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The Strengths Perspective and the Strengths Model Case Management: Enhancing the Recovery of People with Psychiatric Disabilities

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Biography
E. Susana Mariscal is a doctoral student in the University of Kansas, School of Social Welfare. She has a Licenciatura from the Catholic University of Bolivia and an MSW from the University of Kansas, where she has been a research assistant in the Office of Child Welfare and Children’s Mental Health and the Strengths Institute website coordinator since 2006. Her career has focused on violence prevention and resilience, including child sexual abuse, child maltreatment, foster care, street children, and Latino children exposed to domestic violence. She also worked as a consultant and developed programs to enhance youth resilience and positive development, for different Non-Governmental Organizations in Bolivia, such as UNICEF, Foundation La Paz, and S.O.S. Villages. Susana has made several invited and refereed presentations of her research at international and national conferences. As a Fulbright scholar, her research interests include violence prevention, resilience, the Strengths Perspective, and international social work.

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Keywords: Strengths Perspective, Strengths Model of case management, strengths based practice, mental health recovery, implementation fidelity, strengths assessment
Abstract

The Strengths Perspective represents a paradigmatic shift in social work practice, which is particularly evident in the provision of mental health services through the implementation of the Strengths Model of Case Management (SMCM). Strengths-based recovery-oriented services in mental health are necessary to prevent further oppression of people with psychiatric disabilities. This chapter describes basic elements of the Strengths Perspective and the SMCM and how they contribute to the enhancement of the recovery of people with psychiatric disabilities. While this chapter makes a distinction between the theoretical approach of the Strengths Perspective from the practical approach of the SMCM, it underscores the complementary need for both theory and practice, the need for methods and tools as well as the “heart”, in order to assist people in attaining the goals they set for themselves and realizing their unique recovery vision.

The Strengths Perspective in social work practice

The Strengths Perspective emerged in the early 1980s at the University of Kansas from the awareness that the helping professions and American culture, in general, are saturated with a view and understanding of the human condition preoccupied with deficits, disorders, pathology, problems, abnormality, and victimization at the individual, family, and community levels (Saleebey, 1992). This paradigmatic shift started with the publication of the *Strengths Perspective in social work practice* (Saleebey, 1992), which is now in its sixth edition (Saleebey, 2013). This book was edited by Dennis Saleebey, a remarkable scholar, true leader of the strengths-based social work practice, and an amazing mentor and human being.

Practitioners operating from the Strengths Perspective assume that all individuals and environments have strengths which can be used to empower
individuals and help them achieve their goals, dreams, and aspirations (Saleebey, 2013). While traditional models tend to focus on deficits, symptoms, and problems, the Strengths Perspective focuses on strengths, resources, and assets. Harper Lee (1993) in *To kill a mockingbird*, says it beautifully: “People generally find what they look for and hear what they listened for…”— strengths-based practitioners have a deep belief that every individual and every environment have strengths and look for and listen for those strengths. In this sense, if you believe that everybody has strengths, you are more likely to help the individual to look for, discover, mobilize, honour, and build on the resources, skills, assets, wisdom, and knowledge that individuals, families, communities, and their environments have. Instead of focusing only on the limitations, needs, and challenges that individuals face in their environments, you, as a strengths-based practitioner, can see environments as a potential source of resources, assets, and support for individuals (Rapp & Goscha, 2011). Individuals’ and environmental strengths become your resources to kindle the process of transformation and healing.

Strengths-based practitioners do not ignore the problems that clients bring; they do not minimize the clients’ challenges and circumstances (Saleebey, 2013). Strengths-based practitioners focus on the individual as a whole. Almost always, the individual who is in front of you is facing a variety of challenges and has several and complex needs. If you think about it, the person you have in front of you is so MUCH more than a diagnosis, a problem, or a long list of symptoms and needs. For the Strengths Perspective, a profound belief in the client’s capacity for change is what makes the difference; the belief in the client’s experiences and realities and the belief that a person’s life goes beyond a problem. If you get to deeply know the individual, you are likely to discover a great array of resources,
assets, and skills that you can tap into as you collaborate with the individual in achieving his or her goals, dreams, and aspirations. By focusing on what is working well, you acknowledge the individual’s successful efforts to develop adaptive strategies to overcome challenges (Pulla & Mariscal, 2013). The challenges still exist, but by identifying, using, and building on the available strengths, individuals feel empowered to face, solve, overcome, or transform those challenges.

