# Form Follows Function: Adapting the Strength Model to Facilitate Implementation and Sustainability

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Case management is a common social service intervention that has been applied across a range of disciplines, populations, and types of organizations. Despite its widespread use, the activities constituting case management are often poorly specified (Lukersmith, Millington, & Salvador-Carulla, 2016). The Strengths Model is an important exception—not only does it offer a structured approach to service delivery, but it provides enough flexibility to facilitate implementation and support sustainability. The goal of this chapter is to help practitioners think creatively about implementation, so they can meet the needs of their organization while remaining true to the core components of the Strengths Model. In the first part of this chapter, we discuss the delicate balance between implementing a model to fidelity and making adaptations to address organizational barriers and constraints, highlighting some of the prior modifications made to the Strengths Model to ease implementation. In the second part of the chapter, we describe one agency's approach to implementation, the structural adaptations staff made to the Strengths Model, and the benefits and challenges associated with their approach.

## THE TENSION BETWEEN FIDELITY AND ADAPTATION

As policymakers and funders push for the adoption of interventions that have previously demonstrated positive outcomes, service providers are subject to increased pressure to apply "model" programs to new contexts and broader populations (Metz & Albers, 2014). Despite this growing expectation, the adoption of

evidence-based programs among community-based organizations has been relatively low, due in part to the lack of support agencies receive from developers in implementation (Aarons, Hurlburt, Horwitz, 2011). To support transportability and dissemination efforts, many interventions—including the Strengths Model—have established fidelity scales to guide agencies in their implementation (e.g., Marty, Rapp, & Carlson, 2001; Paulson, Post, Herinckx, & Risser, 2002).

Fidelity is broadly defined as the degree to which an intervention is delivered as specified by the developers (Mowbray, Holter, Teague, & Bybee, 2003), and fidelity instruments provide a roadmap for how a model should be implemented in order to produce the desired results. Studies have found that stricter adherence to fidelity guidelines is generally linked to desirable program outcomes (e.g., Durlak & DuPre, 2008). The same appears to be true for the Strengths Model. Specifically, Fukui and colleagues (2012) examined the fidelity scores for 14 case management teams using the Strengths Model and found that increases infidelity fully accounted for the improvements in psychiatric hospitalizations, postsecondary education, and competitive employment observed among clients. Interestingly, fidelity scores were unrelated to changes in independent living, which the researchers ascribed to the relatively high rate of independent living observed across the sample (resulting in a ceiling effect).

Although remaining true to the intended design of a model has important implications for its efficacy during implementation, prioritizing perfect adherence above all else may be undesirable and even counterproductive (e.g., Barber et al., 2006). Indeed, there is increasing recognition of providers' need to make adaptations to better suit their organizational context, as interventions do not perfectly translate from one setting to another (Glasgow, Lichtenstein, & Marcos, 2003; Lee, Altschul, & Mowbray, 2008). Adaptations refer to any changes or modifications made to the original design of an intervention during adoption or implementation, often with the goal of addressing contextual factors that would otherwise undermine programmatic fit (Castro, Barrera, & Martinez, 2004). Providers may feel compelled to make adaptations when navigating structural constraints (e.g., program duration; Hill, Maucione, & Hood, 2007), working with limited financial resources (Swain, Whitley, McHugo, & Drake, 2010), accounting for cultural differences (e.g., Castro et al., 2004), or otherwise attempting to maximize programmatic relevance and participant engagement (Anyon et al., 2019).

Given the pervasiveness of adaptations made during implementation (Moore, Bumbarger, & Cooper, 2013), it is important to note that fidelity and adaptation are not mutually exclusive concepts. Provided the adaptation does not sacrifice the "core components" of the intervention or the specific mechanisms that have been linked to client outcomes, there is the potential for modifications to support fidelity and enhance sustainability (e.g., Aarons et al., 2012). As Stirman and colleagues (2012) put it, "Simply measuring fidelity and characterizing modifications as deviations may obscure the very refinements that facilitate the continued use of some innovations"

(p. 11). The general consensus is that adaptations become problematic when they begin to "drift," or change in ways that result in a fundamental misapplication of the model (Aarons et al., 2012). Thus, specifying the critical ingredients of an intervention is essential to support its diffusion, adoption, and sustainability.

