



Tse, Samson and Tsoi, Emily W.S. and Hamilton, Bridget and O'Hagan, Mary and Shepherd, Geoff and Slade, Mike and Whitley, Rob and Petrakis, Melissa (2016) Uses of strength-based interventions for people with serious mental illness: a critical review. *International Journal of Social Psychiatry*, 62 (3). pp. 281-291. ISSN 0020-7640

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**Uses of Strength-Based Interventions for people with serious mental illness: A critical review**

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|-------------------------------|--|
| Journal:                      | <i>International Journal of Social Psychiatry</i>  |
| Manuscript ID                 | ISP-15-0147.R1   |
| Manuscript Type:              | Review Article   |
| Date Submitted by the Author: | n/a  |
| Complete List of Authors:     | Tse, Samson; The University of Hong Kong, Social Work and Social Administration<br>Tsoi, Emily; The University of Hong Kong, Social Work and Social Administration<br>Hamilton, Bridget; University of Melbourne, School of Health Sciences<br>O'Hagan, Mary; Freelance mental health service consultant,<br>Shepherd, Geoff; Centre for Mental Health,<br>Slade, Mike; King's College London, Institute of Psychiatry, Psychology and Neuroscience<br>Whitley, Rob; McGill University, Douglas Hospital<br>Petrakis, Melissa; Monash University, Department of Social Work  |
| Keywords:                     | case management , recovery, positive psychology, community mental health   |
| Abstract:                     | <p>Background: For the past three decades, mental health practitioners have increasingly adopted aspects and tools of strengths-based approaches. To provide strengths-based intervention and to amplify strengths relies heavily on effective interpersonal processes.</p> <p>Aim: This paper is a critical review of research regarding the use of strengths-based approaches in mental health service settings. The aim is to discuss strengths-based interventions within broader research on recovery, focusing on effectiveness and advances in practice where applicable.</p> <p>Method: A systematic search for peer-reviewed intervention studies published between 2001 and December 2014 yielded 55 articles of potential relevance to the review.</p> <p>Results: Seven studies met the inclusion criteria and were included in the analysis. The Quality Assessment Tool for Quantitative Studies was used to appraise the quality of the studies. Our review found emerging evidence that the utilisation of a strengths-based approach improves outcomes including hospitalisation rates, employment/educational attainment, and intrapersonal outcomes such as self-efficacy and sense of hope.</p> <p>Conclusions: Recent studies confirm the feasibility of implementing a high-fidelity strengths-based approach in clinical settings and its relevance for practitioners in healthcare. More high quality studies are needed to further examine the effectiveness of strengths-based approaches.</p> |

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3 **Title:** Uses of strength-based interventions for people with serious mental illness: A  
4 critical review

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6 **Running title:** Review of strength-based interventions

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11 critical review

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14 **Abstract**

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16 **Background:** For the past three decades, mental health practitioners have increasingly  
17 adopted aspects and tools of strengths-based approaches. To provide strengths-based  
18 intervention and to amplify strengths relies heavily on effective interpersonal processes.  
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23 approaches in mental health service settings. The aim is to discuss strengths-based  
24 interventions within broader research on recovery, focusing on effectiveness and  
25 advances in practice where applicable.  
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33 2001 and December 2014 yielded 55 articles of potential relevance to the review.  
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38 *Quality Assessment Tool for Quantitative Studies* was used to appraise the quality of the  
39 studies. Our review found emerging evidence that the utilisation of a strengths-based  
40 approach improves outcomes including hospitalisation rates, employment/educational  
41 attainment, and intrapersonal outcomes such as self-efficacy and sense of hope.  
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48 **Conclusions:** Recent studies confirm the feasibility of implementing a high-fidelity  
49 strengths-based approach in clinical settings and its relevance for practitioners in  
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9 healthcare. More high quality studies are needed to further examine the effectiveness of  
10 strengths-based approaches.  
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16 **Keywords**

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18 Case management, recovery, positive psychology  
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## Introduction

Serious mental illnesses and their associated symptoms are distressing and debilitating for individuals experiencing the conditions, as well as for families and concerned significant others (Petrakis, Bloom, & Oxley, 2014; Sin, Moone, & Newell, 2007). With the advent of medications that reduce many distressing symptoms, there has been considerable advocacy focusing on personal recovery (Anthony, 1993; Liberman & Kopelowicz, 2002; Roberts & Wolfson, 2004). Strengths-based approaches represent an articulation of mental health's philosophy on recovery (Anthony, 1993; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Whitley, 2010). Although promoting wellbeing or building on a person's strengths are hardly new concepts to mental health practitioners, qualities such as self-efficacy, social problem solving, sense of purpose, empathy, humour, resilience, and hope have only been systematically studied in recent decades (Norman, 2000; Whitley, 2010). As such, a team of researchers sought to quantify strengths in a systematic manner (Linley et al., 2007). In their attempt, an exhaustive review was conducted for literature in psychology, philosophy and social work, and 24 character strengths (e.g., creativity, persistence, social intelligence and hope) were subsequently identified that are considered to underpin our universal

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9 understanding of the latent construct of 'character strengths' as applying to the general  
10 population.  
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16 Regarding the operationalization of strengths-based practices, Norman (2000)  
17 categorized strengths into two levels. The first level is personal level, and the indicators  
18 of strengths are self-efficacy, realistic appraisal of the environment, social problem-  
19 solving, sense of direction or mission, empathy, humour, adaptive distancing and  
20 androgynous sex role behaviour. The second level is called the interpersonal level, and  
21 the indicators in this level are positive caring relationships, positive family environment  
22 or other forms of intimate environment that help to foster resiliency and strengths.  
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34 Across the range of strengths-based approaches to mental health care, there is a focus on  
35 inter-personal processes working with the strengths of the individual and their  
36 community to achieve client-defined goals and personal recovery (Slade, 2009; Smith-  
37 Merry, Freeman, & Sturdy, 2011). The underpinning of these approaches is the  
38 philosophical commitment to attending to human capacity first rather than human  
39 deficiency (Scott & Wilson, 2011). It assumes that every person can build a meaningful  
40 and satisfying life defined by an individual's own terms (Rapp & Goscha, 2012). Rapp  
41 and Goscha (2012, see 'The purpose, principles, and research results' pp.51-69) and  
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10 Marty, Rapp, and Carlson (2001) provide a useful account of what constitutes the  
11 critical elements of strengths-based intervention approach.  
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16 The present paper is a critical review of research (for typology of reviews, see Grant &  
17 Booth, 2009) on strengths-based approaches, which is one of the seven pro-recovery  
18 practices mentioned in an earlier publication by Slade et al. (2014). The present authors  
19 are experts from five countries. The aim is to present and discuss pertinent issues  
20 surrounding strengths-based practices within broader research on recovery, with a focus  
21 on effectiveness and cross-cultural analysis. The three research questions are: (1) What  
22 are the general characteristics of the studies selected for the present review (including  
23 specific cultural elements)? (2) What is the empirical evidence for the effectiveness of  
24 strengths-based practice with regard to specific outcome measures (including if there is  
25 any evidence of negative effects)? (3) What are the advances in practice or new features  
26 revealed in the present review, compared with the last empirical review of effectiveness  
27 of the strengths perspective by Staudt, Howard, and Drake (2001)?  
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## 45 **Methods**

### 46 *Data sources*

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10 We searched six electronic databases for studies published between 2001 and December  
11 2014: Applied Social Sciences Index and Abstracts, PsycArticles, PsycInfo, Social  
12 Services Abstracts, Sociological Abstracts, and MEDLINE. Studies published prior to  
13 2001 were excluded because another empirical review published in 2001 covered these  
14 earlier studies (Staudt et al., 2001). The search terms used included two components: (i)  
15 intervention: 'strengths model'; or 'strengths-based' or 'strengths perspective' and (ii)  
16 clinical condition: 'mental illness'; or 'bipolar'; or 'schizophrenia' or 'psychiatr\*'.  
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18 Following the initial search, two independent reviewers (ST and ET) screened titles and  
19 abstracts. The full texts of potentially relevant peer-reviewed papers on intervention  
20 studies were further examined to determine eligibility (Figure 1). Any discrepancies in  
21 judgment were settled by a discussion between the two reviewers.  
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<Insert Figure 1 Here>

