment and wanted to go to work. Staff were saying that he was not 'ready for work' but that he could demonstrate his 'work readiness' by his behaviours at the day treatment program. A staff meeting was called to decide what to do with David. The prevailing thought was that he would probably need to be re-hospitalised and have his medications adjusted.

This is the situation that a newly assigned strengths model practitioner walked into. The worker had recently been to a training on the strengths model and felt conflicted about what he learned in training regarding starting where the person was at, allowing the person to be the director of the helping process, building on a person's strengths and the prevailing consensus of program staff that David was 'decompensating' and needed an immediate involuntary intervention.

The following contains partial information from David's consumer assessment on admission to a community support service program. Names and places have been changed to protect the anonymity of the individual.

Age: 42

Diagnosis: Schizophrenia, disorganised type. Anti-social personality disorder

Medical: high blood pressure

Other: illiteracy, unemployment

Living situation

David has been living in Brisbane for two years. Spent first five years living in homeless shelters and on the streets. Now resides at a community transitional living facility and shares an apartment with two others. Does not interact much with other residents; is accused of taking food belonging to others and becomes hostile when confronted.

Psychiatric history

First psychiatric hospitalisation at age 17. Mother committed him after he became threatening to her. Spent 14 years in a Townsville Rehabilitation Unit. Discharged to a residential home. Re-hospitalised twelve times in an eight year period of time.

Vocational/educational history

David attended state schools until he was 8 years old and was then home schooled. David has limited reading and writing skills. Has never held paid employment. Only vocational activity has been janitorial work at the hospital in Townsville.

Social history

David's father died when he was 12 years old. Mother died when David was 33. David has no social support network in Queensland. He has difficulty making friends. He has never married.

Financial

David receives a disability pension. The staff reported that he is not able to manage money well.

Prior to the staff meeting, the new worker decided to begin a strengths assessment with David. The worker got permission from the residential home to take David out to the local shops where they looked for a new pair of shoes and also stopped at a café for lunch. The strengths assessment was not filled out by sitting down in an interview, but through casual conversation as they went about shopping. After they finished shopping and during lunch the worker began to write down some of the things they discussed while shopping. What was written down in the strength's assessment is shown below.

Strengths Assessment

for David

Current Strengths: What are my current strengths? (i.e. talents, skills, personal and environmental strengths)	**Individual's Desires, Aspirations:** What do I want?	**Past Resources – Personal, Social, & Environmental:** What strengths have I used in the past?
Home/Daily Living		
Living in residential home - close to bus, all food & utilities included Has bus card	I want a place of my own. I want to learn how to cook chinese food. I need new shoes!	Lived in Townsville hospital. It kept me off the streets I lived with parents
Assets - Financial/Insurance		
Get a disability pension. Nice not to think about paying for rent & food I get $50/wk spending money	I want to pay my own bills & decide how to spend my money. I want more money.	Mum used to organise my money & give me extra money when she had it
Employment/Education/Specialized Knowledge		
I go to psychosocial sessions about symptom management (It doesn't help me at all)	I want a job I want to get out of psychosocial programs	I used to sweep floors and clean the community room in Townsville Hospital I did a good job, I would also wash dishes
Supportive Relationships		
My room mates and I watch TV together & sometimes we order pizza.	I'd like to get married. I like one of the admin girls. I'll ask her out once I get out of here.	Mum - she was always there for me. My uncle would go fishing with me. I don't know where he is now

Wellness/Health		
I'm healthy. I can walk or get the bus. Meds help me sleep but also feels like 'off my head'	I need to get my teeth fixed. I want to stop taking medications. I don't like the side effects	I used to have asthma as a kid, but it hardly bothers me now.
Leisure / Recreational		
I really like watching movies I know a lot of movies & historical facts I've learnt from them.	I want to get Netflix in my room.	Used to go fishing a lot. I had my own rod & tackle I used to go to the movies with neighbours kids.
Spirituality/Culture		
		I used to go to the local Baptist Church with mum. I knew many of the people at church.

What are my priorities?

1. I want a job
2. I want to manage my money
3. I want to stop going to programs
4. I want my own place

Additional comments or important things to know about me:

Getting a job is the most important thing. I want to make my own choices in life.

Over the next few weeks, the worker and David went looking for casual work. David eventually got a job collecting tickets at a local cinema.

Contrasting the information contained in the consumer assessment and the strengths assessment, looks like they do not refer to the same person. What is written comes from the perceptual framework being used. In one, all of David's deficits and shortcomings are made the focus, and the interventions of staff are centred around 'fixing' David's deficits. In the other, David's strengths are brought to the forefront, even in the midst of a challenging situation. What David wants in life is what drives the helping process and his natural energy and intrinsic motivation are drawn upon.

The strengths assessment is an ongoing process and not just a static event with a singular purpose. In reflecting on David, it is possible to see how the shift to using the strengths assessment to guide the helping process opened up doors for David and his worker to explore employment and begin a recovery journey focused on what David wanted in his life rather than correcting deficits that were problematic for staff.

The worker continued to engage with David, adapting the strengths assessment to the changes in David's life circumstances and aspirations.

The strengths assessment below was completed two years after the first assessment. While it doesn't show the messiness of the multiple versions that have been written during the past two years (including things added, crossed off and modified), it does show how different a strengths assessment can look over an extended period of time.

Strengths Assessment

for David

Current Strengths: What are my current strengths? (i.e. talents, skills, personal and environmental strengths)	**Individual's Desires, Aspirations:** What do I want?	**Past Resources – Personal, Social, & Environmental:** What strengths have I used in the past?
Home/Daily Living		
I live in a one bedroom unit I can cook (fried rice, spagetti and tacos). I have a buscard	I want to get a car I need a drivers license I want a BBQ	Lived in Townsville hospital Lived in residential care and they helped me to live on my own. Lived with parents
Assets - Financial/Insurance		
Receives a wage Has set up regular rental payments direct from account on pay day.	I want to afford a car & pay insurance. ± want to save for a P&O cruise with Pauline.	Used to get a disability pension, now I work
Employment/Education/Specialized Knowledge		
I have a job at a bigger cinema. I know how to do most jobs. I do more in the food kiosk.	I want to work more hours so I can help Pauline out. She doesn't have a job.	I used to work at a local cinema. I also helped clean the kiosk after my shift on ticket collecting.
Supportive Relationships		
I have a girlfriend, Pauline. She is everything to me, we do everything together. Mike my neighbour has a car & we go with him.		Used to go fishing. It made my calm & feel like I was free.

Wellness/Health		
I like to go for walks around the creek. It helps me stay calm. My meds help me sleep so I am not so agitated. Being in love is the best.	I need to get veneers on my front teeth at some point I want to keep my meds at a low dose	Most meds have been difficult to adjust to but my current meds seem to be okay.
Leisure / Recreational		
I see every movie that shows at the cinema. I would be able to win every Trivia question about movies	I want to get some camping gear (tent, stove, air mattress) I want to go camping for a long weekend	Used to go fishing Used to have a rod + tackle Used to go fishing with neighbourhood kids as a kid.
Spirituality/Culture		
		Used to go to Baptist church with my mum. Used to know a lot of people at church.

What are my priorities?

1. I want a car
2. I want to go on a P&O cruise
3. I want to go camping + fishing
4.

Additional comments or important things to know about me:

Life is better when there is someone to share it with. I want to travel the world some day.

Things that were once desires and aspirations in the middle column have now moved into the first column since they are now current strengths (a unit, girlfriend, neighbour, fishing etc.). Things that were once in the current strength's column have been moved to past resources (e.g. living in residential care).

Both of these forms are a snap shot in time but they are also a worksheet that helps David map out a vision of what he wants his future to be. It is also a running inventory of the resources that he has at this disposal (both personal and environmental) to help him navigate his desired future.

Once David attained his job the conversations might have changed to discussions around keeping the job. Discussions may include things David liked to do for fun outside of work; skills to help David cope with the challenges at work; or even establishing new goals that he might be in a better position to pursue now that he has a source of income.

The strengths assessment allowed the worker to play an active role in David's recovery and form a working relationship with him rather than a passive role focussing on his deficits.

4. The Personal Recovery Plan applied to a scenario

This plan was handwritten by David as he worked through the process of achieving this goal of finding a job.