This does NOT mean that you simply rename or redefine the problem from a “positive” view. How can you redefine the horrors lived by survivors from a Nazi concentration camp or children who witnessed their father kill their mother? Viktor Frankl (1963), an existential psychiatrist who survived a WWII concentration camp and developed Logotherapy, asserted that individuals facing a great deal of adversity often discover meaning in their own experience and suffering. The meaning attributed to such experience can help transcend and transform the experience itself. In other words, individuals can find a meaning in life and have satisfactory lives in spite of the adversity, horror, and suffering they endured. As Saleebey (2001) clarifies, strengths can be discovered especially in “those elements of character that have ripened as a consequence of coping with dire circumstances” (p. 13).

The Strengths Perspective underscores and nurtures individual resilience (Mariscal, 2012), which is the universal capacity for achieving a positive developmental outcome despite exposure to serious adversity (Masten, 2001). Extensive literature identifies several personal (e.g., cognitive skills, social competence, autonomy, and sense of meaning/spirituality) and environmental (e.g., caring relationships, high expectations, and opportunities for participation) strengths that promote resilience (Benard,
2004; Mariscal, 2012). As a strengths-based practitioner, you will create a healing atmosphere that promotes change through a caring and accepting relationship with your client, as you hold high and achievable expectations for them, as you identify opportunities for them to contribute and participate in the community, and as you collaborate with them in the pursuit of their goals. In doing so, opportunities are created for clients to reclaim personal power in their lives and make decisions that impact them (Rapp & Goscha, 2006).

Clearly, the Strengths Perspective involves an empowering, healing, and completeness process that demands far more than acquiring new techniques, vocabulary, or protocols. This perspective requires a deep transformation of the practitioner’s beliefs and worldview; what we look for and what we listen for shift as we focus on potential, possibility, promise, skills, experience, wisdom, assets, knowledge, and the smallest sparkle of hope. As Saleebey (2001) asserts, to embrace a strengths-based approach involves “changing one’s heart and mind- a personal paradigm shift” (p. 13).

**Moving from oppression to mental health recovery**

Although attitudes and practices are shifting, people with psychiatric disabilities continue to experience oppression and discrimination in their communities. This oppression is often reinforced by the practices of mental health professionals who tend to endorse the damage model (Wolin & Wolin, 1993), and engage in macro and micro aggressions that range from the use of restraints in hospitals to blaming the victim and giving pre-eminence to problems, deficits, and pathology in individuals and environments (Rapp & Goscha, 2011). While naming a problem can provide some sense of relief,
most “names” come from the practitioner and represent a lack or inability in the client. Thus, the power of the professional derives from naming the problem and offering strategies for overcoming it. Labels mostly use a language that does not belong to the client. When you focus on a person’s symptoms and diagnosis, you disregard the meaning of that person’s struggle, strengths, resources, skills, and resilience. When you refer to people with psychiatric disabilities by their diagnosis, you dehumanize them, impacting their identity. Rapp and Goscha (2011) assert that these practices are “rarely done intentionally or with malevolence, but rather elicited by compassion and caring.” (p. 3), they should be avoided as they can be seen as spirit-breaking and oppressive.

