

Strength-based Approaches for Mental Wellness in Seniors and Adults with Disabilities

FINAL REPORT

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A Strength-based Approach

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EXECUTIVE SUMMARY

The purpose of this project is to identify emerging and innovative strength-based approaches to mental wellness for older adults and adults with a disability.

This literature review is intended to provide practical information, lessons learned, and promising practices which have been drawn from recent strength-based reports and related articles.

Strength-based approaches generally conceptualize strengths in two distinct ways. First, assets, resources, and abilities that can be used to assist in helping an adult to continue to develop. Accordingly, strengths are used as building blocks for service planning and program development. Second, some strengths can be developed or enhanced. Consequently, changes in the availability of various assets, resources, and abilities for an individual can be viewed as a service delivery outcome.

A strength-based approach is a manner of working with individuals, families, and organizations grounded in the principle that individuals:

- have existing competencies;
- have resources;
- are capable of learning new skills and problem-solving;
- can use existing competencies to identify and address their own concerns; and
- can be involved in the process of healing and self-health.

All of the strength-based approaches included in this backgrounder have an emphasis on **CAPACITY** and **INTENTIONALITY**. Each approach also recognizes the following characteristics:

- Focuses on **Personal Relationships**
- Acknowledges **Contributions**
- Attends to the **Context**
- Invites Meaningful **Participation**
- Provides Opportunities for **Skill-building / Learning**
- Recognizes **Interrelationships**
- Concentrates on **Solutions / Potential**

Modified from:

Chapin, R., & Cox, E. O. (2001). Changing the paradigm: Strengths-based and empowerment-oriented social work with frail elders. *Gerontological Social Work Practice: Issues, Challenges, and Potential*, 36, 165-179.

Rapp, C.A., Pettus, C.A., & Goscha, R.J. (2006). Principles of strengths-based policy. *Journal of Policy Practice*, 5 (4), 3-18.

STRENGTH-BASED APPROACHES FOR MENTAL WELLNESS IN SENIORS AND ADULTS WITH DISABILITIES

1. INTRODUCTION

The aging of the Canadian population will accelerate over the next three decades, particularly as individuals from the Baby Boom years of 1946 to 1965 begin turning 65. The number of seniors is projected to increase from 4.2 to 9.8 million between 2005 and 2036, and their share of the population is expected to almost double, increasing from 13.2% to 24.5%. Population aging will continue between 2036 and 2056, but at a slower pace. Over this period, the number of seniors is projected to increase from 9.8 to 11.5 million and their share of the total population is projected to rise from 24.5% to 27.2% (McPherson & Wister, 2008). As the number of older adults increases, so does the prevalence of disability (Turcotte & Schellenberg, 2007).

Current prevalence rates suggest that of the 6.85 million seniors in 2021, up to 4% will have serious clinical depression and as many as 15% may experience depressive symptoms. In all age groups, men aged 80+ are likely to retain the highest incidence of completed suicide. Although the prevalence of psychosis in the general population is expected to remain at approximately 1%, it could be as high as 21% in older Canadians due to the occurrence of psychosis with dementias.

Disability and mental health disorders are major factors influencing the quality of life for all Albertans. Mental health concerns (especially depression) are often undiagnosed in older adults. Effective treatment and service delivery are essential to address mental health concerns. However, older adults and those with disabilities can experience a delay in treatment because they require access to age appropriate and accessible services. Transportation challenges, lack of appropriate services, and lack of knowledge of age appropriate services can contribute to a delay in treatment. At the same time, research has shown that many of the mental health challenges faced by older adults are preventable and treatable (Canadian Coalition for Seniors Mental Health, 2009).

The World Health Organization defines disability as an umbrella term, covering impairments, activity limitations, and participation restrictions. “An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives.” (WHO, <http://www.who.int/topics/disabilities/en/>; and <http://www.who.int/classifications/icf/appareas/en/index.html>)

Disability may be present at birth, acquired during childhood or adulthood, or associated with the aging process. The proportion of the population that has a disability increases significantly with age, with the largest group being those with age-associated disabilities. In recent years, there has

been a shift from the differentiation of people with disabilities by diagnostic grouping towards policies that encompasses all individuals with disabilities. A striking feature of individuals with disabilities is their vulnerability to discrimination on the basis of their diagnosis or age, which can significantly diminish the opportunities they are afforded and restrict their lifestyle.