#### *Inclusion and exclusion Criteria*

A study was included in the review if it satisfied all of the following criteria: (i) published in or after 2001, (ii) published in a peer-reviewed journal, (iii) written in English, (iv) was an intervention study using strengths-based intervention as the treatment, (v) provided a description of the intervention in the article, and (vi) used any

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10 quantitative design (i.e., randomized controlled trial or other quasi-experimental type  
11 studies). The inclusion criteria were consistent with the nature of critical review and  
12 were chosen to ensure that the included studies will address the set research questions  
13 (Grant & Booth, 2009). Because Blow and colleagues' (2000) research was not  
14 included in the earlier review by Staudt and colleagues (2001), we included it in this  
15 review. We excluded qualitative studies and opinion/commentary papers because they  
16 did not include empirical evidence on the effectiveness of strengths-based interventions,  
17 which was our second research question.  
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### 29 *Quality assessment*

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31 The quality of the studies was assessed using the *Quality Assessment Tool for*  
32 *Quantitative Studies* developed by the Effective Public Health Practice Project of  
33 McMaster University, Canada (National Collaborating Centre for Methods and Tools,  
34 2008). We assessed both the internal and external validity of a study, as well as the  
35 following criteria: (i) selection of participants, (ii) study design, (iii) confounders, (iv)  
36 blinding, (v) data collection methods, (vi) attrition, (vii) statistical analysis, and (viii)  
37 intervention integrity. This tool has been deemed appropriate and satisfactory for  
38 assessing the risk of bias in public health research (Armijo-Olivo, Stiles, Hagen, Biondo,  
39 & Cummings, 2012). The ratings for each component are computed into a single global  
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9 rating score for the study, with zero weak ratings indicating a ‘strong’ rating overall,  
10 one weak rating indicating a ‘moderate’ rating, and two or more weak ratings indicating  
11 a ‘weak’ rating (National Collaborating Centre for Methods and Tools, 2008). The two  
12 reviewers (ST and ET) independently carried out the quality appraisal and any  
13 discrepancies were settled following discussions between the two reviewers and  
14 members of the wider author team. Every team member helped to evaluate the  
15 interpretations of the results and to write specific sections of the manuscripts.  
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## 27 **Results**

### 28 *Selection of studies*

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31 The search terms generated 619 articles, not including duplications already removed by  
32 the databases. We then identified 55 studies that provisionally met the inclusion criteria  
33 for peer-reviewed intervention studies. After obtaining the full texts of these 55 articles,  
34 48 articles were excluded as they did not meet the inclusion criteria for a variety of  
35 reasons (Figure 1). For example, some of the articles that were excluded focused on the  
36 conceptual or theoretical aspects of strengths-based approaches or the development of  
37 measurement scales, and in some other cases, although the word ‘strength’ was referred  
38 to in the published studies, no detail was provided about how a strengths-based  
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10 approach was executed in the intervention. Hence, only the seven articles that met  
11 inclusion criteria were included in the review.  
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### 14 15 16 *Quality assessment*

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18 The overall agreement rate between the two reviewers was 71%, and discrepancies were  
19 settled after discussion and clarifying interpretation of the studies. Table 1 presents the  
20 results of the quality assessments of the studies. Overall, the majority of the studies  
21 were of moderate to weak quality. Of the seven studies, four did not describe or control  
22 for confounders in the analysis, and four studies received a ‘weak’ score for the blinding  
23 component, which meant that blinding was either not incorporated into the study design  
24 or not described in the article.  
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### 40 41 *Study characteristics*

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43 All of the studies were conducted in developed, high income, Western countries such as  
44 the United States, Canada (Mireau & Inch, 2009), and Sweden (Björkman, Hansson, &  
45 Sandlund, 2002). All of the participants were adults already known to mental health  
46 services and affected by severe and persistent mental illness. The studies had diverse  
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research designs: randomised controlled trials, pre-post designs, between-group comparison, and mixed methods (qualitative and quantitative); follow-up periods for the studies varied between eight and 36 months (Table 1). The most common research designs were cohort studies with non-randomised controls. Only one study's design achieved a 'strong' global rating (Green, Janoff, Yarborough, & Paulson, 2013). Three others were rated as 'moderate' (Barry, Zeber, Blow, & Valenstein, 2003; Björkman et al., 2002; Blow et al., 2000), and the other three as 'weak' (Fukui, Davidson, Holter, & Rapp, 2010; Fukui et al., 2012; Mireau & Inch, 2009).

There was also considerable confounding of the strengths-based approach within the complex, multifaceted interventions, making it difficult to attribute outcomes to this element as opposed to other variables. In a previous review, Staudt et al. (2001) commented that 'The effects of treatment modality and treatment intensity were confounded in these studies... It is unknown whether it was simply the additional services or specific type of services provided that contributed, in some cases, to improved outcomes' (Staudt *et al.*, 2001, p.17). This comment remains accurate.

*Effectiveness of strengths-based interventions*

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10 The results suggest that a strengths-based approach is associated with (i) reducing the  
11 duration of stay in hospital (Björkman et al., 2002; Blow et al., 2000; Fukui et al., 2012);  
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13 (ii) increasing service satisfaction (Björkman et al., 2002); (iii) improving general  
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15 attitudes with respect to recovery-relevant dimensions (e.g., self-esteem, self-efficacy,  
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17 personal confidence, sense of hope, life satisfaction; Barry et al., 2003; Fukui et al.,  
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19 2010; Green et al., 2013); (iv) facilitating greater goal attainment (i.e., improving  
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21 employment and educational outcomes; (Green et al., 2013); and (v) general increased  
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23 utilisation of services (Barry et al., 2003; Mireau & Inch, 2009). In Mireau and Inch's  
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25 (2009) study, these positive changes were reflected in increased job satisfaction and  
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27 improved staff morale: 'Optimism and hopefulness directed toward the client is  
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29 contagious, with counsellors having increased job satisfaction and morale while clients  
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31 experience success in achieving their goals' (Mireau & Inch, 2009, p.68). However  
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33 these improvements should be interpreted with caution given the variable quality of the  
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35 research designs and evidence (Table 1).  
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43 There was one instance of negative results. Björkman et al. (2002) found that the group  
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45 receiving strengths-based case management had *worse* social network and symptom  
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47 scores post-intervention when compared with the group receiving standard care. The  
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49 outcomes in relation to symptom improvement were also inconclusive (Barry et al.,  
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2003; Björkman et al., 2002; Fukui et al., 2010; Green et al., 2013). In an earlier commentary, due to the seriousness of psychiatric symptomatology such as suicidality and persecutory delusions, Taylor (2006) strongly cautioned against using only a strengths-based approach completely isolated from medical treatment approaches.

#### *Advances in practice*

Staudt et al. (2001) concluded in their earlier review that 'It remains unclear whether and how strengths-based CM (case management) differs from other CM models and what components are unique only to strengths-based CM' (Staudt *et al.*, 2001, p.17). This highlights the need for a clearer specification of strengths-based intervention, and it is therefore reassuring that, in the present sample, six out of the seven selected studies (Barry et al., 2003; Björkman et al., 2002; Fukui et al., 2010; Fukui et al., 2012; Green et al., 2013; Mireau & Inch, 2009) included descriptions of what strengths-based practices entail. For example, they cited the *Pathways to Recovery* (Ridgway & Bledsoe, 2002, cited in Fukui et al., 2010) and the *Strengths-Based Brief Solution-Focused Counselling* (cited in Mireau & Inch, 2009). Another example is the application of the *Strengths Model Case Management* (SMCM; Rapp & Goscha, 2012). In Fukui et al. (2012) study, case management teams were able to reach high SMCM fidelity, which meant that SMCM was being implemented (Table 2). Several studies compared



