

# Strengths Model Case Management: Moving Strengths from Concept to Action

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Social work has long acknowledged the importance of focusing on the strengths of people and their environments. From the early years of Jane Addams and the settlement house movement (1902) to Bertha Capen Reynolds (1951) to Charlotte Towle (1953) to Germain and Gitterman (1979), voices from within the social work profession have repeatedly called for a focus on the capabilities, resilience, and empowerment of people and communities that have been marginalized throughout history. The University of Kansas School of Social Welfare drew upon the voices of these early pioneers and articulated the strengths perspective in the 1980's (Weick, Rapp, Sullivan, & Kisthardt, 1989), challenging the field to put the strengths and resources of people, communities, and their environments at the center of the helping relationship. Yet, despite these calls for an emphasis on strengths, deficit-based approaches continue to dominate conventional social work practice (Saleebey, 2009).

It was within this tension that Strengths Model Case Management was developed. The Strengths Model represented a significant paradigm shift for mental health, social work, and other helping professions. People with mental illnesses have historically been oppressed by the societies in which they live, and this has often been reinforced (albeit unintentionally) by professionals responsible for helping them. When the Strengths Model was developed, traditional case management approaches often focused on pathology and diagnosis, held low expectations for what people with mental illnesses could achieve in their lives, and frequently used stabilization and maintenance as measures of success. The Strengths Model arose in response to

this, viewing people not only as capable and possessing a unique array of personal and environmental strengths but also challenging and inviting professionals to focus their efforts and support toward helping people achieve life goals and roles that anyone else in the community might pursue.

This chapter provides an overview and the philosophical underpinnings of Strengths Model Case Management. The principles, research, and tools will be presented, along with a case example to demonstrate how the philosophy and practice approach work together. The chapter will conclude with a view of the implementation process for Strengths Model Case Management within an organizational setting and implications for the model moving forward. The purpose of this chapter is to emphasize the importance of taking strengths from a verbalized concept to an actionable set of practice and organizational behaviors designed to improve the lives of the people.

## **STRENGTHS MODEL CASE MANAGEMENT**

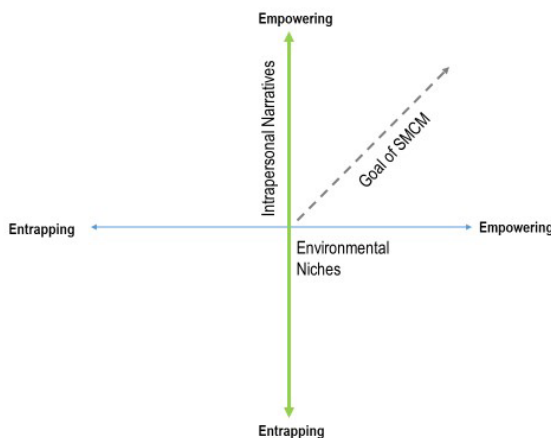
The Strengths Model started with humble beginnings as a pilot project. In 1982, the University of Kansas School of Social Welfare secured a \$10,000 grant from the state mental health authority to develop a case management model. Charlie Rapp, a faculty member at the School of Social Welfare, and Ronna Chamberlain, a student in the doctoral program, approached this task by devising a list of commonly mentioned goals stated by clients receiving community mental health services in Kansas at the time. Rather than typical goals seen on mental health treatment plans (e.g., stay out of the hospital, reduce symptoms, improve social skills, improve hygiene, etc.), clients spoke of aspirations related to having their own place to live, employment, education, relationships, and being part of the community. It was imperative that the model being developed provided a pathway for people to pursue these desired outcomes.

The vision was based more on the premise that there had to be a more effective way to work with people than continuously trying to remediate deficits than it was to fully conceptualize a new model of care. Yet the learning that was developed by this small group of social work students and their professor has resulted in a set of tools, methods, and interventions that have stood the test of time for over thirty years. Eleven studies have tested the effectiveness of the Strengths Model with people who have serious mental illnesses. Four of the studies employed experimental or quasi-experimental designs (Stanard, 1999; Macias et al., 1997; Macias et al., 1994; Modrcin et al., 1988), and six used non-experimental methods (Tsoi et al., 2018; Fukui et al., 2012; Barry et al., 2003; Ryan, Sherman, and Judd, 1994; Kisthardt, 1994; Rapp and Wintersteen, 1989; Rapp and Chamberlain, 1985). These studies have collectively produced positive outcomes in the areas of psychiatric hospitalization, housing, employment, reduced symptoms, leisure time and social and family support. Organizations implementing Strengths Model case management have extended beyond the borders of Kansas to include California, Oregon, Iowa, Oklahoma, Texas, and several countries (Canada, Hong Kong, the Netherlands, Australia, New Zealand, Japan, and Taiwan).

