The Strengths Model: A Recovery-Oriented Approach to Mental Health Services

St Vincent's Mental Health

Adapted with thanks from Paul Liddy's Training Manuals 2006 - 2009
Consultant and Trainer
University of Kansas School of Social Welfare

"……we learn that even when people present with obvious vulnerabilities they also have strengths. Their strengths are in their passions, in their skills, in their interests, in their relationships and in their environments. If mental health practitioners look for strengths they will find them" (Patricia Deegan. Excerpt from the foreward to *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services*, Rapp and Goscha 2011)

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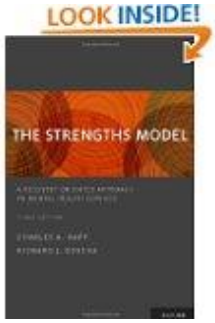
1. TRAINING OBJECTIVES



The two day training sessions will cover many aspects of the Strengths Model of and the aim is to give all participants the opportunity to learn the background and theory of the model and also to have a 'hands on' experience of working with the tools and participating in a brainstorming session.

Much of the material in this manual is based on the book *The Strengths Model: A Recovery-Oriented Approach to Mental Health Services* by Charles Rapp and Richard Goscha (2011).

1. Engagement

Participants will:

- reflect on the process of building a trusting, hope inducing relationship with people that facilitates their recovery;
- reflect on how their own practice can either promote or hinder recovery in the lives of people; and identify common barriers/obstacles to effective engagement

2. The Strengths Model and Principles

Participants will:

- understand the beneficial impact of consumer focused, consumer directed processes;
- have an understanding of the recovery process and how they can contribute to this process in the lives of the people they work with;
- appreciate the factors and events, other than mental illness that people are recovering from in their lives;
- understand the six principles of the Strengths Model and;

3. The Strengths Assessment

Participants will:

- learn how to use a strengths assessment to promote recovery and have a positive impact on the lives of their consumers;
- understand the format and the five critical components of the strengths assessment;
- identify and develop methods to overcome common challenges when completing a Strengths Assessment with their consumers

4. Goal Planning

Participants will:

- develop a basic understanding of the principles of goal planning,
- identify strategies for overcoming common barriers to setting long-term goals;
- discuss the essential components for setting effective long-term goals; and
- learn how to develop a Goal Plan by breaking down the long-term goals into short-term measurable steps.

5. The Wellness Recovery Action Plan® (WRAP®)

Participants will:

- develop an understanding of the importance of planning in the maintenance of wellness and the promotion of recovery;
- reflect on the importance of self-responsibility in the recovery process;
- understand the WRAP® components
- be able to describe the relationship between the WRAP® and risk assessment
- understand how to assist consumers to develop their own WRAP® (including crisis planning) and will apply the WRAP® principles to themselves; and
- reflect on the need for ongoing wellness and support

6. The Family Recovery Assistance Planning (FRAP)

Participants will:

- have an understanding of the impact that family and carer support wellbeing has on people's recovery;
- consider the process of how they may involve family and carers regarding the Strengths Model; and
- understand how to assist family and carers to develop their own FRAP

7. Resource acquisition:

Participants will:

- develop a basic understanding of how naturally occurring community resources assist their consumers to reach their goals; and
- Explore the concept of the ideal niche
- Understand the link between use of resources to goal achievement
- consider why naturally occurring resources are preferred over formal mental health services

8. Group Brainstorming Sessions:

Participants will:

- understand what Brainstorming is
- understand the benefits of Group Brainstorming Sessions; and
- understand the process of effective facilitation and participation in Group Brainstorming Session

9. Mentoring

Participants will

- understand the purpose of Mentoring
- discuss the benefits of Mentoring
- participants will understand the format of Mentoring
- participants will understand about Giving Feedback

2. HISTORICAL OVERVIEW

Mental health services have regularly adjusted to wider ranging social changes that shape the needs and demands of the community, the increasing attention paid to rights and responsibilities for people with mental health issues and the changes in service delivery paradigms, staff training and resourcing.

(Willsmere Hospital Kew, the old Kew Mental Hospital, decommissioned in 1988)

In Australia major changes have included the closing of stand-alone psychiatric facilities, the increasing focus on community based care, the integration of psychiatric services into mainstream medical services, the growth of the Psychiatric Disability Rehabilitation Support Services (PDRSS) sector and the increasing role and impact of consumer and carer participation in service development and review. Some of us may have worked through many of these changes as clinicians, leaders and managers.

(SVHM Services Fitzroy)

The changes to our own consumer community were affected by the Mental Health Act of 1985 that required consumers to be cared for in the least restrictive environments and created legal and clinical systems for intensive community based support. Large facilities like those in the North Eastern Metropolitan Psychiatric Services (NEMPS) were closed and community programs were developed e.g. Community Case Managers (CCT) Mobile Support Teams (MST) and Community Care Units (CCUs) including Footbridge. Our current consumers live in the community, supported by a skilled multi-disciplinary workforce, and receive early treatment, on-going support and rehabilitation services.

St. Vincent's explored a number of recovery-focused models of care and chose the Strengths Model (Rapp and Goscha 2006) as the best fit with St Vincent's broad service aims. It appreciated the emphasis that this model places on the engagement between case manager and consumer to identify the individual's strengths to develop a plan focusing on their goals, rather than those identified and "prescribed" by clinicians. It also appreciated that this model allowed clinicians to use their own expertise and creativity within the Strengths framework utilising the Strengths tools.

The National Action Plan on Mental Health 2006 – 2011 prioritises:

- Focus on promotion, prevention and Early Intervention
- Discharge management
- Streamlined service

DH Victoria, 2011 Framework for Recovery-Oriented practice & Balancing Risk:

- Collaborative partnerships and meaningful engagement
- Focuses on the consumer's strengths
- Promoting a culture of hope

DH Victoria, 2014 Mental Health Act

- Recovery
- Supported decision making
- Nominated Person
- Advanced statement
- Presuming capacity

The St. Vincent's Strengths Model Implementation Group (SMIG) was established to find a model that would:

- Provide consistency and definition to the practice of within our services;
- Support a recovery orientation that would emphasise the development of new meaning and purpose for consumers and support them to pursue their personal goals;

The changes to our own consumer community were affected by the Mental Health Act of 1985 that required consumers to be cared for in the least restrictive environments and created legal and clinical systems for intensive community based support. Large facilities like those in the North Eastern Metropolitan Psychiatric Services (NEMPS) were closed and community programs were developed e.g. Community Case Managers (CCT) Mobile Support Teams (MST) and Community Care Units (CCUs) including Footbridge. Our current consumers live in the community, supported by a skilled multi-disciplinary workforce, and receive early treatment, on-going support and rehabilitation services.

- Promote sustainable improvements in consumer's health, accommodation and vocational aspirations resulting in better outcomes for them;
- Support the impact and participation of consumers and carers on service delivery; and;
- Improve optimism and job satisfaction for staff

3. THE JOURNEY OF RECOVERY

The recovery movement in mental health is part of a larger social movement of empowerment and self-determination.

The recovery model/recovery process has been embraced in the last years by policy and programme developers, clinicians and consumer/carer driven services and has been described as being "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by illness" (Anthony, 1993).

Recovery based care encompasses more than pharmacological interventions and directive psychosocial activities, it places collaboratively identified choices and goal setting at the centre.

> "The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within the beyond the limits of the disability; the aspiration is to live, work and love in a community in which one makes a significant contribution"
>
> (P. Deegan, 2006)

Much of the early recovery literature for people with major mental illness had three main ideological sources. The first was the generic recovery or self-help movement exemplified by 'The Power of Positive Thinking', 12-step groups (e.g. Alcoholics Anonymous, Narcotics Anonymous), self-help/self-transformation and new age philosophies. The second source was the mental health service user movement, and its underlying philosophy of human rights and self-determination. The third source was psychiatric rehabilitation with its focus on community integration and overcoming functional limitations.

The movement has developed and expresses itself through consumer written/presented material, the spread of consumer peer support groups, the adoption of consumer and family/carer advocates in policy development and treatment revision and the creation of recovery-focused care.

The Strengths Model is one of these models. It emphasises the engagement between clinician and consumer that identifies the consumer s strengths and capacities and creates a plan based on the individuals own goals rather that one developed by the clinician / clinical team.

Clinicians have learnt to value the learned experience and wisdom of their consumers to manage their own lives, and to live in sometimes overwhelming circumstances of poverty and discrimination.

The 5 stages of Recovery

- **Moratorium -** A time of withdrawal characterised by a profound sense of loss and hopelessness;
- **Awareness -** Realisation that all is not lost and that a fulfilling life is possible
- **Preparation** – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills;
- **Rebuilding** – Actively working towards a positive identity, setting meaningful goals and taking control of one's life;
- **Growth** – Living a meaningful life characterised by self- management of illness, resilience and a positive sense of self

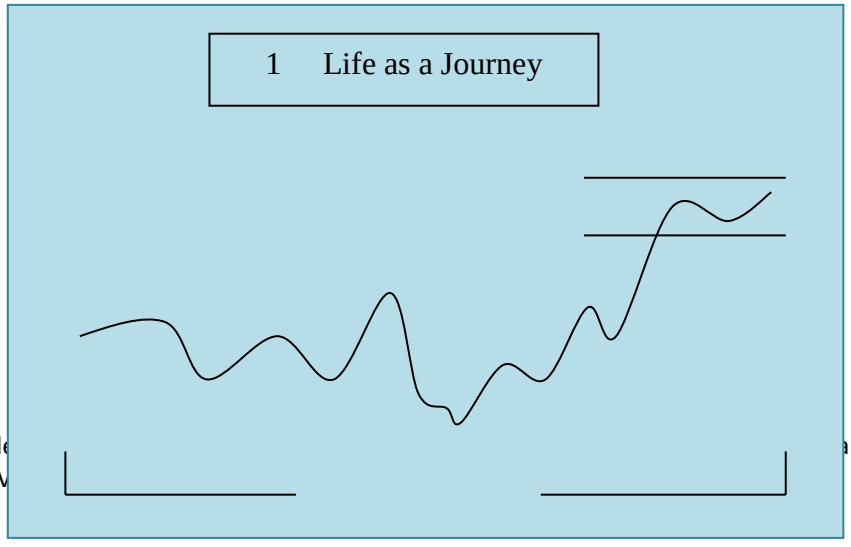
(Andresen et al, 2006)

The lived experience

Patricia E. Deegan Ph.D. (Pat) is an independent consultant who specializes in researching and lecturing on the topic of recovery and the empowerment of people diagnosed with mental illness. Pat is an activist in the disability rights movement and has lived her own journey of recovery after being diagnosed with schizophrenia at the age of 17. She is an Adjunct Professor at Dartmouth College School of Medicine and at Boston University, and at Sargent College of Health and Rehabilitation Sciences in the USA. Pat is also a Principle Investigator with the University of Kansas, School of Social Welfare. She received her doctorate in clinical psychology from Duquesne University. Pat is also a Mum and has been married to her partner for over 20 years!

There is often a period of despair following the diagnosis of a mental illness and the associated negative expectations and community stereotypes. Pat Deegan described this as a shattering of her world, hopes and dreams when she was told she had schizophrenia - an "incurable illness."

Many recovering people describe a period of extreme social withdrawal and frozen inactivity before, during or following a period of illness. P Deegan describes such a period in her life "*as a dark night and paralysis of will to do and accomplish".* In recovery people break through this frozen state of suspended animation and begin to participate actively in life once again.



Common themes in recovery

Recovery is the reawakening of hope after despair

- A period of despair often follows the diagnosis of a mental illness and the associated negative expectations and community stereotypes.

Recovery is characterised by a renewed sense of hope

- A sense of hope can be generated by exposure to another person's story of their experience of and recovery from mental illness. Working with Consumer Consultants or attending peer support groups can assist this process.
- These experiences inform people that it is possible to regain control over one's life and regain independence. Referrals to consumer groups, reading material and audiovisual resources can be made available to consumer s at all stages of treatment and recovery.
- Hope can also be generated by the therapeutic engagement between consumer and clinician where the clinician assists the person to explore their strengths, potential and past successes.

Recovery is breaking through denial and achieving understanding and acceptance

- It is normal for people to deny their psychiatric problems or avoid dealing with them at first. However to move into recovery it is crucial that people develop a way to think about and understand their life experiences and challenges.
- People do not have to accept that they have a mental illness to commence recovery; clinicians and workers can help their consumer s to make some sense of their life experiences, learn from them and accept them.

Recovery is moving from withdrawal to engagement and active participation in life

- Many recovering people describe a period of extreme social withdrawal and frozen inactivity before, during or following a period of illness.
- In recovery people break through this frozen state of suspended animation and begin to participate actively in life once again.
- Individuals may require significant support and encouragement to approach old friends, try familiar activities or attempt something new. Clinicians may act as their cheer squad as they support them to challenge their fears, reminding them that they may need to be "willing to try and fail and try again".

Recovery is active coping rather than passive adjustment

- Recovery means learning to make decisions and choices that are real, taking risks in order to experience growth, and assuming personal responsibility for the individual's recovery process (Lovejoy, 1982). There is no room in active recovery for the passive receipt of care and acceptance of externally driven planning.
- Clinicians help people challenge notions of disability and personal limits; they find the person's passion and work with dreams and goals, understanding that failure and setbacks are a normal part of living and learning.

Recovery means no longer viewing oneself primarily as a person with a psychiatric disorder and reclaiming a sense of self

- People are not diagnoses and should not feel completely defined by their disorder. In recovery, psychiatric problems become a fact of life but not the core of one's life**.** P Deegan writes "in accepting what we cannot do or be, we begin to discover who we can be and what we can do."

Recovery is moving from alienation to a sense of meaning and purpose

- People may experience a profound sense of alienation prior to recovery. Pat Deegan describes this like "a ship floating in a sea with no course or bearings." Her future seemed "a barren place, where no dream could be planted and grow into reality."
  E Leete (1993) writes "Ultimately we must conquer stigma from within, as a first step it is imperative to look within ourselves for our strengths. These strengths are the tools for rebuilding our self-image and thus our self-esteem."
- Stigma can be challenged through the therapeutic alliance between clinician and consumer, in the words they use when discussing the person's recovery pathway. Education for family and friends may also reduce stigma and people may be referred to peer support groups to help address self-esteem issue, reduce emotional isolation and engage in mutual self-help.

Recovery is a complex and nonlinear journey

- People do not make the recovery journey in one grand leap; they learn to feel good about taking very small concrete steps. Pat Deegan began her recovery journey by achieving "small triumphs" through "simple acts of courage" like riding in a car or talking to a friend for a few minutes. Recovery is an evolving process, one that sometimes spirals back upon itself, and may result in a frustrating return to an active disorder after periods of positive functioning. Recovery is individual and unique
- Clinicians and workers can witness and support all phases of recovery, assisting people to make sense of the journey, encouraging growth, celebrating success and being there during relapses or disappointments.

Recovery is not accomplished alone – the journey involves support and partnership

- People describe recovery as a process that invariably involves many other people. While no one can change another person, or force him or her into recovery, other people can strongly influence the process. Peers can spark and support recovery through formal self-help, informal encounters, mutual assistance and exposure to their stories of recovery
- Clinicians and workers can facilitate engagement in a self-directed recovery process where the consumer can realise that another human being cannot fix or set them free yet others can assist them to find their own way. This enables the consumer to take responsibility for their own recovery.