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9 strengths approaches with Assertive Community Treatment (ACT), a well-defined  
10 model that includes a similarly high level of intensity to SMCM. Nevertheless, there  
11 was variability in the degree of detail provided regarding the interventions that were  
12 used. Direct measures of strengths were weak.  
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20 In one of the later studies, the engagement of peer supporters working with  
21 professionals in providing a strengths-based group programme highlighted an important  
22 new development (Green *et al.*, 2013). Peer supporters or peer support workers refer to  
23 individuals with lived experience of mental illness who are recruited, trained, and  
24 supported to use this experience to support other peers during recovery (Davidson,  
25 Bellamy, Guy, & Miller, 2012; Repper & Carter, 2011).  
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## 40 **Discussion**

### 41 *Study design and intervention effectiveness*

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43 The overall results of this critical review are comparable to the results of a recent meta-  
44 analysis of clinical trials of strengths-based practice (Ibrahim, Michail, & Callaghan,  
45 2014). First, both the current critical review and recent meta-analysis considered that  
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10 only a small number of clinical studies met the requirement of a moderate level of  
11 quality (Barry et al., 2003; both of these trials were included in the present review and  
12 the meta-analysis; Björkman et al., 2002). There is a pressing need for further good  
13 quality, well-designed clinical trials to examine the effectiveness of strengths-based  
14 practices. Second, both of the reports have found that the effect of strengths-based  
15 interventions on service users' level of symptoms was either inconclusive (e.g.,  
16 Björkman et al., 2002; Green et al., 2013) or less favourable in comparison to other  
17 service delivery models (Ibrahim et al., 2014). On the other hand, compared to the study  
18 by Ibrahim et al. (2014), the present review holds a more positive view of strengths-  
19 based approaches. For example, the present review found that the approach was  
20 associated with some favourable employment and educational outcomes, whereas the  
21 meta-analysis found no significant difference between the strengths-based approach and  
22 other service delivery models. This may be explained by differences in methodological  
23 approaches between the two reports.  
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43 A critical review is typically narrative by nature, and it aims to provide 'an opportunity  
44 to 'take stock' and evaluate what is of value from the previous body of work. It may  
45 also attempt to resolve competing schools of thought. As such, it may provide a 'launch  
46 pad' for a new phase of conceptual development and subsequent 'testing'' (Grant &  
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10 Booth, 2009, p.93). However, a meta-analysis uses ‘techniques that statistically  
11 combine the results of quantitative studies to provide a more precise effect of the results’  
12 (Grant & Booth, 2009, p.94). The analysis by Ibrahim et al. (2014) included five studies  
13 between 1991 and 2003 and all the studies had control groups. The current review  
14 included seven studies between 2000 and 2013, and six of the studies had a control-  
15 group design.  
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#### 25 *Comprehensive application of a strengths-based approach*

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27 The current review found that there was improved but still limited operationalization of  
28 strengths-based practices. Below, we discuss each stage briefly: assessment,  
29 intervention, and monitoring.  
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36 It is possible to conduct a strengths assessment in mental health service delivery  
37 contexts and practice. A systematic review identified 12 published approaches to  
38 strengths assessment: five quantitative measures and seven qualitative methods (Bird et  
39 al., 2012). The Strengths Assessment Worksheet (SAW) is the most widely utilized and  
40 evaluated qualitative assessment method (Rapp & Goscha, 2006, 2012). The Client  
41 Assessment of Strengths, Interests and Goals (CASIG) has the strongest psychometric  
42 evidence (Lecomte, Wallace, Caron, Perreault, & Lecomte, 2004), and the SAW and  
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10 CASIG assessments have been tentatively recommended for use in practice. Other  
11 approaches to assessing strengths have also been published, such as use of the VIA-  
12 Strengths (Park, Peterson, & Seligman, 2006) approach in mental health services  
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16 (Resnick & Rosenheck, 2006).  
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20 To provide strengths-based intervention and to amplify strengths is a person-centred  
21 process. Interpersonal styles such as coaching are helpful in facilitating a focus on  
22 strengths (Bora, 2012; Shepherd, Boardman, & Slade, 2008). The present review  
23 underlines the high level of engagement that is fostered by the strengths approach, the  
24 significance of the level/intensity of contact, the active and outreaching role of workers  
25 (including peer supporters) that arise from the approach. Blow et al. (2000) matched the  
26 intensive contact and practical outreach elements across ACT and SMCM and found  
27 positive outcomes. Assertiveness alone may not be well received. The service users also  
28 value the positive tone, warmth of engagement, and prize the optimistic tone of  
29 strengths-focused brief interventions (Mireau & Inch, 2009).  
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45 Finally, on the basis of our review, it appears that routine monitoring and reviewing of  
46 strengths is rarely implemented. This process involves the assessment of current and  
47 potential strengths, the activation and use of these strengths, and ambitious but not  
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10 unrealistic goal setting around the acquisition of new or amplified strengths. The most  
11 developed approach to integrating a focus on strengths into routine monitoring is the  
12 SMC (Rapp & Goscha, 2012 cited in Fukui et al., 2012). Practice change has been  
13 achieved through staff training and the introduction of new strengths-based assessments,  
14 planning tools, and team discussions (Petrakis, Wilson, & Hamilton, 2013) based on  
15 Rapp and Goscha's (2012) tools and guidelines.  
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#### 24 25 *The role of peer support workers in strengths-based practice*

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27 Two studies have assessed the impact of *Pathways to Recovery* (Ridgway & Bledsoe,  
28 2002) support groups on participants—one on peer-led groups (Fukui et al., 2010) and  
29 the other on groups co-led by a peer counsellor and a non-peer counsellor (Green et al.,  
30 2013). Both studies found considerable improvements across multiple domains  
31 including hope, self-efficacy, and social support. Further research is needed to  
32 understand how peer supporters can enhance the impact of strengths-based approaches.  
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43 Strengths-based approaches emphasize personal and environmental strengths, as well as  
44 recognition of the character-building impact of trauma and mental distress (Peterson,  
45 Park, & Seligman, 2006; Tse, Divis, & Li, 2010). Peer supporters may have a distinct  
46 advantage over non-peer workers when it comes to personifying and practising these  
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10 principles. For instance, peer supporters can act as powerful role models precisely  
11 because their job requires lived experience (Davidson et al., 2012), or they can amplify  
12 a client's hope that they too can utilise strengths to move beyond their distress (Sells,  
13 Davidson, Jewell, Falzer, & Rowe, 2006). Peer support is also embedded in recovery  
14 philosophy and shares similar origins with the consumer or survivor movement (for  
15 recent reviews on effectiveness of peer support services, see Chinman et al., 2014;  
16 Lloyd-Evans et al., 2014; Trachtenberg, Parsonage, Shepherd, & Boardman, 2013).

### 27 *Applying strengths-based practices cross-culturally*

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29 All of the selected studies in this review were conducted in Western cultures, and  
30 beliefs with regards to one's mental health, expressions of emotions, and strengths are  
31 heavily influenced by culture (Leamy et al., 2011; Tse, Cheung, Kan, Ng, & Yau, 2012;  
32 Tse et al., 2010). The notion of 'strengths' in non-Western cultures is under-researched.  
33 The conceptualization of strengths—the forms of linguistics, metaphors, icons, or  
34 folklore traditions—is culturally specific. In Chinese, the word 'strengths' is commonly  
35 understood as 優勢 (*youshi* or superiority), 強項 (*qiangxiang* or forté), or 潛能  
36 (*qianneng* or potential). Bamboo, an evergreen plant commonly seen across Asia that  
37 thrives even in harsh weather conditions, is often used as a metaphor for strengths and  
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uprightness. In Chinese, Japanese, and Vietnamese cultures, bamboo is viewed as a virtuous symbol of tenacity and perseverance.

It is imperative to understand how cultural variations should be taken into account in the interpretation of 'strengths'. For instance, people in Chinese communities (in some case including Korean and Japanese communities) are heavily influenced by Confucianism, Taoism, and Buddhism (M. H. Bond, 2010; Chen & Davey, 2008; Lu, 2001), which 'advocate spiritual cultivation and mind-work, such as self-retrospection and self-transcendence, they admonish people to eliminate excessive desires, live a simple life and restore a clear mind' (Lai, Cummins, & Lau, 2013, p.608). Chinese people under the influence of traditional culture may interpret 'empowerment' as a challenge to deep-rooted ideas of Confucianism that emphasizes self-sacrifice, harmony, benevolence, and forgiveness. Similarly, under Taoism, people tend to be more modest and they less readily name their strengths, successes, and talents (Tse et al., 2010). Therefore mental health practitioners need to be creative and culturally sensitive when helping service users in exploring and identifying the strengths and virtue of characters within themselves and the wider environment.