Oppression impacts several life domains of people with psychiatric disabilities. For instance, many people with psychiatric disabilities do not have their own space and face mobility problems due to facility rules, inadequate public transportation, and lack of car ownership. Many struggle to control their own time and energy as they conform to directives and “structure” established by professionals and family members. Their social interactions are restricted as they spend most of their time with other clients and staff, resulting in fewer opportunities to interact with the opposite gender and to raise their children. The most devastating consequence of this oppression is that people internalize the oppression as they lose their identity to the negative images that oppressors impose; they become the label; “the depressed”, “the bipolar.” (Rapp & Goscha, 2011)

In recent years, recovery is taking increasing precedence in the provision of mental health services in the United States, underscoring the fundamental idea that people who experience psychiatric symptoms can and do recover (Fukui et al., 2011). Indeed, “mental health recovery is a journey of healing
and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential” (National Consensus Statement on Mental Health Recovery, U.S. Department of Health and Human Services, 2005). Recovery implies both, a process and an outcome (Anthony, 1993; Davidson, Lawless, & Leary, 2005; Deegan, 1988; Frese, Stanley, Kress, & Vogel-Scibilia, 2001). As a process, it follows a complex, unique, and nonlinear path which involves a personal transformation in hopes to live a satisfactory life despite the challenges ahead. As an outcome, recovery implies a powerful and hopeful vision that is intertwined with the individual’s skills, roles, goals, aspirations, values and attitudes (Fukui et al., 2011; Torrey, Rapp, Tosh, McNabb, & Ralph, 2005). Thus, the outcomes of the recovery process can only be determined by the individual.

Recovery does not mean that the person will be symptom-free, and will no longer require mental health services or medication. Recovery refers to the person’s ability to lead a satisfactory life despite the symptoms, stigma, trauma, setbacks, loneliness, despair, and alienation. This means that the person may still use medication or may combine medication with “personal medicine” and that the person may use mental health services differently (Deegan, 2005; Torrey et al., 2005). Rapp and Goscha (2011) identified five critical elements of recovery:

- Reclaiming of one’s sense of self, one’s identity (beyond labels)
- Need for control over one’s life and choices
- Having a sense of purpose and meaning in life
- Having a sense of achievement or assuming a responsible role
- Presence of at least one person (caring, supportive relationships)

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1 Personal medicine is a term that encompasses those “activities that give meaning and purpose to life, and that serve to raise self-esteem, decrease symptoms, and avoid unwanted outcomes such as hospitalization” (Deegan, 2005).
The recovery movement is clearly infused with the Strengths Perspective, the Substance Abuse and Mental Health Services Administration in the National Consensus Statement on Mental Health Recovery (U.S. Department of Health and Human Services, 2005), identified a strengths-based approach as a fundamental component of recovery-oriented services. However, as Fukui and colleagues (2012) recommend, it is important to specify practices which can be evaluated in terms of client outcomes to prevent the term “strengths-based approach” from being applied loosely to different practices that negligibly impact recovery.

**Strengths model of case management (SMCM)**

Charlie Rapp- a passionate leader of strengths-based social work practice, relentless advocate for people with psychiatric disabilities, and a wonderful and genuine human being- developed the strengths model of case management (SMCM) with people with psychiatric disabilities (Rapp, 1993, 1998; Rapp, 2004; Rapp & Chamberlain, 1985; Rapp & Goscha, 2006, 2011). Rick Goscha, a committed leader of the strengths based practice, insightful and supportive colleague, and a fantastic human being, co-authored the Strengths Model of Case Management. Their model of strengths-based practice is infused with the recovery vision, as “every contact with a person can be an opportunity for building hope, increasing confidence, and taking steps to create a better life” (Rapp & Goscha, 2011, p. 36).

The strength model of case management offers both a theory and a set of tools and methods designed to help people with psychiatric disabilities to
recover and transform their lives, by attaining the goals they set for themselves as the needed personal and environmental resources are identified, secured, and sustained. A theory of strengths, which is summarized in Figure 1, and the following six principles guide the SMCM (Rapp & Goscha, 2011):

1. People with psychiatric disabilities can recover, reclaim, and transform their lives
2. The focus is on individual strengths rather than deficits
3. The community is viewed as an oasis of resources
4. The client is the director of the helping process
5. The case manager-client relationship is primary and essential
6. The primary setting for our work is the community

Problems, challenges, and barriers that the individual faces are not ignored in SMCM; instead, they are addressed in term of the goals that the person wants to attain. Personal and environmental strengths are used to achieve those goals or to overcome identified barriers. The essence of the SMCM is beautifully captured in the following quote:

The strengths model is more concerned with achievement than with solving problems; with thriving more than just surviving; with dreaming and hoping rather than just coping, and with triumph instead of just trauma. For this to happen, people need goals, dreams, and aspirations. (Rapp & Goscha, 2011, p. 41)

[Insert Figure 1 here]
Specific practices and methods in the SMCM are designed to help professionals in working from a strengths-based practice and correspond to five functions:

1. **Engagement and relationship**: The quality of the helping relationship is essential for the Strengths Perspective, as it offers a safe and accepting atmosphere to assess attainable goals, enhance hope in the future, and secure resources to promote healing transformation, regeneration, and resilience. This relationship is seen as a collaborative helping partnership, characterized by empathy, genuineness, and unconditional positive regard. These characteristics were originally proposed by Rogers (1961) and consistently confirmed by research as the fundamental characteristics of effective helping relationships. The client-case manager relationship in SMCM is purposeful, reciprocal, friendly, trusting, and empowering (Rapp & Goscha, 2011).

By actively listening to the client’s stories and narratives, a helper can discover the client’s assets, abilities, and resources, as well as his or her concerns and challenges. This relationship creates positive expectations for the individual’s future—hope inducing relationship (Rapp & Goscha, 2006). Positive expectations and hope communicate the practitioner’s belief in the client’s inner power to transform his or her reality (Saleebey, 2001), mobilizing hope and the possibility of a different future (Saleebey, 2009).

2. **Strengths assessment**: It is a process rather than an outcome, in which practitioners gather information regarding seven life domains
(daily living situation, financial/insurance, vocational/educational, social support, health, leisure/recreational, and spirituality/culture) with the purpose of identifying personal and environmental strengths that will serve as the basis for the collaborative work. Figure 2 summarizes the characteristics of the strengths assessment in the SMCM.

3. **Personal planning:** Based on the strengths assessment, the person and the case manager discuss, negotiate, and agree on a long term goal, short term goals or task and assign responsibility to each task and estimated dates for accomplishment. The personal recovery plan includes small, concrete, and measurable steps toward a goal until it is attained.

4. **Resource acquisition:** With a recovery vision and perceiving the community as helping and resourceful, case managers use a variety of interpersonal and strategic skills to procure the environmental resources desired by the person to achieve their goals and ensure opportunities for participation and integration.

5. **Collective continuous collaboration and graduated disengagement:** The helping process is characterized by a multidimensional and ongoing modification and adaptation that will be noted on the personal plan. As a case manager operating from the SMCM you focus more on the person’s ability to use personal and environmental strengths to reach
her or his short term and long term goals as she or he moves along a
unique journey of recovery toward community integration.

Full implementation of SMCM also considers structural components and
supervision practice elements. Structural components include low caseload
sizes (no more than 20:1), low supervisor-to case manager ratio (preferably
no more than 6:1), weekly group supervision using a structured format for
case presentations, specification of job responsibilities for case managers
and supervisors, and use of integrated services. Supervision practice
includes behaviours that correspond to teaching and reinforcing practice
skills of frontline staff, such as weekly review of and feedback on the use of
SMCM tools, and field mentoring.

**Evaluating the SMCM**

Ten studies have evaluated the effectiveness of using SMCM to assist people
with psychiatric disabilities. Five of the studies used experimental or quasi-
experimental designs (Fukui et al., 2012; Macias, Kinney, Jackson, & Vos,
1994; Macias, William Farley, Jackson, & Kinney, 1997; Modrcin, Rapp, &
Poertner, 1988; Stanard, 1999) and five used non-experimental methods
(Kisthardt, 1993; Rapp & Chamberlain, 1985; Rapp & Wintersteen, 1989;
Ryan, Sherman, & Judd, 1994). These studies have demonstrated its
effectiveness in assisting people with psychiatric disabilities in improving
outcomes associated with hospitalization (Fukui et al., 2012; Macias et al.,
1994; Macias et al., 1997; Modrcin et al., 1988), housing (Fukui et al.,
2012; Kisthardt, 1993; Modrcin et al., 1988; Rapp & Wintersteen, 1989;
Ryan et al., 1994; Stanard, 1999), employment (Fukui et al., 2012;
Kisthardt, 1993; Modrcin et al., 1988; Rapp & Wintersteen, 1989), family
burden (Macias et al., 1994), symptoms (Macias et al., 1994; Macias et al.,
1997; Modrcin et al., 1988), health (Kisthardt, 1993; Macias et al., 1994;
Rapp & Wintersteen, 1989), finances (Kisthardt, 1993; Macias et al., 1997; Rapp & Wintersteen, 1989; Ryan et al., 1994), leisure time, and social support (Kisthardt, 1993; Modrcin et al., 1988; Rapp & Wintersteen, 1989).