What RECOVERY does not mean

- Recovery does not necessarily mean that a person will no longer experience symptoms
- Recovery does not mean that a person will no longer have struggles
- Recovery does not necessarily mean that a person will no longer utilise mental health services
- Recovery does not mean a person won't use medication
- Recovery does not necessarily mean that a person will be completely independent in meeting all of his needs

What RECOVERY does mean

- The person has taken control of making decisions in his/her life
- The person has come to an understanding of his/her life experience
- The person has taken a forward-thinking approach to life
- The person is able to take pro-active steps in promoting his/her own wellness
- The person has hope and is able to enjoy life

Recovery-Oriented practice

Recovery-Oriented Practice	Non-Recovery Practice
Hope is communicated at every level of service delivery	There is little communication of hope
The **relationship** between the service provider and consumer is based on **compassion, understanding and knowing each other as unique individuals** and is the basis for good work to happen	Controlling, caring for and protecting people is the basis of the work
There are **high expectations for recovery** and it is considered the service outcome	Stabilisation is the expected outcome
Work with people is purposeful and designed to assist people in <u>their</u> growth and recovery toward their dreams, desires and goals. The primary mechanism that drives this process is with proactive, planned contact using written goals and steps towards achieving goals	Work with people lacks direction and is crisis-oriented. There is little or no planned, purposeful contact. No use of written goal planning and goals are driven by service delivery or service providers
Self-care, self-management and education are emphasised. People are supported in becoming experts of their own self-care. People are educated about medication, self-help, coping strategies and symptom management. Information is openly shared and consumers have access to information	Compliance is desired. Professionals are seen as knowing what is best for the consumer. Information is withheld on the basis that consumers do not understand or will not make good use of it
Community integration is the central focus or practice. This includes: normal, integrated housing, real work, experiences and work that is meaningful for the individual, linking to community, people, social and recreational activities. There is less emphasis on mental health programmes and groups	There is an emphasis on use of mental health programmes for work, social and recreational endeavours.
People are **supported to take risks** (failure is part of individual growth)	Protection and emotional safety are of primary concern
People receiving service are involved at <u>every level</u> of decision-making and directors of their own care. Including service planning and policy making	Professionals reserve decision making power and know what is best for the consumer
Peers support and mutual self-help is encouraged and valued	Peer support and mutual self-help is not talked about by service providers
Staff anticipate crisis and do pre-crisis and post crisis planning with consumers	Staff do not spend time on health and wellness planning and therefore much time tending to crises

Consumers tell us about what made a difference to their recovery.....

Decent clothing and food
People to be with
A way to be productive
A way to manage symptoms
A way to be part of the community
Individualised treatment
Flexibility in services
Case management

De Sisto et al, 1999

Research on the Strengths Model reported in Rapp and Goscha (2006) describes nine studies some using experimental or quasi experimental designs and others non-experimental methods.

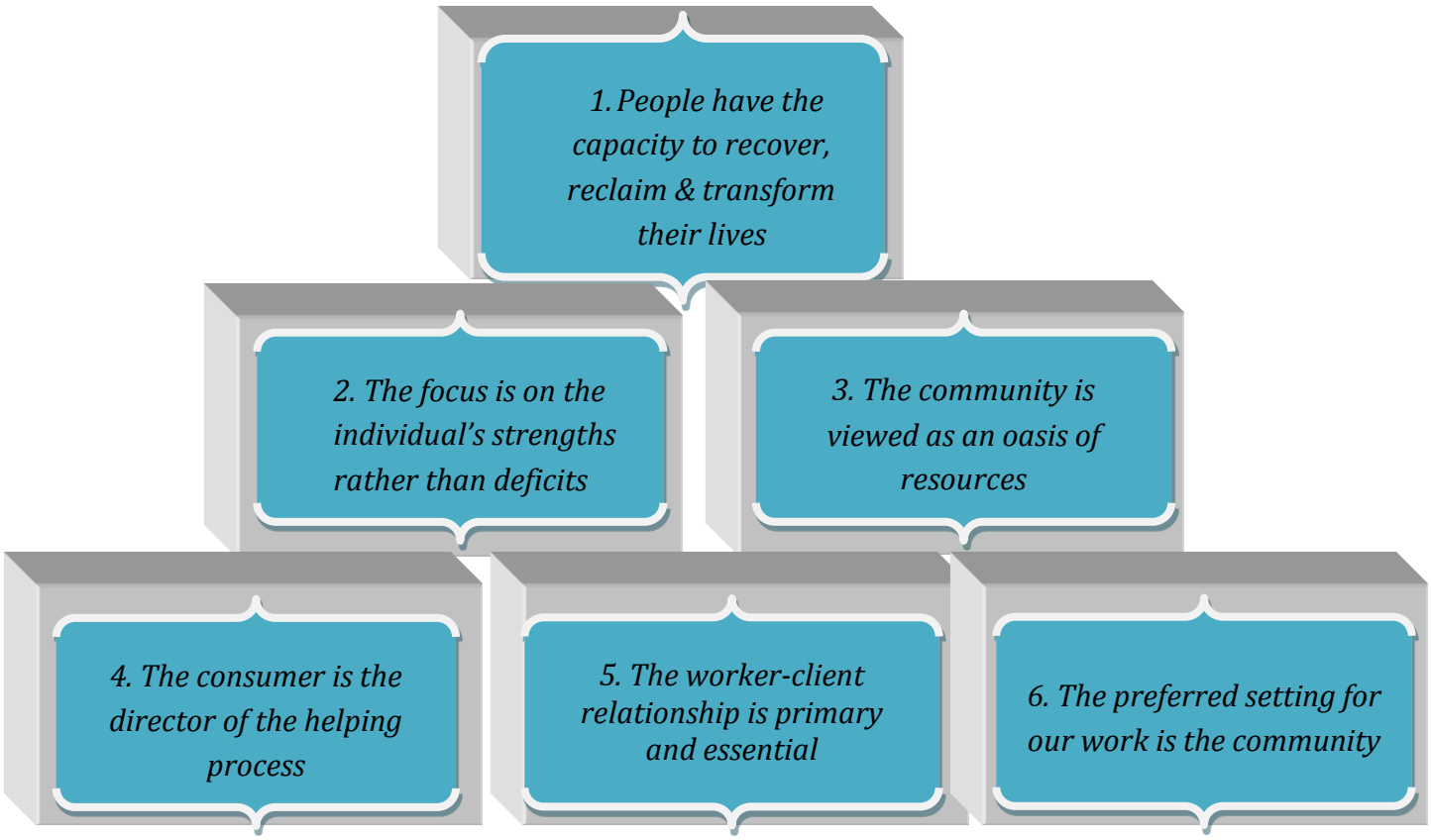
A detailed exploration of these studies can be found in the book which also includes a summary of the findings.

In brief:

- *Hospitalisation levels were measured* and the studies suggest that those people receiving strengths model had fewer hospitalisations and emergency department presentations;
- *Independence of Daily Living* outcomes from suggested that this model offers people an increase in goal setting, greater competence in daily living and increased stability in their lives and living arrangements;
- *Vocational and education outcomes* – there was some suggestion that there was an increase in vocational training;
- *Leisure time and social support*: the research suggests greater engagement with leisure and social activity;
- *Financial/ Legal issues*: greater stability in these areas was associated with those clients receiving strengths model ;
- *Health:* the studies suggest that people receiving the strengths model show greater physical and mental health; and
- *Symptomatology*: people receiving strengths model reported fewer problems with mood and thinking and greater psychological wellbeing. Family members and staff also reported improvement in client mental health and behaviour.

4. THE STRENGTHS MODEL AND PRINCIPLES

The 6 Strengths Principles



"The belief in (a person's) capacity for growth oriented change is an essential ingredient in the dynamic of the relationship. Stimulating this positive energy begins first with the act of belief. The person, family, or community, deeply mired in the complexities of the trouble, typically does not believe that they possess any resources that would be useful in resolving the problem. They have already tried to fix the situation without success. Professionals communicating their belief in the inner strength and resourcefulness of a person, family, or community becomes the beginning step in restoring people's faith in themselves and in their capacity to influence the shape of their lives."

A Weick & R Chamberlain, 2000

PRINCIPLE 1 People have the capacity to learn, grow and change

- ✓ Our emphasis and central belief is that people can continue to learn, grow and change;
- ✓ We believe that positive / negative belief is a self-fulfilling prophecy;
- ✓ We employ the power of 'positive expectations' when working with people;
- ✓ We employ the spirit of 'can do' in every contact with them; and
- ✓ We believe that the majority of people with major mental illness eventually recover.

PRINCIPLE 2 The focus of our work is on the person's strengths rather than deficits

- ✓ People's growth is based on and inspired by their individual interests, aspirations and strengths;
- ✓ People use the resources of their family and community to succeed in life;
- ✓ People tend to spend time doing things they do well, enjoy and have meaning for them;
- ✓ A focus on strengths enhances people's motivation while a focus on a person's deficits enhances feelings of hopelessness and depression; and
- ✓ Identifying and person's strengths and interests enhance individualization of the person.

PRINCIPLE 3 The community is viewed as an oasis of resources

- ✓ The community is the source of mental health/support;
- ✓ The community provides consumers with the opportunities, caring and supportive people and the resources necessary to succeed in living;
- ✓ A person's well-being is in large part determined by the resources available and the expectations of others toward the person;
- ✓ The clinician or worker's task is to create community collaborators;
- ✓ Resource acquisition should emphasise normal or natural resources, (not limited to specialist mental health services); and
- ✓ The identification and use of community strengths and assets are as critical as the identification and use of an individual's strengths

PRINCIPLE 4 The consumer is the director of the helping process

- ✓ The case manager should do nothing without the person's approval, involving them in discussion regarding every step of the process;
- ✓ All opportunities to move the person closer to being the director of their own care should be exploited;
- ✓ We understand the best programs provide what people want and need:
  - Money;
  - A decent place to live;
  - Transportation;
  - Meaningful employment / activities;
  - Opportunities for socialization and relationships; and
  - Accessible health care

PRINCIPLE 5 The worker-client relationship is primary and essential

- ✓ The relationship between the person and the clinician is seen as a keystone in virtually all approaches to casework, counselling and therapy;
- ✓ The clinician helps the person access the community resources and information that will truly empower them; and
- ✓ The clinician needs to be there to celebrate the person's success as well as to support them in times of hardship

6. The primary setting for our work is the community

- ✓ Most contact with the person will take place in a setting of their choosing;
- ✓ A person is a product of their life experiences and the environments they inhabit;
- ✓ To properly assess and appreciate a person's strengths and aspirations the work of assessment and support should be done in those environments;
- ✓ In vivo instruction produces more lasting skill retention than attempts at skill transfer; and
- ✓ Meeting people in their own environment encourages the use of naturally occurring (non-MH) services

Strengths Principles vignettes

Sue is leaving the hospital & making plans for where to live. After careful consideration with her case manager over all of her options, Sue decides that she wants to live with her sister. However, the hospital staff think that moving to a group home would be a better option & try to persuade Sue. By focusing on the environmental strengths that are available to Sue in the community, identifying how she has used her relationship with her sister to be successful in the past, & highlighting the fact that it is Sue's right to choose where she wants to live, the key worker convinces the hospital staff to allow Sue to move in with her sister.

Strengths Principle # or Non-Strengths Practice (NSP) _____

Mike is experiencing troubling symptoms and loneliness on the weekends with little to do. Tony, his case manager, arranges for Mick to attend the weekend psychosocial outing program to have some more activities.

Strengths Principle # or Non-Strengths Practice (NSP) _____

Jim, a case manager at a local mental health programme, regularly asks every consumer where they would like to meet (e.g. in a park, at McDonalds, at their home) rather than meeting at the mental health centre out of convenience

Strengths Principle # or Non-Strengths Practice (NSP) _____

The Strengths Principles Worksheets

What are 3 ways that key workers demonstrate they believe in their consumer's capacity to learn, grow and change?

1.

2.

3.

What are 3 benefits for a consumer when engaged in strengths-focussed case management/care?

1.

2.

3.

What are 3 ways of ensuring that our consumers are directors of the helping relationship?

1.

2.

3.

What are 3 naturally occurring (non-MH) resources available in your community?

1.

2

3.

How do case managers communicate to consumers that their relationship is primary and essential?

1.

2.

3.

What would be three concrete signs that a case manager was doing the majority of their work out in the community?

1.

2.

3.

5. ENGAGEMENT AND RELATIONSHIP: ENTERING IN TO A PARTNERSHIP

"Given the importance of the relationship as the bedrock of work, and the painful histories of professional and interpersonal relationships experienced by people with severe mental illness, engagement is viewed as the indispensable and critical first step."

Rapp, C (1998)

Critical Elements of the Helping Relationship

PURPOSEFUL
RECIPROCAL
FRIENDLY
TRUSTING
EMPOWERING

Engagement is a specific function

What are people recovering from?

Poverty
Dreams that never materialized
Loss of Relationships
Loss of Identity
Isolation from community
Physical/Sexual Abuse
Addictions
Mental Health Systems

Hope Inducing Engagement

We are drawn to people who appreciate us, not those who are interested only in our failures.

General engagement strategies include:

- Listening actively to the person (e.g. good eye contact, feeding back what they are saying/paraphrasing etc.);
- Being available when they need to talk;
- Demonstrating caring and kindness;
- Doing things with them that are fun/useful to them;
- Communicating "I believe in you" and "I am on your side";
- Accepting them whether they succeed or fail and celebrating the effort if they do not succeed;
- Showing genuine enthusiasm for what they are saying or doing; and
- Letting them know we're "human" too e.g. "yes, I have bad times too", "I make mistakes", etc.

Focusing on the positive:

- Talking about the future as holding opportunities for the person rather than dwelling on past occurrences that may not have gone well;
- Focusing on what they've been doing well and their strengths / capacities;
- When things are not going well, reminding them of their past successes;
- Normalizing their experience by letting them know that other people experience similar things; and
- Letting them know they can try again or something else if a plan doesn't succeed.

Being there for the person:

Going with the person to a doctor's appointment or court hearing for support and to help reduce fear;

- Advocating for them when they are unable to obtain a resource by themselves;
- Visiting them if they are in the hospital; and
- Helping them discuss their medications with their psychiatrist if they have questions or are concerned about this.

Helping people work toward their own goals:

- Helping a person establish their own goals;
- Helping them achieve their goals by breaking them down into achievable steps, helping to access resources, recognising small steps, etc;
- Showing enthusiasm and excitement about their goals; and
- Working on goals that move them to self-sufficiency and independence (e.g. budgeting, jobs, education, etc.).

Promoting choice:

- Supporting the person to appreciate their right to make their own life decisions;
- Generating options for them;
- Linking them to information and resources to make informed decisions;
- Ensuring that they have a choice of services and the ability to change providers; and
- Including them in all treatment decisions and discussions

Providing relevant information:

- Providing information to the person about the clinicians role, the relevant mental health services and methods to access all relevant care / crisis intervention;
- Providing them with information about their illness, methods for symptom reduction and medications;
- Informing them of all relevant treatment options;
- Informing them about the Mental Health Act and its impact on them; and
- Educating family members / carers to enhance relationships and promote understanding.

Promoting a future beyond the mental health system:

- Communicating to people that they may not need MH services forever;
- Spending time with them outside the mental health settings; and
- Promoting their place in their community by using local resources and engaging them in non-mental health related activities

Core Behaviours required for effective engagement:

1. The clinician schedules meetings with the person at a time and place that is mutually agreed upon;
2. The clinician and person are involved in an informal activity as a backdrop for getting to know each other (e.g. cup of coffee, shopping, walking, etc.);
3. The clinician engages the person in a conversational manner, exploring the interests and experiences they have in common;
4. The clinician uses empathy and positive reinforcing verbal and non-verbal messages;
5. The clinician discusses the purpose of, mutual expectations, expected length of engagement and relevant transitional arrangements;
6. The clinician uses every opportunity to identify the consumer's personal and environmental strengths; and
7. If having difficulty engaging with a person, the clinician reviews this challenge in a formal Strengths Brainstorming session.

Hope inducing behaviours

Building hope and providing respect

- Listening actively (e.g., good eye contact, feeding back what they are saying, etc.) Being available when the person needs to talk
- Demonstrating caring and kindness
- Doing things with the person that are fun
- Communicating that "I believe in you" and "I am on your side"
- Giving positive, encouraging comments
- Accepting a person whether they succeed or fail and celebrating the effort if they do not succeed
- Asking a person's opinion choice about all aspects of the helping process
- Showing genuine enthusiasm for what the person is saying or doing
- Sharing something in common with the person
- Sharing personal experience when appropriate
- Letting them know you're "human" e.g. "yes, I have bad times too", "I make mistakes", etc.