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In the present authors' research and clinical work, we found it helpful to highlight specific domains and invite service users to identify what they consider as their sources of strength: personal (i.e., knowledge, academic qualifications, life experience, talents, problem-solving skills, life skills, interests, character, and attitude towards life), career/occupation, religious/spiritual sphere, family, colleagues at work, friends, neighbourhoods, social groups (formal or less formal), or the wider community.

*Directions for policy, future research, and service provision*

Strengths-based, recovery-oriented approaches are increasingly relevant to and welcomed by policy makers. An example is the Irish Mental Health Commission report 'A recovery approach within the Irish mental health services: A framework for development' (Higgins, 2008) as well as a report launched by the Commonwealth of Australia, 'A national framework for recovery-oriented mental health services: Policy and theory' (Australian Health Ministers' Advisory Council, 2013). Further research in non-Western settings is important, especially considering cultural differences regarding the definition and conceptualization of strengths as noted in this review. Also, there may be cultural differences within nation states, particularly regarding ethnic minorities, indigenous people, and immigrants. Another gap in research relates to the implementation of strengths-based approaches in routine mental health settings (G. R.



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10 Bond, Drake, McHugo, Rapp, & Whitley, 2009; McHugo et al., 2007; Whitley,  
11 Gingerich, Lutz, & Mueser, 2009). Existing research provides little evidence-based  
12 guidelines on the best approaches to training staff in strengths-based approaches. This is  
13 critically important given that much clinical training continues to focus on deficits and  
14 symptoms, fostering a paternalistic attitude toward patients (O'Hagan, 2004; Slade,  
15 Adams, & O'Hagan, 2012; Whitley, 2014). Adopting a strengths-based approach may  
16 require a 180 degree turn away from embedded attitudes of 'clinician knows best.'  
17 Finally, to support an individual to maximise one's own strengths and work toward  
18 his/her own goals, there must be a transformation within the workplace, as well as a  
19 change in the system's culture (Shepherd, Boardman, & Burns, 2010; Tew et al., 2012).  
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34 To conclude, there is a need for more high quality studies to further examine the  
35 effectiveness of strengths-based approaches. This review has revealed emerging  
36 evidence that the utilisation of a strengths-based approach is effective for yielding  
37 desirable outcomes, including 'hard' outcomes such as duration of hospitalization,  
38 adherence to treatment, and employment/educational attainment, as well as 'soft'  
39 outcomes such as self-esteem, self-efficacy, and sense of hope. Strengths-based  
40 approaches emphasize the autonomy, assets, and goals of the individual client, and  
41 practitioners are considered facilitators of the recovery process. Successful  
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implementation of a high-fidelity strengths-based approach in clinical settings requires collaboration from service users, staff, administrators, and policy makers.

#### **Conflict of interest**

The authors declare that there is no conflict of interest.

#### **Funding acknowledgement**

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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47 participation in mental health services. *International Review of Psychiatry*, 24(1), 40-47.  
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For Peer Review

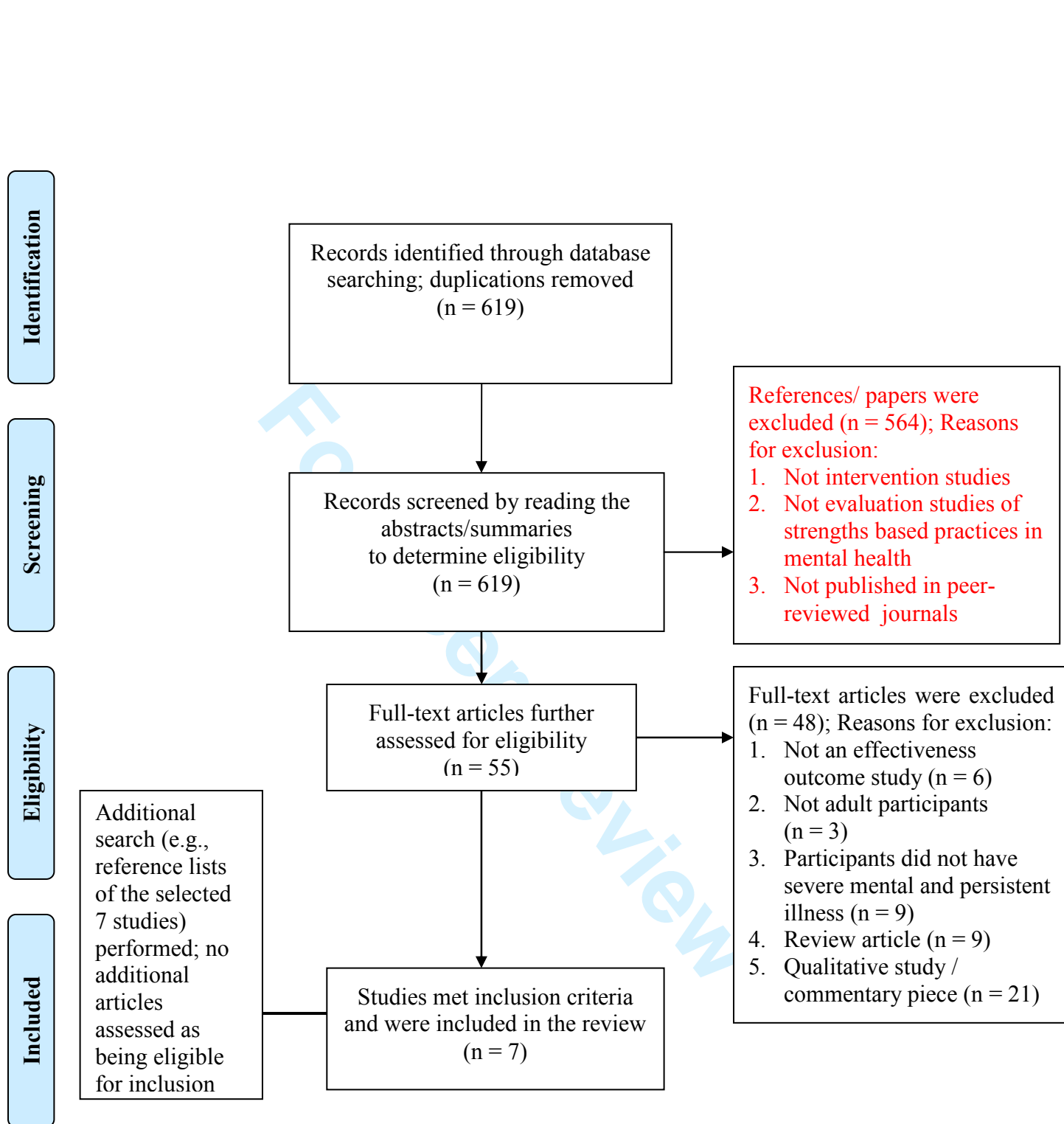


Figure 1. Flow chart showing the summary of the literature search of strengths-based intervention studies.