In addition, two studies have demonstrated the association between the level of model adherence (fidelity) to SMCM in assisting people with psychiatric disabilities and improvement in client outcomes (Fukui et al., 2012; Petrakis, Wilson, & Hamilton, 2012). Petrakis and colleagues (2012) conducted their study in Australia and their findings are presented in another chapter in this book. Fidelity refers to the degree to which the implementation of SMCM reflects the actual theories and methods proposed in the model. SMCM fidelity was assessed through the Strengths Case Management Fidelity Scale, which consists of 12 items corresponding to three major domains: structure (e.g. caseload size, use of group supervision, etc.), supervision (e.g. review and feedback on the use of SMCM tools and field mentoring), and clinical practice (e.g., use of strengths assessment, hope-inducing behaviours) (Fukui et al., 2012; Teague, Mueser, & Rapp, 2012). This scale serves three purposes: monitoring the SMCM implementation and assuring its quality; providing a tool to state mental health authorities for state-level monitoring, and providing a practical tool to distinguish the rhetoric of programs and theories from the actual practice and implementation of the SMCM.

Findings revealed that, over time, client outcomes improved in terms of psychiatric hospitalization, competitive employment, postsecondary education, and independent living (Fukui et al., 2012). However, these improvements depended on fidelity scores with the exception of housing. Most teams of the 14 teams in the study achieved high fidelity within 12
months, suggesting that SMCM is a feasible practice to be implemented in community mental health centres with positive impacts on client outcomes.

**Strengths-based recovery-oriented self-management tools**

Practitioners who embrace the Strengths Perspective and use the SMCM also encourage the use of recovery-oriented self-management tools that assist in identifying and mobilizing the person’s internal and external strengths. These self-management educational approaches can be easily implemented to foster recovery. Although several self-management programs have been developed in recent years, two widely spread programs have been evaluated: Pathways to Recovery (PTR) and the Wellness Recovery Action Plan (WRAP). PTR translated the Strengths Perspective and methods of the strengths model of case management into a self-management approach for adults with severe psychiatric symptoms. It was developed by researchers at the Office of Mental Health Research and Training at the University of Kansas, School of Social Welfare, in collaboration with mental health consumers, recovery educators, and mental health providers (Ridgway, McDiarmid, Davidson, Bayes, & Ratzlaff, 2002).

Pathways to recovery was developed with the objective of encouraging users to develop a personalized recovery plan as they express goals and desires, discover strengths, and use them as the foundation for finding meaning and purpose in life. Nine life domains are explored, including home, education and learning, personal assets, work and career, social support, health and wellness, intimacy and sexuality, leisure and recreation, and spirituality (Ridgway et al., 2002). PTR was evaluated through a group intervention
consisting of 12 weekly sessions led by a peer trained facilitator. Findings suggested significant decreases in self-reported psychiatric symptoms, and significant increases in participants’ self-esteem, self-efficacy, social support, and spiritual well-being (Fukui, Davidson, Holter, & Rapp, 2010; Fukui, Davidson, & Rapp, 2010). Further, the benefits of PTR seemed to extend to other dimensions, as a participant explains:

“Attending the Pathways group changed my life in lots of ways. I’ve made my own personal ‘recovery turnaround.’ I’m exercising, getting out with friends, and thinking about going back to school. Pathways gave me the tools I needed to be able to see these goals can be achieved. My own recovery is richer now.” (Fukui, Davidson, & Rapp, 2010, p. 944)