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

Strengths Model Case Management is both a philosophy of practice and approach to practice embedded within specific tools and methods designed to help people: 1) identify and achieve meaningful and important life goals; and 2) increase their ability to exercise power related to how they view themselves and how they interact with their environment.

A key component of Strengths Model practice is helping people make movement on two critical levels that impact a person's recovery and wellbeing: 1) movement from entrapping intrapersonal narratives to empowering intrapersonal narratives; and 2) movement from entrapping environmental niches to empowering environmental niches. Figure 1. illustrates the positioning of Strengths Model Case Management as it relates to helping people make movement from entrapping narratives and niches to empowering ones.



**Figure 1.** Empowering and Entrapping Intrapersonal Narratives and Environmental Niches

Intrapersonal narratives are the messages we tell ourselves that have a profound impact on our behavior (Hayes, 2004). While many times these messages can be empowering (e.g., “I am intelligent,” “I am a good parent,” “I am hardworking,” “People enjoy being around me.”), they can also be entrapping (e.g., “I can’t do this because of the anxiety or voices,” “I don’t deserve anything better,” “I have nothing to contribute to others or my community,” “I ruin everything,” “I am just an addict.”). These entrapping intrapersonal narratives can constrain people from making movement toward the life they want by contributing to and reinforcing fears, self-doubt, self-blame, and resignation. Entrapping intrapersonal narratives can develop and become engrained as a response to traumatic events or experiences, negative messages we internalize through the words of others, or views about ourselves that we personalize based on stereotypes, stigma, and discrimination.

The Strengths Model recognizes that helping people build or rebuild a life is not just about changing our internal thoughts. The people we work with do experience real problems, barriers, and challenges that can constrain movement toward a desired life. People can also be caught in entrapping niches in which movement and choice may seem limited. A “niche” is “the environmental habitat of a person or category of persons” (Taylor, 1997). This could include the places where people live, work, and socialize, but it can also include the relationships people engage in, their social networks, and systems designed to provide help and support. These niches can fall on a continuum of empowering (those that provide abundant opportunities for learning, growth, support, and movement to other empowering niches) to entrapping (those that restrict or suppress learning, growth, and support, and are devoid of opportunities to move to more empowering niches).

Entrapping environmental niches include, but are not limited to homelessness, poverty, abusive relationships, unemployment, social isolation, resource-poor neighborhoods, and unsafe housing. These niches are often stigmatized and create additional barriers for people achieving valued goals and roles in their life. Strengths Model Case Management provides intensive community-based support to help create opportunities for people to move toward empowering niches (employment; educational diplomas, certificates, or degrees; supportive relationships; meaningful involvement in the community; a place that offers safety and feels like home) by marshaling and building upon useable strengths that the person already possesses.

The Strengths Model rests on six core principles (Rapp & Goscha, 2012):

**Principle #1:** People can recover, reclaim, and transform their lives. The Strengths Model emphasizes that the capacity for growth and recovery already exists within the individual or family. The Strengths Model does not define recovery as a cure or remission of symptoms as viewed from a medical lens. Rather, the Strengths Model honors the resiliency of each individual to continue building or rebuilding a life despite life circumstances. Recovery

is about an individual's ability to recover their sense of self, their identity, their hopes and dreams (apart from clienthood or disability) and recognize and leverage the capabilities and strengths they possess to achieve desired life goals and roles. Our job as helping professionals is to help create conditions in which growth and recovery are most likely to occur. It is important to recognize that we do not possess the power to control or predict how one's recovery journey will unfold, so we embrace the dignity and worth of each person before us and work from a lens of possibility and opportunity.

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

Recovery is not fueled merely by overcoming problems, barriers, and challenges. In fact, many people recover despite the problems, barriers, and challenges faced in their lives. The Strengths Model does not ignore problems. The Strengths Model practitioner validates the person's experience and responds to the immediate challenges that people face. Yet merely solving problems, at best, returns the person to an equilibrium. However, exploiting strengths and opportunities promotes growth. People tend to flourish based on their individual interests, aspirations, and strengths. Rather than ignoring problems, the Strengths Model calls for us to push further and exploit the strengths and capabilities that will help the person build or rebuild the life they desire.