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Table 1. Quality Assessment of Selected Studies

| Authors                  | Selection Bias | Study Design | Confounders | Blinding | Data collection method | Withdrawals and dropouts | GLOBAL RATINGS:<br>Strong= no '3' rating<br>Moderate= one '3' rating<br>Weak= two or more '3' ratings | Agreement between reviewers' Global Ratings (Yes/No) |
|--------------------------|----------------|--------------|-------------|----------|------------------------|--------------------------|---|--|
| 1. Blow et al., 2000     | 2              | 2            | 1           | 3        | 1                      | 1                        | Moderate  | Yes  |
| 2. Björkman et al., 2002 | 2              | 1            | 3           | 2        | 1                      | 1                        | Moderate  | No   |
| 3. Barry et al., 2003    | 2              | 2            | 1           | 3        | 1                      | 1                        | Moderate  | No   |
| 4. Mireau and Inch, 2009 | 2              | 2            | 3           | 2        | 3                      | 3                        | Weak  | Yes  |
| 5. Fukui et al., 2010    | 2              | 2            | 3           | 3        | 1                      | 1                        | Weak  | Yes  |
| 6. Fukui et al., 2012    | 2              | 2            | 3           | 3        | 2                      | Not Applicable           | Weak  | Yes  |
| 7. Green et al., 2013    | 2              | 1            | 1           | 2        | 1                      | 1                        | Strong  | Yes  |
|                          |                |              |             |          |                        |                          | Reviewers' agreement =  | 71%  |

Notes:  
Item quality ratings: 1 = Strong; 2 = Moderate; 3 = Weak (for details on rating descriptors, see National Collaborating Centre for Methods and Tools, 2008)

Table 2. Table 2. Characteristics of Studies Included in this Critical Review

| Author(s)                         | Sample Size (people with severe mental illness) | Study design   | Control group  | Intervention group  | Description of strengths-based intervention   | Results  |
|-----------------------------------|---|--|--|---|---|--|
| 1. Blow and colleagues (2000)     | n=1,425, attrition at 32%, final n=861          | Intervention-control groups design; 3-year follow up                         | Standard care: Traditional inpatient treatment   | Three intervention subgroups:<br>1) Sustained treatment and rehabilitation (STARii) transitional inpatient programme;<br>2) Day treatment centres (DTCs);<br>3) Assertive community treatment (ACT) and strengths model(SM) | 1) Inpatient rehabilitation incorporating several psychosocial rehabilitation components and functional skills training; 2) Partial hospitalization, structured outpatient programme, 10-25 hours/week; 3) Programme was based on ACT and SM* (Rapp and Wintersteen, 1989). | ACT users had greatest decrease in days of hospitalization (-85%), followed by DTC (-64%), STARii (-44%), and standard care (-16%). Significant three-way interaction effect of time-by-program-by diagnosis. Decreased in psychiatric symptoms for patients in STARii and ACT programmes; DTC patients became more symptomatic. ACT programme appeared to have best outcomes, but best approach for users with more serious symptoms would be to begin with STARii. |
| 2. Björkman and colleagues (2002) | n=77  | Randomized controlled trial, 36-month follow up (baseline, 18- and 36-month) | Standard care: Joint management for outpatient and inpatient, and day-care facilities, small therapeutic communities | Strengths model of case management service (SCM)  | SCM* (Mueser <i>et al.</i> , 1998): Moderate emphasis on skills training and high-level service users' input; less emphasis on integration of services.   | SCM was effective in the following ways: 1) Improving service satisfaction; 2) Greater reduction in need for care at 36-month follow-up; 3) Fewer days in psychiatric inpatient care. SCM group had worse social network and more symptoms at baseline compared with standard care group.  |
| 3. Barry and colleagues (2003)    | n=225, attrition at 22.7%, final n=174          | Intervention-control groups design; 2-year follow up                         | ACT (Wisconsin model)  | Strengths model (SM1)   | SM1* (Saleebey, 1996): Patient-centred focused on finding membership in community; training, booster sessions, group training to ensure fidelity.   | SM was effective in: 1) Increasing service utilisation; 2) Reducing positive and negative symptoms; 3) Improving global life satisfaction.   |
| 4. Mireau and Inch (2009)         | n=1,370   | Intervention-control groups design; 3-year follow up                         | Regular non-time-limited counselling   | Strengths-based, brief solution-focused counselling (BSFC)  | BSFC* (Blundo, 2001; Saleebey, 2002): Counsellors engaged clients quickly, formed a relationship with them, and kept them focused on strengths, goals, and priorities; limited to 10 sessions.  | BSFC users liked the idea of focusing on strengths. Less than 1% decided to switch to non-time-limited counselling. Dropout rate in brief therapy was half that of clients in long-term therapy. Users were  |

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|                                |  |   |  |   |  | more likely to plan to end their counselling relationship in the BSFC programme than in the non-time-limited services.   |
| 5. Fukui and colleagues (2010) | n=47, attrition at 32%, final n=32     | Pre-post design; 8-month follow up  | No control group; compared to results of baseline measures   | Pathways to Recovery (PTR): A Strengths Recovery Self-Help Workbook                       | PTR* (Ridway and Bledsoe, 2002 which is largely grounded in the work by Rapp and Goscha, 2012): Users identified and pursued life goals on the basis of on personal and environmental strengths. Used self-help groups with less hierarchical relations among peers. Users completed self-assessments and action plans to observe accomplishments and to sustain motivation toward recovery. | Statistically significant improvements for PTR participants in terms of self-esteem, self-efficacy, social support, spiritual well-being, and psychiatric symptoms.  |
| 6. Fukui and colleagues (2012) | n=1,195, attrition at 33%, final n=802 | Pre-post design   | No control group; compared to results of baseline measures (fidelity scores and psychosocial outcomes) | Strengths model of case management (SMCM)   | SMCM* (Rapp and Goscha, 2012): Goal oriented. Low caseload sizes, low supervisor-to-case manager ratio. Weekly group supervision using structured format for case presentations. Administered strengths assessment. Used personal recovery plan tools and naturally occurring resources to achieve goals; in-person service delivery.  | SMCM users improved in terms of the following outcomes: competitive employment, psychiatric hospitalization, and post-secondary education rates. Service users' improvement depended on fidelity scores except in the case of independent living.  |
| 7. Green (2013)                | n=82, across 5 cohorts, final n=70     | Five cohorts. Cohort 1: Feasibility pilot study and development of materials. Cohorts 2+3: Ten-week randomized controlled trial (RCT) Cohort 3: delayed-intervention control group. Cohorts 4+5: Pre-post | Cohort 3: delayed-intervention control group   | Strengths-based group intervention, based on service user-developed recovery workbook PTR | Groups co-facilitated by a professional mental health counsellor and a trained peer counsellor. Participants also used PTR workbook (Ridgway <i>et al.</i> , 2002).  | User-developed workbook was useful. Users also reacted positively to having peer co-leaders. Duration of intervention was important; users needed enough time for reflection to work through exercises and explore key topics (about 17-18 weeks). Significant reduction of mental health symptoms and significant improvements in functioning, personal confidence, and hope were noted. Lastly, users demonstrated greater goal and success orientation. |

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4 \*Notes: Key references on strength-based approaches

5 Blundo, R. (2001) Learning strengths-based practice: Challenging our personal and professional frames, *Families in Society: Journal of*  
6 *Contemporary Social Services*, 82(3), 296-304.

7 Mueser, K. T. Bond, G. R. Drake, R. E., & Resnick, S. G. (1998) Models of community care for severe mental illness, *Schizophrenia Bulletin*,  
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9 Rapp, C. A., & Wintersteen, R. (1989) The Strengths model of case management: Results from twelve demonstrations, *Psychosocial*  
10 *Rehabilitation Journal*, 13(1), 23-32.

11 Rapp, C. A., & Goscha, R. (2012) *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services*, New York, Oxford  
12 University Press.

13 Ridgway, P., & Bledsoe, C. (2002) *Pathways to Recovery: A Strengths Recovery Self-Help Workbook*, Office of Mental Health Research &  
14 Training, School of Social Welfare, University of Kansas.

15 Saleebey, D. (1996) The strengths perspective in social work practice: Extensions and cautions, *Social Work*, 41(3), 296-305.