The Alberta health care system is under stress. The sheer number of older adults will increase significantly as the Baby Boomers reach advanced age. The presence of a mental health concern magnifies the difficulty in having their needs addressed by current senior-specific and disability-specific service providers. A lack of coordination and collaboration across various sectors contributes to inefficiencies within the system with negative consequences for individuals with mental health concerns (Clinton, 2007; Conn et al, 2006) and/or disabilities.

To effectively meet the mental wellness needs of older adults and those with disabilities, a strength-based approach is recommended. This perspective suggests that there is a need to find out what has helped the older adult / individual with a disability get to where he or she is in life. A strength-based approach operates on the assumption that people have strengths and resources for their own empowerment. Traditional health intervention models concentrate on deficit based approaches, ignoring the strengths and experiences of the participants. In a strength-based approach the focus is on the individual not the problems or concerns. Drawing on strength-based approaches does not ignore problems. Instead they shift the frame of reference to define the issues. By focusing on what is working well, informed successful strategies support the promotion of mental wellness in older adults with mental illness or in adults with a disability.

2. PURPOSE OF REPORT

The purpose of this project is to identify emerging and innovative strength-based approaches to mental wellness for older adults and adults with a disability.

This literature review is intended to provide practical information, lessons learned, and promising practices which have been drawn from recent strength-based reports and related articles. The reported findings will be presented in the form of answers to the following questions:

- How have strength-based approaches been defined within the context of older adults with mental illness and for adults (18 years and older) who have a disability?
- What strength-based research has been and is being done in general and specific to older adults with mental illness and adults with a disability?
- What does the research say?
- What evidence based mental health and strength-based best practices are relevant to an examination of older adults with mental illness and adults with disabilities?
- What are the implications of this research and related literature findings for Alberta?

3. METHOD

A literature review was conducted of the following data bases: ERIC, Social Services Abstracts, SocIndex with Full text and PsycInfo using the following search terms: disability, seniors, aging, mental health, best practices, and strength-based approaches. A hand search of located articles was also conducted to increase the number of articles reviewed.

Data collection focused on:

- Definition of strength-based approach in general and strength-based approaches specific to mental wellness and to disabilities in particular;
- The roles and responsibilities of health care providers specific to strength-based approaches;
- The actual usage of strength-based approaches in mental wellness practice specific to older adults with mental illness and those with disabilities; and
- Evidence based practice guidelines in mental wellness that have a strength-based perspective.

Seventy five (75) articles/reports/research studies were identified and reviewed. The literature search was conducted from 1995 to 2011. See Appendix 8.2 for the SWOT tool, which was used to facilitate the data analysis.

4. FINDINGS IN RELATION TO RESEARCH QUESTIONS

4.1. How have strength-based approaches been defined within the context of older adults with a mental illness and for adults (18 years of age and older) who have a disability?

4.1.1 What is a strength-based approach?

A strength-based approach is a manner of working with individuals, families, and organizations grounded in the principle that individuals:

- have existing competencies;
- have resources;
- are capable of learning new skills and problem-solving;
- can use existing competencies to identify and address their own concerns; and
- can be involved in the process of healing and self-health.

All of the strength-based approaches included in this backgrounder have an emphasis on **CAPACITY** and **INTENTIONALITY**. Each approach that was included is also likely to:

- Focuses on Personal **Relationships**
- Acknowledges **Contributions**
- Attends to the **Context**
- Invites Meaningful **Participation**

- Provides Opportunities for **Skill-building / Learning**
- Recognizes **Interrelationships**
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A strength-based approach is more than a set of hard and fast rules. It is a perspective. It strives to lead with the positive and values trust, respect, intentionality, and optimism. It is based on the idea that people and environments interact and change each other in the process. Each has the ability to build the other's capacity.