**Principle #3:** The community is viewed as an oasis of resources. This principle is a corollary of the previous one. Strengths Model practice focuses not only on the strengths of the individual but also on the strengths of the environment. Most obvious to helping professionals are what communities lack and the difficulties encountered accessing the few resources available. From a strengths perspective, we must find pockets of strengths in our communities—the employers, property managers, teachers, neighbors, family, friends, and other community members who could be mobilized to help people achieve specific goals. While the community can contribute to the distress in a person's life, the community also provides the opportunities and resources needed for people to thrive. The concept of finding empowering niches is important here.

**Principle #4:** The client is the director of the helping process. Helping professionals bring expertise and information about various strategies, resources, options, and methods for achieving specific client goals; however, it is important to recognize that people

receiving services are the experts concerning their own values, preferences, desires, and experiences. Opportunities to reinforce the person as the director of the helping situation must be found, created, and promoted. The benefit of this approach is to keep workers centered on what is meaningful and important to the person rather than what professionals or others within the system deem “best” for the person. Strengths Model practitioners should do nothing without the person’s approval and should involve the person in decisions during every step of the process.

**Principle #5:** The relationship is primary and essential.

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

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

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

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

## THE STRENGTHS ASSESSMENT

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

## THE PERSONAL RECOVERY PLAN

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

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

## CASE EXAMPLE

Kenny heard persecutory voices since he was young. Because of this, he also experienced intense social anxiety being around others. He always feared that others could hear the same voices he heard, and they would judge him. Kenny had been fascinated with martial arts since childhood and remembered taking a community education class to learn karate when he was 14 years old. Though he enjoyed the class, his mother could not afford to pay for more lessons. Even so, he continued to practice the skills and techniques he learned on his own.

Now an adult, Kenny continues to hear voices. Though the medications help to soften them somewhat, he avoids social situations whenever possible. A standard goal of his treatment plan is to increase social interaction. He has made little progress on this goal. Attempts to encourage him to do things in the community often proved futile.

While doing a Strengths Assessment with Kenny, his worker learned about his love of martial arts and some of the skills he developed over the years. Kenny rebuffed initial discussions about taking another karate class, but he continued to discuss karate. Over time, Kenny asked more questions about taking karate classes, such as where they were held, what the instructors might be like, what if everyone there was better than he was, how he would afford the class, what if the voices got bad during a class, etc. The worker offered to explore each of these questions with Kenny and they eventually started a Personal Recovery Plan with the goal of earning a black belt in karate.

Together they visited the two martial arts studios in town. He really liked the instructor at one place and was allowed to observe a few of the different classes offered. He was even offered a free two-week membership. Kenny also became comfortable enough to discuss that he heard voices with the instructor. This turned out to be a good match. The instructor had a brother with autism, and he understood the difficulties some people experience in social situations. They talked about how he could leave class whenever he felt uncomfortable and return at any time. Kenny succeeded in the class and eventually received his black belt in karate.

This case example highlights a significant trajectory shift in the life of a person. Kenny had spent nearly 10 years receiving services from a community mental health program. When Kenny entered services in his late teens, it was in response to a desperate plea from his family for help. He had withdrawn from all social encounters, was doing poorly in school, started shouting at voices that others could not hear, his behaviors were at times antagonistic, and he stopped caring for his personal hygiene. Kenny was started on antipsychotic medication, assigned a therapist, and started attending groups. Initially, there was relief for the family when he started to stabilize, but it was short-lived. Over the next 10 years, Kenny was in and out of the hospital, had difficulty keeping housing, had difficulty with adherence to medica-



tions, and had difficulty forming relationships due to the increasing paranoia and anxiety. Furthermore, Kenny was losing hope, assuming the role of clienthood, and passively resigning his life over to illness.

When Kenny started working with a case manager skilled in Strengths Model practice, his life situation did not immediately change, nor did the problems and challenges he experienced. What changed was an elevation in expectations for what was possible and a focus on the well-aspects of Kenny's life, even amid distressing voices, confusion, and fear. The Strengths Model recognizes that people cannot organize a recovery journey around the absence of things or deficits. As Pat Deegan aptly states, "You can't organize recovery in a vacuum" (Deegan, 2018). You can't build or re-build a life merely around staying out of the hospital, or not hearing voices, or not using drugs or alcohol. The Strengths Model approaches building or re-building a life in the same manner anyone in the community would do so: around something of meaning, importance, and value to the person and leveraging the tangible strengths we already possess (either personal or environmental). For Kenny, that meant building around his desire to do karate and the skills and talents where he already had competency.