Personal Recovery Plan

For David

My goal (This is something meaningful and important that I achieve as part of my recovery):

I want to get a job

Why is this important to me:

I want to make my own choices about my life,

What will we do today? (Measurable, Short Term Action Steps Toward Achievement)	Who is Responsible?	Date to Be Accomplished	Date Accomplished	Comments
Get a newspaper to look for job	David	Oct 25	Oct 29.	Few jobs there.
Get application form for cinema job.	David	Oct 30	Oct 30	Filled out form – case manager (Sue) looked it over

5. The Strengths Model Core Competencies Evaluation Tool

(The following evaluation tool has been taken directly from: The Strengths Model, a recovery oriented approach to mental health services, by Charles A. Rapp and Richard J. Goscha, 2012, 280-285)

Competency area	Evidenced by	Rating
Values		
1. Demonstrates belief that all people with psychiatric disabilities can recover, reclaim or transform their lives.	• Use of recovery-orientated language in group supervision, documentation and discussions with co-workers. • Does not use spirit breaking language in group supervision, documentation and discussions with co-workers. • Positive feedback from clients demonstrating worker's belief in their recovery goals and abilities.	1 2 3 4 5
2. Demonstrates the ability to focus on strengths rather than deficits.	• Emphasizes strengths (talents, skills, internal motivators and personal characteristics) in group supervision, documentation and in discussions with co-workers. • Emphasizes what people can do over what they cannot do.	1 2 3 4 5
3. Demonstrates belief that the client is the director of the helping process.	• Involves clients in using strengths assessment, personal recovery plan and development of recovery plan goals. • Reports from client that goals on the recovery plan are ones most important to them. • Reports from client that goals on the personal recovery plan and the steps taken to achieve those goals are directing them.	1 2 3 4 5
4. Demonstrates belief that the relationship with the client is primary and essential.	• Returns calls to clients within 24 hours. • Keeps appointments and shows up on time. • Meets with clients in places that are desired by the client. • Reports by clients that they have a positive working relationship with their Case Manager.	1 2 3 4 5

Competency area	Evidenced by	Rating
Engagement		
1. Demonstrates ability to effectively build rapport and trust and ability to relate to a wide variety of people.	• Projects warmth and interest when speaking with clients. • Change's their engagement style depending on the nature of the person they are working with. • Tolerant of different levels of client's readiness to engage. • Effective use of self-disclosure and sharing common interests with clients. • Reports by clients that they have a positive working relationship with their mental health professional.	1 2 3 4 5
2. Demonstrates ability to assertively reach out to clients who are difficult to engage.	• Uses multiple strategies for engaging, including phone calls, home visits, writing letters, and /or contacting family members (with release). • Is not quick to close clients from services who do not engage immediately.	1 2 3 4 5
3. Demonstrates the ability to self-reflect on personal barriers to engagement with clients as well as empathize with factors related to client's as well as empathize with factors related to client's difficulty with engagement.	• Asks for feedback from supervisor or co-workers during group supervision on how they can more effectively engage with specific clients. • Can discuss a situation from the client's point of view in a non-blaming manner.	1 2 3 4 5

Competency area	Evidenced by	Rating
Strengths assessment		
1. Demonstrates ability to list client's desires and aspirations with detail and specificity.	• The middle column of SA lists what the person wants with specificity. • Priorities on the SA are unique to the client.	1 2 3 4 5
2. Demonstrates ability to use client's language throughout the strength's assessment.	• Use of quotations on SA. • Use of 'I' statements on SA.	1 2 3 4 5
3. Demonstrates ability to list client's talents and skills with details and specificity.	• Client's talents and skills are specific and unique to the client. • Does not use words like 'none', 'nothing', 'unemployed', 'homeless', 'no-friends', etc. but rather finds clients skills or talents in daily living, vocational, educational, social, support, and leisure/recreational areas.	1 2 3 4 5
4. Demonstrates ability to list environmental strengths currently available to the client with detail and specificity.	• Indication on SA of how environmental resources (e.g. family, friends, hobby, faith community, medication, personal wellness strategy, etc.) are strengths. • Does not use words like 'none', 'nothing', 'unemployed', 'homeless', 'no-friends', etc. but rather finds environmental strengths the client does have.	1 2 3 4 5
5. Demonstrates ability to involve clients in completing the strengths assessment.	• Uses conversational approach to working on strengths assessment. • Indication of progress notes that clients are involved in working on SA. • Offers copy of SA to clients. • Reports by clients that they are familiar with the SA and work on the SA with practitioner.	1 2 3 4 5
6. Demonstrates the ability to use strengths assessment on a frequent basis with clients.	• Uses SA to develop recovery plan goals every 90 days. • Indication from progress notes that SA is being used in interventions in majority of contacts with clients. • Reports from clients that Case Managers frequently use the strengths assessments to gather information about wants/desires, record strengths and develop strategies to achieve goals.	1 2 3 4 5

Competency area	Evidenced by	Rating
Integration of Strengths Assessment with Recovery Plan		
1. Demonstrated ability to use information from the strengths assessment to form recovery goals.	• Clear link between goals and/or objectives on the recovery plan and SA. • Reports from clients that the goals and objectives on the recovery plan reflect their wants and desires. • Use of client language embedded in the recovery plan (e.g. use of client quotes, works like 'so that …' or in order to …' reflecting a client passion, etc.)	1 2 3 4 5

Competency area	Evidenced by	Rating
Personal Recovery Plan		
1. Demonstrates ability to write goals on the PRP that are taken from the priority section on the strength's assessment.	• Clear links between goal and PRP and the priority section of the SA. • Goal on PRP clearly reflects a client's passion and is unique to the client.	1 2 3 4 5
2. Demonstrates ability to write goals and action steps in the client's own words.	• Use of everyday language throughout the PRP (no use of professional jargon).	1 2 3 4 5
3. Demonstrates ability to break down goals on the PRP into smaller, specific, measurable action steps.	• Writes concrete action steps that can be accomplished within the next few meetings with the client of between the next few meetings. • Use of action words (e.g. take, call, list, write, go, pick up, etc.) to describe next steps rather than using vague language (e.g. explore, continue, plan, think, monitor, address, etc.).	1 2 3 4 5
4. Demonstrates ability to write action steps that are positive.	• Writes what will be done rather than what will not be done.	1 2 3 4 5
5. Demonstrates the ability to write specific action steps that have specific target dates.	• Action steps have specific dates listed of when they will be accomplished (no use of 'ongoing' or far distant dates 'summer 2017')	1 2 3 4 5
6. Demonstrates ability to document dates when action steps are accomplished.	• Dates are written in 'date to be completed section' of the PRP after the step is completed.	1 2 3 4 5

Competency area	Evidenced by	Rating
7. Demonstrates ability to write notes on goal progress in the comments section of PRP.	• Comments section has information regarding progress towards goal. • Statement of encouragement are written into comments section.	1 2 3 4 5
8. Demonstrates ability to write action steps that include information/resources from the strength's assessment.	• Action steps reflect strategies that make use of a person's strengths (e.g. talents, skills, environmental resources, desires, aspirations). • Reports from client's that action steps on PRP are the ones that they want to do.	1 2 3 4 5
9. Demonstrates ability to involve the client using the PRP.	• Clients name listed in the 'responsibility' column of the PRP for specific action steps. • Clear indication in progress notes that client and Case Manager are using PRP together. • Report from clients that they are familiar with PRP and have used it in the past month with their practitioner.	1 2 3 4 5
10. Demonstrates the ability to use the PRP with almost all clients.	• PRPs are available for at least 75% of clients with whom the practitioner works in any particular month. • Reports from clients that they are familiar with the PRP and have used it in the past month with their Case Manager.	1 2 3 4 5
11. Demonstrates the ability to use PRP on frequent basis with clients.	• Progress notes clearly reflect that the PRP is being used with the majority of contracts with a client. • Reports from clients that they are familiar with the PRP and have used it in the past month with their practitioner.	1 2 3 4 5

Competency area	Evidenced by	Rating
In Vivo services		
1. Demonstrated ability to provide services for clients in places where they live, work and interact in the community.	• Progress notes show that over 80% of all client contact occurs in the community. • Ask for strategies that are community-based during the MDT or clinical supervision.	1 2 3 4 5

Competency area	Evidenced by	Rating
Use of naturally occurring resources		
1. Demonstrates the ability to assist clients identify naturally occurring resources when considering strategies for goal achievement.	• Progress notes report the listing of multiple naturally occurring resource options with clients. • Uses MDT or clinical supervision time to identify naturally occurring resources that will benefit clients. • Can identify multiple naturally occurring resources for any given goal when asked. • Strengths assessment documents multiple, specific, naturally occurring resources.	1 2 3 4 5
2. Demonstrates ability to assist in client's access to naturally occurring resources with the majority of goals on the recovery plan.	• Progress notes report naturally occurring resources being accessed with assistance from the practitioner with at least 75% of all recovery plan goals. • Reports from clients that their practitioner is assisting them with specific naturally occurring resources. • Naturally occurring resources have been added to the SA since the beginning of the working relationship. • PRP documents action steps to access a naturally occurring resource.	1 2 3 4 5
3. Demonstrates the ability to help clients to make plans and set goals that trend toward the use of naturally occurring resources.	• Recovery plan goals are worded in such a way as to end in the attainment of a naturally occurring resource (e.g. housing, employment, friends, community groups or activities, etc.) • Recovery plan goals or objectives are used to assist the client be able to do something on their own or with the assistance of a naturally occurring resource.	1 2 3 4 5