It is an alternative to the historical deficit approach found in the fields of mental health and social services where deficits, problem behaviours, and pathologies are the focus. Within the last decade researchers and practitioners within the fields of education, mental health, psychology, social work, and child welfare have begun to question the deficit-based approach and move toward a more holistic model of development (Trout, Ryan, La Vigne & Epstein, 2003). Rather than focusing on individual weaknesses or deficits, strength-based practitioners collaborate with adults to discover individual functioning and strengths. At the foundation of the strength-based approach is the belief that adults have unique talents, skills, and life events, in addition to specific unmet needs (Olson, Whitebeck & Robinson, 1991 as cited in Epstein, 1999).

Within the body of literature reviewed, it is evident that the term "strength-based approach" may include the following: a) a perspective used to work with individuals and families; b) formalized assessment tools; c) specific interventions targeted to particular populations; and, d) formalized models. As the terms "approach" and "model" are not defined, it sometimes is not clear what constitutes an "approach" or a "model". In order to distinguish between approaches and models, **we considered strength-based approaches that focused on individuals to be interventions and those that can be applied to communities as models.**

a) Strength-based perspectives

Health care and human service professionals may utilize a strength-based perspective in their work with individuals. While they do not explicitly follow a particular model, they view and define individuals "by their values, strengths, hopes, aspirations, and capacities, regardless of the stressful or burdensome nature of the situation around them" (Peacock et al., 2010, pp 642-643). This perspective guides their work as they seek to balance problems with the strengths of individuals and their environments (Chapin & Cox, 2001; Perkins & Tice, 1995; Rashid, 2009) and form plans of care to fit individuals and families (Kivnick & Stoffel, 2005; Powell et al., 1997). Professionals may engage individuals in "strength-chats" to identify the individuals'

strengths, goals and treatment plans. Thus, a strength-based perspective is embedded throughout the professionals' assessments, interventions, and evaluations of clients' progress.

A strength-based perspective is collaborative and reduces the power differential between professionals and individuals/families (Anuradha, 2004; Greene, 2000; Rashid & Ostermann, 2009). A strength-based perspective includes guiding concepts such as empowerment and social justice (Anuradha, 2004; Chapin & Cox, 2004). While practitioners utilizing a strength-based perspective may refer to the influence of solution focused therapy, positive psychology or health and human care professionals' emphasis upon individual strengths, their descriptions suggest that they are influenced by such approaches, rather than by actually utilizing the models.

b) Strength-based assessment tools

In contrast to the ubiquitous deficit based assessment tools, strength-based assessment tools provide practitioners with positive methods to assess strengths and competencies, and thereby develop a strength-based intervention plan. "Over time we have learned that asking the right question often has more impact on the client than having the correct answer" (Miller, 1994, as cited in Clark, 1997, p.98). Practitioners working from a strength-based approach emphasize the importance of asking the client the "right questions".

The majority of validated assessments for adults have relied on a deficit oriented model. For example, validated assessment tools, such as the Revised Behaviour Problem Checklist (Quay & Peterson, 1987), and the Child and Adolescent Functional Assessment Scale (Hodges & Wong, 1989) document pathologies, deficits, and problems. While these tools have proven useful for understanding what is wrong with individuals, they provide little insight to the strengths that clients may have in overcoming some of their problem behaviours.

Formal assessment tools used by researchers in attempt to standardize strength-based measures include but are not limited to the Strength and Difficulties Questionnaire (Goodman, 1997), the Child and Adolescent Strengths Assessment Scale (Lyons et al., 1997), the Profiles of Student Life: Attitudes and Behaviours (Benson et al., 1998), the Scales for Predicting Successful Inclusion (Gilliam & McConnell, 1997), and the Behavioural and Emotional Rating Scale (BERS) (Epstein & Sharma, 1998). Two strength-based assessment tools were identified in our literature search: The Behaviour and Emotional Rating Scale (Epstein & Sharma, 1998) and the Care-Receiver Efficacy Scale (Cox, Green, Seo, Inaba, & Quillen, 2006).

The Behavioural and Emotional Rating Scale (BERS) (Epstein & Sharma, 1998) is perhaps the most well researched and widely documented strength-based assessment tool. The BERS was developed to provide professionals with a reliable, valid, standardized assessment tool to measure strengths of youth and gradations of improvements over time. In 2001-2002, the BERS was reformed on a large, nationally representative sample of parents/caregivers and adults and adolescents. The original items were rewritten to develop the BERS-2: Parent Rating Scale (Epstein, 2004), BERS-2: Youth Rating Scale (Epstein, 2004), and the BERS-2:

Teacher Rating Scale (Epstein et al., 2004). The measures were adjusted to reflect separate parent, youth, and teacher perspectives and designed to be used with youth from ages 11-18.