The Strengths Model tools (the Strengths Assessment and the Personal Recovery Plan) serve as a visual representation of the life-building work that is the hallmark of strengths-based practice. The most valuable tool in the Strengths Model is not the Strengths Assessment nor the Personal Recovery Plan; it is the workers themselves. The tools are mere repositories for key information that is elicited within the dynamic relationship between two people: the worker and the client. It takes a purposeful, curious, intentional, and dedicated worker to see strengths amid a plethora of deficits, problems, and obstacles. The strengths-based worker must continuously develop the relationship with the client by creating an environment of trust, empathy, and genuineness in order to engage the client around the well-aspects of their life. The worker must also communicate their sincere investment into the life of another person; that the person's hopes and dreams are important, their pain is real, and the worker is invested in working alongside them to help them move forward.

While it is important for the worker to see the strengths a person possesses, it is more important for the client to be able to see their strengths and use them. Herein lies the primary value of using the Strengths Assessment and the Personal Recovery Plan. At its core, these visual tools are a means to communicate both hope and empowerment to the client. Snyder (2010) defines hope as consisting of three major components: goals, pathways, and agency. Using Snyder's (2010) framework, goals are the mental targets that guide human behavior, pathways are the ability to generate multiple routes to the desired goal, and agency is the perceived ability to initiate and generate movement along a pathway. Figure 2 is the beginning of a Strengths Assessment that was generated over a few conversations between Kenny and his worker.

**Figure 2.** Kenny’s Strengths Assessment

**Strengths Assessment for Kenny**

<b>Current Strengths:</b> What are my current strengths? (i.e. talents, skills, personal and environmental strengths)	<b>Individual’s Desires, Aspirations:</b> What do I want?	<b>Past Resources – Personal, Social, &amp; Environmental:</b> What strengths have I used in the past?
<b>Housing/Daily Living</b>		
I currently live with my mother – she cooks the best meals I like living in a small town. I can get almost anywhere without a car.	I would like my own apartment.	I have lived on my own in an apartment. I like the freedom. I was able to cook my own meals and decorate it the way I like.
<b>Financial/Insurance</b>		
I am currently receiving SSI. My mom gives me money when I’m running low.	I would like to get off SSI and work.	I worked for a few months stocking shelves at a grocery store. I like to organize things and make sure everything is where it needs to be. I volunteered once for Salvation Army during Christmas. I liked that I got to see people, but not have to talk to them.
<b>Vocational/Educational</b>		
I know how to do some karate – basic moves and kicks	I want to get back into karate I want to get a job so I can have more money to go out to eat when I want.	I took karate classes when I was 14. I was pretty good.
<b>Social Supports</b>		
“My mom cares about me. I know that” – she let me come home when I had no other place to go. She cooks for me.	I would like someone to do things with, like go to a movie or someone to teach me how to camp.	My dad was a support to me before he died a few years ago. I went camping with my cousins when I was younger. I had a best friend in elementary school before he moved away. He got me into comic books.



Model posits that these conversations lack the impact and relevance to the person outside of a context that is meaningful and important to the person. It is much more impactful to have a conversation about symptoms, behaviors, and problems when it is framed within the context of what the person desires to accomplish. For Kenny, this was getting back into karate, getting his own apartment, learning how to camp, and eventually getting a job.

Using the Strengths Assessment also starts from the position that most people are aware of the problems, barriers, and challenges they experience. They are much less aware of the well-aspects of their life. The problems, barriers, and challenges that people experience often serve as the lens through which people filter other aspects of their life. This filter can contribute to and reinforce the entrapping narratives that people communicate to themselves. The Strengths Assessment serves as a vehicle to create space for an alternative narrative to initially co-exist and eventually possibly replace an entrapping narrative with a more empowering one.