## CORE COMPONENTS OF THE STRENGTHS MODEL

The Strengths Model introduced a recovery-oriented approach to case management and encouraged practitioners to shift their focus from clients' deficits to their strengths (Rapp & Sullivan, 2014). The goal of the model is to support individuals in cultivating personally meaningful lives by helping them access naturally occurring resources and pursue their self-defined goals (Rapp & Goscha, 2012; Rapp & Sullivan, 2014). The six core principles of the model are (1) individuals can recover, reclaim, and transform their lives, (2) the focus is on strengths instead of deficits, (3) the community is full of resources, (4) the client directs the helping process, (5) the relationship between the client and their case manager is primary and essential, and (6) work primarily takes place in the community (Rapp & Goscha, 2012). Although it was originally developed for adults with serious mental health issues, the Strengths Model has been applied—in whole or in part—to a range of different populations, described more fully below (e.g., Francis, 2014; Rapp & Sullivan, 2014).

Acknowledging the widespread adoption of the Strengths Model and the need for quality assurance tools to support its dissemination, Marty and colleagues (2001) surveyed a sample of experts to identify the core components of the model. Building off a preexisting list of behaviors integral to the Strengths Model, the researchers began by consulting with local experts to revise and refine the list to ensure its comprehensiveness (individuals with demonstrated familiarity with the model were considered experts). Several rounds of feedback and revisions resulted in a questionnaire consisting of five subsections—engagement, strengths assessment, personal planning, resource acquisition, and structural components—that captured the essential elements of the model. This survey was circulated to a broader sample of experts, who were asked to rate the relevance of each item to the Strengths Model and respond to a handful of open-ended questions. Results revealed a high degree of inter-rater reliability across the five subsections, with 94% of the items considered to be critical aspects of the model. Respondents were able to differentiate between the core aspects of the Strengths Model and other service delivery models, and there was substantial agreement with respect to the ideal target population, caseload size, and composition of the case management team.

Upon identifying the core components of the Strengths Model, the developers introduced a fidelity scale in 2003 to help practitioners measure their adherence to the model. This scale has been refined over the years, and its most recent iteration consists of nine sections; each section is comprised of one to nine items scored on a 5-point scale. These nine sections are used to measure structural aspects of implementation (caseload ratios, community contact, group supervision), super-

visory components (file reviews, file feedback, field mentoring, and the ratio of direct service workers to supervisors), and key elements of clinical practice (use of the Strengths Assessment and Personal Recovery Plan, the integration of these two tools, the use of naturally occurring resources, and hope-inducing practices; Teague, Mueser, & Rapp, 2012).

As hoped, the development of this fidelity tool has supported implementation and quality assurance efforts (see, e.g., Krabbenborg, Boersma, Beijersbergen, Goscha, & Wolf, 2015). However, as the strengths-based philosophy has grown in popularity, the adoption of the Strengths Model far outpaced the use of its fidelity tools (Rapp & Sullivan, 2014). Below, we provide a brief overview of prior extensions and adaptations of the Strengths Model.

## PRIOR APPLICATIONS AND ADAPTATIONS OF THE STRENGTHS MODEL

Over the last 30 years, use of the Strengths Model has expanded far beyond its home state of Kansas. For instance, the Strengths Model has been adopted by organizations in Egypt (Ibrahim, Callaghan, Mahgoub, El-Bilsha, & Michail, 2015), Israel (Gelkopf et al., 2016), the Netherlands (Krabbenborg et al., 2015), Hong Kong (Tsoi et al., 2019), and Australia (Chopra et al., 2009), among others (see Francis, 2014). In applying the model, many practitioners made adaptations to streamline implementation. For instance, some had to translate the tools into different languages and account for cultural variations in participants' understanding of "strengths" (e.g., Tsoi et al., 2019). In other cases, some of the adaptations were more pronounced. For instance, Ibrahim and colleagues (2015) blended elements of the Strengths Model with treatment as usual at an inpatient psychiatric facility. Services were group-based and, instead of emphasizing the importance of individual goal planning, focused on providing psychosocial and life skills training. Despite these adaptations, participants showed improved functioning and reduced symptomology compared to individuals receiving treatment as usual.

Although the model continues to be used primarily with adults with psychiatric disabilities, practitioners rapidly applied the Strengths Model to other populations, starting with individuals in treatment for substance misuse (e.g., Rapp, Siegal, & Fisher, 1992). Since then, the Strengths Model has been successfully used with people diagnosed with HIV/AIDS (Craw et al., 2008), men preparing to exit prison (Hunter, Lanza, Lawlor, Dyson, & Gordon, 2016), caregivers (Whitley, White, Kelley, & Yorke, 1999), and survivors of domestic violence (Song & Shih, 2010).