The BERS-2 scales were modeled after the original BERS scales which included 52-items divided into 5 subscales. An overall Strength Index provides a summary strength score of the five subscales. The five subscales include: Interpersonal Strength (identifies the child's ability to interact with others in social situations), Family Involvement (assesses adults' relationships with their family), Intrapersonal Strength (identifies adults' perceptions of their competence and accomplishments), School Functioning (addresses child's competence/performance in the classroom), and Affective Strength (assesses child's ability to give and receive affection from others) (Buckley, Ryser, Reid & Epstein, 2006). The BERS-2 is a psychometrically sound instrument with adequate content validity, convergent validity, criterion validity, discrimination validity, inter-rater reliability, and test-retest reliability. The BERS-2 was designed to be completed by families within 10 minutes, rating the adult on items from 0 (Not at all like the adult) to 3 (Very much like the adult).

According to Epstein et al. (2004), the BERS-2 can be used as a way to document children's emotional and behavioural strengths, identify children with limited emotional and behavioural strengths, set goals for individual education programs, and document progress in strength areas following intervention. The multi-faceted, reliable, and valid nature of the BERS-2 makes it a valuable tool when working with youth and families. Its use with adults remains largely unexplored.

Another strength-based tool is the Care-Receiver Efficacy Scale (CRES) (Cox et al., 2006). The CRES assesses self efficacy in older adults who are care-receivers. This scale was developed in order to fill the need for assessment of self efficacy of older adults, and also to assist in the measurement of empowerment and strength-oriented approaches that are designed to increase self efficacy in older adults receiving care. The CRES was tested on older adults (177) 55 years of age and older who required at least 6 hours of care per week and were cognitively able to participate (mean of age participants was 78.4 years). The scale has 5 subscales: 1) Self-care performances; 2) Relational coping with caregivers; 3) Perceptions of dependence; 4) Performance-related quality of life; and 5) Accepting help. The authors determined that the CRES "generally showed adequate internal consistency reliability" (p. 645).

c) Strength-based interventions

Strength-based interventions are designed to enhance the strengths of particular populations. Such interventions are tailored to the specific needs of the populations, such as cognitive impairment in older adults with dementia, or behavioural issues in children with disabilities. The following interventions were identified within our literature search.

1. **Person-centered later life planning program:** Heller, Factor, Sterns and Sutton (1996) evaluated the impact of the "Person-centered planning for later life: A curriculum for adults with mental retardation", on older adults with mental retardation. This training

program involves 15 – 2 hour long sessions and includes information on leisure, work and volunteer opportunities, as well as on how to make choices and plans for the future. The sample size for this study included 70 adults: 42 in the intervention group and 38 in the control group. The sample included adults 35 years of age and older with Down's Syndrome and adults with mental retardation (not Down's Syndrome) that were 50 years of age and older. Interviews were conducted before the training, 6 months after the pre-tests and also observations were made. The intervention group demonstrated significant increase in knowledge of leisure, retirement and work and volunteer opportunities, but did not show significant improvement regarding making choices and actions plans or living arrangements. The intervention group demonstrated a decrease in life satisfaction, and the researchers attribute this to lower satisfaction with living in residential dwellings. The observational component of this study revealed greater participation of family members in planning meetings for clients, greater encouragement by staff for individual clients to participate, and greater involvement of clients' wishes in planning.