16 Saleebey, D. (2002) *The Strengths Perspective in Social Work Practice*, Toronto, Allyn and Bacon.  
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10 **Title:** Uses of Strength-Based Interventions for people with serious mental illness: A  
11 critical review

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14 **Abstract**

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16 **Background:** For the past three decades, mental health practitioners have increasingly  
17 adopted aspects and tools of strengths-based approaches. To provide strengths-based  
18 intervention and to amplify strengths relies heavily on effective interpersonal processes.  
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22 **Aim:** This paper is a critical review of research regarding the use of strengths-based  
23 approaches in mental health service settings. The aim is to discuss strengths-based  
24 interventions within broader research on recovery, focusing on effectiveness and  
25 advances in practice where applicable.  
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32 **Method:** A systematic search for peer-reviewed intervention studies published between  
33 2001 and December 2014 yielded 55 articles of potential relevance to the review.  
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37 **Results:** Seven studies met the inclusion criteria and were included in the analysis. The  
38 *Quality Assessment Tool for Quantitative Studies* was used to appraise the quality of the  
39 studies. Our review found emerging evidence that the utilisation of a strengths-based  
40 approach improves outcomes including hospitalisation rates, employment/educational  
41 attainment, and intrapersonal outcomes such as self-efficacy and sense of hope.  
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48 **Conclusions:** Recent studies confirm the feasibility of implementing a high-fidelity  
49 strengths-based approach in clinical settings and its relevance for practitioners in  
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10 healthcare. More high quality studies are needed to further examine the effectiveness of  
11 strengths-based approaches.  
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16 **Keywords**

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18 Case management, recovery, positive psychology  
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## Introduction

Serious mental illnesses and their associated symptoms are distressing and debilitating for individuals experiencing the conditions, as well as for families and concerned significant others (Petrakis, Bloom, & Oxley, 2014; Sin, Moone, & Newell, 2007). With the advent of medications that reduce many distressing symptoms, there has been considerable advocacy focusing on personal recovery (Anthony, 1993; Liberman & Kopelowicz, 2002; Roberts & Wolfson, 2004). Strengths-based approaches represent an articulation of mental health's philosophy on recovery (Anthony, 1993; Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Whitley, 2010). Although promoting wellbeing or building on a person's strengths are hardly new concepts to mental health practitioners, qualities such as self-efficacy, social problem solving, sense of purpose, empathy, humour, resilience, and hope have only been systematically studied in recent decades (Norman, 2000; Whitley, 2010). As such, a team of researchers sought to quantify strengths in a systematic manner (Linley et al., 2007). In their attempt, an exhaustive review was conducted for literature in psychology, philosophy and social work, and 24 character strengths (e.g., creativity, persistence, social intelligence and hope) were subsequently identified that are considered to underpin our universal

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9 understanding of the latent construct of 'character strengths' as applying to the general  
10 population.  
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16 Regarding the operationalization of strengths-based practices, Norman (2000)  
17 categorized strengths into two levels. The first level is personal level, and the indicators  
18 of strengths are self-efficacy, realistic appraisal of the environment, social problem-  
19 solving, sense of direction or mission, empathy, humour, adaptive distancing and  
20 androgynous sex role behaviour. The second level is called the interpersonal level, and  
21 the indicators in this level are positive caring relationships, positive family environment  
22 or other forms of intimate environment that help to foster resiliency and strengths.  
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34 Across the range of strengths-based approaches to mental health care, there is a focus on  
35 inter-personal processes working with the strengths of the individual and their  
36 community to achieve client-defined goals and personal recovery (Slade, 2009; Smith-  
37 Merry, Freeman, & Sturdy, 2011). The underpinning of these approaches is the  
38 philosophical commitment to attending to human capacity first rather than human  
39 deficiency (Scott & Wilson, 2011). It assumes that every person can build a meaningful  
40 and satisfying life defined by an individual's own terms (Rapp & Goscha, 2012). Rapp  
41 and Goscha (2012, see 'The purpose, principles, and research results' pp.51-69) and  
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10 Marty, Rapp, and Carlson (2001) provide a useful account of what constitutes the  
11 critical elements of strengths-based intervention approach.  
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16 The present paper is a critical review of research (for typology of reviews, see Grant &  
17 Booth, 2009) on strengths-based approaches, which is one of the seven pro-recovery  
18 practices mentioned in an earlier publication by Slade et al. (2014). The present authors  
19 are experts from five countries. The aim is to present and discuss pertinent issues  
20 surrounding strengths-based practices within broader research on recovery, with a focus  
21 on effectiveness and cross-cultural analysis. The three research questions are: (1) What  
22 are the general characteristics of the studies selected for the present review (including  
23 specific cultural elements)? (2) What is the empirical evidence for the effectiveness of  
24 strengths-based practice with regard to specific outcome measures (including if there is  
25 any evidence of negative effects)? (3) What are the advances in practice or new features  
26 revealed in the present review, compared with the last empirical review of effectiveness  
27 of the strengths perspective by Staudt, Howard, and Drake (2001)?  
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## 45 **Methods**

### 46 *Data sources*

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10 We searched six electronic databases for studies published between 2001 and December  
11 2014: Applied Social Sciences Index and Abstracts, PsycArticles, PsycInfo, Social  
12 Services Abstracts, Sociological Abstracts, and MEDLINE. Studies published prior to  
13 2001 were excluded because another empirical review published in 2001 covered these  
14 earlier studies (Staudt et al., 2001). The search terms used included two components: (i)  
15 intervention: 'strengths model'; or 'strengths-based' or 'strengths perspective' and (ii)  
16 clinical condition: 'mental illness'; or 'bipolar'; or 'schizophrenia' or 'psychiatr\*'.  
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18 Following the initial search, two independent reviewers (ST and ET) screened titles and  
19 abstracts. The full texts of potentially relevant peer-reviewed papers on intervention  
20 studies were further examined to determine eligibility (Figure 1). Any discrepancies in  
21 judgment were settled by a discussion between the two reviewers.  
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#### *Inclusion and exclusion Criteria*

A study was included in the review if it satisfied all of the following criteria: (i) published in or after 2001, (ii) published in a peer-reviewed journal, (iii) written in English, (iv) was an intervention study using strengths-based intervention as the treatment, (v) provided a description of the intervention in the article, and (vi) used any

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10 quantitative design (i.e., randomized controlled trial or other quasi-experimental type  
11 studies). The inclusion criteria were consistent with the nature of critical review and  
12 were chosen to ensure that the included studies will address the set research questions  
13 (Grant & Booth, 2009). Because Blow and colleagues' (2000) research was not  
14 included in the earlier review by Staudt and colleagues (2001), we included it in this  
15 review. We excluded qualitative studies and opinion/commentary papers because they  
16 did not include empirical evidence on the effectiveness of strengths-based interventions,  
17 which was our second research question.  
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### 29 *Quality assessment*

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31 The quality of the studies was assessed using the *Quality Assessment Tool for*  
32 *Quantitative Studies* developed by the Effective Public Health Practice Project of  
33 McMaster University, Canada (National Collaborating Centre for Methods and Tools,  
34 2008). We assessed both the internal and external validity of a study, as well as the  
35 following criteria: (i) selection of participants, (ii) study design, (iii) confounders, (iv)  
36 blinding, (v) data collection methods, (vi) attrition, (vii) statistical analysis, and (viii)  
37 intervention integrity. This tool has been deemed appropriate and satisfactory for  
38 assessing the risk of bias in public health research (Armijo-Olivo, Stiles, Hagen, Biondo,  
39 & Cummings, 2012). The ratings for each component are computed into a single global  
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10 rating score for the study, with zero weak ratings indicating a 'strong' rating overall,  
11 one weak rating indicating a 'moderate' rating, and two or more weak ratings indicating  
12 a 'weak' rating (National Collaborating Centre for Methods and Tools, 2008). The two  
13 reviewers (ST and ET) independently carried out the quality appraisal and any  
14 discrepancies were settled following discussions between the two reviewers and  
15 members of the wider author team. Every team member helped to evaluate the  
16 interpretations of the results and to write specific sections of the manuscripts.  
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## 27 **Results**

### 28 *Selection of studies*

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30 The search terms generated 619 articles, not including duplications already removed by  
31 the databases. We then identified 55 studies that provisionally met the inclusion criteria  
32 for peer-reviewed intervention studies. After obtaining the full texts of these 55 articles,  
33 48 articles were excluded as they did not meet the inclusion criteria for a variety of  
34 reasons (Figure 1). For example, some of the articles that were excluded focused on the  
35 conceptual or theoretical aspects of strengths-based approaches or the development of  
36 measurement scales, and in some other cases, although the word 'strength' was referred  
37 to in the published studies, no detail was provided about how a strengths-based  
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10 approach was executed in the intervention. Hence, only the seven articles that met  
11 inclusion criteria were included in the review.  
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### 14 15 16 *Quality assessment*