Competency area	Evidenced by	Rating
Group supervision		
1. Demonstrates the ability to be a full participant in MDT meetings and the clinical supervision process.	• Presents at multidisciplinary team meetings or clinical supervision regularly. • Asks questions during MDT meetings or supervision based on the SA. • Offers constructive suggestions to team members based on the SA. • Shares celebrations with team members.	1 2 3 4 5
2. Demonstrates ability to make a formal presentation at MDT meeting.	• Brings copy of SA of client presented for all team members. • Starts presentation by stating client's goal(s). • States specifically what they want help with from the group. • Gives a brief overview of what strategies have currently been tried. • Answers questions from team members without the use of spirit-breaking language. • Writes down all suggestions offered by team members without 'yes, but etc.' • States specific plan of action with client based on the suggestions provided.	1 2 3 4 5
3. Demonstrates the ability to use suggestions provided at clinical supervision or from MDT with clients in practice.	• Progress notes show that some of the suggestions were used. • Recovery plan goals or objectives have been added or modified to reflect a suggestion from supervision or MDT meeting. • PRP reflects use of a suggestion from supervision. • SA reflects use of a suggestion from MDT meeting or supervision. • Report by presenting practitioner at subsequent MDT or supervision on progress using suggestions from previous meetings.	1 2 3 4 5

Competency area	Evidenced by	Rating
Purposeful nature of practice		
1. Demonstrates ability to use purposeful strategies in practice with clients.	• Progress notes reflect clear intentions for the intervention the practitioner is using. • Case Manager can clearly state the purpose of any given strategy (e.g. use of goal or objective on recovery plan, plan to engage client to use SA and PRP to set and achieve goals, teach client skill to further independence, plan to disengage with client etc.). • Goals and/or objectives are being achieved on the PRP.	1 2 3 4 5

Competency area	Evidenced by	Rating
Decisional conflict/decisional uncertainty		
1. Demonstrates the ability to engage clients in change talk to assist them in working through decisional conflict or uncertainty.	• Progress notes practitioner's awareness of the stages of change. • Progress notes show that strategies are being used to help clients work through decisional conflict or uncertainly (e.g. use of pro-con lists, 1-10 scale, decision trees, grid analysis, etc.) • PRP shows that strategies are being used to help clients work through decisional conflict or uncertainty. • Case Manager refrains from telling client what decision they should make. • Case Manager avoids using consequences to coerce client into making a decision.	1 2 3 4 5

Competency area	Evidenced by	Rating
Decisional conflict/decisional uncertainty		
1. Graduated disengagement	• Progress notes show concrete steps taken to reduce the number of formal mental health services (e.g. use of naturally occurring resources to replace formal services, clients learning a skill to do something on their own, etc.). • Goals and/or objectives are being achieved on the personal recovery plan. • Uses group supervision time to formulate a plan for disengagement. • Client is successfully leaving professional services.	1 2 3 4 5

6. Literature review and further reading

Literature review 2015

The process of exploring a recovery oriented model of case management involved an extensive literature search of contemporary models of case management which are utilised with consumers of mental health services.

This paper presents our findings.

Introduction

This literature review aims to firstly provide an overview of current models of case management utilised with people living with mental health concerns and secondly to explore how the models fit within a recovery paradigm.

The review is organised into an overview of case management, case management models in mental health and then moves on to a brief description of each model of case management, and finally explores how a recovery model of case management is supported by the National Standards of Mental Health Service and the EQuIP National standards.

Overview of Case Management

Case management models have often been compared to the following three part analogy for travel:

- travel agent model – where a professional sits behind their desk offering advice and sends you on your way with that advice for you to do with it what you will
- travel companion model – where someone goes with you on your travels but who knows as much as you do about the destination
- a travel guide model – where a person will not only be there and do things with you, but also has appropriate training, experience and expertise to know the most scenic routes, how to take shortcuts without getting lost, how to consistently avoid the pitfalls, and to arrive reliably at the desired destination (Diamond & Kantor, 1998, cited in Rosen & Teesson, 2001, p. 732).

Case management has been viewed historically as an entity (usually implemented by person/persons) for distributing and co-ordinating services on behalf of clients (Thornicroft, 1991). Thornicroft (1991) notes further that Case Managers will co-ordinate, integrate and allocate care within limited resources. The primary functions of case management being assessment, planning, advocacy, linkage and monitoring (Intagliata, 1982).

Additionally, Case Managers provide a single point of contact for people who require a complex range of services and/or require intensive levels of support in an ongoing, short- term or episodic manner.

More recently, the Case Management Society of Australia (CMSA 2004) defines case management as ‘a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-effective outcomes’.

The term health is used here in its broadest sense based on the World Health Organisation which states that health is ‘a state of complete physical, mental and social well-being, not just the absence of disease or infirmity’. In general terms, case management focuses on the full range of health and social care needs of individuals with complex care needs. Case management is noteworthy for its breadth across health and community sectors and its implication for longer term support in response to people’s complex needs and circumstances.

CMSA (2004) says that case management requires:

- a single point of contact where the relationship with the Case Manager is the foundation on which the case management process is based, working in partnership with the individual and their carer, Case Managers are also a single point of contact for other service providers

- a strengths approach which acknowledges that every individual has strengths that should be the focus of the interaction between the Case Manager and the individual, this approach maximises the physical, social and psychological well- being of the individual to achieve their optimal level of independence and assist in the participation in the community commensurate with their capacity and choice, case management facilitates the personal development of individuals
- collaboration between Case Managers, other service providers and professionals involved with a person to ensure the best possible result for that person
- individualised and person focused support which ensures each person receives the appropriate level and type of support according to their needs, culture, budget restraints while working towards jointly agreed goals
- continuity of care and support whereby people have a right to expect continuity of service across time and boundaries in order to have their needs met
- boundary-spanning, whereby Case Managers draw upon all available resources, both informal and formal to provide support in the most cost effective manner
- culturally appropriate responses ensuring diversity is respected and catered for
- creativity by Case Managers to find innovative ways to meet agreed needs
- empowerment of people being supported, through the provision of information, to manage their own affairs as far as possible
- confidentiality to be maintained at all times in accordance with legislative requirements and program standards.

Case Management emerged in mental health in response to deinstitutionalisation

As a function of the deinstitutionalisation movement of the 1950s and 1960s, the primary mechanism of treatment for persons with a severe mental illness changed from hospital to community-based (Mueser, Bond, Drake, & Resnick, 1998). The introduction of multiple additional mental health treatment options at the community level had some positive consequences, such as the ease of access to services by persons with less severe mental illness who had never been a patient within an institution. However, the growing complexity of the mental health system along with the deluge of new services made it difficult for persons with a severe mental illness to appropriately navigate and access services (Mechanic, 1991). It subsequently became clear that those seriously ill persons showed little initiative to seek out psychiatric services and were unable to advocate for their own needs and were also difficult to engage in the surfeit of community-based services. Mueser et al. (1998) point out that, in recognition of the need to better serve those with a severe mental illness, and to co-ordinate the different services available, a new service function and service professional were created: case management and the Case Manager, respectively.

The underlying notion of case management is that there is a single point of contact that is responsible for helping people with mental illnesses receive the relevant services from systems of care that may be somewhat fragmented or lacking in continuity (Rapp & Goscha, 2004). It is important to realise that case management is a process that can be utilised by all users of a mental health service, and is not only restricted to people who experience mental illness with long-term needs that are living in the community.

The emergence of models of Case Management in mental health:

- broker/generalist model
- clinical case management model
- assertive community treatment model
- intensive case management model
- strengths model
- rehabilitation model.

There is a relatively high level of agreement amongst reviewers as to the type, number and characteristics of case management models (Center for Substance Abuse Treatment, 2000; Marshall, Gray, Lockwood, & Green, 1998; Mueser et al., 1998; Rosen & Teesson, 2001; Vanderplasschen, Wolf, Rapp, & Broekaert, 2007). This is somewhat surprising given the overwhelming diversity of approaches to case management and the overlap of models as they are implemented in practice. For the purposes of this review only the most widely used and well-recognised models of case management are outlined below.

Brokerage Model

In its least complicated form, case management can be conceptualised simply as a means of co-ordinating services (referred to as 'brokerage'). In a perfect example of the model, each mentally ill person is assigned a Case Manager who is expected to:

- assess the person's needs
- develop a care plan
- arrange for suitable care to be provided/linking to services
- monitor the quality of the care provided
- maintain contact with the person/advocacy (Holloway, 1991; Intagliata, 1982).