In the Wellness Recovery Action Plan (WRAP), participants identify internal and external resources for facilitating recovery, and then use these tools to create an individualized self-management plan. WRAP was developed with the objective of encouraging health-related behavioural and attitudinal change, as participants acquire information and develop skills to better manage symptoms and maintain increased levels of health and functioning (Copeland, 1997; 2004). WRAP users create individualized action plans to assist them in identifying the progression of symptoms and plan how to manage these symptoms. Evaluation of a WRAP group intervention revealed significant improvements in terms of hope and psychiatric symptoms among WRAP participants (Fukui et al., 2011; Starnino et al., 2009). As Fukui and colleagues (2011) affirm, “by participating in a WRAP group and developing a WRAP plan, individuals can gain a sense of hope and empowerment while learning effective self-management skills to better control their symptoms, and become an active participant in their own recovery.” (p. 215)
Discussion

It is critical that mental health services become recovery-oriented in order prevent further oppression of people with psychiatric disabilities (Rapp & Goscha, 2011). The Strengths Perspective provides a fertile soil for recovery and the SMCM provides the tools, water, and sun to nurture and enhance it; the seeds of recovery, resilience, and transformation reside in each person. In other words, the Strengths Perspective provides the vision and the belief in the possibilities and promise embedded in the person’s inner strengths and the natural occurring resources in the environment—it provides the heart. The SMCM provides the theory, practice methods and tools, and structural elements necessary to realize the recovery vision as uniquely defined by the person. This recovery vision consists of long term and short term goals that are set by the person with assistance from practitioners. The SMCM methods and tools assist the person in mobilizing hope, building confidence, and developing detailed step-by-step plans for goal attainment.

However, having a philosophical approach and rhetoric derived from the Strengths Perspective is not enough to fulfil the growing demand for evidence-based practices in the provision of mental health services. The SMCM provides specific methods, tools, structural elements (e.g., group supervision), and evaluation protocols which can be used to monitor the implementation of the SMCM intervention, assess its effectiveness in assisting people in attaining the goals they set for themselves, and assess the quality of the relationship between case manager and client. Thus, the Strengths Perspective clarifies and guides the SMCM theory, methods and tools, but the SMCM informs, refines, and tests the Strengths Perspective. As Figure 3 shows, the Strengths Perspective corresponds to a grand or umbrella theory, the theoretical propositions included in the SMCM
correspond to a mid-range theory, and the methods and tools included in the SMCM correspond to a practice theory.

[Insert Figure 3 here]

In addition, it is not enough to use the SMCM methods and protocols; it is necessary to put your “heart” into it. As a strengths-based case manager, your actions, your words, your thoughts, and your expectations transpire a Strengths Perspective: you believe in the possibilities and promise that each person brings; you can see beyond limitations, symptoms, and challenges; you acknowledge the resilience, heroism, resourcefulness, and strengths in the person and the environment; you believe that the person is capable of achieving his or her dreams, goals, and aspirations and you provide assistance in doing that; you rejoice in the person’s accomplishments; and you support them through rough times without losing the vision because you know they will get there. Also, you see yourself as a resource for the person; you are a human being establishing a relationship with another human being.

Without the profound transformation in your personal paradigm that is embedded in the Strengths Perspective, you may think that you adequately use the SMCM by assisting the person in setting goals and a personal plan, asking the suggested questions for the strengths assessment and “completing” it. You may not realize, however, that you rushed to “complete” the form and you did not actually get to know the person or get an idea of what recovery means for this person; you limited her or his goals instead of breaking them down in different achievable pieces; your voice was
louder and you used your power to impose your ideas. You forgot that the person and the environment are constantly changing and they are an endless source of strengths, and thus, a strengths assessment is never complete; it should be on-going. Without a strengths-based vision, you may forget the person and only focus on the tools; you may forget that the process is more important that the tools, that the quality of the relationship is more important than the questions you ask, and that person is at the centre of SMCM leading the process.