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18 The overall agreement rate between the two reviewers was 71%, and discrepancies were  
19 settled after discussion and clarifying interpretation of the studies. Table 1 presents the  
20 results of the quality assessments of the studies. Overall, the majority of the studies  
21 were of moderate to weak quality. Of the seven studies, four did not describe or control  
22 for confounders in the analysis, and four studies received a 'weak' score for the blinding  
23 component, which meant that blinding was either not incorporated into the study design  
24 or not described in the article.  
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### 40 41 *Study characteristics*

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43 All of the studies were conducted in developed, high income, Western countries such as  
44 the United States, Canada (Mireau & Inch, 2009), and Sweden (Björkman, Hansson, &  
45 Sandlund, 2002). All of the participants were adults already known to mental health  
46 services and affected by severe and persistent mental illness. The studies had diverse  
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research designs: randomised controlled trials, pre-post designs, between-group comparison, and mixed methods (qualitative and quantitative); follow-up periods for the studies varied between eight and 36 months (Table 1). The most common research designs were cohort studies with non-randomised controls. Only one study's design achieved a 'strong' global rating (Green, Janoff, Yarborough, & Paulson, 2013). Three others were rated as 'moderate' (Barry, Zeber, Blow, & Valenstein, 2003; Björkman et al., 2002; Blow et al., 2000), and the other three as 'weak' (Fukui, Davidson, Holter, & Rapp, 2010; Fukui et al., 2012; Mireau & Inch, 2009).

There was also considerable confounding of the strengths-based approach within the complex, multifaceted interventions, making it difficult to attribute outcomes to this element as opposed to other variables. In a previous review, Staudt et al. (2001) commented that 'The effects of treatment modality and treatment intensity were confounded in these studies... It is unknown whether it was simply the additional services or specific type of services provided that contributed, in some cases, to improved outcomes' (Staudt *et al.*, 2001, p.17). This comment remains accurate.

*Effectiveness of strengths-based interventions*

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10 The results suggest that a strengths-based approach is associated with (i) reducing the  
11 duration of stay in hospital (Björkman et al., 2002; Blow et al., 2000; Fukui et al., 2012);  
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13 (ii) increasing service satisfaction (Björkman et al., 2002); (iii) improving general  
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15 attitudes with respect to recovery-relevant dimensions (e.g., self-esteem, self-efficacy,  
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17 personal confidence, sense of hope, life satisfaction; Barry et al., 2003; Fukui et al.,  
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19 2010; Green et al., 2013); (iv) facilitating greater goal attainment (i.e., improving  
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21 employment and educational outcomes; (Green et al., 2013); and (v) general increased  
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23 utilisation of services (Barry et al., 2003; Mireau & Inch, 2009). In Mireau and Inch's  
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25 (2009) study, these positive changes were reflected in increased job satisfaction and  
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27 improved staff morale: 'Optimism and hopefulness directed toward the client is  
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29 contagious, with counsellors having increased job satisfaction and morale while clients  
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31 experience success in achieving their goals' (Mireau & Inch, 2009, p.68). However  
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33 these improvements should be interpreted with caution given the variable quality of the  
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35 research designs and evidence (Table 1).  
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43 There was one instance of negative results. Björkman et al. (2002) found that the group  
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45 receiving strengths-based case management had *worse* social network and symptom  
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47 scores post-intervention when compared with the group receiving standard care. The  
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49 outcomes in relation to symptom improvement were also inconclusive (Barry et al.,  
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2003; Björkman et al., 2002; Fukui et al., 2010; Green et al., 2013). In an earlier commentary, due to the seriousness of psychiatric symptomatology such as suicidality and persecutory delusions, Taylor (2006) strongly cautioned against using only a strengths-based approach completely isolated from medical treatment approaches.

#### *Advances in practice*

Staudt et al. (2001) concluded in their earlier review that 'It remains unclear whether and how strengths-based CM (case management) differs from other CM models and what components are unique only to strengths-based CM' (Staudt *et al.*, 2001, p.17). This highlights the need for a clearer specification of strengths-based intervention, and it is therefore reassuring that, in the present sample, six out of the seven selected studies (Barry et al., 2003; Björkman et al., 2002; Fukui et al., 2010; Fukui et al., 2012; Green et al., 2013; Mireau & Inch, 2009) included descriptions of what strengths-based practices entail. For example, they cited the *Pathways to Recovery* (Ridgway & Bledsoe, 2002, cited in Fukui et al., 2010) and the *Strengths-Based Brief Solution-Focused Counselling* (cited in Mireau & Inch, 2009). Another example is the application of the *Strengths Model Case Management* (SMCM; Rapp & Goscha, 2012). In Fukui et al. (2012) study, case management teams were able to reach high SMCM fidelity, which meant that SMCM was being implemented (Table 2). Several studies compared



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9 strengths approaches with Assertive Community Treatment (ACT), a well-defined  
10 model that includes a similarly high level of intensity to SMCM. Nevertheless, there  
11 was variability in the degree of detail provided regarding the interventions that were  
12 used. Direct measures of strengths were weak.  
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20 In one of the later studies, the engagement of peer supporters working with  
21 professionals in providing a strengths-based group programme highlighted an important  
22 new development (Green *et al.*, 2013). Peer supporters or peer support workers refer to  
23 individuals with lived experience of mental illness who are recruited, trained, and  
24 supported to use this experience to support other peers during recovery (Davidson,  
25 Bellamy, Guy, & Miller, 2012; Repper & Carter, 2011).  
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## 40 **Discussion**

### 41 *Study design and intervention effectiveness*

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43 The overall results of this critical review are comparable to the results of a recent meta-  
44 analysis of clinical trials of strengths-based practice (Ibrahim, Michail, & Callaghan,  
45 2014). First, both the current critical review and recent meta-analysis considered that  
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10 only a small number of clinical studies met the requirement of a moderate level of  
11 quality (Barry et al., 2003; both of these trials were included in the present review and  
12 the meta-analysis; Björkman et al., 2002). There is a pressing need for further good  
13 quality, well-designed clinical trials to examine the effectiveness of strengths-based  
14 practices. Second, both of the reports have found that the effect of strengths-based  
15 interventions on service users' level of symptoms was either inconclusive (e.g.,  
16 Björkman et al., 2002; Green et al., 2013) or less favourable in comparison to other  
17 service delivery models (Ibrahim et al., 2014). On the other hand, compared to the study  
18 by Ibrahim et al. (2014), the present review holds a more positive view of strengths-  
19 based approaches. For example, the present review found that the approach was  
20 associated with some favourable employment and educational outcomes, whereas the  
21 meta-analysis found no significant difference between the strengths-based approach and  
22 other service delivery models. This may be explained by differences in methodological  
23 approaches between the two reports.  
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43 A critical review is typically narrative by nature, and it aims to provide 'an opportunity  
44 to 'take stock' and evaluate what is of value from the previous body of work. It may  
45 also attempt to resolve competing schools of thought. As such, it may provide a 'launch  
46 pad' for a new phase of conceptual development and subsequent 'testing'' (Grant &  
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10 Booth, 2009, p.93). However, a meta-analysis uses ‘techniques that statistically  
11 combine the results of quantitative studies to provide a more precise effect of the results’  
12 (Grant & Booth, 2009, p.94). The analysis by Ibrahim et al. (2014) included five studies  
13 between 1991 and 2003 and all the studies had control groups. The current review  
14 included seven studies between 2000 and 2013, and six of the studies had a control-  
15 group design.  
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#### 24 25 *Comprehensive application of a strengths-based approach*