In recent years, the Strengths Model has been applied to a range of youth populations, including youth with serious mental health issues (Mendenhall & Grube, 2017), youth experiencing homelessness (Krabbenborg et al., 2015), and other vulnerable youth (Arnold, Walsh, Oldham, & Rapp, 2007; Craig, 2012). Each site made some type of adaptation to improve either cultural or developmental fit. Some of

these adaptations were structural in nature, whereas others were more philosophical. For instance, Krabbenborg and colleagues (2015) expanded the theoretical framework of the model to include citizenship, social quality, and self-determination—constructs deemed highly relevant to Dutch culture, particularly for youth experiencing homelessness. In addition, they introduced a three-phase, systematic approach to service delivery (as well as several new tools, such as ecomaps) to help case managers navigate their day-to-day work with clients. These adaptations allowed for a more tailored approach to implementation while remaining true to the core components of the Strengths Model.

More recently, the Strengths Model has been adopted by a non-profit in Austin, Texas, that provides wraparound services to highly vulnerable transition-age youth. Given the range of programs offered by this organization, the unique characteristics of the target population, and the complexity of their funding streams, staff had to find creative ways to work toward fidelity. In the remainder of the chapter, we describe LifeWorks' experience using the Strengths Model, focusing on the specific adaptations made to ease implementation, the benefits and challenges that staff experienced as a result of these modifications, and implications for practice.

## IMPLEMENTATION OF THE STRENGTHS MODEL AT LIFEWORKS

LifeWorks is a large non-profit in Austin, Texas, that provides a comprehensive array of services to vulnerable transition-age youth. Programming includes office- and community-based mental health services, high school equivalency classes, supported employment, aftercare services for youth aging out of foster care, and a continuum of housing options, ranging from street outreach to permanent supportive housing. Eight of LifeWorks' 19 programs include case management as the primary intervention.

Youth receiving case management at LifeWorks have often experienced a range of hardships, including homelessness or housing instability, systems involvement, early parenthood, and complex trauma (see Schoenfeld & McDowell, 2016). As is often the case with vulnerable youth (Petr, 2003), youth seeking services at LifeWorks have been involved with child welfare, juvenile justice, mental health systems, or other social services. The goal of these systems is to solve some underlying "problem," encouraging providers to focus on the past (instead of the future), identify and address deficits (instead of strengths), and assign labels or diagnoses (instead of adopting a whole-person perspective; Saleebey, 1996). This approach is perpetuated by funders, contractual requirements, and precedent. The resulting services promote the pursuit of generic or normative outcomes, rather than outcomes defined by the clients themselves. Given these parallels and the growing evidence that a strengths-based, goal-focused approach may be effective for youth (as described above), LifeWorks decided to implement the Strengths Model across its eight case management programs.

Before the Strengths Model, the agency did not have a standardized approach to case management. As a result, services varied across programs, case managers were unable to look to their peers in other programs for guidance, and youth's experiences differed dramatically from program to program. Although all services were ostensibly "strengths-based," there was no shared understanding of what being strengths-based meant in practice.

When LifeWorks first implemented the Strengths Model, staff tried to remain true to the original design, including the supervisory structure outlined in the fidelity guidelines. Specifically, each supervisor was expected to conduct weekly group supervision, file reviews, individual feedback sessions, and field mentoring. However, the agency was unable to reallocate the supervisors' existing responsibilities, so each manager was left trying to squeeze an additional eight hours of work into an already full week. What's more, several managers supervised small teams of only two or three case managers (who, in turn, had small caseloads), which made the supervisory expectations feel unnecessarily burdensome and of limited utility.

Because of the way services were structured and staffed, leadership recognized it would be unrealistic to expect programs to reach fidelity. After closely examining the fidelity guidelines, staff realized the supervisory responsibilities could be removed from program managers and consolidated into a single position. This role could fulfill all the supervisory requirements associated with the model. In 2018, LifeWorks hired a director of evidence-based programming (DEBP), who is responsible for overseeing the implementation of the Strengths Model. To facilitate implementation, the DEBP created three "teams" comprised of case managers from multiple programs. As a result of this structure, the total amount of staff time dedicated to implementation decreased dramatically (from 40 hours per week, when overseen by the program managers, to 24 hours per week, under the supervision of the DEBP). To promote further philosophical and programmatic alignment, other support staff at LifeWorks (e.g., employment specialists, peer supporters) were invited to attend group supervision and utilize the same tools and documentation as the case managers.