Treating people with respect

- Supporting a person's decisions and desires by accepting them and helping achieve them rather than putting down or minimising (even subtly) a person's choices and desires
- Following through on appointments Returning calls and promptly Keeping all promises Being on time
- Treating people like you want to be treated

Focusing on the positive

- Talking about the future as being positive rather than dwelling on past occurrences that may not have gone well
- Focusing on what a person has been doing well and their strengths
- Praising things that are going well
- When things are not going well, reminding the person of past successes
- Normalizing a person's experience by letting him/her know that other people experience similar things
- Communicating a "Can do" attitude
- Pointing out achievements/success
- Letting a person know he/she can try again if something doesn't work out

Celebrating accomplishments and success

- Giving specific praise about things a person does well
- Celebrating accomplishments/successes - big and (particularly) small ones

Being there for the person/sticking with them

- Going with a person to a doctor appointment or court hearing for support and to help reduce fear
- Advocating for a person when he/she is unable to obtain a resource by educating others, convincing the keeper of the resource to assist the person, etc.
- Visiting the person if they are in the hospital
- Helping the person negotiate with the psychiatrist around medications if he/she is having difficulty (support what they need and want).

Helping people work toward the goals that is important to them

- Helping a person establish goals
- Helping a person achieve their goals by breaking them down into achievable steps, helping to get resources, recognising small steps, etc.
- Making sure the goals you are working on are actually the persons goals
- Letting the person know that his/her goals are possible to achieve
- Showing enthusiasm and excitement towards the person's goals
- Working on goals that move people to self-sufficiency and independence (e.g. budgeting, jobs, education, etc.)

Promoting choice

- Acknowledging and supporting the right for all people to make their own life decisions and having control of their course of treatment
- Generating many options for what the person wants
- Linking the person to information and resources to make informed decisions
- Having choice of services and ability to change providers
- Including people in all treatment decisions and discussions

Avoiding and navigating spirit breaking circumstances:
The therapeutic relationship with our consumers may have to survive crisis, misunderstandings and involuntary treatment. At times we may be the bearer of unwelcome news or directly involved with instigating and managing their involuntary admission to inpatient services.

At all times we must maintain our optimism for the consumer's recovery and be honest with them as we co-manage the various phases of our relationship.

Avoiding restrictive attitudes
We avoid:
- monitoring a consumer's medications when they are capable of managing it themselves;
- telling a person they can't get better unless they take their medication for the rest of their lives;
- telling people what they can do, who they can befriend and what their capacities are;
- focusing on symptoms and diagnoses rather than the person; and
- imposing our own standards of living on people.

Avoiding disrespectful interactions
We avoid:
- treating adults like children or as if they lack intelligence;
- giving compliments that are conditional (e.g., "You did this great, but...")
- talking about someone in front of them;
- not acknowledging them in non-clinical settings;
- completing paperwork in a review session rather than relating directing to them;
- going to people's homes unannounced; and
- making promises and not following them through.

Avoiding restrictive service delivery
We avoid:
- focusing services on maintaining people at their current level rather than helping them achieve goals;
- building people up to accomplish something and then taking months to get them the resources they need;
- refusing to do something because "it's not my job" and not referring them to services that may better meet their needs;
- changing key workers or psychiatrists once a relationship with the person has been developed;
- referring consumers to too many services at once; and
- putting contingencies on resources (e.g. you can only have assistance with housing if you go to groups)

Addressing Spirit Breaking Living Circumstances
Our consumers may experience the following spirit breaking circumstances and we work with them to address, reduce or eliminate them.

The distress of poverty
- they always have to worry about "how am I going to pay for this?"
- they are unable to engage in 'normal' age appropriate activities e.g. concerts, festivals;
- they are unable to attend celebrations because they have no money for gifts;
- they are unable to take care of their hygiene and appearance because they have no money for deodorant or haircuts;
- they are unable to go out because they have no money for public transport;
- they have to eat very basic/unhealthy or uninteresting food, or they run out of food towards the pay/pension/benefit fortnight;
- they experience poor dental health/chronic dental pain because they have no money to pay for private dentists; and
- they become reliant on charity.

The distress of discrimination
- they have to live in poor quality accommodation because many places will not accept people with a history of mental illness;
- they are discriminated against or experience bullying in the workplace;
- they experience side effects of medication that contribute to them feeling or looking "different" from other people e.g. weight gain, impotence;
- they are embarrassed about having a mental illness because the general public doesn't understand it or thinks they are dangerous/violent;
- they are fearful of meeting new people or going on dates because they don't want to talk about their recent life experiences; and
- they are fearful of meeting old friends/acquaintances because their circumstances have reduced and they don't want to talk about their current circumstances/employment relationship status etc.

Obstacles to Establishing Relationships
Suspicious attitude
Pessimistic attitude
Unwilling to communicate or respond to questioning
Not keeping appointment or continuously changing the established appointment time

How do friendships differ from professional helping relationships?
- Defined purpose & role in assisting the client – friendship is not the goal
- The helping relationship is constrained & limited by time
- The helping relationship is for the client
- The helping relationship is a planned & controlled relationship whereas friendships develop spontaneously
- One receives more information than the other

Engagement Scenarios

Think of ways to engage these consumers using a strengths-based, hope inducing, recovery-oriented framework:

You have been assigned to a new client whose name is Robert. He is presently in the hospital and is being discharged in two days. He has no home to go to and no resources in place. You go to the hospital to begin working with him and when you introduce yourself to him as his new case manager, he becomes agitated and tells you to "get the hell out of here." He then sits there and stares at you.

You have been assigned a new client whose name is Jenny. When you meet with her for the first time in her flat she appears dishevelled and distraught. She says she is very grateful you are there because she has a litany of problems she wants you to fix. She quickly begins to tell you about them: she is drinking too much, her boyfriend has just broken up with her, she can't pay her rent, her mother who has been a major source of support is moving to the country, she needs to get her prescription refilled and she says her neighbour is constantly bugging her.

You have been assigned to a new person whose name is Stephen. He agrees to meet with you in his apartment. He is sitting on the couch smoking cigarettes. He has a blank look on his face and can't think of anything he wants to work on. He appears pleasant, but has very little to say. He answers most questions in a single word.

6. THE STRENGTHS ASSESSMENT

> "All people possess a wide range of talents, abilities, capacities, skills, resources and aspirations. No matter how little or how much may be expressed at5 one time, a belief in human potential is tied to the notion that people have untapped, undetermined reservoirs of mental, physical, emotional, social and spiritual abilities that can be expressed. The presence of this capacity for continued growth and heightened well-being must be accorded the respect that this power deserves. This capacity acknowledges both the being and the becoming aspects of life"
>
> Rapp, C 1998

Types of Strengths

ENVIRONMENTAL Consumers may have safe or secure accommodation, a home, a big brother, a great dog, cultural support, a good relationship with a GP or be a member of a church or self-help group.

INTERESTS/ASPIRATIONS Consumers may enjoy playing computer games, gardening, watching old movies on TV or going to coffee shops and "hanging out". They may want to be a musician, go fishing, have a partner, spend more time with family members or own a car.

TALENTS People can surprise themselves and us by the skills and talents they have (or once had but forgot). E.g. they may know how to play a musical instrument, juggle, recite poetry, solve crossword puzzles, run, lift weights, bake bread, give massages, collect coins, understand a foreign language or help others. Talking to people about any one of these can assure them of their resourcefulness and help us to see them as individuals.

PERSONAL QUALITIES/CHARACTERISTICS Many of our consumers find it difficult to identify their personal qualities and we may have to provide them with positive feedback to assist this process. E.g. they may have a sense of humour or strength under pressure, be reliable, caring, hopeful, honest, hard-working, kind, patient, sensitive, easy to talk to, generous, willing to stand up for the underdog or friendly - these qualities (and others) are natural and renewable resources.

People have pride; often it is "survivor's pride." They have surmounted or are in the process of surmounting great difficulties or barriers. It is this pride which can be summoned to encourage change and growth.

People's awareness of the world/knowledge: our consumers have learnt much about the world through personal experience, books, exposure to tradition/culture and family. This knowledge is a valuable resource and must be acknowledged.

Personal awareness: people develop personal insights and skills through struggle, pain and illness as well as success and rewards. We assist people to reframe challenges/failures as opportunities for growth and we work together to set alternate goals and access new resources.

Cultural, spiritual and ethnic lore: These are strengths which are frequently overlooked by clinicians. E.g. consumers may have skills as a natural healer, have succeeded in raising/fostering children in economically disadvantaged environments, may have participated in an extended family or have ritual and spiritual ties with the natural world. Every culture has means of healing and being a 'part of'; these should be recognised and tapped.

Helping consumers identify their strengths

Many of our consumers are so practiced in discussing their disabilities and problems they find it hard to tell us about their strengths and resources. An essential role of the case manager involves encouraging or prompting people to identify their strengths and choices. By supporting their potential and resources we are setting the stage for their empowerment.

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We may identify peoples' strengths by asking questions about what they're doing well and what's currently working for them. For example we may ask "What are doing to keep your head above water in this difficult time?" This question contains an implicit assumption that the person is already working on fixing their own problem, coping with it and already possesses certain skills.

∞

We may also provide direct feedback. For example we may say, "I'm impressed with how well you've maintained multiple appointments through the week despite having the stress of looking after your family at the same time. Many people might have just given up, but you've managed to keep a positive attitude."

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The following are examples of strengths often apparent in initial sessions which can be acknowledged, supported and cultivated:

- The person faces problems and seeks help, rather than denies or otherwise avoids confronting them;
- They take responsibility for their actions and show an interest in making changes;
- They demonstrate courage by sharing problems with the clinician - a stranger;
- They have personal principles;
- They seek to be independent;
- They've persevered to keep a family together under difficult circumstances;
- They make sacrifices on behalf of children and others;
- They can express loving and caring feelings to their family members;
- They demonstrate the ability to maintain relationships;
- They seek to understand the needs and feelings of others;
- They describe the emotional capacity to function effectively in stressful situations;
- They are resourceful and creative in making the most out of limited resources or managing and surviving upon a meager income;
- They seek to further their knowledge, education, and skills;
- They are willing to assert their rights rather than submitting to injustice; and
- They consider alternative courses of actions and the needs of others when solving their own problems.

The Strengths Assessment

This is a tool designed to help the consumer and worker become conscious of the resources the consumer possesses. This enables the consumer to explore not only their strengths at one point in time, but what they have already accumulated in experience and knowledge in the past. Also, what external resources they possess and have access to.

The middles column asks 'what do I want?' This is at the very heart of the work we are doing with our consumers and harnessing these aspirations is critical to recovery.

During the course of multiple conversations, strengths will become apparent, is noted and begin to populate the Strengths Assessment. Deficits or negative comments are not part of this assessment.

Guidelines for completing a Strengths Assessment

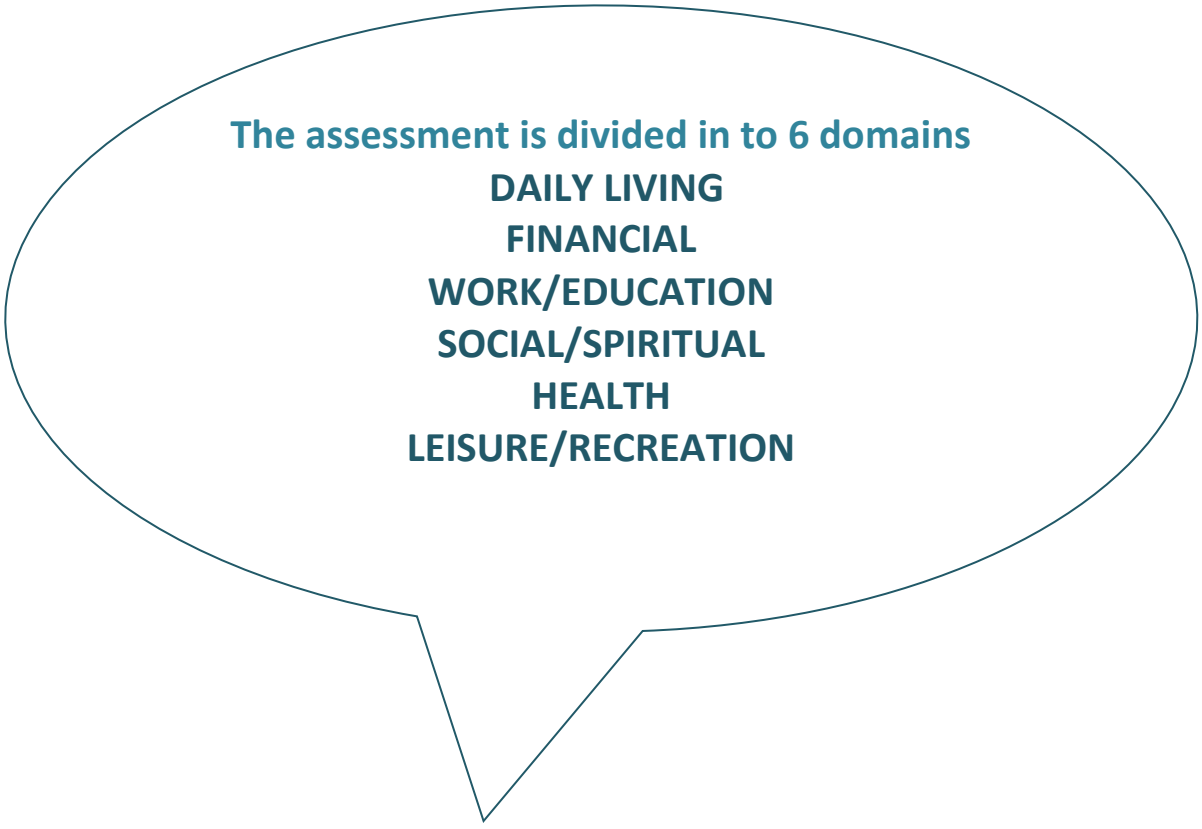
We give pre-eminence to the person's understanding of the facts. The central focus of the assessment is on the person's view of their circumstances, how they feel about it and the meaning they ascribe to their situation/life experiences;

We discover what the person wants. We explore the person's desires and expectations and we ask what they want in relation to their current situation;

We ensure that the strengths assessment is multidimensional. A strengths perspective means believing that the strengths and resources to resolve a difficult situation lie within the person's interpersonal skills, motivation, intellectual and emotional strengths, as well as environmental opportunities. We also include an examination of the person's power and power relationships in transactions between the person and the environment

The Five Critical Components of the Strengths Assessment is that it be:

1. Thorough, detailed and specific;
2. Developed on an on-going process/updated on regular basis
3. Conducted in a conversational manner
4. Created at the consumer's pace
5. Written in the consumer's own language



STRENGTHS ASSESSMENT

Name: _____

1	**Current Status:** What's going on today? What's available now?	**Future Wishes:** Desires, aspirations. What do I want?	**Past Resources:** Personal, social. What have I used in the past?
Daily Living Situation			
Financial Situation			
Work/Education			

2	**Current Status:** What's going on today? What's available now?	**Future Wishes:** Desires, aspirations. What do I want?	**Past Resources:** Personal, social. What have I used in the past?
Social/Spiritual Support			
Health			
Leisure/Recreation			

Personal Characteristics

Consumer's comments:	Case Manager/worker's comments:
Consumer's signature:	Case Manager/worker's signature:

Some questions you may use to explore the specific domains of the Strengths Assessment

Daily Living:
Current daily living status:

- Where do you live? How long have you lived there?
- Do you live with anyone else?
- What is good about where you live?
- How do you get around (car, bike, bus, walk)?
- Do you have pets or animals?
- What personal assets related to daily living do you have e.g. a phone, computer, TV, dishwasher, washer/dryer etc.? Note: This can help identify wants - does the person wish they had a vacuum cleaner?
- Are there details, special attributes about your home you are proud of or enjoy?
- What do you enjoy doing or are good at doing in terms of daily living tasks, if anything? (e.g., cooking, cleaning, doing errands, grocery shopping, etc.)

Future daily living wishes:

- Do you like where you live? Where else would you like to live?
- Do you like living alone? With other people?
- If you could change one thing about your living situation, what would it be?
- What would your ideal living situation be? (E.g. living on a farm, buying a home etc.)
- Is there anything you would want to make your living situation easier? (E.g., day care for kids, a car, assistance to do the shopping etc.)
- What is most important to you in your living situation: (e.g., feeling safe, near friends, near business, having a pet, etc.)