The major emphasis of brokered case management is on the assessment of the needs of clients, the subsequent referring to appropriate services and then co-ordinating ongoing treatment and monitoring outcomes. A limitation of this model is that Case Managers are expected to connect clients with the needed clinical services without acting as clinicians themselves (Marshall et al., 1998; Mueser et al., 1998).The brokerage model assumes that clinical skills are not needed to perform effective case management and that an appropriate provider can always be found to provide the necessary clinical services. This can be problematic and somewhat at odds with the concept of the Case Manager as someone who facilitates a path to recovery.

Clinical Case Management Model

Building upon the foundations of the brokerage model, the clinical case management model (CCM) was developed in recognition of the fact that Case Managers must often act as clinicians by providing direct services to their clients. Clinical case management emphasises the professional status and therapeutic skills of the Case Manager and may lean towards having a 'psychodynamic' or 'psycho-educational' focus. Particular emphasis is placed on the importance of the power of the therapeutic relationship between the Case Manager and the client (Marshall et al., 1998). Kanter (1989) describe clinical Case Managers as providing services in four general areas:

- initial phase – engagement, assessment, planning
- environmental interventions – linking with community resources, consultation with families/caregivers, maintenance of social networks, collaboration with doctors and advocacy
- patient interventions – intermittent psychotherapy, training in independent living skills and psycho-education
- patient-environmental interventions – crisis intervention and monitoring.

The 1980s saw the development of 'enhanced' models of case management. Rapp and Goscha (2004) point out that this change was driven partly by research evidence but also anecdotal accounts suggesting that traditional case management was not producing the outcomes desired. Thus, the latter models utilised dramatically different practices and structures, including smaller caseloads, a more overt team structure and an increased provision toward direct service rather than making referrals.

Assertive Community Treatment Model

As a function of the perceived limitations of the earlier models of case management, Stein and Test (1980) created a program that was designed as a community-based alternative to hospitalisation for those persons presenting with a mental illness.

The original program, called the Program for Assertive Community Treatment, was a specialised care package that met the needs of clients with more pronounced psychiatric impairments, typically characterised by a diagnosis of severe or chronic impairment or a pattern of high service use (Stein & Test, 1980). The model aims to take a comprehensive treatment approach that goes beyond the somewhat restricted mandates of the broker or clinical case management models.

Assertive community treatment (ACT) emphasises team working – the vital link is between the team and its client, rather than between individual team members and particular clients (Marshall et al., 1998). The basic principles of the ACT model, as defined by Stein and Test (1980), include:

- low client to staff ratios (10-15:1)
- most services provided in the community, e.g. in clients' homes or places of work
- caseloads are shared across clinicians, rather than individual caseloads
- 24-hour coverage
- most services are provided by the ACT team and not brokered out to external providers
- time-unlimited service.

Intensive Case Management

As with the ACT model, the intensive case management (ICM) model was developed to meet the needs of high service users (Mueser et al., 1998). It was recognised that many clients with severe mental health disorders could not be engaged in treatment using traditional case management practices; however they consumed many of the most costly treatment services such as emergency room visits (Surles & McGurrin, 1987). To overcome this, ICM employs a low staff to client ratio, provides assertive outreach and services in the clients' natural environment as well as practical assistance in daily living skills. An important contrast to the ACT models is that the team approach is not involved and shared caseloads do not exist (Dieterich, Irving Claire, Park, & Marshall, 2010).

Strengths Model

Another important approach to case management is the strengths model. First outlined by Weick, Rapp, Sullivan, and Kisthardt (1989) in the context of social work, this model was further developed in response to concerns that approaches to case management for persons with a mental illness tend to focus on the limits and impairments of the illness at the cost of ignoring the personal resources that can be harnessed towards achieving individual goals. Rapp (1993) summarises the principles of the strengths model as follows:

- the focus is on individual strengths rather than pathology
- the Case Manager-client relationship is primary and essential
- interventions are based on client self-determination
- the community is viewed as an oasis of resources, rather than an obstacle
- aggressive outreach is the preferred mode of intervention
- people suffering from even severe mental illness can continue to learn, grow and change.

Rehabilitation Model

The rehabilitation model shares the strengths approach of providing case management services based on the individual clients' desires and goals, rather than on goals defined by the mental health system (Mueser et al., 1998). A special focus of this model emphasises the development of skills needed to function well in the community, to be well affiliated to the community and to create environmental changes to help meet clients' needs.

Outcomes/evidence

Much work has been done to assess the effect of case management as a means for caring for severely mentally ill people in the community; across most reviews and meta- analyses, the main indices of effectiveness/outcome measures are:

1. numbers of people remaining in contact with psychiatric services
2. extent of psychiatric hospital admissions or rehospitalisation
3. clinical and social outcome; and
4. costs.

Most reviews have compared the outcomes of the more prominent models of case management against traditional or standard service approaches. Findings of the most widely referenced reviews are outlined below.

In a review that combined four models of case management (full support – otherwise known as ACT, strengths, rehabilitation and expanded broker) for severely mentally disabled clients, Solomon (1992) indicates that case management is most effective in reducing the number of hospitalisations and reducing the lengths of stay.

Case management was also found to improve the quality of life of clients, and that satisfaction with treatment was consistently high for case management services (Solomon, 1992). In their review of the outcome literature, Holloway, Oliver, Collins, and Carson (1995) concluded that the practice of case management can have some beneficial impacts on patients' use of services (including a significant decrease in in-patient bed days and reduced number of hospital admissions); satisfaction with services, engagement with services; and social networks and relationships when it is delivered as a direct clinical service with high staff to patient ratios.

In one of the most exhaustive reviews to date, Mueser et al. (1998) appraised the results of 75 studies including all major models of case management along with multiple experimental designs (random assignment, quasi-experimental and pre-post design). The authors suggest that the use of ACT and ICM models reduces patient time spent in hospital, and improves housing stability or independence. The controlled studies reviewed provided modest support for ACT or ICM in decreasing the severity of symptoms and increasing the quality of life of patients. In addition, the review found that there was little positive effect of ACT or ICM on social or vocational functioning, time spent in jail or number of arrests (Mueser et al., 1998).

In their landmark Cochrane reviews, Marshall and colleagues analysed the effectiveness of ACT and other models (e.g. brokerage, strengths, which are collectively referred to by the authors as 'clinical case management') of case management separately (Marshall et al., 1998; Marshall & Lockwood, 1998). The meta-analysis of the effectiveness of ACT found that clients undergoing ACT were more likely than clients of standard care to remain in contact with services, less likely to be admitted, spent less time in hospital and had better outcomes with regards to accommodation status, employment and satisfaction with services (Marshall & Lockwood, 1998). Another meta-analysis by the same authors regarding clinical case management reached conclusions for only two outcome domains. Using data from 11 randomised controlled trials, it was found that case management increased the numbers of people remaining in contact with psychiatric services, but that it also *increased* the rates of hospital admission. Marshall et al. (1998) point out also that there was some evidence to suggest that case management increased compliance/reduced drop-out rates from mental health services.

Ziguras and Stuart (2000) used meta-analytical methods to investigate 11 domains of outcome for case management across 35 studies; ACT or CCM models were compared with usual treatment methods. Both models were found to be effective in reducing symptoms of illness, improving social functioning, reducing client drop-out from services and increasing client and family satisfaction with services.

The authors note further that the total number of admissions and the proportion of clients hospitalised were reduced in ACT programs and increased in CCM programs; and both models the number of days spent in hospital by clients, but ACT was significantly more effective (Ziguras & Stuart, 2000).

Is there a Recovery Focused Model of Case Management?

Worldwide, national health systems have traditionally adopted a view of mental health disorders that are highly influenced by the medical model, where severe mental illnesses are considered to be chronic with irreversible neuropathological brain changes and information processing deficits (Farkas, 2007). In an effort to overcome the historic medico-centric bias prevailing in mental health,

the consumer movement of the 1970s and 1980s – primarily through the writings, lived experience and insights of consumers/survivors/clients, introduced the concept of psychiatric rehabilitation, now commonly referred to as recovery (Anthony, 1993). The most widely used definition of recovery comes from Anthony (1993):

> ***…a deeply personal unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (p. 527).***

The definition of recovery outlined above now underpins current mental health policy in Australia and is named as a priority area in the National Mental Health Policy and the Fourth National Mental Health Plan 2009-2014 (Commonwealth of Australia, 2009; Department of Health, 2009) and in Queensland (Mental Health Branch, 2007, 2008). The principle of recovery is mandated also in the National Standards for Mental Health Services (Standard 3.2, Standard 6.7 & Standard 10.1, Australian Government, 2010), the National Safety and Quality Health Service Standards (Standard 2, Australian Commission on Safety and Quality in Health Care, 2012), and the EQuIP National Guidelines (Standard 11: Provision 4, Standard 12: Provision 1, The Australian Council on Healthcare Standards, 2012). Indeed, the importance of recovery as a part of mental health service delivery in Queensland is highlighted in Queensland Health's recovery paper, *Sharing responsibility for recovery* (2005), which notes that the facilitation of recovery is considered best-practice. The paper also provides a philosophical framework of sorts for mental health services and, more specifically, case management:

Recovery is an extremely unique and individual process that is more about the journey than the destination. It is a process that involves an overall upward trend but is not linear or planned. It involves growth and setbacks, and periods of slow and rapid change. It is a process that is often lengthy and complex, and does not necessarily mean symptom elimination or individuals returning to pre-illness state. Recovery is the journey toward a new and valued sense of identity, role and purpose outside the parameters of mental illness; and living well despite any limitations resulting from the illness, its treatment, and personal and environmental conditions (Queensland Health, 2005, p.9).