To better understand LifeWorks' approach to implementation, 37 interviews were conducted with case managers, supervisors, support staff, and executive leadership. Specifically, we were interested in the benefits and challenges associated with each of LifeWorks' two major structural adaptations to the Strengths Model: (1) the centralization of supervisory responsibilities, and (2) the creation of interdisciplinary teams. First, the raw data were separated into codable segments ("quotations"), which were then sorted into two categories for each adaptation (i.e., the benefits and challenges associated with the adaptation). Two authors (BW and AY) coded the quotations independently, using a coding scheme originally developed as part of the National Implementing EBP Project (Torrey, Bond, McHugo, & Swain, 2012) and refined by Bond et al. (2014). This coding scheme consisted of seven domains impacting the sustainability of evidence-based programs: workflow, prioritization, client compatibility, reinforcement, workforce, leadership, and financial. Coding

discrepancies were reviewed with the primary investigator (ES), and codes were finalized through consensus.

## ADAPTATIONS TO THE STRENGTHS MODEL

**Centralized supervisory responsibilities.** As described above, a director of evidence-based programming (DEBP) position was created to oversee LifeWorks' implementation of the Strengths Model and carry out the supervisory responsibilities in lieu of the program managers. Case managers, supervisors, and executive leadership all praised this structural adaptation. Nearly half of the staff mentioned workflow benefits (49%, including 63% of executive leadership and 83% of supervisors), and more than half described the reinforcement opportunities offered by this structure (57%, including 73% of case managers and 100% of supervisors). Specifically, staff thought this adaptation allowed for greater consistency in implementation, reduced burden on program directors, and increased philosophical alignment.

Across the board, staff valued having a single position dedicated to supporting case managers in their use of the Strengths Model. As the resident expert in the model, the DEBP was a key resource for staff and represented a single source of "truth" regarding the model and its implementation. As one case manager put simply, "you know who you can go to if you have a question." Staff also described how the DEBP helped ensure that case managers were able to consistently translate the model's principles into practice. When the program managers were responsible for the supervisory components, this resulted in varying perspectives, interpretations, and recommendations. One person likened this structure to a customer service department:

> You may get different answers because there's…different people giving you information. But if you have that one specific [individual with expertise in] the model, then you will have consistent delivery of content and responses to questions as they come up.

Staff also appreciated that the DEBP was able to devote her full attention to the implementation of the Strengths Model and not be distracted by other programmatic or administrative concerns. One case manager summed it up nicely: "Where our other supervisors are maybe focused on funding requirements and contractual agreements, this person [the DEBP] can really look at how we implement this model to fidelity."

The competing demands on supervisors' time also interfered with their ability to provide quality feedback or be easily accessible to their teams. Case managers were hesitant to approach their supervisors for support in the model, but the DEBP role alleviated these issues:

> …before, [my supervisor] did a great job, but I'm like, "I don't want to ask her any questions," because she would do research and I

> can't take away [her] time—she's doing a million other things…I think having [the DEBP] dedicated to the role, having the ability to schedule time with her…I think that's great.

What's more, the DEBP provided staff with access to a broader, agency-wide perspective. Rather than being limited to their own programmatic lens, the DEBP offered staff an "unbiased" point of view. Case managers regularly approached the DEBP for assistance when navigating complex situations with their clients, and this position's ability to disseminate information and best practices was perhaps its biggest asset:

> I think the benefits are having one pair of eyes and one pair of ears who can see across all programs and understand the shared learnings…it allows for cross-pollination of processes. It allows for the ability to find a best practice and immediately moves it across programs…When you are seeing all the challenges people face and all the wins that people are having, you are then able to find those winning practices and… within a short period of time, everybody has that knowledge and can start doing it. The same thing with, "Oh, wow, here's a pitfall we're falling into." You can immediately address that...

Overall, having a dedicated position helped the Strengths Model become more deeply ingrained and a defining aspect of the organization's culture. Staff expressed how "the Strengths Model is such a part of LifeWorks and where we're going [as an agency] that you hear about it daily." Such repeated exposure to the model and its principles increased understanding and buy-in among staff. As described by one member of the executive team:

> …we don't hear any more about concerns around understanding… [like] "What is the Strengths Model?"…And that used to be [the case], so I think that's now our current practice and philosophy and belief and part of our culture…I can't tell you the last time I heard about…a situation coming up with the staff not understanding….