Past daily living resources:

- Where have you lived in the past? With whom? For how long? What was the type (flat, group home, house, boarding house) and location?
- What did you like about any of the past living situations?
- What was your favourite living situation? Why?
- Are there things you had in a past living situation that you don't have now but would like to have again?

Financial Situation:
Current financial status:
How do you support yourself?

- Income (type and amount);
- Disability Pension, New Start Allowance;
- Income from work; and
- Family/friends loans/assistance.

Do you have health insurance?
Do you have a health care card?
Do you have superannuation?
How do you manage your money?

- Do you have a bank account? What kind?
- How do you budget & manage your money?
- Do you have extra spending money each week: How much?

Do you use assistance programs?

- Food banks;
- Subsidised phone, transport etc.;
- Rent assistance.

Financial desires/aspirations:

- What would you like to be different with regard to finances? How?
- What is important to you regarding your finances? (E.g. I want extra money each week to go out to eat, I want to be able to rent movies, I wish I had a savings account etc.).

Ask yourself are there benefits they are entitled to, but not getting? You may need some assistance to review the current opportunities.

Past financial resources:

- What was your income in the past? From what sources?
- Did you use/have any resources in the past that you are not using now? (E.g. budget advice, taking a financial management class, used to have a savings account etc.)

Work/Education:

Current work/educational status

- What are you doing with regard to employment or education? Include type, where, and amount of time. (E.g. CAE classes).
- Activities that could be included in this category: volunteer work, school, odd jobs, helping others, work in an activities program, looking for work, involvement in vocational programs, active parenting, taking care of sick or elderly friend or relative etc.
- What is your highest level of education (E.g. Secondary School, vocational training, university etc.)
- What do you like about your current job, activities etc.?
- What is important to you about your current activities? (E.g. "I like the extra money", "helping people", "being around people", "being in charge of something" etc.)

If the person is not doing anything in this area we ask them about their interests, skills and abilities related to productive activity? (E.g. "I'm very mechanical", "I enjoy playing with kids", "Art is my passion" etc.)

Work and education desires/aspirations:

- Do you have any desire to work? Go to school? Volunteer? Earn extra money?
- If so, what would that be doing? What do you enjoy doing? What do you have experience doing? (E.g. "I'd like to get a nursing degree", " I like to work outside and with my hands", "I like helping people" etc.)
- If you could be or do anything you wanted (career-wise), what would that be?
- What is it about that that interests you?
- If the person is doing some type of activity currently we ask if they're satisfied with what they're doing. Is there anything about what they're doing they would like to change? Is there other activity they'd like to do in addition?

Past work and educational resources:

- What type of activity (work, school, volunteer work, training, etc.) have you done in the past? For how long? When? Where? What did you like or not like about it?
- What kind of vocational services have you received in the past?
- Have you been/are you on any work incentive programs?
- What work situations have you found most enjoyable and why?

Social/Spiritual Supports:

Spirituality refers to any set of beliefs and/or practices that give a person a sense of hope, comfort, meaning, purpose in their life, or a connection to the greater universe. For some people this may have to do with God and some type of organized religion, for others it may be an individual relationship with a higher power, for others it may not be specifically defined. Religion is not necessarily synonymous with spirituality. This is a domain where you may introduce sexuality and relationships.

We don't limit the definition to organised religion and we avoid imposing our own views onto the person. Examples of spiritual activities include meditation, art, music, temple/church/mosque attendance, 12 Step Fellowships e.g. AA and NA, cultural rituals, political justice, community activism and altruism/giving.

Current social/spiritual status

- Who do you spend time with? Who are your friends? Who comes to visit you? Who do you feel close to? Who makes you feel good when you're around them? What kind of things do you do together?
- What organisations, clubs, and groups do you participate in? (E.g. church, Alcoholics Anonymous/Narcotics Anonymous, football club, neighbourhood groups etc.)
- Do you have a pet? Would you like one?
- Do you visit with any members of your family? Are the visits pleasant or stressful? Do you rely on any members of your family for support?
- What is it you like and dislike about being with other people?
- Do you like being alone? If yes - what is it about being alone that you like? What kinds of things do you do when you are alone? What do you do when you feel alone?
- Where, outside of your home, do you feel most at ease?
- Is there anything in your life that brings you a sense of comfort, meaning, or purpose? If yes – how do you describe/understand it?
- What gives you the strength to carry on in times of difficulty?
- What do you believe in?
- What do you have faith in?

Social/spiritual aspirations/desires:

- Is there anything you would like to be different in your social life?
- Are there any areas of your social life you would like to have more support in? (E.g. better relationship with family, more friends, someone to go camping with etc.)
- Are there organizations, groups, clubs that you don't currently belong to but would like to? (E.g. church, rotary club, book club, astrology club etc.)
- Is there anything you would like to be different in your spiritual life?
- Are there spiritual organisations/groups you would like to belong to?

Past social/spiritual resources:

- Have there been important people in your life (E.g. friends/family) that you have felt supported by in the past but currently don't spend time with? Who?
- Are there places you used to hang out/people you used to hang out with that you don't currently see? Describe who and where.
- Did you belong to any groups, clubs, and/or organizations in the past you don't attend anymore? What were they? Did you enjoy them? What did you enjoy about them?
- Have you had a deeper spiritual connection with life or engaged in any religious, cultural or spiritual activities in the past that used to give you comfort or peace. If so – what were they?

Health:

Current Health Status

Current mental/emotional/sexual health:

- Who are your psychiatrist/mental health clinicians? How often do you see them?
- Which medications do you take and what is the dose? Any side-effects?
- Do you experience symptoms of your illness? What are they like? What kinds of things do you do to cope with or manage your symptoms?
- What produces stress for you? What do you do to manage stress?

Current general health:

- Who are your regular GP and dentist?
- Who is your usual pharmacist, where do they practice? Where do you collect your medication?
- How would you describe your general health? Do you have any health problems/issues?
- What do you usually eat? Are you happy with your diet; is there anything you want to change?
- Do you exercise? What type?
- Are you taking any over the counter medications, what type, how much and how regularly?
- Are you currently using birth control?
- Do you smoke cigarettes? If yes- how much do you smoke on an average day? Are you interested in reducing / stopping?
- Do you drink or take other drugs? If yes – which ones, how often, how much and are you interested in changing this?

Desires/aspirations for health:

- Are there things you are working on or would like to work on with regard to your physical or mental health? (E.g. losing weight, managing symptoms, smoking less, drinking less etc.);
- Would you like information regarding your medication / health issues?
- Do you want to engage with a regular GP if you don't have one?
- What's important to you in this area? Is there anything you would like to learn more about, improve or change in this area?

Past health resources:

- List health resources / agencies used in the past for any of the areas mentioned in their current status.
- Patterns of hospitalisation: When was your last admission to hospital? Was it public or private? How often do you typically go into the hospital? What happens before you go in (precipitating factors)? Are the hospitalisations usually voluntary or involuntary?
- Which resources have you found to be useful in the past (E.g. Doctors, hospitals, exercise activities, medications, diets, symptom management techniques etc.)? What kind of help/ support was most effective and why?

Leisure/Recreation:

Current leisure/recreation status

- What do you do for fun?
- What are your hobbies?
- What do you do to relax and enjoy yourself?
- Do you ever go out and do things on weekends? If so, what do you usually do?
- Do you have a TV? Would you like one? What is your favourite TV show?
- Do you like movies? What kind? Who is your favourite actor?
- Do you like to read? Who is your favourite author? Do you go to the library?

- Do you like to cook? What is your favourite meal? Do you like to go out to eat?
- What talents do you have? What are your hobbies?
- If you could do anything you wanted for one day, what would it be?
- When do you get bored? What do you do when you get bored?

Examples of leisure/recreational activities:
- Sports;
- Outdoor/nature activities e.g. bush walking, fishing, kayaking, picnics, hunting, camping;
- Social Pursuits e.g. parties, visiting, table games, talking on the phone, shopping with friends;
- Individual entertainment e.g. listening to the radio, watching TV, people watching, listening to music, cooking, knitting;
- Intellectual pursuits e.g. reading, lectures, classes, going to the library;
- Cultural/Artistic pursuits e.g. playing musical instruments, painting, crafts, visiting museums, going to art classes or concerts;
- Meditative Pursuits e.g. prayer, yoga, bible study; and
- Trips, excursions and/or holidays.

Recreation desires/aspirations
- What things do you like to do, but are not doing currently?
- Have you ever wanted to try something that sounded like fun, but you've never done it? If yes – what was it?
- Explore desires listed in current status.

Past recreation resources
- Explore their past involvements, interests, activities listed in current status. Where did you do the activities? Who with?
- What activities did you most enjoy in the past? What was it about the activities you enjoyed?

It is very important that is enabled to tell their story about their life so far. They may have experienced a lot of painful times and struggled with many things.

As a Case Manager/Clinician you will listen and acknowledge what has happened to the client, both good and not so good! The client will then be helped to look at what strengths they have drawn on in the past to help through bad times

Encourage the client to think about what is good in their life now; what is making them happy or content; what and who are the people who are positive and make life better for them (current strengths)?

The current section should focus on what the strengths are not the problems or deficits. There are other places these can go. Despite the illness and difficult parts of their life, what is keeping them going? What skills and talents and personal characteristics are there to self-manage and achieve some quality of life the client wishes for?

Case study

Ann P is a 27 year old woman who lives in a 2 bedroom flat with her 2 year old son, Timothy. They have lived in the flat, which is nicely decorated with paintings done by Ann, for the past 5 months. Previous to living in the flat Ann and Timothy lived with her family and for the 2 years prior to Timothy's birth, Ann lived with Timothy's father.

Ann does not have her own transport and uses the buses to get around. She likes to cook and likes the flat to be tidy. Before she became ill Ann worked as a waitress for a couple of years where she was able to earn "good money", though she noted she didn't like dealing with complaints. At the moment she doesn't have a job, is on unemployment payments and spends her days caring for Timothy. Her Mum and Dad help out occasionally with extra money. Ann currently has no savings, wants to increase her weekly income and would consider going on DSP.

Timothy is very important to Ann. Ann says she wants to be a "better parent" and that "sometimes I don't know how to handle him". She likes to have him with her but wants to have a few hours a week when she could do what she wanted without worrying about him. Ann believes her family "want to take my son" and "they don't believe me when I tell them some things." Child Protection services are involved with Timothy. Ann said she wants her family to "understand and believe in me".

Having had lots of friends in the past Ann would like to make more friends now. She used to enjoy dancing and painting (some of her paintings are now hanging in her flat) and said she would like to attend art classes. Ann has painting supplies but has not been motivated and her time is taken up with Timothy. She likes reading romances and used to enjoy riding bikes, playing social netball and attending church. Ann says she'd like go to church again but it "has been difficult to believe in God after all I've been through". She also liked to meditate and would like to be able to do it again. She feels she has little time to do "the things I like to do".

She is in good health with no current medical issues. She takes lithium for Bi-Polar Affective Disorder, smokes 20 cigarettes a day which she wants to cut down on and has an occasional drink. Some days she feels very anxious. Ann has been hospitalized twice, the longest being for 6 months. She wants to stay well and out of hospital and described her last key worker as being really helpful. She has noticed some change on her libido recently.

Ann said her main priorities are to keep her son, stay out of hospital, have some fun and get back into her painting.

Name: *Ann P*

	Current Status: **What's going on today?** **What's available now?**	**Future Wishes:** **Desires, aspirations.** **What do I want?**	**Past Resources:** Personal, social. What have I used in the past?
Daily Living Situation	*27 yrs old.* *Lives in 2-bedrm flat with 2 yr old son Timothy.* *Nicely decorated with paintings she did.* *Uses buses to get around.* *Likes to cook.* *Likes flat to be tidy.*	*I want to stay out of hospital.* *I want to keep my son.* *I want to have some time for myself and would like to find some good childcare for Timothy.*	*Longest admission was 6 months.* *Has lived in current flat 5 months.* *Previously lived with family.* *Lived with Timothy's father for 2 yrs before he was born.*
Financial Situation	*Unemployment Payments* *Rental Assistance* *Mum and Dad help out occasionally with extra $.*	*I want to increase my weekly income.* *I will consider going on Disability Support Pension.* *I would like to be more self-sufficient when it comes to money*	*Used to earn "good money" as a waitress.*
Work / Education	*Looking for a job at moment maybe as a waitress again as money quite good and enjoyed it*	*I would like to attend art classes*	*Worked as waitress for a couple of years before illness.* *Did not like having to put up with complaints.*

	Current Status: **What's going on today?** **What's available now?**	**Future Wishes:** **Desires, aspirations.** **What do I want?**	**Past Resources:** **Personal, social. What have I used in the past?**
Social / Spiritual Support	*Timothy is very important to me.* *Mum (Pat) and Dad (Mark) and 2 sisters, Lucy, Liz, live nearby – some support*	*I want to keep my son.* *I want to make more friends.* *I want my family to "understand" me and "believe" in me."* *I would like to go to church again.* *I would like to be able to meditate again.* *I want to be a "better parent."*	*Used to have lots of friends.* *Used to enjoy dancing and painting.* *Her last key worker really helped her.* *Used to go to church and had firm beliefs.* *"It's been difficult to believe in God after all I've been through."* *Meditated a lot and got a lot out of it.* *I used my skills in getting on with people and chatting with the customers when I was waitressing*
Health	*Good health.* *Currently taking lithium for Bi-Polar Affective Disorder.* *Wants to cut down her smoking.* *Some days feels very anxious.* *No medical issues.*	*I want to cut down on my smoking.* *I want to exercise more.* *I want to stay well and out of hospital.*	*Used to be a vegetarian.* *Did activities that were good for my health.*
Leisure / Recreation	*Ann has little time to do "the things I like to."* *Has painting supplies ready to start painting again.* *Likes to read romances.*	*I want to have a few hours a week when I can do what I want to do without worrying about Timothy.*	*Used to love riding bikes* *Used to play social netball* *Used to meditate*
Personal Characteristics: *Resourceful, creative, spiritual, good sense of humour, caring mother, fun-loving, bright*			

What are my priorities?

1 *I want to keep my son*

2 *I want to stay out of hospital*

3 *I want to get back into my painting*

The Strengths Assessment in practice

Strengths Assessment	Problems/deficits assessment
What the person wants, desires, aspires to, dreams of; a person's talents, skills, knowledge. **A holistic portrait**	**Defines diagnosis as the problem**. Questions are pursued related to problems. Needs, deficits, symptoms
Gathers information from the standpoint of the person's view of their situation. **Ethnographic**	The problem assessment searches for the nature of the person's problem from the perspective of a professional. **Analytical**
Is conversational and purposeful	**Is an interrogative interview**
The focus is on the here and now, leading to a discussion on the future/past; asking how far they have **survived**	The focus is on diagnosis assessment procedures to determine the level of **functioning**
Consumers are viewed as **unique human beings** who will determine their wants with the self and the environment	Consumers are viewed as **lacking insight** regarding behaviour or in denial regarding scope of problem or illness
Is ongoing and never complete with the relationship primary to the process. Encouragement, coaching and validation are essential to the process	Consumers become passive receptacles for interventions as providers direct decision making
Strengths assessment is specific, detailed and individualises the consumer	Places the consumer in diagnostic or problem category. Generic, homogenous language
Explores the rejuvenation and creation of natural helping networks	Emphasises compliance and management of problems and needs with formal services seen as a solution
Consumer authority and ownership	Is controlled by the professional
The professional asks "what can I learn from you"'	The professional dictates "what I think you need to learn/work on"

7. PERSONAL/GOAL PLANNING Creating the Achievement Agenda

Goal setting is a powerful process for thinking about your ideal future, and for motivating yourself to turn your vision of this future into reality.
The process of setting goals helps you choose where you want to go in life. By knowing precisely what you want to achieve, you know where you have to concentrate your efforts. You'll also quickly spot the distractions that can, so easily, lead you astray.

MIND Tools, 2012

Why goals are not achieved – factors relating to everyone, not just our consumers!