Similarly, every component, every method, and every tool included in the SMCM conveys a recovery vision. For instance, hope-- which is essential to recovery (Torrey et al., 2005)-- is a central tenet of the SMCM. Hope is intertwined in the strengths assessment, recovery plan, and engagement and relationship. Also, hope inducing behaviours are reviewed during group supervision. In addition, the recovery movement underscores the participation of people in decision making as directors of their own care. In the SMCM, the person leads the process, establishing the desired outcomes and individualized recovery plan, whereas the case manager provides assistance and support for the person to achieve those goals and realize the plan. The desired outcomes in SMCM often include different elements of community integration, such as housing, real work experience and education, and opportunities for social interactions. Community integration is the focus of recovery, which is enhanced by the supportive relationships the person has (Torrey et al., 2005). A relationship between case manager and client should be purposeful, proactive, empathetic, compassionate, friendly, encouraging, and empowering, as the SMCM proposes. This proactive relationship provides an ideal atmosphere to discuss and plan for crises and setbacks which should be included in the recovery plan. Also, this atmosphere is ideal to explore and mobilize resources, strengths and
opportunities, including peer-support and self-management tools such as PTR and WRAP to enhance self-care and self-management which are also central components of recovery.

Further, there are new approaches to service provision in mental health that take advantage of the latest technological advances which are infused with the recovery vision and the Strengths Perspective. CommonGround is a web-based application designed by and for people with psychiatric disabilities to support recovery and shared decision making in psychiatric medication clinics (Campbell, 2009; Deegan, 2010; Goscha, 2009; Stein et al., 2012). This application provides a set of tools that re-define and re-structure the collaboration between prescribers and people with psychiatric disabilities in order to arrive at shared decisions about the next steps in treatment (Deegan, 2010; Goscha, 2009). Innovations such as CommonGround speak of a world of transformation and possibilities to enhance the recovery of people with psychiatric disabilities.

The Strengths Perspective has definitely made an impact in all fields of social work practice in the United States, and although practice theories such as the SMCM are still necessary in many fields, transformation has started and it is evidently growing. The influence of the Strengths Perspective is gradually expanding to several countries around the world, including England, Sweden, Australia, the Netherlands, Japan, Malaysia, India, and China. The Strengths Perspective particularly “makes sense” in community-centred cultures, which are characteristic of many developing countries, such as my country, Bolivia. Using the community resources comes “natural” to us, because that is how people have been able to endure adversity for centuries. However, in our countries people with psychiatric disabilities suffer much more the consequences of stigma, discrimination, and
oppression; many of them are institutionalized or hidden at home because of the shame that psychiatric disabilities entails for the family. In this context, recovery is not even in the vocabulary of mental health practitioners. Thus, it is now, our responsibility, as the new generation of social work practitioners, to take the Strengths Perspective and the SMCM to a new level, to transpire strengths, recovery, and resilience in everything we do, in every interaction we have, in every contact we have, in every person. The transformation of social work practice in mental health is in your hands. After all, as Gandhi said, you can be the change you want to see in the world.
Figure 1. Strengths Model of Case Management Theory of Strengths

Source: Adapted from Rapp and Goscha (2011)
Figure 2. Characteristics of the SMCM strengths assessment

Source: Adapted from Rapp and Goscha (2011)
Summary

The Strengths Perspective represents a paradigmatic shift in social work practice that includes a focus on the strengths, assets, and resources that people and communities have which can be used to assist people in realizing their hopes and dreams. The strengths model of case management (SMCM) offers both a theory and a set of tools and methods designed to help people with psychiatric disabilities to recover and transform their lives by attaining the goals they set for themselves and by identifying, developing, and using the needed personal and environmental resources. From a hierarchical approach, the Strengths Perspective corresponds to a grand or umbrella theory, the theoretical propositions included in the SMCM correspond to a mid-range theory, and the methods and tools included in the SMCM correspond to a practice theory. Thus, both the strengths perspective and
the SMCM are necessary to establish an empowering, collaborative, purposeful, and effective relationship with individuals. Strengths-based recovery-oriented services in mental health are necessary to prevent further oppression of people with psychiatric disabilities. Recovery, empowerment, and hope are essential to the Strengths perspective and are intertwined in every component, method and tool of the SMCM. While the Strengths Perspective provides the vision and the belief in the possibilities and promise embedded in internal and external strengths, bringing the heart into practice, the SMCM provides the theory, practice methods and tools, and structural elements necessary to realize the recovery vision as uniquely defined by the person.