In Kenny's case, the Strengths Assessment represents a truth about himself that is just as real as the voices he experiences, the fact that he is not currently employed, or the fact that he feels intense anxiety being around people. The Strengths Assessments brings to the forefront that even amid the challenges Kenny has and is currently experiencing, he still has hopes and dreams for his life. And Kenny still has concrete strengths that could be mobilized to build the life he wants, including the specific ways his mom currently supports him, he loves and knows how to do some karate, reads comic books, lifts weights, and believes in a higher power. All these things exist independently of his challenges and in fact, are things that contribute to him being well and are worthy of being amplified. The Strengths Assessment is about building hope and gaining traction for movement forward. For Kenny, these were the seeds that needed nourishing for growth.

While the Strengths Assessment is an important tool in the arsenal of the Strengths Model practitioner, it only realizes its full impact when accompanied with the Personal Recovery Plan. As noted previously, Snyder (2010) mentions three components of hope: goals, pathways, and agency. The Strengths Assessment opens the door to goals and potential pathways. The Personal Recovery Plan selects a pathway that best aligns with the internal motivation of the person and one where the person can exercise a capability they possess (agency).

Figure 3 shows the initial Personal Recovery Plan (PRP) that Kenny and his case manager Sarah started after Kenny decided he wanted to pursue karate classes.

Figure 3 only demonstrates steps that were taken in the first month. There were many more steps that were added between the time Kenny turned in the trial membership form and his eventual attendance at the ceremony where he was presented with his black belt. It is also important to note that not all the steps that are recorded on the PRP in Figure 3 were recorded on the same day. The PRP is an



allows the opportunity to celebrate even the smallest steps as progress and worthy of acknowledgment. For some clients, this is particularly important when trying to create space for empowering narratives as it emphasizes the client's capabilities and generates hope around possibilities.

Lastly, this approach allows for immediate re-assessment if the step doesn't go as planned. At times people can retreat or even abandon a goal when something doesn't go well, which can potentially reinforce an entrapping narrative (e.g. "I knew I couldn't do this," "This is never going to happen," "I give up"). The iterative approach to the PRP allows the worker the opportunity to acknowledge the client's effort, re-visit the importance and value of the overall goal, explore alternative pathways toward achieving the goal or even re-attempting the same step with added supports or breaking it down into smaller, more manageable, and achievable steps. The important thing is for the worker to help the client arrive at the next "best step" for them based on the information and outcome of the preceding step to generate movement.

The work of the Strengths Model centers around movement more so than the achievement of the stated goal itself. People change their mind about goals and what they want. People are constantly re-evaluating goals as they take steps toward it. Most people are actually looking for the "active ingredients" they hope will be derived from the goal they set. For example, a person may set a goal of losing weight. If we explore this goal with the client further, we may find that the person is unhappy with how they look and believes losing weight might make them more attractive to a potential partner. But what if the person loses 50lbs, but never finds that partner who they envision will enjoy spending time with them and sharing common interests? Did they achieve their goal? On the other hand, what if the person ends up gaining 10lbs, but finds that partner who adores them for who they are? Did they achieve their goal?

This is what makes the iterative approach of goal planning in the Strengths Model so critical. It keeps the worker constantly focused on the thought process and meaning the client assigns to each step of the goal planning process. It keeps the worker from getting too far ahead of the client and overly myopic on accomplishing the stated goal. Instead, efforts are channeled toward helping people make movement, whether this means deciding to take another step toward the goal, addressing an entrapping narrative that obstructs movement, re-evaluating a goal after understanding more about what a person desires, changing or setting a new goal, discussing alternative pathways and options, or sometimes even being comfortable with a client's indecision as they process options for a pathway forward.

## **IMPLEMENTATION OF STRENGTHS MODEL CASE MANAGEMENT ON AN ORGANIZATION LEVEL**

The case example of Kenny shows the Strengths Model at work at the individual worker-client level. While helping direct service workers learn how to use the tool,

and specific methods, techniques, and interventions embedded within the model, the Strengths Model has its greatest impact when the development of these skills is part of a larger organizational shift and commitment to providing recovery-oriented services. From 1989 to 2004, instruction on Strengths Model practice was approached primarily through a two-day workshop. In 2002, Kansas joined the National Evidence-Based Practices project through Dartmouth and began a more robust and systematic process to the implementation of evidence-based practices based on implementation science (Rapp, Goscha, and Carlson, 2010). Kansas started with the implementation of the Individual Placement and Support (IPS) model of Supported Employment and Integrated Dual Disorders Treatment (IDDT) in 2002 and added Strengths Model case management in 2004. Implementation support for Strengths Model case management was provided over a two-year period and included the following sets of activities:

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

**Implementation:** This included the 2-day Strengths Model workshop and also involved online coaching calls and onsite visits to help staff build skills in areas such as: engaging people around their definition of recovery; assessing strengths; understanding motivation and goal setting; understanding the “active ingredients” desired through specific goal pursuits; use of naturally-occurring resources; maximizing choice and autonomy; generating movement through an iterative process of personal goal planning, and working towards graduated disengagement. Support was also given directly to the supervisor to learn how to review Strengths Model tools and provide feedback to staff, learn how to conduct in-vivo field mentoring sessions with their staff to help staff apply skills in actual practice with clients, and support to establish Strengths Model group supervision.