The goal as written is not the consumer's goal
Resources that are needed to complete the goal are not available
Access to needed resource is blocked
Resource people do not accommodate particular needs of the consumer
Lack skills needed to complete goal
Lacks or has inaccurate information need to complete the goal
Fear of failure/fear of success
Too many goals going at one time
Not enough time
Goal set is too high/too low
No fun
No positive reinforcement/reward
Circumstances change, goal no longer desirable or feasible
Influence of significant other who does not support the goal
Consumer changes their mind
Too tired, become ill
Forgot
Goal has not been broken down into manageable steps; too abstract
Goal is not in consumer's power to achieve alone (relational goal)

Developing a Personal Goal Plan

- Personal goal planning provides the opportunity for the clinician and consumer to work towards goals that are meaningful, precious and rewarding.
- The consumer sets their own agenda for the work and has their dreams and desires respected and considered.
- The clinician listens, clarifies and confirms the persons aspirations and assists them to identify and reach the steps necessary to reach their goals.

Goal planning:

- Induces hope when used as a tool to help the person reach their goals;
- Helps the person and clinician stay organised and focused;
- Conveys a sense of commitment to the therapeutic relationship; and
- Provides the opportunity for people to experience success and manage challenges and set-backs.

Strengths Goal Planning

The worker and consumer review the Strengths Assessment with particular emphasis on the middle column – Desires and Aspirations. They also review the consumer's priorities. They work together to explore these goals and determine which of the long term goals they will work on first.

The long term goal is:

- Derived from the aspirations (middle) section of the strengths assessment;
- Written in the person's own words;
- Specified as precisely as the person understands it; and
- Not debated or rejected but rather accepted and reinforced

Factors affecting goal achievement:

- The person's interests – whether or not they're pursuing something they really want or are doing what other people want e.g. finish their degree;
- Their level of desire regarding the outcome;
- Their available time;
- Their current health e.g. level of sedation, chronic dental pain;
- Competing priorities e.g. child care;
- Their current skills;
- Their confidence;
- Their response to set-backs;
- The level of moral/practical support they receive from others; and
- Their other environmental resources and supports.

Examples of Long-Term Goals

A good long-term goal is one the individual has some "passion" about. It is a statement that is reflective of their true desires, hopes and dreams in life. Not all people will express these "passion statements" during our first few meetings together however sincere, persistent engagement will encourage them to share their hopes with us.

The following are examples of good long-term goals, written in the person's own words, that you may see on their personal plan:

- I want to maintain custody of my son;
- I want to get my own place;
- I want a job where I can work with animals;
- I want to buy a car;
- I want to have more friends; and
- I want a girlfriend.

The Goal Planning Tool:

- is a statement of the person's recovery plan used to identify and reference 'the passion';
- has space to break their larger goal into smaller achievable measurable steps/ goals;
- has a space to assign responsibility for completing the step;
- has a space to designate when each step is projected to be accomplished and when it is actually accomplished; and
- has a section to make notes about the progress of achieving the goal.

Goals written in clinical terms e.g. increase socialisation improve daily living skills, do not inspire the hope and passion that is needed for person's to commit their time, energy and resources to attain the goal.

Some people may not wish to write down their goals however it is important for clinicians to maintain a record of the person's goals and their goal-directed activities to monitor progress, learn from challenges, celebrate successes and maintain the focus of the work.

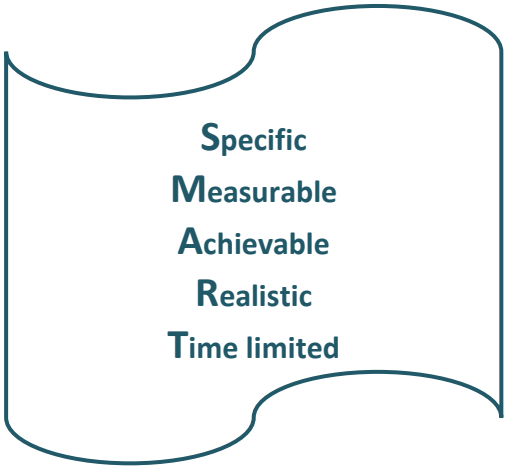
The goal plan becomes a key document in the person's file and is referenced in clinical reviews, progress notes and ongoing assessments.

The Goal Plan

Name: _____

Long-term Goal (the passion statement)				
Short-term Goals/Steps Toward Achievement	Whose Task?	By When?	Date Achieved	Comment

Long-term Goal				
Short-term Goals/Steps Toward Achievement	Whose task?	By When?	Date Achieved	Comment



Short term goals:

- are stated in positive terms have a high probability of success;
- are measurable and observable;
- are specific, small and time-limited; and
- are understandable and meaningful to the person

The goal plan becomes a key document in the person's file and is referenced in clinical reviews, progress notes and on-going assessments.

Effective goal planning requires creativity and patience
Clinicians don't debate goals with their consumers; if they believe a goal is unattainable they don't share this with the person, they instead discuss:

- the aspirations behind the goal e.g. I want to become a rock star may become I want to be important, I want to be admired; and
- the small steps it might take to reach the high goal e.g. choose an instrument, take classes, find musical collaborators.

The clinician assists people to take steps towards reaching these goals / aspirations whilst building/maintaining the helpful relationship. Who knows, they might indeed become a famous rock star after all.

Clinician Responsibility and Risk Management:
If the clinician believes the person may put themselves in danger by following a goal then it is the risk/danger that must be addressed not necessarily the goal.

Clinicians talk openly about their concerns and work to co-develop a safety plan/crisis management plan if necessary.

Common Challenges to Setting the Long-Term Goal (Personal Exercise)

For each of the 3 scenarios, come up with 3 responses that reflect a hope inducing, strengths based, and recovery- oriented approach.

1. The person's goal seems unrealistic, grandiose or delusional.
The person has stated their goal is to be a rock star

1) _____
_____

2) _____
_____

3) _____
_____

2. The person's goal is vague.
The person comes to you saying all they want is to be happy.

1) _____
_____

2) _____
_____

3) _____
_____

3. The person has no goals

When asking the person what goals they want to work on, their response is either "I don't know," or "Nothing".

1) _____
_____
2) _____
_____

3) _____
_____

8. THE WELLNESS RECOVERY ACTION PLAN® (WRAP®) Self Help Through Planning, Monitoring and Action

The WRAP® is an evidence-based system that is used world-wide by people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness. It was developed by a group of people who have a lived experience of mental health difficulties, people who were searching for ways to resolve issues that had been troubling them for a long time.
Mary Ellen Copeland, 2012

The WRAP® was developed with friends, colleagues and service users in Vermont on the East Coast of the USA.

Mary Ellen has been diagnosed with Bipolar Disorder. In June 2006 Mary Ellen was awarded the John Beard award for outstanding contributions to the field of psychosocial rehabilitation and because her contributions to the mental health field have led to decisive, lasting, and far-reaching advances.

The WRAP® is not a Strengths Model tool, but is used as an inherent part of the model at St. Vincent's, to complement the Strengths Assessment, Goal Plan and the Family Recovery Assistance Plan (FRAP).

The WRAP® is `a plan developed by the consumer and appropriate support people to:

- **identify activities/resources that maintain the person's optimal wellness -** Wellness Maintenance;
- **develop a daily/weekly/regular plan to utilise these activities / resources to support their wellness;**
- **develop and maintain an awareness of early warning signs that they may be becoming unwell;**
- **develop practical** relapse prevention **strategies; and**
- **develop a** crisis and post-crisis plan**.**

The WRAP® may also have a section where family and support people identify what they can do to help.

Anecdotal reporting from people who are using WRAP®s indicates that;
- it helps them to feel prepared to manage their own life and crises;
- it helps them to feel better more often; and
- it improves the overall quality of their life.

Clinicians/workers assist people to develop their own WRAP® by:
- providing the WRAP® document and being available to work through each section of the plan;
- appreciating the impact that mental illness may have on a person's sense of themselves, their happiness and safety;
- understanding methods/activities to minimize the impact of mental illness e.g.; reduce the impact of negative moods, hearing voices, unusual beliefs, self-harm and suicidal urges, and crises;
- supporting people to self-monitor triggers and early warning signs;
- understanding the importance of exercise, nutrition, sleep, spirituality, creative outlets and stress management;
- supporting people with medication management; and
- informing people of the likely impact on their health of alcohol, other recreational drugs and smoking.

Matching the WRAP® to the person's immediate needs:
We assist the consumer to explore and determine their own wellness maintenance, relapse prevention and crisis / post crisis management within warm respectful conversations.

These plans take time and can be introduced over a long period of time and each section can be developed when most useful to the person. For e.g. many people complete a wellness maintenance plan in early recovery and develop a relapse prevention plan when they explore their experience of illness gain some insight into the impact of their mental health on their lives.

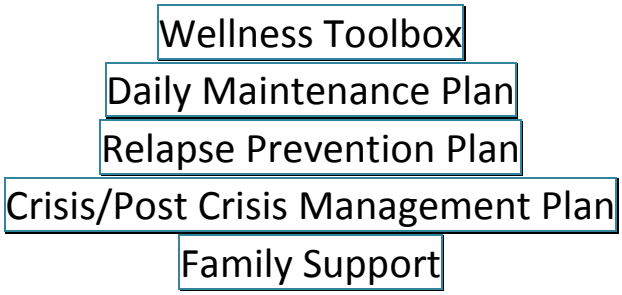
There are no rules about the order that these sections of the WRAP® are addressed; we match the development of the WRAP® to the person's interests and needs.

The consumer may wish to work with the whole WRAP® or divide it into sections and work with one or two of them at a time. For e.g. it may be very confronting for a person to develop a relapse prevention plan when they're still grappling with the idea they have any kind of mental illness.

The consumers use their own language in a WRAP® and determine their own priorities; they may complete it by themselves, work with the clinician or ask for help from their family members.

The clinician/worker is responsible for ensuring that the WRAP® is available to other clinicians/workers e.g. a person's crisis plan should be accessible to crisis services so that it informs the persons treatment.

The WRAP® components



A. The Wellness Toolbox

We encourage the consumer to write a description of what they're like when they're feeling well and what others notice about them when they're well.

∞

If this is difficult for them they can write down a few words e.g. *bright, cheerful, reliable, and curious*.

∞

Consumers may not be able to describe themselves and may find it easier to describe themselves from someone else's point of view. For e.g. my mother says I'm less irritable when I'm well.

∞

This discussion includes a clear message that they've been well before and the suggestion that they'll be well again/maintain their current level of wellness. It also provides clinicians with a vision of the person at their best.

We also ask them what they do/might do for fun when they're down and what helps them feel well. The following includes the things many people use to stay well and help relieve symptoms:

Talk to a friend/family member; talk to a health care professional; try relaxation or meditation; journal their thoughts-write in a note book; use positive affirmations; exercise; Have a balanced diet;
Get extra rest/early nights;
Take prescribed medication;
Attend a support group;
Wear something that makes them feel good;
Make a list of their accomplishments;
Does something that makes them laugh;
Get some little things done;
Take a warm bath;
Listen to favourite music;
Take time off from work / usual routine; or
Go someplace they feel calm

The Daily Maintenance Plan

A Daily Maintenance Plan may seem silly or simplistic and you may be tempted to skip or skim over it, however, most people find it's the most important part of their whole plan.

∞

A daily maintenance plan helps people recognize those things they need to do to remain well and plan their days accordingly.

∞

If they are starting to feel "out of sorts" it can often be traced back to "not doing" something on from the plan:

a) Encourage people to make a list of the things they need to do each day to keep themselves feeling alright. E.g. *exercise for 1/2 hour, eat well, get to bed early, meditate;*
b) Encourage them to identify things they might need to do each week / every so often to keep themselves feeling alright. E.g. *get a massage, go to the movies, have some quiet time, go for a walk; and*
c) Encourage them to make a list of people who are helpful to them and how often they need this contact.

We encourage people to make their own list and then plan to address the issues if they arise. For e.g. *If I notice that I am experiencing these signs I must …….. Do the things on my daily maintenance plan, spend at least an hour in an activity I enjoy each day, talk to my key worker etc.*

B. Relapse Prevention Plan

We encourage people to take an active part in preventing their possible relapse into illness. We ask them to identify things/situations that may increase their general levels of stress.

When working with people to identify these thing/situations we can divide them into those that are:

- more likely to occur e.g. workloads, family friction, being overtired;
- those which may already be occurring; and
- those which are less likely but may create significant stress or activate symptoms of illness.

We encourage the person to make a list of ways to respond to these things/situations. For e.g. *Make sure I do everything on my daily maintenance plan, do some deep breathing exercises. Remember that it's okay to take care of myself*

Early Warning Signs/Signs that stress is becoming difficult to manage

We discuss the nature of stress and how to identify when it's becoming difficult to manage. We explain that people may begin to experience stress even though they are working hard to stay well. We explain that reviewing stress levels regularly helps people to become more aware of themselves and allows them to take action before things worsen.

Some signs.....

Anxiety/nervousness
Forgetfulness
Inability to experience pleasure
Lack of motivation
Feeling slowed down or sped up
Avoiding others or isolating
Being obsessed with things that don't really matter
Not keeping appointments
Increased negativity/irritability
Aches and pain
Dizziness
Feelings of abandonment
Controlling behaviours
Weepiness
Compulsive behaviours
Increase in smoking/increase or recommencing drinking alcohol or taking other drugs
Spending money on unneeded items
Overeating *or* under eating
Feeling unconnected to their bodies.

C. Developing a crisis plan

We support people to determine their own ways of responding to this type of situation. We assist them to make a crisis plan that describes their preferred crisis intervention e.g.:

- Role of supporters, friends, neighbours;
- Preferred medication;
- Preferred treatments;
- Who to call if they are hospitalised;
- Who they do not wish to have contacted if they are hospitalised

We assist them to write the plan in simple and easy to follow terms and we assist them to revise the plan as they continue down the road to recovery. We also encourage them to give a copy of their crisis plan to their supporters if appropriate.

Signs of the need to take action

The consumer works with the clinician/worker to identify signs and triggers that things are becoming out of control or 'breaking down'.

Some signs may be:

Unable to sleep
Having suicidal thoughts
Wanting to use more alcohol and/or drugs
Not eating/eating too much/bingeing
Experiencing paranoid type ides
Being unable to slow down

Preoccupied by negative thoughts
Impulsive
Acting out of character
Headaches
Irritability
Spending lots of money or more than usual

A plan is developed with the consumer that describes their preferred treatment in a crisis situation. The plan is written in the consumer's language and in simple terms so it is easily understood by the treating team and family/carers. This should include:

- The role of any supports, including family, carers and friends
- Preferred medication
- Preferred place of treatment
- Who to call/who they don't want to be contacted if there is need to be admitted to hospital

We remind them that although the plan may not prevent a crisis from happening it may reduce the level and impact of the crisis.

Many services encourage their consumers to complete a crisis plan so that it informs their Triage, CATT and acute inpatient services staff of the person's treatment preferences if they're not able to express them at the time of contact.

Explanations are given to the consumer if the plan cannot be followed. This may happen due risk and safety reasons. Decisions can be made for future crisis planning based on the conversations and assist all treating teams and supports to better understand what is needed.

Post Crisis Management
Sometimes so much time is spent trying to avert a crisis that there is no plan for post-crisis support and activity.

Some people know that they need some time off work or away from their parenting responsibilities whilst others prefer to resume their full life as quickly as possible. These decisions may be based on previous experience or something they've discussed with their family and friends.