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27 The current review found that there was improved but still limited operationalization of  
28 strengths-based practices. Below, we discuss each stage briefly: assessment,  
29 intervention, and monitoring.  
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36 It is possible to conduct a strengths assessment in mental health service delivery  
37 contexts and practice. A systematic review identified 12 published approaches to  
38 strengths assessment: five quantitative measures and seven qualitative methods (Bird et  
39 al., 2012). The Strengths Assessment Worksheet (SAW) is the most widely utilized and  
40 evaluated qualitative assessment method (Rapp & Goscha, 2006, 2012). The Client  
41 Assessment of Strengths, Interests and Goals (CASIG) has the strongest psychometric  
42 evidence (Lecomte, Wallace, Caron, Perreault, & Lecomte, 2004), and the SAW and  
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10 CASIG assessments have been tentatively recommended for use in practice. Other  
11 approaches to assessing strengths have also been published, such as use of the VIA-  
12 Strengths (Park, Peterson, & Seligman, 2006) approach in mental health services  
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16 (Resnick & Rosenheck, 2006).  
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20 To provide strengths-based intervention and to amplify strengths is a person-centred  
21 process. Interpersonal styles such as coaching are helpful in facilitating a focus on  
22 strengths (Bora, 2012; Shepherd, Boardman, & Slade, 2008). The present review  
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27 underlines the high level of engagement that is fostered by the strengths approach, the  
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30 significance of the level/intensity of contact, the active and outreaching role of workers  
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32 (including peer supporters) that arise from the approach. Blow et al. (2000) matched the  
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35 intensive contact and practical outreach elements across ACT and SMCM and found  
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38 positive outcomes. Assertiveness alone may not be well received. The service users also  
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41 value the positive tone, warmth of engagement, and prize the optimistic tone of  
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44 strengths-focused brief interventions (Mireau & Inch, 2009).  
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47 Finally, on the basis of our review, it appears that routine monitoring and reviewing of  
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50 strengths is rarely implemented. This process involves the assessment of current and  
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60 potential strengths, the activation and use of these strengths, and ambitious but not

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10 unrealistic goal setting around the acquisition of new or amplified strengths. The most  
11 developed approach to integrating a focus on strengths into routine monitoring is the  
12 SMCM (Rapp & Goscha, 2012 cited in Fukui et al., 2012). Practice change has been  
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14 achieved through staff training and the introduction of new strengths-based assessments,  
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16 planning tools, and team discussions (Petrakis, Wilson, & Hamilton, 2013) based on  
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18 Rapp and Goscha's (2012) tools and guidelines.  
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#### 24 25 *The role of peer support workers in strengths-based practice*

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27 Two studies have assessed the impact of *Pathways to Recovery* (Ridgway & Bledsoe,  
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29 2002) support groups on participants—one on peer-led groups (Fukui et al., 2010) and  
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31 the other on groups co-led by a peer counsellor and a non-peer counsellor (Green et al.,  
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33 2013). Both studies found considerable improvements across multiple domains  
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35 including hope, self-efficacy, and social support. Further research is needed to  
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37 understand how peer supporters can enhance the impact of strengths-based approaches.  
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43 Strengths-based approaches emphasize personal and environmental strengths, as well as  
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45 recognition of the character-building impact of trauma and mental distress (Peterson,  
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47 Park, & Seligman, 2006; Tse, Divis, & Li, 2010). Peer supporters may have a distinct  
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49 advantage over non-peer workers when it comes to personifying and practising these  
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10 principles. For instance, peer supporters can act as powerful role models precisely  
11 because their job requires lived experience (Davidson et al., 2012), or they can amplify  
12 a client's hope that they too can utilise strengths to move beyond their distress (Sells,  
13 Davidson, Jewell, Falzer, & Rowe, 2006). Peer support is also embedded in recovery  
14 philosophy and shares similar origins with the consumer or survivor movement (for  
15 recent reviews on effectiveness of peer support services, see Chinman et al., 2014;  
16 Lloyd-Evans et al., 2014; Trachtenberg, Parsonage, Shepherd, & Boardman, 2013).

#### 27 *Applying strengths-based practices cross-culturally*

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29 All of the selected studies in this review were conducted in Western cultures, and  
30 beliefs with regards to one's mental health, expressions of emotions, and strengths are  
31 heavily influenced by culture (Leamy et al., 2011; Tse, Cheung, Kan, Ng, & Yau, 2012;  
32 Tse et al., 2010). The notion of 'strengths' in non-Western cultures is under-researched.  
33 The conceptualization of strengths—the forms of linguistics, metaphors, icons, or  
34 folklore traditions—is culturally specific. In Chinese, the word 'strengths' is commonly  
35 understood as 優勢 (*youshi* or superiority), 強項 (*qiangxiang* or forté), or 潛能  
36 (*qianneng* or potential). Bamboo, an evergreen plant commonly seen across Asia that  
37 thrives even in harsh weather conditions, is often used as a metaphor for strengths and  
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uprightness. In Chinese, Japanese, and Vietnamese cultures, bamboo is viewed as a virtuous symbol of tenacity and perseverance.

It is imperative to understand how cultural variations should be taken into account in the interpretation of 'strengths'. For instance, people in Chinese communities (in some case including Korean and Japanese communities) are heavily influenced by Confucianism, Taoism, and Buddhism (M. H. Bond, 2010; Chen & Davey, 2008; Lu, 2001), which 'advocate spiritual cultivation and mind-work, such as self-retrospection and self-transcendence, they admonish people to eliminate excessive desires, live a simple life and restore a clear mind' (Lai, Cummins, & Lau, 2013, p.608). Chinese people under the influence of traditional culture may interpret 'empowerment' as a challenge to deep-rooted ideas of Confucianism that emphasizes self-sacrifice, harmony, benevolence, and forgiveness. Similarly, ~~in the Taoistic concept of mental health, the virtue of tolerance and endurance may be preferred to exercising 'self-determination.'~~ Under Taoism, people tend to be more modest and they less readily name their strengths, successes, and talents (Tse et al., 2010). Therefore mental health practitioners need to be creative and culturally sensitive when helping service users in exploring and identifying the strengths and virtue of characters within themselves and the wider environment.

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In the present authors' research and clinical work, we found it helpful to highlight specific domains and invite service users to identify what they consider as their sources of strength: personal (i.e., knowledge, academic qualifications, life experience, talents, problem-solving skills, life skills, interests, character, and attitude towards life), career/occupation, religious/spiritual sphere, family, colleagues at work, friends, neighbourhoods, social groups (formal or less formal), or the wider community.

*Directions for policy, future research, and service provision*

Strengths-based, recovery-oriented approaches are increasingly relevant to and welcomed by policy makers. An example is the Irish Mental Health Commission report 'A recovery approach within the Irish mental health services: A framework for development' (Higgins, 2008) as well as a report launched by the Commonwealth of Australia, 'A national framework for recovery-oriented mental health services: Policy and theory' (Australian Health Ministers' Advisory Council, 2013). Further research in non-Western settings is important, especially considering cultural differences regarding the definition and conceptualization of strengths as noted in this review. Also, there may be cultural differences within nation states, particularly regarding ethnic minorities, indigenous people, and immigrants. Another gap in research relates to the implementation of strengths-based approaches in routine mental health settings (G. R.



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10 Bond, Drake, McHugo, Rapp, & Whitley, 2009; McHugo et al., 2007; Whitley,  
11 Gingerich, Lutz, & Mueser, 2009). Existing research provides little evidence-based  
12 guidelines on the best approaches to training staff in strengths-based approaches. This is  
13 critically important given that much clinical training continues to focus on deficits and  
14 symptoms, fostering a paternalistic attitude toward patients (O'Hagan, 2004; Slade,  
15 Adams, & O'Hagan, 2012; Whitley, 2014). Adopting a strengths-based approach may  
16 require a 180 degree turn away from embedded attitudes of 'clinician knows best.'  
17 Finally, to support an individual to maximise one's own strengths and work toward  
18 his/her own goals, there must be a transformation within the workplace, as well as a  
19 change in the system's culture (Shepherd, Boardman, & Burns, 2010; Tew et al., 2012).  
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34 To conclude, there is a need for more high quality studies to further examine the  
35 effectiveness of strengths-based approaches. This review has revealed emerging  
36 evidence that the utilisation of a strengths-based approach is effective for yielding  
37 desirable outcomes, including 'hard' outcomes such as duration of hospitalization,  
38 adherence to treatment, and employment/educational attainment, as well as 'soft'  
39 outcomes such as self-esteem, self-efficacy, and sense of hope. Strengths-based  
40 approaches emphasize the autonomy, assets, and goals of the individual client, and  
41 practitioners are considered facilitators of the recovery process. Successful  
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implementation of a high-fidelity strengths-based approach in clinical settings requires collaboration from service users, staff, administrators, and policy makers.

#### **Conflict of interest**

The authors declare that there is no conflict of interest.

#### **Funding acknowledgement**

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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