Less than a third of the staff mentioned any challenges associated with centralizing the supervisory components of the model (30%, including only 13% of case managers). Of these, the majority expressed concern about possible role confusion between the DEBP and the supervisor, particularly with respect to managing difficult client situations (an aspect of "workflow," as outlined by Bond et al., 2014). Importantly, supervisors did not mind relinquishing the file reviews, file feedback sessions, and field mentoring to the DEBP, but some missed facilitating group supervision. One supervisor explained, "Especially in the beginning, I felt disconnected to my own program…I kind of felt like my people were taken from me…."

To address this concern, supervisors were encouraged to attend group supervision alongside their case managers, and case managers were coached to keep their supervisors informed about their clients. Additionally, the DEBP scheduled a monthly meeting with the supervisors. In these meetings, supervisors receive updates about their case managers' performance, opportunities for improvement, and other key information pertaining to the model (e.g., results of fidelity reviews). As a result, supervisors are better equipped to monitor their staff's performance, reinforce the DEBP's trainings, and help their team move closer toward fidelity.

Ultimately, because these remedies were introduced shortly after the creation of the DEBP position, staff's concern about role confusion was largely framed as a hypothetical or a potential risk, rather than an actual problem. However, without careful delineation of responsibilities and regular communication, this type of structural adaptation could lead to conflict or competition between the supervisors and the DEPB.

Aside from the overinflated concern about possible role confusion, only one other barrier to sustaining the DEBP position was mentioned more than once. Specifically, staff expressed concern about the DEBP's long-term bandwidth, especially as new case management programs continue to be introduced: "As LifeWorks grows and diversifies…[h]ow do we do more evidence-based programming and keep that centralized model without diluting [quality]?" Such problems are not insurmountable, however; if the number of case managers exceeds the capacity of the DEBP, an additional position could be created (or the responsibilities of an existing position could be reallocated) to ensure there is adequate support.

**The creation of interdisciplinary teams.** For years prior to the adoption of the Strengths Model, LifeWorks struggled with how to improve communication and collaboration across programs. Although youth typically only worked with one case manager at a time, many were enrolled in more than one program and worked with multiple staff (e.g., peer supporters, employment specialists). This often led to role confusion, duplication of effort, and a general lack of clarity regarding one's responsibility toward a shared client.

By assigning case managers from different programs to the same "team" and inviting other direct service staff to attend, group supervision became a forum for mutual learning, resource sharing, and intentional collaboration. Staff found this interdisciplinary approach to be extremely beneficial, with more than half referencing workflow benefits (54%, including 50% of support staff, 67% of supervisors, and 88% of executive leadership). Staff appreciated having access to people with different expertise and programmatic backgrounds—not only did they feel like it benefited their work and, in turn, their clients, but they also felt like it promoted a shared vision and greater agency alignment. As one staff member described:

> …everyone became part of the Strengths Model….[During group supervision] we bring in all disciplines, whether they are, again, doing the case management model or not, so that we truly have the well-informed understanding of where the client is right now... by creating those bridges, we have just really enhanced our ability to function as an agency instead of a collection of programs.

The creation of these interdisciplinary "teams" also provided staff with a shared language and a standardized approach to service planning. Regardless of program affiliation, staff have a consistent way of helping youth pursue their goals and an equally consistent way of sharing their work with colleagues. For instance, one peer supporter described service planning as follows:

> …a goal is like, 'I want to not use [substances] for two days'…and then we establish steps around that goal, and it's like, 'Well, who around you can support you?' And it…goes back to Strengths Assessment because a lot of that is, like, resources in your community and resources like support systems. So, we reference that, and we…build off of those strengths to make them into steps.

To further streamline workflow and ensure that services are well-coordinated, all staff who share a client use the same Strengths Assessment and service plan. Because these documents are stored in the agency database, staff have greater visibility to the work being done with clients who are shared across programs. Such visibility reduces duplicative work and allows staff to more strategically divide tasks: …we are all working on a different angle [of] the same issue, which truly does support the youth in a more comprehensive way and we're not undermining each other by accident…that sort of synergy and shared priority amongst programs…is probably the most transformative piece of the Strengths Model as that has trickled out beyond case management.