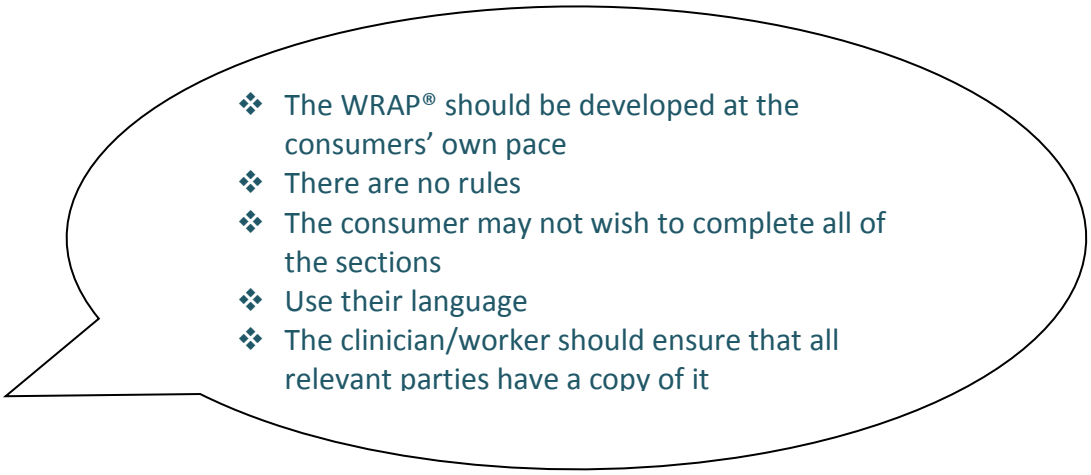
We explore discharge planning for e.g. where they would prefer to live, the people they would prefer to spend time with, how long they will need away from stress and how they'd prefer to make amends for the distress they may have caused others.

We refer people back to their **Wellness Tool Box** to get some ideas of how to manage their lives post crisis/discharge.

D. Family Support (Optional)

This section is a way of involving the family/carers to recover and engage them in discussions of what the consumer needs from them.

More discussion and documenting of the ways also to support the family as well as the consumer are explored in the next section (the FRAP).



My WRAP®

NAME:
Date:
PART A Wellness Toolbox and Daily Maintenance Plan
Wellness Tool Box What I'm like when I'm feeling well? What do other people notice about me when I'm well?
What I do for fun when I'm down, that lift my spirits and help me feel well and things that I might try in the future:
Daily Maintenance Plan Things I need to do each day to keep myself feeling alright (for example: exercise for ½ hr., talk to 1 other person, eat well, get to bed early, meditate…)**:**
Things I might do each week / few weeks to keep myself feeling alright (such as getting a massage, spending time with a friend, having some quiet time, going for a walk)**:**
People who are helpful to me – when and how often do I need to contact them:

PART B Relapse Prevention
Things that may increase my stress such as loss of sleep, arguments, drug taking, skipping medication:
Things I can do to reduce my stress (reflect on Wellness Toolbox section):
Signs that my stress is becoming difficult to manage / what would other people notice about me if I'm having difficulty managing my stress?
When I find I cannot manage stress on my own I need:

PART C Crisis Management
How would I know I'm in crisis? How would others know I was in crisis?
This is the list of help I would prefer to receive and the people I would prefer to receive it from: Be quite *specific* about these preferences. Who what you need them to do, what medications work for you, who to call, who to not call, medications that don't work for you.

Post Crisis Management
How will I know the crisis has passed? Things I need to do as soon as I'm out of crisis? Things that can wait? Things I need to do to recover from the crisis – (refer to wellness tool box and maintenance plan)
During week hours I can contact my Case manager first on:_____ Out of hours I can contact Triage on: _____ Other resources include: _____ _____
Commenced by: _____ Date: _____
Copy given to family/support person and purpose explained. Y/N Date: _____

PART D Family Support (Optional)
How have my family and friends been involved in my treatment / supported me in the past?
How would I like them to support me in the future?
What kind of information do they need to support me best?

How can they help me to avoid crises? (For example letting me know if they think that I'm getting stressed) Who is my main support person and what are their contact details? Who can be contacted if my main support person cannot be contacted in a crisis? What are their contact details?	
My Family / friends helped to develop this WRAP® YES / NO	
Copy given to family/support person and purpose explained.	Date:

9. THE FAMILY RECOVERY ASSISTANCE PLAN (FRAP)

This is a means of inviting carers to take an active role in supporting the consumer's recovery and understanding the Strengths Model and ways of working with the family member/person they are caring for.

Developed to complement the WRAP by Paul Liddy and others at Timaru, South Canterbury, New Zealand.

It is intuitive and also clear from research evidence, those carers and significant others have a marked impact on our consumer's recoveries and in many cases constitute a person's primary strength. Therefore mental health services have a responsibility to work effectively with these support people to promote the best possible outcomes for our consumers.

Many carers do not know how best to support their family member/friend. They may be exhausted by the time their family member is referred to our services and feel that they have run out of ideas, energy and hope. They may be confused about their supportive role, have had many contacts with health services and received contradictory information, felt excluded from the person's care, experienced multiple confusing referrals and even blamed themselves for the problems their family member/friend is experiencing.

Their care of their family member/friend may have had a significant impact on their own health, the stability of their families and their finances. They may also have experienced the grief of watching someone they love lose their career, relationships, independence and possibilities and experience involuntary admission and uncomfortable medication.

We routinely invite carers/significant others to participate in sessions to discuss their experiences, their needs and identify the ways they can support their family member/friend.

Sometimes consumers are not initially willing to have clinicians invite their carers/support persons to such a meeting however clinicians inform the person of the potential benefits, the likely agenda and will re-introduce the idea regularly.

Some clinicians will always include the consumers in these meetings while others have found it is beneficial to have at least one carer session without the consumer present. This will depend on the consumer's wishes, the issues to be discussed and the carer's preferences.

Communication and release of information arrangements need to be clear and abide by all relevant legislation; the Mental Health Act gives clinicians the opportunity to discuss the consumer's treatment and progress with relevant carers who are already engaged in supporting them.

Using the FRAP to maximize carer support for the consumer

Our first meeting with carers is intended to provide clear information about our role in the consumer's recovery, the broader service, the consumer's rights and the Strengths model of care. However the carers may also need to explore their own needs and dilemmas and we generally book at least an hour for the first session and bring referral information for family /carer support services.

We give the carers clear information regarding the Strengths Model of Care. This information sheet was developed through consultation with carer groups. We provide them with a hard copy of this document so they can review it at home. We may introduce the FRAP at this meeting but many clinicians make some notes of the session and deal with immediate questions, issues and needs before completing documents or making formal assessments.

These needs may relate to support needs specific to carers that may be met through early referral to family resources, access to carer funds, referral to internal carer support groups or family therapists/specialists or simply an invitation to attend at least two more sessions with the case manager.

We use the FRAP to document our discussions with the carers regarding their actual and potential support for the consumer.

It is filed in an accessible place so that all members of the treatment team can easily access relevant information regarding the carer and their involvement in the person's care. It may also include referral and support information given to the family/carer to maintain their own wellness.

We may complete a FRAP during sessions with the carers although some people will be happy to write their own and bring it to the case manager for discussion.

The FRAP has 4 domains

FAMILY

INFORMATION/EDUCATION

SOCIAL/SPRITIUAL/CULTURAL

WRAP®

Family
Encourages discussion about the carer's past experience, reactions and beliefs regarding mental illness. It also explores the consumer's current family/support system including who is immediately involved with caring for them and which members may be estranged. It encourages the clinician and carers to consider ways the carers can continue to support the person and to develop a robust effective communication system between carer and mental health services

Information/Education
Encourages discussion regarding previous experience with mental health services, current understanding of treatment interventions, recovery and the Strengths Model. It explores the carer's understanding of the Mental Health System and clinician roles and identifies their wishes regarding ongoing education, support and meetings with doctors and clinicians

Social/Spiritual/Cultural Support
Encourages discussion regarding the consumer's previous support systems, identification of any current supports and exploration of the potential support needs of the consumer and the carers. This domain may assist the clinician to make effective referrals for both consumer *and* carers

WRAP® (Wellness Recovery Action Plan®)
Provides an opportunity for carers to discuss the WRAP® development and commitment process, it enables them to understand the recovery process from the consumer's point of view and identifies the part that they can play in assisting the person to maintain their own wellness. This domain should be discussed whether or not the consumer has developed their own plan at that time.

The Domains in the FRAP provide the clinician and carers with an opportunity to explore important aspects of the carer's experience and role in supporting the consumer

The FRAP also provides the carers and clinician with the opportunity to develop a priority list for the carer's involvement in the consumers recovery. This discussion may assist the carer to feel less overwhelmed and more focussed. It also assists clarification of the differences in roles between the clinician and support persons.

It is common and desirable to have ongoing contact with carers throughout the consumer's care. These contacts are recorded and clinicians may use FRAPs to track changes to carer involvement, psycho-education, attendance in carer groups and input into the consumer's WRAP etc.

FAMILY RECOVERY ASSISTANCE PLAN – (EXAMPLE)

	Current Situation What's going on today? What's available now?	**Future Wishes** Desires and aspirations What does the family want?	**Past Resources:** Resources, personal, social, What has the family used in the past?
Family	Denise Smith (Mum) in 70's looks after Callum (Lee's son) who is 15 and goes to Boys High. Owns own home. Lee's Dad built house. Brother, Luke died in 1997. 2 sisters Joy who lives in Coburg and Fiona lives in the Ballarat. Very supportive Family	Wants to help Lee to stand on her own two feet. For Lee to develop other supports and use them when distressed. Key Worker to contact Mum to give update once a month or visit face-to-face. MIF to ring Denise weekly, to check on how things are going.	Not happy with past experience with service. Lived with her Mum for 20yrs Financial support provided by mum. Felt Mental Health services told her what to do. Given multiple diagnoses. Felt not listened to or supported by Key Worker. Blame service for consequences of Lee's time in Melbourne Denise believes she has Schizophrenia. Sees Lee's behaviour as a result of illness and not responsible for her actions.
Information / Education	Has been actively present on Ward i.e. at least 4 X per week. Ringing Team to find out what's going on, for support and reassurance. Confused at times re current diagnosis how services were delivered in past and current changes.	Would like to see Lee copying as an adult woman independent of Mum. Would like Lee to be thinner and knows that medication is to be reduced, in the future. Would like to attend all key meetings. Progress report from Ward would like information re: - Sleep - Activities undertaken. - Any changes re medication. - Emotional State. - Potential discharge date. - Reassurance that the service will help.	Given information re Mental Health Act. Have copies of Family Kit, medication and the Strengths Model.

Social / Spiritual / Cultural Support	Mental Illness Fellowship (MIF) sees Denise every fortnight. Her grandson Callum who lives with her provides support. Home help x 1 per week Friends – Carol and Irene Currently is Physically unwell, arthritis. Provides financial help to Lee Conflict – between Lee and her role as grandmother to Lee's son.	Continued support from MIF. Contact from Mental Health Services x 1 per month. Would like Callum to be independent. Take time out to deal with physical ailments.	MIF has been involved for the past 6 years and finds them great! Had contact from Mental Health Services Key Worker, last admission but it was not regular.
WRAP® (Wellness Recovery Action® Plan)	Denise knows who to contact. Has had lots of information re CATT Copies of WRAP given 25.4.04 Some understanding of warning signs i.e. lack of sleep, becomes irritable, begins spending, and stays out late, gambles money.	Due to her physical health Denise wants minimal involvement in crisis situations and would like others to help. Wants to know progress not the problems i.e. when Lee is admitted.	Can be intimidated by Lee. Has some idea of the requirements of the personal plan but finds it difficult putting it into action.

What are my priorities?

1. Wants to be able to stand back from responsibilities of family members.

2. Continued support from MIF.

3. Take time to deal with physical health.

_____

Key worker Signature **Person's Signature**

_____ _____

FRAP QUESTIONS TO ELICIT INFORMATION FROM FAMILIES

	Current Situation What's going on today? What's available now?	**Future Wishes** Desires, aspirations What does the family want?	**Past Resources** Resources, personal, social What has the family used in the past?
Family	Who are considered family members? What are their names? What are their connections? What are the roles in the family? i.e. who does the house work, bread winner, child minder etc What pets do they have and their names How close are the family members in terms of location	How would you like to support your family member? What would you like to happen for your family member? What would you like from the service? i.e. monthly visits with MIF worker and family members and Mental Health service key worker, and/or monthly, weekly phone calls etc.	Has your family experienced issues of mental illness within your family in the past? How did your family feel and deal with this? What are the families' views and beliefs?
Information/Education	What do you know about the current service? How does it work? What is the role of the members of the team? What is expected of the family member and family from entry – exit. Has the family received information about "recovery" and the "strengths model"?	What information would you like to have? How would you like this discussed? What meetings would you like to attend – discharge, review meetings etc., Do you want copies of the 3 monthly review forms etc.? Would you like time with the Key Worker without your family member being present?	What have you heard about service? What do you already know about the illness? What do you know already in terms of the strengths model, recovery, the service, medication, side effects, legal aspects e.g. mental health act

Social / Spiritual / Cultural Support	What services have you assisting/supporting you currently? What social activities are the family members involved in? Who is there to support the family to maintain energy and hope? How supported does the family feel currently? What things are an issue i.e. is support being provided to the children?	What would you like to have happen now i.e. in terms of support and assistance for the family? Can you identify what services and needs that you or your family member may have i.e. Mental Illness Fellowship, ARAFEMI, domestic assistance, other social agencies	What services have been involved in the past? How have you supported your family member in the past i.e. time, financial, etc. Was there anything you might do differently this time based on what you now know?
WRAP (Wellness Recovery Action Plan)	How does your family deal with crisis situations? What do you know about the Wellness Recovery Action Plan? What were the signs of your family member becoming unwell? How was crisis dealt with this episode, could anything have been done differently?	What would you like to have happen in the future? (Level of involvement, copies of plan, who to contact, emergency situations what to do, relapse signs?)	How has crisis situations been dealt with in the past? What signs did you notice in the past of your family member becoming unwell? How was the experience in the past for your family member when they were in crisis? What things were actioned?

10. RESOURCE ACQUISITION putting community back in to Community Mental Health.

The mental health of people with severe mental illness will continue to suffer as long as mental health is seen as separate from community, is only seen as a group of professionals with specialized talents, is only seen as formally constituted services largely segregated from the rest of life. While the community is not the source of mental illness, it is the community that is the source of mental health. It is the community that is rich with opportunities, resources, and people. Therefore, a primary task of the strengths model case manager is to break down the walls separating consumers from the community, to replace segregation with true community integration

Rapp, C 1998

Why use naturally occurring (not MH) resources?

- They increase opportunities for a person to fully participate in the life of their community;
- They generate highly individualized supports that offer a sense of "fit" for the person;
- They promote participation in natural settings rather than in artificially segregated environments;
- They create personal relationships that often become lifetime supports;
- support and engagement that exists beyond a person's discharge from a MH service;
- They foster hope and recovery rather than maintenance and "illness management"; and
- They make the job of the key worker more interesting.

Types of resources

Formal – e.g. GP; drug & alcohol service

Community – e.g. Drop in centre, mental health support group

Naturally occurring – e.g. gym, library, cafe

Check the four As

√ Availability - available for the consumer to make use of

√ Accessibility - the consumer can use them easily

√ Accommodation – the service/place is supportive and not abusive

√ Adequacy – meets the consumer's needs

We should focus on the environment as much as we focus on the consumer. It is important to help the person see the importance of this too.

The attitudes of the community are often a lot more responsible for the disability than the illness itself.

The Perfect Niche

What resources already exist that may be a good match or create a perfect "niche" for a person in terms of their attributes, strengths and goals? For e.g. a resource that doesn't need to change or require the person to change to form a good fit.

The talents, desires and idiosyncrasies of the consumer are matched with the needs and requirements of the setting.

Any perceived deficits the consumer may have are irrelevant to the setting they are in, whether this is a cafe or a hairdresser's!

Wanda was in her late 30s and had spent much of the last 10 years in and out of hospital. She wanted a job as a maid at a hotel/motel, which she had done for 2 brief periods in the last decade. She had all the necessary skills. Due to her tardive dyskinesia (side-effects of long-term medication), she has rather a rigid style of walking with her head tilted to one side. She also said "hi, how are you?" indiscriminately whenever she was confronted or passed someone. If she passed you, turned around and passed you again, she would say it twice. This hotel of choice has always been a lower scale of establishment. The strengths case manager, in contrast, recognised that it was up-scale hotels that devoted considerable resources to having all employees be friendly and greet their guests. The case manager helped Wanda get a job at a more expensive hotel where her goal, her skills and even her 'inappropriate' behaviour were valued.

A guide to Resource Acquisition

1. What naturally occurring resources are available in my community that may satisfy a specific need related to a person's stated goal?

2. If a perfect niche cannot be found, what accommodations (formal or informal) could be made for the person to be successful in using this resource?