2. **Acquiring New Skills While Enhancing Remaining Strengths: (ANSWERS)** for dyads coping with mild to moderate dementia. This program involves 6 – 90 minute curriculum guided sessions (education about dementia and memory loss, communication, recognizing emotions and behaviours, etc) (Judge, Yarry & Orsulic-Jeras, 2010). The goal of this program is to provide a set of skills to help caregivers and care-receivers cope with mild to moderate dementia. Judge et al. (2010) evaluated the effectiveness of this program with 52 dyads (75% of caregivers were women). Caregivers and care-receivers were asked to complete a Likert like evaluation. Overall, both care-receivers and caregivers rated the program as very helpful and indicated that they would highly recommend the program.
3. **Functional-age model of intergenerational treatment:** This is a strength-based assessment and intervention that focuses on the older adult's functional capacities and looks at how older adults can meet the demands of the environment. This approach can be used to assess the older adult's environment and to assess the interdependence between family members (Greene, 2000). In assessing functional age, the professional examines three aspects of capacity: biological, psychological, and sociocultural.
4. **Vital involvement practice (VIP):** is a strength-based intervention for working with older, frail adults (Kivnick & Stoffel, 2005). The intervention involves tailoring individual care plans to: a) systematic identification of individual strengths and assets, including the environment; b) consideration of strengths in relation to individual and environmental challenges.

Within the context of the Vital Involvement Practice intervention, strengths refers to both physical and psychosocial strengths that underlie each individual's engagement with his/her environment. It encourages older adults to exercise their existing abilities, to act on their personal values and commitments, and to engage the environment in terms of the interdependent give and take that characterizes adulthood, rather than the unilateral

dependence which characterizes fragile old age. This approach seeks to maximize the engagement of older adults with their social environment, contributing to meaningful roles in and to society, and also slowing down the individual deterioration that contributes to institutionalization, and terminal decline.

5. **Improving mood-promoting access to collaborative treatment:** IMPACT is a program for older adults who have a major depression or dysthmic disorder (Centers for Disease Control and National Association of Chronic Disease Directors, 2009).
6. **Program to encourage active rewarding lives for seniors:** PEARLS is a brief, time limited, and participant driven program, which teaches depression management to older adults with depression. It is home based (Centers for Disease Control and National Association of Chronic Disease Directors, 2009).
7. **Identifying depression, empowering activities for seniors:** IDEAS is a community depression program that is focused at the detection of depressive symptoms in older adults in order to reduce their intensity (Centers for Disease Control and National Association of Chronic Disease Directors, 2009).

d) Strength-Based Assessment in Practice

While there are a wide variety of ways to implement a strength-based approach to working with adults and families, many programs that follow a strength-based approach often emphasize wraparound services, multi-level approaches, and comprehensive mental health models.

Given that the BERS offers a reliable and valid way to assess programs using strength-based approaches, it is imperative that future studies strive to define specific features that qualify a program operating from a “strength-based” approach. Further, it is necessary that researchers employ randomized controlled designs to be able to determine whether strength-based approaches prove to be superior to traditional deficit based approaches in serving older adults and adults with disabilities.

While many programs serving families across a wide array of settings use a strength-based approach, the lack of one consistent intervention strategy limits researchers’ ability to accurately assess the effectiveness of this model. For example, it is common for programs employing a strength-based approach to engage in additional practices that may positively influence family outcomes. While evaluating the effectiveness of the strength-based approach in general seems an impractical task, evaluating the application of specific techniques and strategies that indicate a strength-based approach may offer researchers insight into the process of a strength-based approach in relation to the promotion of optimal outcomes for youth, adults, older adults, and families.

4.1.2 Strength-based Models

There are a number of strength-based models identified in the literature. We will address the following ones: i) Appreciative Inquiry; ii) Capacity-building / Asset-based community development; iii) Quality of Life; iv) Resiliency; and v) Solution-focused. A number of these models are not specific to older adults with mental illness challenges or adults with disabilities, but can be applied to these populations.

The strength-based approaches included in this backgrounder have an emphasis on **CAPACITY** and **INTENTIONALITY**. Each approach also recognizes the following characteristics:

- Focuses on **Personal Relationships**
- Acknowledges **Contribution**
- Attends to the **Context**
- Invites Meaningful **Participation**
- Provides Opportunities for **Skill-building / Learning**
- Recognizes **Interrelationships**
- Concentrates on **Solutions / Potential**

i) APPRECIATIVE INQUIRY

Appreciative Inquiry (AI) is strongly influenced by theories of discourse and narrative especially as applied to organizational change (Havens, Wood & Leeman, 2006; Knibbs et al., 2010; Marshak & Grant, 2008; Moyle et al. 2010; Oswick, Grant, Michaelson & Wailes, 2005). It was originally designed to bring about organizational change; it has now been applied to effect individual health changes (Moore & Charvat, 2007).