Key Terms Explained

Strengths Perspective

The Strengths Perspective represents a paradigmatic shift in social work practice that focuses on the strengths, assets, and resources that people and communities have to assist people in achieving their goals and realizing their hopes and dreams. This perspective emerged in the early 1980s at the University of Kansas under the leadership of remarkable scholars such as Dennis Saleebey, Charles Rapp, and Ann Weick.

Strengths-based practice

A strengths-based practice encompasses any practice that focuses on facilitating the discovery, exploration, mobilization, development, and use of the strengths, assets, and resources that people and communities have in order to achieve their goals and realize their dreams and aspirations.
**Strengths Model of case management**

The strength model of case management offers both a theory and a set of tools and methods designed to help people with psychiatric disabilities to recover and transform their lives, by attaining the goals they set for themselves as the needed personal and environmental resources are identified, secured, and sustained. It is a practice theory that contains structural, supervision, and practice elements developed by Charles Rapp and Richard Goscha at the University of Kansas.

**Mental health recovery**

Mental health recovery refers to the unique, individualized, and non-linear journey of healing and transformation that enables people with psychiatric disabilities to live a satisfactory, meaningful life, despite the challenges faced in hopes of achieving their full potential. Mental health recovery implies a powerful and hopeful vision as people with psychiatric disabilities set goals for themselves that usually relate to community integration.

**Implementation fidelity**

Fidelity refers to the degree to which the implementation of a practice model reflects the actual theories and methods proposed in the model.

**Strengths assessment**

A strengths assessment is an on-going, conversational, and purposeful process which gathers information regarding different life domains with the purpose of identifying a holistic portrait of personal and environmental strengths, assets, and resources that will be used to help the person achieve the goals they set for themselves and realize their hopes, dreams, and
aspirations. A strengths assessment is led by the person and the practitioner-client relationship is prioritized.

**Reflective/Practice Questions**

1. What is the difference between the Strengths Perspective and the Strengths Model of case management for people with psychiatric disabilities?
2. What characteristics should the relationship between case manager-client have? Why?
3. What specific practices and methods does the SMCM propose?
4. What are the characteristics of a strengths assessment according to the SMCM?
5. How do the Strengths Perspective and the SMCM enhance the recovery of people with psychiatric disabilities?

**References**


Mariscal, E. S. (2012). Resilience and strengths among children exposed to IPV. In V. Pulla, L. Chenoweth, A. Francis & S. Bakaj (Eds.), *Strengths Based Practice in Social Work and Human Service* (pp. 191-201). New Delhi, India Allied Publishers Pvt.Ltd.


**Other Web Resources**


The **Strengths Institute** Website at the University of Kansas, School of Social Welfare provides information on the Strengths Perspective, including principles, lexicon, paradigm shift, assessment, and relationship with other frameworks and theories (e.g. resilience, solution-focused therapy, positive psychology). It also includes a database of publications using the Strengths Perspective in several areas of social work practice, including articles, books, and book chapters.

*Office of Mental Health Research and Training*: University of Kansas School of Social Welfare [http://mentalhealth.socwel.ku.edu/projects/Emerging/cm.shtml](http://mentalhealth.socwel.ku.edu/projects/Emerging/cm.shtml)
The Office of Mental Health Research and Training at the University of Kansas, School of Social Welfare provides information on research and training regarding the **Strengths Model of Case Management** (e.g. principles, primary tools, supervision). Other evidence-based practices (e.g. supported employment, integrated dual diagnosis treatment, family psycho-education), emerging and promising practices (e.g. supported education, supported housing), value-based practices (e.g. consumers as providers, Wellness Recovery Action Plan, pathways to recovery, common ground, spirituality, and online psychiatric medication training), and supervision, policy, and administration (e.g. supervisory training, consumer outcome monitor package, workbench).