3. How adequate is this resource to meet the needs of this person?

4. Is the person interested in using this resource? How many alternatives are available?

5. Who will decide if a person gains access? How can the person (and/or I) best build a relationship with the person who manages this resource/service?

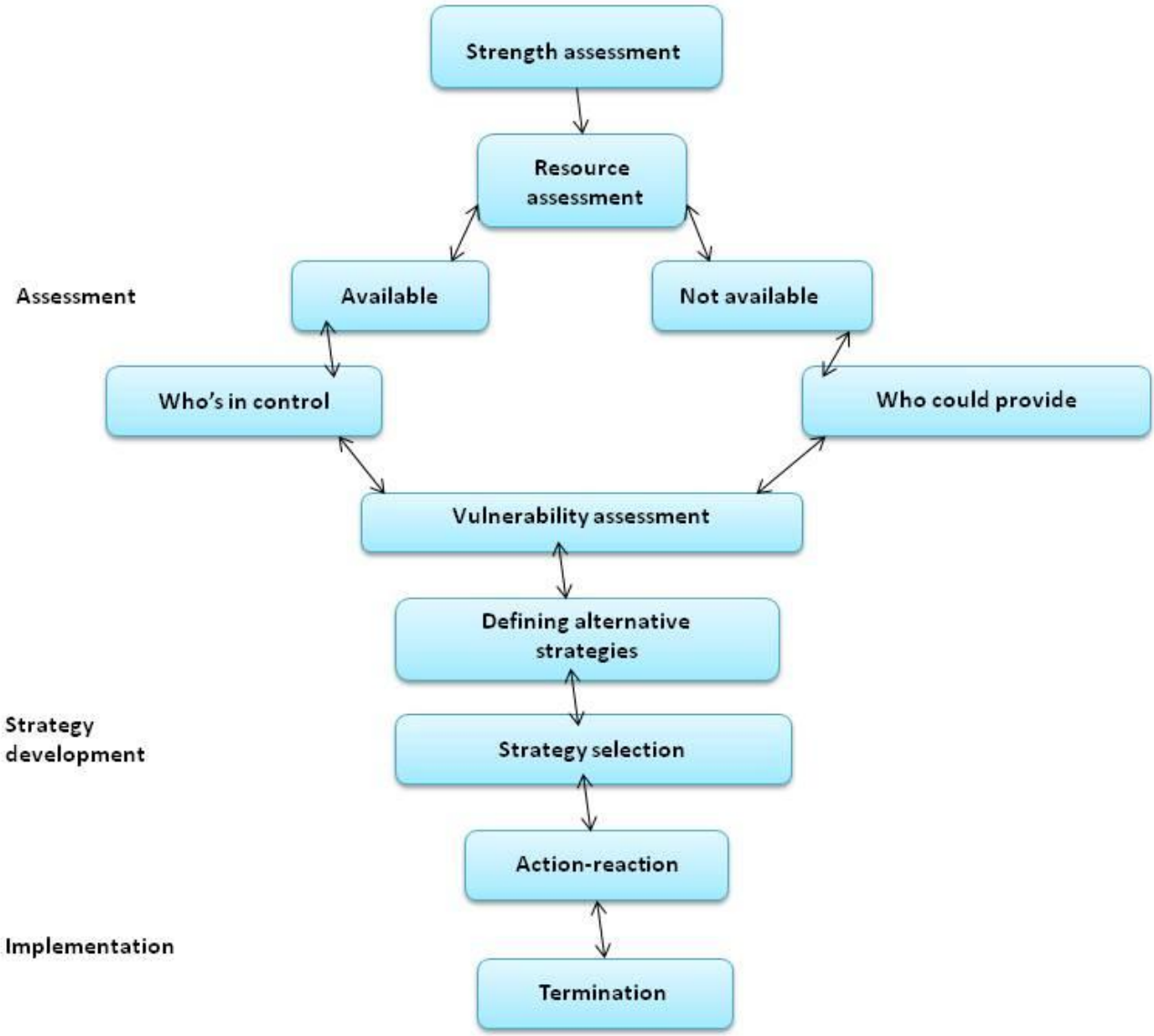
6. Who should be the one to initially approach the resource person? How does the consumer feel about disclosure? How much do we need to disclose?

7. What does the decision maker/assistance provider have to gain in making this resource available? How can the process be a win/win?

8. Am I avoiding high-pressure tactics when they may be necessary? Have I discussed plans to move toward more conflict-oriented strategy with supervisor, team, and person? (E.g. legal advocacy/anti-discrimination commissioner etc.)

9. Am I doing effective follow up after the connection has been made, either with the person I am supporting, the resource person or both?

Linking resource acquisition to the Strengths Assessment and Goal Planning



11. GROUP BRAINSTORMING a team approach

Group Brainstorming provides clinicians/workers with:

- support and affirmation of their skills;
- new ideas for working with people; and
- opportunities to learn about community resources, interventions and other relevant services and ideas (sharing information)

Group Brainstorming is the fuel that keeps the strengths model practice alive and strong on a team level.

Another benefit of these sessions is the opportunity for clinicians to confirm and update their use of the model and discuss how to effectively use the tools of strengths assessment and goal planning

Group Brainstorming

- Is usually conducted on a weekly or fortnightly basis for 1 to 2 hours. It's usual to have set number of participants (usually 10) meet with a facilitator in a place where they will not be interrupted. During the time available one to four people/families are discussed in detail.
- Discussion usually focuses on clinician challenges e.g. difficulties developing an effective relationship with a consumer, trouble identifying their strengths or wanting to find community support/resources to support their goals.
- Learning takes place in this model when staff members present their challenges or questions to the team/group within a supportive established framework.
- The Brainstorming framework /structure was developed to allow open and free discussion where all ideas are welcomed and none are dismissed prematurely. New ideas can better generate new ideas if all opinions and suggestions are invited.
- Each staff member goes away from the meeting with new ideas and increased options and other group/team members have had the advantage of hearing a variety of options for situations that may occur in their own work.
- Some groups collate a resource list from the Brainstorming Sessions for use by all staff and consumers.

The process

The brainstorming process is designed to keep the team focused on generating creative strategies rather than digressing into venting or rehashing problems.

We have found it best to organise a regular time and place for the sessions and encourage staff to prioritise their attendance. We find a room where we won't be interrupted and follow the formal guidelines so that everyone becomes familiar with the process.

The session

Activity
The participants share their recent successes – this is beneficial for all participants to share any of their recent successes with the group. This helps break the ice, energise clinicians/workers and encourage future efforts.

Steps
Step 1: The presenting clinician hands out the consumer's Strengths Assessment (or WRAP®) - The presenting clinician makes copies of the relevant strengths assessment for every participant and hands them out. The process won't work unless everybody has their own copy of the strengths assessment for the person being presented.

Step 2: The clinician poses a question to the group i.e. they describe the consumer's goal(s) and ask for specific help from the group. For example, "Joe has a goal to go back to work. I'd like some ideas about jobs that might match his interests," "Mary wants more friends in her life. I'd like some ideas about where she might go to meet more people." The consumer's goal(s) takes centre stage in this process.

If the person doesn't have a specific goal, then the question to the group could relate to ways to engage with the consumer to find a goal that is passionate and meaningful to them.

Being specific at this point in the process keeps the team focused on what is to be accomplished.

Step 3: The clinician describes the current situation and the things that have already been tried? - The presenting clinician gives a quick one to two minute description of the current situation and a few things that have already been tried.

Step 4: The group asks questions regarding the Strengths Assessment. The participants take a few minutes to look over the strengths assessment. Then, for five to ten minutes, they ask questions of the presenting clinician to further clarify anything that is written down or areas that have not been fully explored. For example, "It says here that the grandmother is supportive. Tell us more about her role in the person's life."
No advice can be given in this section. This step provides participants with the opportunity to understand as much about the person as possible so that creative and specific suggestions can be offered in the next step.

Step 5: Brainstorming the question - For ten to fifteen minutes the group brainstorms ideas. It is important that these ideas are related to the person's goal(s).

The presenting clinician *must* write down every idea without speaking (ie no evaluation of the ideas or "yes - buts"). This allows the team to remain creative and solution-focused.

Often some of the best ideas come toward the end of brainstorming as the ideas begin to build. A good brainstorming will generate between 20 to 40 ideas.

Step 6: The presenting clinician makes a plan based upon the suggestion. The presenting clinician reviews all the ideas and identifies three (3) suggestions they believe are most likely to succeed. They then share this plan with the group e.g. "I will meet with Jean this Thursday. I'll take this list with me and see if she wants to pursue any of these suggestions to help her get more involved in the community," "I like the idea of taking Jim out to the zoo since he loves animals. While we are there I'll use some of the motivational interviewing techniques to gauge where he is at in his goal of stopping drinking. I will also build on the strengths assessment to see what supports have been helpful to him in the past when he's been able to stay sober."

Activity
Feedback Loop. You may wish to create a roster where clinicians provide feedback to the group about the results of previous Brainstorming plans/suggestions.

This provides the opportunity to reflect on successes and challenges and review/expand on the usefulness of the suggestions generated by the previous sessions.

You may keep a list of participants and presenting consumers or ideas to allow you to ensure that all clinicians/workers attend regular sessions and that a broad range of consumers and issues are discussed.

Strengths Brainstorming has 6 steps and St Vincent's staff have added 2 activities to enhance the group support process.

A clinician brings a consumer/issue to the session to discuss; the session consists of seven steps; each is distinct and critical to the success of the process.

Group Brainstorming Worksheet

Consumer's Name: _____

Date of Strengths Assessment: _____ (If are there any additional strengths that can be added or expanded upon prior to the Brainstorming Session, please do so)

What is the Consumer's Goal(s)? (This can reflect what is most important or meaningful to the person at this time and/or a future goal that holds some passion for them. If you don't know what that is at this time, you can state that here).

What would I like help with from the team: (This should be a simple specific statement used to guide the team in brainstorming. It may be related to helping the person achieving the above goal(s), overcoming barriers or challenges related to achieving the goal(s), helping them to identify a recovery goal, or ideas for engaging them in a working relationship)

Overview of the Current Situation: (This should be a brief snapshot of where you are at now in relation to helping the person to achieve or identify a goal and what you have tried so far).

Team Brainstorming:

1.	2.
3	4
5	6
7	8.
9	10
11	12

and many more - as many suggestions as can be gathered in the session..

Next Steps: This may include a list of three (3) suggestions you believe may work best for the person, what you intend to do next time you meet with them and what specific steps you might take prior to that meeting.

Follow-up Report (3-4 weeks):

12. MENTORING

Mentoring is a supervisory tool used to help staff further develop and refine their use of skills and/or tools in actual practice. The environment for mentoring should be one of mutual learning and professional development rather than micro-management. There should be an expectation that all staff continue in their professional development throughout the year, and the role of the mentor is to support the enhancement of their professional skills.

Purposes of Mentoring

- Observe Skills of Staff
- Provide Feedback on Skills e.g. assessing strengths, formulating goals, building relationships, processing decisional uncertainty, motivational interviewing, etc.
- Modelling Skills
- Prompting of Skills

Benefits of Mentoring

- Reinforce Strengths of Staff
- Enhance Transfer of Training
- Build Skills
- Build Confidence
- Better assist staff in areas they identify that they struggle with.

Format for Mentoring

- Agree on the goal of the mentoring session (using the SA with clients who are reticent to speak, breaking down the goal on the RGW, etc.)
- Choose a client that will best help the case manager learn the skill.
- Agree on the role each of you will play in the mentoring session.
- Plan for time afterwards to process.

Processing after Mentoring

- Restate the purpose of the particular mentoring session.
- Point out specific strengths of the case manager observed during mentoring.
- Point out specific words, behaviors or actions that might have been obstacles to the case manager reaching his or her desired outcomes.
- Make a plan for follow-up.

The Power of Positive Reinforcement

- Reinforce Specific Behavior
- Use Immediate Reinforcement
- Reward Small, Incremental Achievements
- Use Intermittent Reinforcement

Types of Rewards

- Verbal Praise
- Written Praise
- Symbolic Rewards

Factors in Implementing a Reward-based Environment

- Diversity in Rewards
- Amount of Rewards
- Specificity
- Sources
- Individualise

Mentoring focuses on enhancing the strengths of the case manager rather than focusing on their deficits

The following are some examples of ways to provide mentoring.

Mentoring Interventions

Intervention #1 Observe ↓ Provide Feedback ↓ Role Play ↓ Discuss	Intervention #2 Model ↓ Discuss ↓ Observe ↓ Provide Feedback
Intervention #3 Observe ↓ Prompt Skills ↓ Model Skills ↓ Discuss/Provide Feedback	Intervention #4 Role Play ↓ Provide Feedback ↓ Observe ↓ Provide Feedback

Intervention #1 – Here the case manager takes the lead role in working with the client with minimal involvement from the mentor. After the session, the mentor and case manager discuss what worked well and what did not. Using role play, the mentor models as the case manager and presents alternative ways the session might have been conducted. The role play is discussed, along with possible switching of roles for further practice.

Intervention #2 – Here the mentor takes the lead role in working with the client for the purpose of modelling how to use a specific skill or tool. The mentor and case manager discuss the session afterwards. On a subsequent session, the mentor observes the case manager using the skill or tool. Afterwards, they discuss the session.

Intervention #3 – Here the case manager takes the lead role in working with the client and will try using a new skill or tool. If needed the mentor might intervene during the session and assist by modelling the skill or tool. Afterwards the mentor and case manager discuss the session.

Intervention #4 – Here the mentor and case manager role play using a new skill or tool prior to meeting with the client. The mentor gives the case manager feedback on using the skill or tool. The mentor then goes out with the case manager to observe him/her using the skill or tool with an actual consumer. Afterwards, the mentor provides feedback to the case manager.

Mentoring - Enhancing the Use of the Strengths Assessment and Goal Planning worksheet

Reviewing Strengths Model Tools

- We recommend spending at least two hours per week reviewing Strengths Model tools (i.e. Strengths Assessments and Recovery Goal Worksheets
- Review of tools is enhanced when the mentor is familiar with the client, the client's goals, and the services provided to the client
- There are two core components of reviewing tools: quality and integration

Reviewing Quality

- Mentor must be skilled at knowing how to complete the specific tool with quality
- Mentor must understand the importance of using the tool.
- Provide staff with examples of how you want the tool to be used
- Give staff the opportunity to practice using the tools
- Give staff regular feedback on the quality of the tools and use in practice

Use of Strengths Assessment

- Engagement
- Helping people to set goals
- Viewing larger context of recovery
- Magnifying people's strengths
- Identifying ways to achieve goals
- Focusing on naturally-occurring resources
- Enhancing group supervision

Types of Strengths

- Qualities/Personal Characteristics
- Talents/Skills
- Environmental Strengths
- Interests/Aspirations

Critical feedback

Reflective Practice, Practice Development, Supervision and Mentoring are the backbone of good clinical practice, and the Strengths Model of provides effective clinical feedback practice in Group Brainstorming and Mentoring. Both these activities include the provision of critical feedback.

What Is Critical Feedback?

When it comes to criticism, most of us believe it is more blessed to give than to receive. Yet valid critical feedback from others, when properly given, can make the difference between success and failure in our lives. It provides us with information on what is working and what is not, and can help us develop and grow personally and professionally.

Why, then, do we find critical feedback so difficult to handle? We often view critical feedback as something totally negative rather than a valuable opportunity to expand our understanding and an effective tool for achieving positive results. Properly given, critical feedback becomes constructive feedback.

Why Is Critical Feedback Difficult to Handle?

Critical feedback is an indispensable part of our lives. If we can understand and use it, this feedback can empower us to communicate more openly and improve many facets of our daily lives. Why, then, do so many of us resist taking full advantage of what can be such an enormous benefit?

One of the reasons why we tend to resist critical feedback is that a good part of our self-image is based on how others view us. When we find that someone sees us in a less-than-positive light, we may feel devastated.

People tend to like to hear what is consistent with their own views and resist ideas contrary to their belief structures. But if we knew we were doing something ineffectively, wouldn't we automatically try to improve the deficiency? Critical feedback implies that we could be wrong. What could be more personal and threatening? It takes an open mind to be able to listen to an opposing view.

What is Feedback?