How then is policy translated into practice? Shepherd, Boardman, and Slade (2008) suggest that the aim of a recovery-oriented approach to mental health service delivery should be to support people to create and maintain a (self-determined and self-defined) meaningful and satisfying life and personal identity, regardless of whether there may be lasting symptoms of a mental illness.

Thus, a recovery-oriented approach may be seen to represent a movement away from the biomedical view of mental health to one that has a more holistic approach to wellness that builds on individual strengths. A recovery oriented service system should encapsulate mental healthcare that:

- encourages self-determination and self-management of mental health and wellbeing
- involves tailored, personalised and strengths-based care that is responsive to people's unique strengths, circumstances, needs and preferences
- supports people to define their goals, wishes and aspirations
- involves an all-encompassing approach that addresses a range of factors that impact on people's wellbeing such as housing, education and employment, and family and social relationships
- support people's social inclusion and community participation (Department of Health, 2011).

If we take as a given that recovery-oriented mental health care focuses on people's strengths and supports resilience and capacity for personal responsibility, self-advocacy and positive change, it seems to make sense then to adopt a model of practice that is strengths-based. Strengths-based practice refers to the identification of strengths within an individual, family or community (Francis, 2014). The acknowledged strengths are then employed to help in promoting healing and self-fulfilment in a client. Francis (2014) draws attention to the beneficence of the model by noting that the practice shows a marked shift away from language and actions that are based on a client's pathology or deficits.

The tenets of strengths-based practice, initially developed for the social work domain (Brun & Rapp, 2001), have been successfully applied to the field of mental health using the Strengths Model of Case Management. As outlined by Rapp (1998), Strengths-Based Case Management (SBCM) is based on the theory of strengths which attempts to identify specific factors impacting on an individual's life and how they can be changed for the better.

Central to the theory is the notion that clients must identify the paths they hope to take in areas such as: achievements, quality of life, life satisfaction, sense of competency and empowerment to achieve (Rapp, 1998). The theory further asserts that the 'niches' in which clients live (e.g. living arrangement, education level) directly impact whether those paths can be taken. In turn, individual (e.g. competencies or aspirations) and environmental (e.g. resources or opportunities) strengths directly influence the quality of an individual's niches. So, through the creation of niches that enable instead of entrap, clients can accomplish their desired life outcomes.

It may be seen then that the theory is based on internal as well as external factors that influence clients' lives. Rapp (1998) points out the methods or functions of the model, including: engagement of the therapist and the development of a real relationship with the client, strengths assessment, resource acquisition, personal planning and continual collaboration and gradual disengagement. With this in mind, Arnold, Walsh, Oldham, and Rapp (2007) eloquently note that SBCM is not simply providing referrals to needed services and then waiting for contact from the client if services are not received; Case Managers using the SBCM model must make the effort to know the persons with whom they are working and to engage them in a collaborative effort aimed at achieving their goals.

Support for the Strengths Model of Case Management

The strengths model was originally conceived for use with adults suffering from severe and persistent mental illness. Support for the SBCM model is fairly widespread, indeed Slade et al. (2014) nominate the strengths model as one of the 10 most important empirically-validated interventions which support recovery, by targeting the key recovery processes of connectedness, hope, identity, meaning and empowerment. The SAMSHA Consensus Statement on Recovery also included 'strengths-based' as one of its 10 essential components (Substance Abuse and Mental Health Services Administration, 2006).To date, five studies testing the effectiveness of SBCM have used experimental or quasi-experimental research designs (Björkman, Hansson, & Sandlund, 2002; Macias, Farley, Jackson, & Kinney, 1997; Macias, Kinney, Farley, Jackson, & Vos, 1994; Modrcin, Rapp, & Poertner, 1988; Stanard, 1999) and five have used non-experimental methods (Barry, Zeber, Blow, & Valenstein, 2003; Kisthardt, 1994; Rapp & Wintersteen, 1989; Rapp & Chamberlain, 1985; Ryan, Sherman, & Judd, 1994). Overall, the level of social functioning across a range of life domains (e.g. social support, leisure time, independence of daily living) was improved and symptomatology was reduced. In the studies using an experimental design, statistically significant differences in favour of individuals receiving SBCM were found in areas of:

- competencies of daily living (Macias et al., 1994)
- income (Macias et al., 1997)
- overall physical health (Macias et al., 1994)
- rates of psychiatric hospitalisation (Björkman et al., 2002; Macias et al., 1994)
- satisfaction with services provided (Björkman et al., 2002).
- skills regarding community living (Modrcin et al., 1988; Stanard, 1999)
- symptomatology (Barry et al., 2003; Macias et al., 1997; Macias et al., 1994)
- tolerance of stress and use of leisure time (Modrcin et al., 1988).

Some promising work has also been conducted in relation to the fidelity (level of adherence to the model) of SBCM programs and staff and client outcomes. Fukui et al. (2012) examined the link between SBCM fidelity and client outcomes of psychiatric hospitalisation, employment, independent living and post-secondary education and found a significant positive effect on clients over an 18-month period.

This suggests that the general beneficial client outcomes seen using SBCM can be further enhanced by increasing the standard of implementation of the model. Using standardised instruments, Petrakis, Wilson, and Hamilton (2013) evaluated the degree of fidelity to group supervision under the SBCM model in residential and community mental health services in Melbourne, Australia. Very high fidelity for group supervision was achieved for group interaction, client work and Case Managers. The authors note that the fidelity items, taken as a group, were useful in assisting the service, program and team to become strengths- focused especially during the establishment phase of using SBCM; and that this focus would allow for a more faithful recreation of the model for the benefit of clients (Petrakis et al., 2013).

7. Frequently asked questions about the Strengths Assessment

How do I proceed if the person says they don't want to fill out the strength's assessment?

Always remember the fourth principle - the relationship (not the assessment form) is primary and essential. The care coordinator should always use the strengths assessment in the context and flow of the relationship, not as a static document that is forced on a person whether they like it or not. If the person is resistant to having information about them written down in this manner, respect their decision. You can fill out a strength's assessment on your own simply as a way of keeping track of the client's strengths for your own recall.

Every few meetings try introducing the document in a new way. Be sure to focus on the fact that this is not a typical 'treatment' form, but rather a way to keep track of the abilities, strengths, and dreams that the person wants to achieve. When people understand that the strengths assessment is not the typical deficit, professionally directed form, but rather a celebration of all that makes them unique, they usually become more willing to give it a try.

What if the person has a history of criminal behaviour, suicide attempts, or problematic use alcohol or drugs, but they don't want it to be on the form? Do you just leave it out of the assessment?

The short answer to this question is… yes. The strengths assessment is a document that is directed by the client. Many consumers may be able to reframe such things as past criminal behaviour or an addiction as a strength (e.g. how far they have come, what they have learned through the process, etc.) or as a goal (e.g. I want to take my 12 step program more seriously). However, if it is not something the person wants to be on their assessment, that choice must be honoured. As a trusting relationship develops, this information may be something that will come up at a future time.

Remember, the strengths assessment is not typically the only written assessment that is completed by the mental health agency. For billing, legal, or other risk assessment protocol most programs require a complete psychosocial history be completed in the first few weeks of intake. These documents may include important information related to past behaviour to assess for risk that the care coordinator may need to know. However, they do little to inspire the hope and future focus that promotes recovery. Some agencies have a separate intake worker fill out the initial psychosocial assessment at intake rather than the Case Manager. This separation helps to keep the primary helping relationship with the care coordinator focused primarily on strengths.

How do you keep the strengths assessment as an on-going, working document?

Remember – the strengths assessment is a 'working document'. This means that it is constantly being updated. The strengths assessment can be added to or amended at any time but it is most beneficial if this can be done in conjunction with the client. The client should have a recent copy and there should be a recent copy in the chart to be referenced by other staff (e.g. vocational counsellors). Remember, the strengths assessment is not paperwork, but a central tool to promote recovery and growth. Do not let it get buried in the chart with all the other forgotten forms!