**Sustainability:** This involved fidelity reviews to determine alignment with specific practice standards and detailed fidelity reports to guide improvement efforts. In 2004, the University of Kansas Center for Mental Health Research and Innovation developed a 9-item fidelity scale divided into three core areas: 1) structure, 2) supervision/supervisor, and 3) practice/service.

The importance and impact of a structured implementation process for a practice that involves complex skills sets like Strengths Model case management cannot be overstated. The impact can be seen in the study by Fukui et al. involving 14 teams at 10 agencies serving an average of 953 clients (2012). In this study, there was a statistically significant association found between higher fidelity to the model and positive outcomes related to psychiatric hospitalization, competitive employment,

and post-secondary education. To date, this is only one of two Strengths Model studies in which fidelity was measured (the other being Tsoi et al., 2018, which also produced positive results), increasing the confidence that the intervention clients received was aligned with Strengths Model practice.

**Table 1.** Agency Commitments Required by Fidelity Item

Fidelity item	Agency commitment
<b>Structure</b>	
1. Caseload Size	Commitment to keep average caseload size for case managers under 25:1. This could be an individual case manager who has a caseload of 25:1 or a combination of staff (case manager/peer support worker) who can support the person in the community whose combined time equates to a caseload under 25:1.
2. Community Contact	Commitment to ensure that 75% or more of case management contacts with the clients occur in the person’s home or in the community (not at the offices of the agency)
<b>Supervision/Supervisor</b>	
3. Group Supervision	Commitment to start the group supervision process within the first three months of implementation. This does not have to be a new meeting, it can be a re-organization of a current team meeting where clients are discussed.
4. Supervisor	Commitment to allow the team supervisor time to review Strengths Model tools and give feedback to staff (In the beginning, as teams are learning Strengths Model practice, this might be two hours per week and built into coaching calls with the supervisor.). Commitment to allow the team supervisor time (at least once per month) to provide field mentoring for case manager.
<b>Practice/Service</b>	
5. Strengths Assessment – Quality	Commitment to start using one Strengths Assessment with one client following the initial Strengths Model workshop. Within six months, a Strengths Assessment should be started on each client being served by the case management team.
6. Strengths Assessment – Integration	Commitment to improving the quality of treatment plans by using information attained through using the Strengths Assessment
7. Personal Recovery Plan	Commitment for each case manager to start using one Personal Recovery Plan with one client within six months of implementation. Within one year, case managers should be using the Personal Recovery Plan with 75% of all clients being served by the team.
8. Naturally Occurring Resources	Commitment to using naturally-occurring resources with clients to achieve goals whenever possible
9. Hope Inducing Practice	Commitment to align with clients around goals that are meaningful and important to them and respect client choice and autonomy whenever possible.



Implementation of Strengths Model case management at an organizational level requires commitment at a leadership level. Table 1 outlines the agency commitments, related to each item on the Strengths Model fidelity scale that are needed prior to providing the full range of implementation support. Many of these items (i.e. caseload size, community contact, use of naturally occurring resources) are grounded in research over the past 40 years on effective case management practices (Rapp & Goscha, 2004). Others, like group supervision (Rapp, Goscha, and Fukui, 2014) and key supervisor behaviors (Carlson, Goscha, & Rapp, 2016), and the choice and autonomy subitems of hope inducing practice (Dixon, Holoshitz, & Nossel, 2016) are supported in the literature.