In human interaction, feedback is a process by which the effect of a person's specific behaviour is brought to that person's attention. Feedback is given only for the purpose of helping the other person to see the result of her or his actions so he or she may choose whether or not to change to get a different result. If feedback is given for any other reason, it is not feedback—it is criticism, judgment or mandate.

Feedback is not… evaluation, judgment, criticism or venting.
Feedback must only be given… when you intend to be helpful to the other person.
Feedback must never be given… for the purpose of making you feel better or to relieve your frustration, when you are angry or upset, or if your intention is to be hurtful in some way.

Good Example of Feedback:
You notice that when one of your colleagues, Lee, speaks to you in a loud voice, talks quickly, and does not respond to your questions or comments; you feel intimidated and stop sharing ideas. You think you can be helpful to Lee by describing what happens. You say:

"*Lee, I have some information that I think may be helpful to you. Can we set aside a few minutes so that I may give you feedback about something that happens when you speak?"*

After Lee has agreed, during the meeting you say words to this effect:

"I don't know if you are aware of it, but when you raise your voice, talk quickly, and don't respond to questions, I feel intimidated and stop sharing ideas. I am telling you this because I think you are interested in what I have to contribute to the business and want to hear what I have to say."

Stop here and wait for Lee's response. Do not suggest other ways to interact unless **Lee**

Bad Example:

You approach Lee and say:

"What's wrong with you? Why do you treat me so disrespectfully? Stop cutting me off when I'm trying to tell you what's on my mind!"

Ten Tips for Handling Feedback

Here are 10 reminders and suggestions for dealing with feedback.

1. Seek feedback on projects or assignments *before* miscommunication occurs and mistakes become a crisis.

2. Ask others for positive feedback if none has been offered. An example might be "What did you especially like about how I handled the project meeting?"

3. Keep a *Me* file with examples of work you are especially proud of, letters of appreciation, and notes of congratulations you receive throughout the years.
Review your *Me* file when you are feeling down and need an encouraging boost because of others' critical feedback.

4. Listen carefully to your mentor to make sure you understand the critical message.

5. Do not automatically assume your mentor is right or wrong. Take time to assess whether the feedback is valid before taking action. Ask questions to clarify the feedback or get specific examples of where you were wrong.

6. Evaluate the source of feedback and whether it was offered constructively.
Does the feedback give you action to consider? Is it future-oriented? Or is it offered destructively, with words such as *always*, *never*, and *should*? Is it focused on the past?

7. Do not passively accept critical feedback or become a silent victim. You will appear to have little self-confidence and may lose the respect of others and yourself.

8. When you have made a mistake, avoid over-apologizing or overcompensating.
Instead, freely admit your errors rather than trying to cover up. Cover-ups usually come back to haunt you.

9. Do not make overly general negative assessments about your character or ability based on one mistake, such as "I'm such a jerk!" or "I'll never be any good at this." Give yourself credit for past victories and accomplishments.

10. Lower your emotional temperature when dealing with critical feedback.
Use positive self-talk such as "I'm okay. I may have made a mistake, but learning from this error will increase my professionalism."

13. FREQUENTLY ASKED QUESTIONS (FAQs) about the Strengths Model in practice

(1) "How do I proceed if the person says they don't want to fill out the strengths assessment or goal plan?

Always remember the fourth strengths principle - the relationship (not the document) is primary and essential. The case manager should always use the strengths documents in the context and flow of the relationship, not as a static document that is forced on a person whether they like it or not. If the person is resistant to having information about them written down in this manner respect their decision. Clinicians can fill out a strengths assessment on their own simply as a way of keeping track of the consumer's strengths for their own recall and present their version to the consumer for discussion when this seems appropriate.

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

(2) "What if the person has a history of criminal behaviour, suicide attempts, or alcohol or drug abuse, but they don't want it to be on the form? Do I just leave it out of the assessment?"

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

Remember; the strengths assessment is unlikely to be the only written assessment that is completed by the mental health agency. Most services require risk assessments, treatment plans and comprehensive psychosocial histories be completed shortly after intake. These documents will generally include important information related to past behaviour however they do little to inspire the hope and future focus that promotes recovery.

(3) How do you keep the strengths assessment as an on-going, working document and also keep a current copy in the chart?

Remember; the strengths assessment is a "working document". This means that it is constantly being updated. The case manager should always have a copy of the most recent strengths assessment available when they meet with the person, they may also choose to copy it to the person's electronic file so it is always readily available e.g. in the office, for CATT during an urgent assessment etc. New information can surface at any moment and it is critical that it be added quickly to the document to avoid it being lost or forgotten.

Furthermore, the person should have a recent copy and there should be a recent copy in the chart to be referenced by other staff (e.g., vocational counsellors). Remember; the strengths assessment is not just paperwork, but a central tool to promote recovery and growth. Do not let it get buried in the clinical file with all the other forgotten forms!

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

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

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

(5) ***Do consumers need to accept they have a mental illness in order to take control of their lives and make plans? And if not, how can they do this?***

Consumers do not necessarily have to have insight or fully accept their diagnosis to be able to have dreams and goals. Pathology does not define the person. The consumer is an individual with unique skills and interests and passions. When a consumer wants to take control of their lives they will need to have a sense of hope and of purpose. The clinician and service need to view the consumer as an expert in their own life journey while the consumer directs the pace and progress. The focus is on possibilities and abilities. The consumer is the most important person in a recovery based service. The consumer takes on an active role in identifying what gives meaning and passion in their lives.

(6)*What is a 'community' strength?*

One of the principles of the strengths Model is that the community is seen as an oasis of resources. A community strength is an external resource that enables the consumer to meet their specific goals. The community strength can be a facility, a location, a particular service. The community strength can be part of mainstream culture as well as targeted at a specific user group.

(7)*Should Clinicians support impossible or improbable goals?*

At times our consumers may express goals that on the face of it may seem delusional or grandiose. Rather than rejecting such a goal, the role of the clinician is to explore and understand the deeper meaning and significance behind wanting to be a rock star or the Queen. The outcome of such explorations may uncover the desire to take up singing lessons, or to gain the respect of one's peers. Through listening and curious enquiry the clinician can

uncover multiple meanings and ways to break down the goal into realistic and achievable steps.

(8)Does the consumer have to fill out their own Goal Planning worksheet?

The most important aspect of the goal planning process is that the goals are meaningful, valued by the consumer and that the goals are consumer driven. If a consumer declines to write on the worksheet, the clinician can record the identified goals and steps to achieve the bigger goal. The clinician will need to check in with the consumer that what is recorded on their behalf is a true reflection of what has been discussed. Timelines and achievements are recorded on a regular basis and the next step identified. The consumer can record their goals in a medium that suits them, e.g. a diary, journal using a scrap book, creating a file on the computer. The goal plan is a person's 'To Do' list towards a more satisfying life.

(9)Is it OK to see the consumers at the clinic, do we have to meet them in the community?

Yes, you can see the consumers at the clinic as the model doesn't state you cannot do this. In fact some consumers may prefer to be seen there. It is however preferable where possible to see consumers in an environment that is familiar to them and conducive to open discussion and relationship building.

(10)Why can't I refer consumers to community MH programs, isn't that where they will find peer support and empathy?

You can certainly refer consumers to community MH programs if the consumer feels the community MH programs are the correct places for them. It is always preferable to refer someone to a naturally occurring resource where possible.

(11)What if there is a conflict between what the consumer wants and the clinician's judgment?

A discrepancy in views does not mean that the two must arrive at an artificial and unhelpful adoption of each other's opinion. The clinician explores the basis for a consumer's desires and works on determining short term goals, breaking them into small steps whilst the greater issue e.g. 'I want to cease my medication', can be explored. The strengths model is not an alternative to good clinical care; it focuses clinicians and consumers attention on reaching the individual's goals. The model demands good engagement and collaboration which in turn can increase trust and communication.

(12)What about the potential ethical challenge of balancing clinician identified issues and consumer directed goals, paternalism vs autonomy.

These views may not be in opposition. The good on-going rapport developed from the consumer feeling that they are listened to and their opinions respected may support robust discussions regarding on-going goal planning. The clinician may develop substantial trust in the consumer's capacity to determine their own future and manage their challenges.

(13)What about consumers with significant chronic psychiatric disabilities? How would autonomy work with this group?

There is evidence that low expectations create their own momentum and that higher expectations encourage hope.

(14) How is working with the strengths model different from what I already do?

Before the implementation of the Strengths model we were not exactly sure how every clinician was working with their consumers; different disciplines have different approaches and sometimes different languages often causing translations difficulties.
Strengths is a consumer centred approach that probably uses all the skills and interventions you have been using all along, it is just a way to use a common focus, language and structure:

Strengths:

a. Is consumer centred; the consumer is the director rather than collaborator;
b. Focuses on strengths rather than deficits/diagnosis;
c. Focuses on solutions rather than problems/prognosis/limits;
d. Offers a structured way to assess strengths and develop goal plans;
e. Provides for team brainstorming sessions;
f. Uses a WRAP to increase consumer self-efficacy in managing their own issues, including crisis planning.

(15) Do the Strengths documents take the place of the ISPs?

Here at St Vincent's the Strengths Assessments and Goal Plans *do* replace the ISP for our (non 'clinical' work) with our consumers. Where the old ISP also contained information about clinical problems and interventions this information is now captured in the MHA Treatment Plan which is now updated at least quarterly for all consumers regardless of their legal status. Case Managers are encouraged to record these interventions in specific terms, outlining the role of all participants in the plan clearly.
This is also a logical place to record evidence that consumers have been made aware of the nature of their treatment as well as their rights and responsibilities.

(16) Isn't this just more paperwork?

Arguably our clinicians have less paperwork owing to the substitution of the strengths documents for the ISP and the fact that consumers are ideally producing their own Strengths Assessments and Goal Plans.

(17) Do clinicians need to review the Strengths Assessment/Goal Planning every 3 months with clinical reviews?

Strengths Assessments and Goal Plans are ideally constantly being updated and added to by consumer and case manager. Whilst they do not form part of the suite of forms which must be updated for each clinical review it is expected that clinicians will make reference to the consumer's progress in setting and achieving goals when providing a comprehensive update on the consumers progress since last review.
These comments would be part of the 'Progress/Change since Last Review' section of the Case Review document.

(18) Does a consumer have to have a WRAP® before I can discuss this document with carers?

Although this is ideal – it may not be the case. Carers are given information regarding the Strengths Model of which includes the use of a WRAP. Clinicians can use the WRAP format to explore ways the carer can assist the consumer's recovery and can also collect information regarding the consumer's early warning signs and any previous relapses to assist the consumer to develop their own WRAP.

(*19) Do we have to follow the Brainstorming Guidelines?*

The simple answer is – *yes*. The guidelines were developed to maximize the opportunity to provide support and suggestions to the presenting clinician; we encourage teams to maintain the integrity of a system that effectively supports open-mindedness, creativity, problem solving and colleague support. Whilst clinical reviews, handovers and case conferences provide opportunities to discuss consumer strengths and progress, we believe that Strengths Brainstorming Sessions encourage more creativity and less self-consciousness for finding effective solutions for clinician challenges.

(20) How can I apply these concepts to my practice without losing my own consumer-centred processes?

The Strengths Model of adapts itself to work with individual clinician skills and interests. We use the Strengths documents to frame our work and assist communication regarding consumer strengths and interests, progress with their goals, work with their families as they support the consumer and encourage people to take responsibility for their own wellness.
The model has not been adopted to limit clinician interventions, rather to organise them for effective communication, review and implementation.

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APPENDICES

QUALITY REVIEW OF PERSONAL/GOAL PLAN

Consumer's name _____ Date reviewed_____
Case Manager's Name _____

LONG - TERM GOAL

YES NO Goal is taken from the "wants" section of the strengths assessment, that is, long-term goal clearly reflects what the person wants, what motivates him/her, not what others think they need to do

YES NO Goal is written in the person's own words

SHORT - TERM GOALS (action steps/tasks)

YES	SOMETIMES	NO	Date is recorded that the action step is written
YES	SOMETIMES	NO	Goals are measureable (outcomes oriented)
YES	SOMETIMES	NO	Goals are achievable (broken down into small steps)
YES	SOMETIMES	NO	Goals are positive (what *will* be done rather than what *will not* be done)
YES	SOMETIMES	NO	Dates to be achieved are recovered (no on-going)?
YES	SOMETIMES	NO	Are tasks being achieved and target dates recorded?
YES	SOMETIMES	NO	Is goal progress reflected in comments section?
YES	SOMETIMES	NO	Resources/information from the strengths assessment are reflected in the goal plan
YES		NO	The consumer has signed the plan

Taken from - The Strengths Model: Case Management with People with Psychiatric Disabilities Second Edition Charles A. Rapp & Richard J. Goscha

QUALITY REVIEW OF STRENGTHS ASSESSMENT

Consumer's name _____ Date reviewed _____
Case Manager's Name _____

YES	SOMEWHAT	NO	Complete and thorough – each life domain has rich and detailed information
YES	SOMEWHAT	NO	Individualised and specific – gives a clear picture of who the person is. (Here's a good test. Blank out the name and make copies for everyone on the team. Team members should be able to readily identify this person by the information provided)
YES	SOMEWHAT	NO	Clear indication of the person's involvement in the assessment – signature, personal comments, information written by the person, written in the person's own words
YES	SOMEWHAT	NO	Used in an on-going manner – updated regularly upon meeting with the person (weekly for the first few meetings, at least monthly after that)
YES	SOMEWHAT	NO	Includes natural resources (as opposed to only formal resources) in *each* area
YES	SOMEWHAT	NO	The individual's wants and desires are listed, prioritised and written in the person's own language (vs. unprofessional jargon)
YES	SOMEWHAT	NO	Reflects cultural, spiritual, ethnic and/or racial information that holds meaning for the person
YES	SOMEWHAT	NO	Reflects consumer's skills, talents, accomplishments and abilities – what they know about, care about, have a passion for each life domain

Taken from - The Strengths Model: Case Management with People with Psychiatric Disabilities Second Edition Charles A. Rapp & Richard J. Goscha

STRENGTHS MODEL OF CASE MANAGEMENT
Brainstorming (Group Supervision) monitoring tool

1. GROUP INTERACTION		
a) Did the session start on time?	YES	NO
b) Is the seating arrangement circular (everyone can see everyone else) and comfortable?	YES	NO
c) Was the discussion among all the participants or was it predominantly directed toward the facilitator?	YES	NO
d) Did the facilitator laugh during the session?	YES	NO
e) Did the case managers laugh during the session?	YES	NO
f) Was the brainstorming atmosphere optimistic and positive (i.e. focussed on what can be done rather than what cannot be done)?	YES	NO
g) What interruptions occurred during the session?		
h) Which client situations were reviewed?		
i) Which case manager dominated (if any)?		
j) Who is generating alternatives?		
k) Who made excuses to shot down a potential resource or idea?		
l) What conscientious efforts which failed were celebrated?		
m) Who left the brainstorming feeling energised?		
2. CLIENT WORK		
a) Was the brainstorming atmosphere optimistic and positive (i.e. focussed on what can be done rather than what cannot be done)?	YES	NO
b) Did each client situation discussion end with a specific plan for case management action or strategy?	YES	NO
c) Did each client situation discussion close with the case manager identifying the specific tasks to be done?	YES	NO
d) If any case manager was frustrated with a client or others, did the facilitator help him/her make more realistic expectations and/or break tasks into smaller steps?	YES	NO
Who used the strengths assessment to identify goals, tasks or strategies?		

For each client discussed what natural resources or helpers in the community were identified?
For each client situation discussed what strategies for involving natural helpers were generated?
If words like “problems” and “deficits” were used rather than “interests”, “strengths” and goals, how did the facilitator reframe them?
What patterns and similarities between client situations were identified to enhance learning?
e) What successes did group members celebrate?
f) Who received positive feedback for : Use of client strengths? Use of natural helpers? Specific client achievements and goal attainment? g) Did the group identify policies within the agency or within other agencies or programmes which indicate supervisory advocacy? h) Any other observations?

Taken from - The Strengths Model: Case Management with People with Psychiatric Disabilities Second Edition Charles A. Rapp & Richard J. Goscha

NOTES

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