What if the person gives you information that you think is delusional (e.g. 'What is your income?' 'I receive a million dollars a year from the FBI.') Do I write that down?

The short answer, once again, is…you guessed it – yes. Writing something down on the strength's assessment does not imply that we fully agree with it. The strengths assessment is a record of what the consumer tells us about themselves, their ideas and beliefs, not our opinion of the validity or 'truth' of their views. If we were to not write this information down (or worse yet, attempt to convince the consumer that what they are telling us is false) we will run the risk of breaking the trust that is the foundation of the helping relationship.

What we should do is seek to learn more and find out what is underneath people's perceptions about themselves. For example, if someone were to say, 'I have a telepathic relationship with my boyfriend in New York,' we might explore with, 'What about your relationship do you enjoy? What parts are difficult?' When done with good clinical skill and genuine interest, this type of exploration does not reinforce a harmful delusional system but rather sets the foundation of trust and safety that people often need to step out into recovery.

(pp. 33-34 "Strengths Model manual for Special Care Settings", Paul Liddy, 2009)

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9. Further reading

Permission has been granted by Melissa Petrakis to include this article in this workbook.

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ORIGINAL PAPER

Implementing the Strengths Model of Case Management: Group Supervision Fidelity Outcomes

Melissa Petrakis · Mick Wilson · Bridget Hamilton

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Abstract To evaluate group supervision implementation fidelity in the Strengths Model of case management within one adult mental health service. A fidelity audit was undertaken to analyse data across three service settings—residential and community—during the initial three months, utilising instruments developed by Rapp and Goscha (The Strengths Model: Case management with people with psychiatric disabilities, vol 2. Oxford University Press, New York, 2006). Very high fidelity for group supervision was achieved for group interaction (74.8 %), client work (77 %) and by case managers (90 %). A standardised approach to group supervision process and documentation greatly supported fidelity in implementation. The Rapp and Goscha tools had utility as both learning aids and audit instruments.

Keywords Implementation fidelity · Recovery · Strengths Model · Case management · Mental illness

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Introduction

Evidence of clinical effectiveness is extremely important to key stakeholders in contemporary mental health service provision: clinicians, service managers, funding bodies, policy makers, and consumers and their families and carers. Evidence-based practice is increasingly prioritised and methods to achieve this are being developed (Aarons et al. 2010; Benton 1999; Chorpita et al. 2005). Recent literature has noted the importance of 'empirically supported, theory-based treatments' and that 'intervention delivery must be evaluated for fidelity to content and process' (p. 2) to ensure outcomes can be accurately attributed to the intervention or its application (Schoenwald et al. 2010). The challenge though is that studies have shown that most consumers with severe and persistent mental illness frequently do not receive evidence-based therapeutic services (Farkas et al. 2005; Lehman et al. 1998; Torrey et al. 2005).

The difficulty at present is that, while consumer outcomes represent the best and most accurate measures of service effectiveness, accurate data is rarely available (Hamilton 1999; Rapp et al. 2005). Rapp et al. (2005, p. 354) suggest that 'In lieu of outcomes, states could reward the attainment of high fidelity', noting that, for example, New York used Assertive Community Treatment (ACT) fidelity measures to renew licenses, with longer-term licenses linked to higher fidelity scores. Measurements of fidelity quantify and track the core components of an evidence-based practice model or intervention and provide scales for ascertaining the degree of adherence. It has been noted that such measures can be used to establish clear standards, monitor meaningful performance of programs over time, improve performance, and document the relationship between adherence to a model and outcomes (Bond et al. 2000; Rapp et al. 2005).

Strengths-based recovery models have become increasingly prevalent in mental health self-help agencies in the last 10 years (Hodges et al. 2004). A key goal that underlies this approach is to foster empowerment in individual service users (Dickerson 1998). Though the recovery movement has gained momentum over the last 20 years, in the psychiatric disability rehabilitation and support sector, it is still only recently being heard and responded to in clinical psychiatric services both in Australia and overseas.

While few randomised controlled trial studies have investigated outcomes of case management based on the Strengths Model compared to standard care, initial results are promising (Björkman et al. 2002). The Strengths Model has been found to be at least as effective as ACT on participant outcomes and utilization at 2 year follow-up (Barry et al. 2003). Services that have moved towards high fidelity Strengths Model practice have reported outcomes such as increases in numbers of individuals living independently, numbers competitively employed, numbers involved in tertiary education, and decreases in psychiatric hospitalizations (Rapp and Goscha 2006, p. 231).

Fidelity of Strengths Model implementation can be measured through use of the 12-item Strengths Case-Management Fidelity Scale (SCMFS). Two items explicitly relate to group supervision frequency and focus and a further four are impacted considerably by group supervision through the development of the strengths assessments, personal (goal) plans, the brainstorming of naturally occurring resources and an emphasis on hope-inducing behaviours (Rapp and Goscha 2006, pp. 264–266).

Group supervision for the authors of the model came about some 30 years ago to replace individual meetings as an efficiency measure (C.A. Rapp and Chamberlain 1985). Since then Rapp has attested that 'We have come to believe that group supervision is indispensable to effective case management practice' (Rapp and Goscha 2006, p. 218). In the Strengths Model, supervision sessions have three purposes: (1) support and affirmation of case manager efforts, ingenuity and accomplishments, (2) the generation of promising ideas to work more effectively with consumers, and (3) to facilitate case manager learning that can be applied to similar situations in future.

Brunero and Stein-Parbury (2008) noted (p. 87) that 'Whilst the practice of clinical supervision is established in other developed countries, such as the United Kingdom and the United States of America, at present it is underdeveloped in the Australian context'(Brunero and Stein-Parbury 2008). It has been observed though, in the United Kingdom, that many staff 'do not have regular, protected access to confidential conversations about the everyday challenges of their work, which would give them space and time to consider how they deal with increasing the quality of care with limited resources, and with ethical and moral issues' (Waskett 2010a), further:

> Often clinical supervision is "fudged" and slipped in under the headings of management supervision, appraisals, one to one meetings with team leaders, or even team meetings.

How consumers view any model of practice implemented within area mental health services to develop and support recovery-oriented practices by case managers is very important. Qualitative investigations of strengths-based practice found that, while consumers experienced an initial mistrust of the approach and the challenge of holding on to strengths and deficits simultaneously, the approach was viewed favourably, especially the relationship with the case manager (Brun and Rapp 2001). From a consumer perspective, in a seminal paper more than 20 years ago, Patricia Deegan established four recommendations for creating programs that enhance recovery (Deegan 1988). She noted (p. 18) that:

> perhaps most fundamentally, staff attitudes are very important in shaping rehabilitation environments.

A review of 40 years of outcome research in psychotherapy, including multidisciplinary perspectives, echoes this knowledge with the conclusion that the therapeutic relationship accounts for 30 % of action or change achieved by clients (Duncan et al. 2004).

The aim of this study is to evaluate the degree of fidelity to group supervision under the Strengths Model during its implementation in one public adult area mental health service; further to examine how this American model transfers and translates to an Australian clinical services context.

Service Development Strategies

In the Australian context, the Australian National Mental Health Plan 2003–2008 directed that services should adopt a recovery orientation (Commonwealth Government, 2003). During 2005–2006 St Vincent's Mental Health Service (SVMH), Melbourne, determined to implement the Strengths Model as a development of existing case management practice (Chopra et al. 2009). The model was directly and explicitly based on 'The Strengths Model: Case Management with people with psychiatric disabilities' (Rapp and Goscha 2006). The purpose of adopting this model was to refocus case management offered by the service, in line with current evidence, mental health policy directions and in keeping with the values of the acute hospital.

The model was first implemented in the intensive rehabilitation services: the Mobile Support Team, and the residential Footbridge Community Care Units (CCU). In 2007 the model was extended to Hawthorn and Clarendon

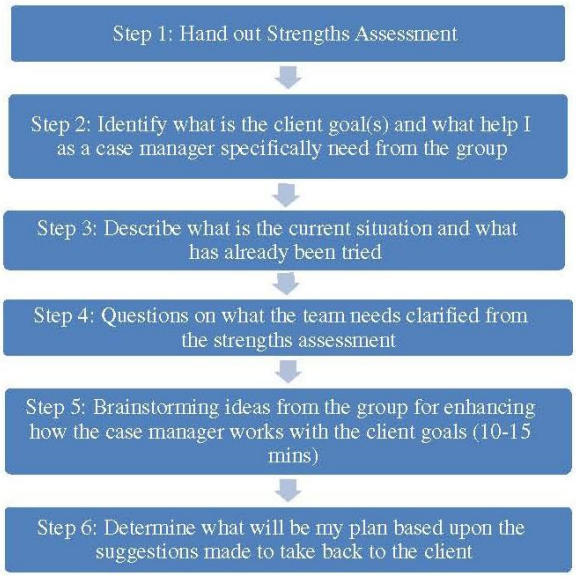

Fig. 1 Process description of strengths group supervision at St Vincent's Mental Health

clinics, the two community-based Continuing Care Teams (CCTs), providing case management to consumers with major mental illness.