In addition to these commitments, the organization must collect and report monthly client outcomes. At a minimum, these outcomes must include: independent living, competitive employment, post-secondary education, satisfaction with supportive relationships, and satisfaction with community involvement. These outcomes take primary importance within the Strengths Model because they are areas that people within any community build upon to achieve health and wellness. While Strengths Model case managers work with people in a variety of areas where there are challenges and concerns (e.g. health concerns, mental health symptoms, substance use, legal, transportation, benefits, and activities of daily living), it is more consistent with Strengths Model practice when work in these outcomes are viewed in the context of key recovery-oriented outcomes. For example, “I want to manage diabetes so I can do more things with my family (supportive relationships),” “I want to stop hearing voices so I can think at work (employment),” “I want to quit using so I can keep my apartment (housing).” This focus of key recovery-oriented outcomes differentiates Strengths Model case management from other models of case management. All models of case management focus on helping people address immediate needs; the Strengths Model strives to help people build or rebuild a life that brings meaning, purpose, and valued identity.

While many organizations have aspired to implement Strengths Model Case Management over the years, it’s dissemination into routine practice in mental health has been plagued by difficulties experienced by implementing any evidence-based practice (Bond et al., 2014). Implementing evidence-based practices is complex and often requires changes in the state infrastructure of policy and financing, the design of how programs are structured, and practice methods used by staff. For a practice like Strengths Model Case Management to be implemented at high fidelity, there must be a synergy of interventions in five critical areas: state policy levers, program leadership, fidelity and outcomes reporting, supervisor training and support, and staff training (Rapp, Goscha, & Carlson, 2010).

The state mental health authority strongly influences the implementation of any evidence-based practice (Isett et al., 2008; Rapp et al., 2005; Bond et al., 2009). Strategies that have been employed include publicly recognizing high-performing evidence-based practice providers, enhanced reimbursement rates, paying agen-

cies for better clinical outcomes, and fast-tracking providers using evidence-based practices in the competitive bidding process (Stewart, 2018). In Kansas, the state incorporated into their managed care contract a rate structure for case management reimbursement that was higher for agencies that achieved high fidelity in Strengths Model Case Management.

Leadership at the site level was the common facilitating factor for programs that sustained high fidelity in an evidence-based practice in the National EBP Study conducted by Dartmouth University (Bond et al., 2009). When implementing Strengths Model Case Management in Kansas, two major mechanisms were used to facilitate support from local leaders. One was a contract signed by the agency executive with the University of Kansas (who provided the implementation support) and the state mental health authority (who certified teams achieving high fidelity in the Strengths Model to be eligible for the enhanced reimbursement rate). Elements of this contract included: 1) participation in the activities needed to successfully implement Strengths Model Case Management (e.g. leadership teams meetings, fidelity reviews, and staff training); 2) creating a plan to resolve barriers to achieving high fidelity; 3) making the structural changes necessary to implement the practice (e.g. lowering caseloads, increasing the time case managers saw clients in the community versus the office; decreasing staff to supervisor ratio, etc.); and 4) ensuring that the team supervisor can devote the time needed to help staff build skills, lead group supervision, and review and give feedback to staff on their use of the Strengths Assessment and Personal Recovery Plan in practice. The second mechanism was the creation of a leadership team to oversee the successful implementation and sustainability of the model. Typically, the leadership team was comprised of the senior executive leader or other staff who had decision-making authority within the organization, the program leader, the team supervisor, a representative from case managers implementing the model, a representative from the state mental health authority, as well as client and family representation. In Kansas, leadership teams often met quarterly for the first two years of implementation and annually thereafter. The role of the leadership team is to review progress, discuss barriers, and develop strategies and action plans to remove obstacles to improved fidelity.

Fidelity reviews are a critical element of any EBP implementation (Bond et al. 2009; Rapp et al. 2008). In Kansas, these reviews were conducted every six months for the first two years of implementation and annually thereafter for Strengths Model Case Management. Each review, typically lasting one day, was conducted by two reviewers knowledgeable in Strengths Model practice and also included a representative from the state mental health authority (who was responsible for certification). Each review culminated in a report that contained the scores, evidence for the ratings, highlights of achievement, and recommendations for improvement. After review by the agency executive, the fidelity review report was submitted to the leadership team to take action. While fidelity reviews by themselves may not spur action, when linked with the financial incentives as described above, there is increased motivation on the part of an organization to take the necessary steps to achieve high fidelity.