This sense of alignment was more than merely operational; staff reported feeling less isolated and more connected to their coworkers. For case managers specifically, knowing that they were all using the same framework and being held to the same standards, regardless of their program affiliation, was also an added benefit. Except for two individuals (5%; one of who worked in an outlying area and whose concerns mainly stemmed from her geographic separation), staff did not perceive any challenges associated with this interdisciplinary approach.

## RECOMMENDATIONS FOR PRACTICE

Staff's overwhelmingly positive response to these structural adaptations have important implications for Strengths Model practitioners. These modifications led to improvements in workflow (e.g., reduced burden, increased programmatic alignment) and reinforcement (e.g., improved supervision, shared learning). Although

staff pointed out a few opportunities for improvement—specifically with respect to other aspects of workflow (i.e., possible role confusion)—these challenges are not insurmountable and highlight the feasibility of this approach to implementation.

Centralizing the supervisory responsibilities of the Strengths Model may increase the likelihood of organizations achieving fidelity, particularly if the organization has multiple case management programs or is otherwise structurally complex. Additionally, if supervisors have significant administrative or contractual responsibilities, they may not have sufficient bandwidth to provide quality feedback to their case managers. Reallocating responsibilities and providing opportunities for role specialization is associated with improved collaboration and greater organizational effectiveness (Bassett & Carr, 1996; Reeves, Lewin, Espin, & Zwarenstein, 2010). The creation of the DEBP position allowed for greater role specialization among staff and introduced a new (and highly effective) mechanism for sharing information across programs, two factors that facilitate an agency's ability to implement evidence-based programming (see Aarons et al., 2011).

Although several staff indicated that assigning the supervisory components of the Strengths Model to someone other than the program manager might result in role confusion, this did not appear to be an issue in practice. By creating opportunities to meet with the DEBP on a regular basis, supervisors were able to remain informed about their staff's performance and continue to support the agency's journey toward fidelity.

As with the DEBP position, staff believed the move toward interdisciplinary teams offered more benefits than challenges. This structure lent itself to improved cross-program collaboration and communication, which are critical yet difficult to support in large, departmentalized organizations (Yang & Maxwell, 2011). Although interdisciplinary teams are a standard feature of some case management models (e.g., Bond & Drake, 2015), they are the exception rather than the norm among those using the Strengths Model. Provided staff build authentic partnerships characterized by a shared service philosophy, regular communication, and clearly delineated roles, these types of collaborations are associated with improved client outcomes (e.g., Slack & McEwen, 1999).

One straightforward way to support interdisciplinary teams is through shared documentation. By working off the same tools, staff have greater visibility to each other's work, allowing for increased care coordination and more integrated services (Kunkell & Yowell, 2001). However, organizations must ensure that the documentation meets the needs of all staff involved and is not overly burdensome (see, e.g., Stanhope & Matthews, 2019).

Although LifeWorks has not yet achieved high fidelity in the Strengths Model, it is not uncommon for this journey to take two or more years (see, e.g., Krabbenborg et al., 2015; Bond, Drake, McHugo, Rapp, & Whitley, 2009). The agency has conducted

three fidelity reviews to date (approximately every six months), and their scores have shown consistent improvement over time. During their most recent review, the teams received scores of 3.3, 3.4, and 3.7 (their average scores on the Supervision subscale were 3.6, 3.9, and 4.0). Thus, it appears that the structural adaptations that were made are not likely to preclude the organization's ability to achieve full fidelity. Of course, these types of structural adaptations may not be necessary for every organization. However, they pose a promising solution for agencies with numerous case management teams, small team sizes, a significant proportion of clients enrolled in more than one service. Depending on the size and complexity of the organization, it might make more logistical sense to have two positions responsible for overseeing implementation instead of just one. Organizations that do not have the resources available to create a new position can explore repurposing an existing position or otherwise reallocating managerial responsibilities to allow for more focused oversight of the model.

## CONCLUSION

The two structural adaptations described in the latter part of this chapter—the consolidation of supervisory responsibilities into a single position and the formation of interdisciplinary teams—illustrate that flexible approaches to implementation are not necessarily at odds with fidelity. Agencies should feel empowered to critically evaluate their existing structure and available resources to develop an implementation structure tailored to their organizational context, rather than feeling pigeonholed by how things have historically been done. By making adaptations that support or amplify the key components of the Strengths Model, programs can achieve positive outcomes for their clients in a sustainable way.

## END NOTES

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