The Group Supervision Approach Utilising Strengths Assessment and Goal Planning

The approach to group supervision adopted consisted of 6 steps. These are depicted in a flow chart (Fig. 1).

Methods

Strengths group supervision was initiated as a 3-month pilot (November 2008–January 2009 inclusive) across three sites: the intensive residential CCU and the two community CCT sites. This was conducted as described by Rapp and Goscha (2006). The supervision was held weekly at the CCU, for all but 2 weeks over Christmas, resulting in 10 sessions. For the two community-based CCT sites supervision was held fortnightly, resulting in 6 sessions for one site, and 6 and 5 sessions for the two teams at the second site.

The Group Supervision Feedback Documents as Tools in Evaluation

For the pilot the supervision process was monitored through the use of three documents: the facilitator's feedback form, the presenter's feedback form and multiple copies of the group feedback form completed for each session. The facilitator's feedback form was directly modelled on the questions for 'Supervisor's Group Supervision Monitor', pages 233-4 in the Rapp and Goscha text (2006). The presenter's feedback form was directly modelled on the questions for 'Case Managers—Group Supervision Feedback', pages 232–233 (Rapp and Goscha 2006). All group participants also completed a feedback form based on the 'Case Managers—Group Supervision Feedback', to assist them to orient themselves to the Strengths process and remain actively engaged with the monitoring of strengths-sensitive practice, even when they were not themselves presenting a case. These group feedback forms served as a reiteration and cross-check of the presenter's feedback form. The forms were standard,

Table 1 'Supervisor's group supervision monitor' for facilitator feedback

Group interaction
1. Session start on time
2. Seating circular and comfortable
3. Discussion among all participants
4. Own laughter in session
5. Participants laughter in session
6. Atmosphere optimistic and positive
7. No interruptions
8. Client situations were reviewed
9. Individual did not dominate the process
10. Ideas generated by majority of the group
11. No person made excuses to shoot down potential resources or ideas
12. Conscientious efforts which failed celebrated
13. People left feeling energised/more optimistic
Client work
1. Three or more options or ideas for tasks forward
2. Discussion ends with a specific plan or strategy
3. Discussion ends with specific tasks to be done
4. If frustrations help the clinician reframe expectations and/or break tasks into smaller steps
5. Use of the strengths assessment to identify goals, task or strategies
6. Community resources identified
7. Strategies for involving natural helpers
8. Did reframe 'problems'/'deficits' to 'interests'/'strengths' or 'goals'
9. Patterns or similarities between situations identified
10. Group identified and celebrated successes
11. Group members received positive feedback regarding the use of client strengths
12. Group members received positive feedback regarding the use of natural helpers
13. Group identified policies requiring advocacy

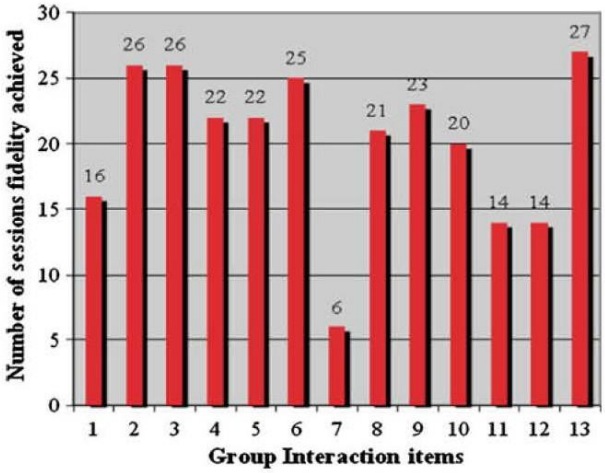

Fig. 2 Group interaction fidelity

however it should be noted that CCT site 1 utilised two-thirds of the facilitator feedback items rather than the full complement adopted at the other two sites for the pilot. In analysis for the seven missing items the mean was substituted.

Results

Twenty-five of the 26 items set out by Rapp and Goscha (2006, pp. 233–234) for the 'Supervisor's Group Supervision Monitor' were audited (Table 1). The final item 'Group identified policies requiring advocacy' was omitted for the pilot since policy redevelopment was beyond the scope of the initial piloting of these tools. These were sub-grouped into 'Group Interaction' and 'Client Work' as suggested by Rapp and Goscha (2006). Fidelity audit data from the intensive residential rehabilitation CCU unit and the two community CCT sites, including two teams within one site was collected.

High fidelity was achieved for Group Interaction. The mean fidelity score was 20.2 (74.8 %). Fidelity was most strong for 'People left feeling energised/more optimistic,' for 'Seating circular and comfortable' and 'Discussion among all participants' (Fig. 2). There was lower fidelity for 'No interruptions,' for 'No person made excuses to shoot down potential resources or ideas' and 'Conscientious efforts which failed celebrated'.High fidelity was achieved for Client Work. The mean fidelity score was 20.8 (77 %). Fidelity was most strong for 'Three or more options or ideas for tasks forward,' for 'Discussion ends with a specific plan or strategy' and 'Discussion ends with specific tasks to be done' (Fig. 3). There was lower fidelity for 'Patterns or similarities between situations identified,' for 'Did reframe problems/deficits to interests/strengths or

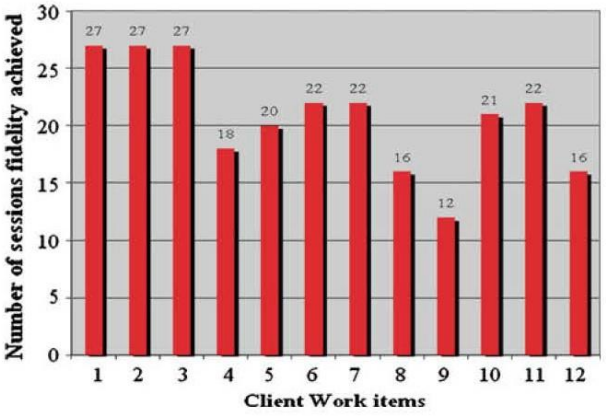

Fig. 3 Client work fidelity

Table 2 'Case managers—group supervision feedback' for presenter feedback

Receive help to:
1. Identify goals, tasks or strategies
2. Identify natural occurring non-mental health resources
3. Identify activities to be done by client/community
4. Break goals into smaller tasks
5. Translating problems into goals
6. Identify patterns or similarities between cases
7. Identify what clients want to work on
8. Engage clients in relationship
9. Identify client strengths
10. 3 or more options or ideas for tasks forward
11. Atmosphere optimistic and positive
12. Positive feedback on…/successes identified…
13. Conscientious efforts which failed acknowledged
14. Own laughter/enjoyment in session

goals' and 'Group members received positive feedback regarding the use of natural helpers'.

All 7 items, including sub-items, set out by Rapp and Goscha (2006, pp. 232–233) for the 'Case Managers—Group Supervision Feedback' were audited (Table 2). The form within our service has been titled the Presenter Feedback form.

High fidelity was achieved for Client Work. The mean fidelity score was 24.3 (90 %). Fidelity was most strong for 'Receive help to: Identify goals, tasks or strategies,' for 'Receive help to: Identify natural occurring non-mental health resources,' for 'Receive help to: Identify client strengths,' and both '3 or more options or ideas for tasks forward' and identification of specific 'Positive feedback on…/Successes identified…' (Fig. 4). There was lower fidelity only for 'Conscientious efforts which failed acknowledged'.

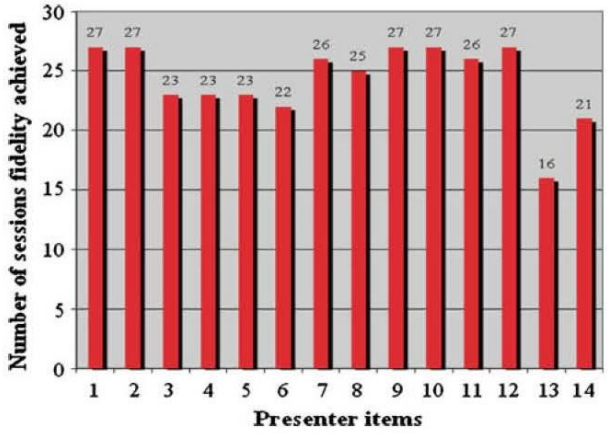

Fig. 4 Presenter fidelity

Qualitative Feedback

Following the 3-month pilot feedback was sought from staff who wished to clarify what was working well or could be improved. Positive feedback received emphasised that Strengths group supervision re-invigorated practice. There were slight differences in tone based on level of professional experience that the supervision process was contributing to. As one occupational therapist noted: "as a clinician you have a refreshed view and some new ideas which you can bring to the client." As one graduate nurse noted:

> Generally I have found the Strengths supervision to be useful. The brainstorming sessions provide useful ideas for the clinician presenting a consumer as well as other clinicians who may take ideas to other consumers. I also feel it helps clinicians to get some perspective on the challenges they may be encountering with the consumer they care for. Also it is very encouraging to here all clinicians express positive experiences they have had with clients.