The role of the supervisor is indispensable to the successful implementation of an evidence-based practice (Corrigan et al., 2001; Rapp et al., 2008). The Strengths Model Case Management fidelity scale requires the implementation of key supervisory behaviors. This includes: 1) leading the team in group supervision for 90 minutes to two hours depending on team size; 2) reviewing Strengths Assessments and Personal Recovery Plans and providing feedback to staff; 3) and providing field mentoring. Field mentoring, in particular, has been an important driver in helping staff build the needed skills to do Strengths Model practice (Carlson, Goscha, & Rapp, 2016). Field mentoring refers to a supervisor accompanying their staff in the field for the purpose of teaching or improving a specific skill or method of practice. While we would like to believe that the way a staff person practices can be gleaned from what is written on practice tools such as Strengths Assessments and Personal Recovery plans or recorded in case notes, it is only in the direct observation of staff interacting with clients that we can learn the processes and approaches used as part of their practice. Effective field mentoring is not intended to be an exercise in micromanagement, but rather conducted in the spirit of learning and professional growth. It is an essential component of Strengths Model Case Management implementation to ensure that staff are implementing the “spirit” of the model, not just adhering to the structural elements and completing required tools.

While the structural elements of the model are important, it is the development of staff skills that is at the heart of the model and the essential ingredient needed to affect practice change. Yet, it is an area that is not often given the attention it requires in the implementation of an evidence-based practice (Carlson, Goscha, & Rapp, 2016). Training is necessary, but an insufficient mechanism by itself, to become proficient in a complex skillset like Strengths Model practice. While Strengths Model Case Management implementation starts with a 2-day workshop to understand how the philosophy, principles, tools, interventions, and methods of the model fit together, opportunities for skill development are embedded throughout the two-year implementation process. Early in implementation, much of the focus is on building the skills of the supervisor via web-based coaching calls and onsite visits so they are equipped to provide clinical direction and support for their staff. Supervisors learn how to create a learning environment through group supervision, how to review tools and provide feedback, how to conduct field mentoring sessions, how to use outcome data to guide quality improvement efforts, and how to track the development of staff skills using the Strengths Model Core Competencies tool. The process of helping staff build skills is iterative. The skill-building exercises used in the initial 2-day workshop are geared toward one primary goal: to help each participant start one Strengths Assessment with one client. The goal is movement, mirroring the process staff are expected to do with clients.

Implementation of Strengths Model Case Management at an organizational level takes time, energy, resources, and commitment. Many dedicated organizations over the years have demonstrated that implementing the model to high fidelity is doable. While making the investment in a model that is effective may seem daunting,

mental health systems already expend a considerable amount of time, energy, and resources doing what they currently do, whether it makes a difference in the lives of the people they serve or not. So, the question for policymakers and mental health leaders is how should we invest our time, energy, and resources? A phrase commonly attributed to Paul Batalden, Professor Emeritus in Pediatrics at the Dartmouth Institute, is “every system is perfectly designed to get the results it gets.” If we are to improve outcomes for the people we serve, we are obligated to continuously scrutinize the design of our service delivery systems.

Implementation of Strengths Model Case Management at an organizational level elevates the commitment and accountability that mental health leaders verbalize to improve the lives of people diagnosed with serious mental illness. It is an acknowledgment that in order to help people build or rebuild lives, apart from our systems of care, that have meaning, purpose, and valued identity, then we must provide more than just treatment for mental health symptoms and behaviors. We must strive to create opportunities for people that are similar to opportunities for anyone else in the community.

## CONCLUSION

We are in an era of mental health services where the term “strengths” exists in common nomenclatures, like terms such as empowerment, recovery-oriented, and person-centered. Our desire is that these terms are reflective of our practice and organizational designs. However, what we believe about our practice and behaviors and what we actually do are not always aligned. Thirty years ago, Ann Weick and others at the University of Kansas School of Social Welfare challenged us to align “the doing of social work with its system of values” and that “uncovering these strengths and framing them in an accessible and useful way” is a core social work process (Weick, Rapp, Sullivan, and Kisthart, 1989, p.354). Strengths Model case management has continued to evolve over the years to keep that spirit alive within the profession by helping people exercise their own power for change and movement toward the life they want. Strengths Model case management provides a structured set of methods and interventions, that are grounded in practice tools, and can be embedded within an organizational design.

Strengths Model case management is not a panacea for the challenges we face as a society. It does not abdicate social workers’ responsibilities to advocate for social change and human rights. But it calls us to take action and create opportunities where we can for people who must navigate a pathway forward. The Strengths Model is a challenge to elevate our expectations of what people can achieve, amplify our awareness of the strengths, capabilities, and resiliency people possess, and vigilantly seek opportunities where people can thrive, not just survive.

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