Critical feedback concerned process aspects to be addressed following the pilot, prior to service-wide implementation. As one graduate nurse noted:

> A problem I find with strengths supervision is that the discussion prior to brainstorming can be unfocused and the purpose of this section unclear if the clinician running the session does not actively manage the group.

In suggesting recommendations, one experienced psychiatric nurse noted: "I think it could be useful in the future to consider the client being involved in the supervision session, obviously depending on mental state and level of engagement."

Discussion

Internationally there have been considerable challenges noted in implementing evidence-based practices into mental health services (Lehman et al. 1998). Changing mental health professional practice to recovery-oriented principles has met resistance, even when there has been a highly supportive policy environment, strong management support, and positive staff response following training (Deane et al. 2006).

The results of this study indicate that St Vincent's Mental Health Service has been faithful in its implementation of the Strengths Model of Case Management as outlined by Rapp and Goscha (2006). There has been consistent and careful application of process measures and paperwork to facilitate case managers becoming strengths-oriented in their practice. When case managers present how they are working with consumers and what they need support and assistance to achieve in a still more strengths oriented manner, this was viewed by clinicians as a highly productive undertaking. This is evidenced by the presenter feedback result of 90 % fidelity to group supervision according to this model. There has been consistent application of approach by those senior clinicians facilitating group brainstorming to support case manager efforts in undertaking meaningful and strengths-focused reflections, and the planning of their ongoing casework.

It is important to note that there has been a language shift in our implementation at St Vincent's Mental Health from 'Supervisor' to 'Facilitator'. The supervision has been uncoupled from line or performance management and instead is facilitated by an interested Senior Clinician peer. Further, this monitoring—initially called 'Group Supervision' as per Rapp and Goscha (2006, pp. 216–234)—is now called 'Strengths Brainstorming'. Again, staff feedback was that it was easier to be consumer-centred, goal-oriented and solution-focused in a session that was not conceptualised as 'supervision'. Since the key purpose of the meetings are to brainstorm consumer goals as a team, to open up new ideas and creative solutions to take back to the consumer, 'brainstorming' seemed a more appropriate term (Osborn 1963; Rickards 1999).

While these three tools were designed to facilitate supporting clinicians to adopt consumer-centred and strengths-oriented practice, they proved to be meaningful documents in an audit sense. They were efficacious as evaluative tools to monitor program and service adherence to the group supervision component of the Strengths Model. It has been noted that 'Supervision is likely to be established in a more sustainable way if the whole organisational process is carefully designed and monitored' (Hawkins and Shohet 2003). The importance of baseline measurement taken at an early stage for later comparison has been emphasised

(Waskett 2010b). In the results the facilitator and presenter feedback were collated, to clarify positive achievements in staff use of group supervision as well as areas for further development; a process in keeping with, or a mirroring of, the reflective and respectful framing that is a hallmark of this strengths-oriented work with consumers.

It is possible that there are some cultural differences between a North American community-based care context and an Australian clinical mental health service context. It was not immediately apparent to our staff, for example, that laughter in a group brainstorming session was a good thing or strengths-oriented. Many case managers and facilitators were understandably earnest in their attempts to use brainstorming to gain ideas to best support the consumers they work with. A conservative view of the appropriateness of laughter has negatively impacted fidelity scores on items 4 and 5 for CCT site 1 in the 'Group Interaction' section on the facilitator feedback form and item 14 for the CCU on the presenter feedback form.

For all four sites or teams there was low fidelity for the item of 'no interruptions,' at item 7 in the 'Group Interaction' section on the facilitator feedback form. This goal may not be readily achievable in a clinical context where crisis presentations for consumers are not uncommon. A low score may even be indicative of prioritising flexibility in meeting consumer needs and goals ahead of service quality assurance activities, rather than implying a lack of strengths-focused work being undertaken.

There were some site or team differences in interpretation of certain items. An example is that in facilitator feedback for 'Group Interaction' item 10, at the intensive residential CCU service, ideas were 'generated by the majority of the group' 9 out of 10 sessions. For CCT site 1 this was the case in 2 out of 6 of sessions, however the response to item 9 noted that simultaneously 'an individual did not dominate the process' in 6 out of 6 sessions. A very low item 9 score of fidelity for 1 out of 5 sessions from one team at CCT site 2, despite an overall group interaction fidelity mean of 4 out of 5, is further indication that these items taken individually may not reflect the fidelity being achieved. Dominance of a group member may not infer how strengths-oriented contributions are. Most groups have norms that become established over time, including that certain individuals may be looked to as leaders, with contributions particularly valued or beneficial to the group, and assertiveness by others may also be tolerated and absorbed.

That said, the fidelity items taken as a group were useful to assist a service, program or team in becoming strengths-focused, particularly during the establishment phase of utilising the Strengths Model. Totals for supervisor fidelity to group interaction and client work, and the extent to which the case manager presenting felt they received the help they sought, were highly relevant to fidelity of a Strengths Model as implementation was taking place, to monitor and modify that implementation. The items were useful prompts, enabling measurement and auditing, to ensure teams and programs remained faithfully strengths-oriented in their approach to reflecting on the work they were undertaking with the consumers they were aiming to support and assist.

Limitations

Although some diversity of case management and rehabilitation contexts was incorporated, with both continuing care and residential services included, a limitation of the study was that all three sites were from the same mental health service. It may not be possible to generalise results to other programs and services with their own specific organisational cultures, practices and policies. There may have been variations in staffing, the implementation of protocols, and program emphasis at each site that can affect outcomes (Barry et al. 2003). The study was one based in a clinical service setting, and in an Australian context, so results and implications may not be directly transferrable to psychiatric disability rehabilitation and support service contexts and to other programs and service cultures.

It should not be underestimated that St Vincent's Hospital Melbourne is explicitly a values-based organisation, and one that comes with a long history of ministering to those challenged by adversity in addition to ill health. The mission of the Sisters of Charity is guided by the values of compassion, justice, human dignity, excellence and unity; values that informed the Mental Health Service in its substantive implementation of a recovery approach and its endeavours to bring this in systematically across all components of the service. It may not be readily possible to implement the group supervision aspects of the Strengths Model as outlined by Rapp and Goscha (2006) in other clinical services without local modifications.

Conclusions

This evaluation of fidelity in the group supervision component of the Strengths Model of case management, implemented within one area mental health service, suggests that the two sets of items provided by Rapp and Goscha (2006) to confirm fidelity have utility for group facilitators and case managers. The group supervision feedback items for case managers were directly applicable when presenting challenges they were seeking to address in their work with consumers. The supervisor's group supervision monitor was beneficial during implementation of the model, however somewhat long at 26 items for ongoing

use. It was unclear whether items on laughter in sessions and the extent to which ideas were generated by all group members were reliably reflective of the Strengths Model in use.

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10. Appendix: Strengths Model Tools (templates)

Strengths Assessment for:

Current strengths: *What are my current strengths? (e.g. talents, skills, personal and environmental strengths)*	**Individual desires and aspirations:** *What do I want?*	**Past resources (personal, social, environmental):** *What strengths have I used in the past?*
Home/daily living		
Assets: Financial/insurance		

Employment/education/specialised knowledge		
Supportive relationships		
Wellness/health		

Leisure/recreational		
Spirituality/culture		

What are my priorities?

1.

2.

3.

4.

Additional comments or important things to know about me:

This is an accurate portrait of the strengths we have identified so far in my life. We will continue to add to these over time in order to help me achieve the goals that are most important to my recovery.	*I agree to help this person use the strengths identified to achieve goals that are important and meaningful in their life. I will continue to help this person identify additional strengths as I learn more about what is important to their recovery.*
My signature: _____	Clinicians signature: _____
Date: _____	Date: _____

Personal Recovery Plan for:

My goal (this is something meaningful and important that I achieve as part of my recovery):

Why is this important to me:

What will we do today? (Measureable, short term action steps toward achievement)	Who is responsible?	Date to be accomplished	Date accomplished	Comments

The goal listed above is something important for me to achieve as part of my recovery. My signature: _____ Date: _____	I acknowledge that the goal listed above is important to this person. Each time we meet, I will be willing to help this person make progress towards this goal. Service providers signature: _____ Date: _____