The purpose of AI is to focus on the positive aspects of people, organizations, and systems including the potential for meaningful and valuable change. AI is often used for promoting organizational or systems change through group processes involving discussion. Those involved in a system determine what works best within that system and how the system could be improved. The AI process includes a cycle of four inquiry stages: (1) “discover” what works; (2) “dream” or imagine the ideal system and the potential of the system in the future; (3) “design” a plan to achieve that ideal system, and; (4) “deliver” by putting into action the designed process. AI provides the opportunity, through collaborative group discussion, to explore prior success of individuals, organizations or systems, and envisions future potential and action. The belief that change is likely, positive, and possible is important for the success of this process.

Theory base

Appreciative Inquiry developed from the premise that systems are in a constant state of change and that in order to have positive change within a system, members of the system must think

positively about the future. The idea that discussing and reflecting on previous positive experiences and successes, particularly within a group setting, contributes to a belief in positive future change. AI also stemmed from the premise that individuals and systems can become “self fulfilling prophecies”; if individuals believe themselves and their future to be successful and promising their beliefs will become reality.

Key principles

- Affirmative questions can generate positive beliefs about self, others, change, and the future
- Change is positive
- Belief that the future is positive can make it so as people will act in ways to make their beliefs about the future reality
- Language and beliefs construct reality
- Sharing positive stories about a system can lead to positive change

Why it's a strength-based approach

- Attends to the Context / Systems
- Emphasizes Capacity and Intentionality
- Invites Meaningful Participation
- Recognizes Interrelationships
- Concentrates on Solutions / Potential

Reading suggestions

Whitney, D., Trosten-Bloom, A., & David Cooperrider, D. (2010). *The power of Appreciative Inquiry: A practical guide to positive change*. San Francisco: Berrett-Koehler.

Moore, S.M., & Charvat, J. (2007). Promoting health behavior change using appreciative inquiry: Moving from deficits models to affirmation models of care. *Family and Community Health, 30* (1S), S64-S74.

Internet resources

Appreciative Inquiry Commons: <http://appreciativeinquiry.case.edu/>

ii) CAPACITY BUILDING / ASSET-BASED COMMUNITY DEVELOPMENT

Capacity Building is about harnessing the talents and skills of every member of a community, supporting continued skill development, and fostering relationships based on mutual benefit. The concept of Capacity Building has been applied in the framework of community development. It is based on the work of the Asset-Based Community Development Institute, co-directed by Kretzmann, McKnight, and others.

Theory base

Capacity Building is any process that increases the capability of individuals to produce or perform. It involves giving individuals knowledge, providing opportunities for them to make decisions, and empowering them to act. Capacity building enables all stakeholders to carry out their tasks to the best of their ability.

Underlying principles

Asset-based community development:

- Starts where the community is at
- Appreciates inquiry and input from all members of the community and proposes that mapping individual resources will identify assets that may not have been known to the community
- Identifies and includes the “giftedness” of individuals who are often marginalized in the community
- Recognizes that social capital and networking are important assets within a community
- Allows members of the community to take a participatory approach and ownership of their own development
- Focuses on how to engage people as citizens, rather than clients, and how to make local governance more effective and responsive
- Encourages collaboration with local organizations
- Gives priority to “local definition, investment, creativity, hope and control” (Kretzmann & McKnight, 1993, p. 9)

Why it’s a strength-based approach

- Emphasizes Capacity and Intentionality
- Invites Meaningful Participation
- Recognizes Interrelationships
- Provides Opportunities for Skill-Building / Learning
- Concentrates on Solutions / Potential

Reading suggestions

Chaskin, R.J., Brown, P., Venkatesh, S., & Vidal, A. (2001). *Building community capacity*. New York: Aldine DeGruyter.

Mathie, A., & Cunningham, G. (2003). From clients to citizens: Asset-based community development as a strategy for community-Driven development. *Development in Practice*, 13, 474-486.

Internet resources

Asset-Based Community Development Institute. (2007).

<http://www.abcdinstitute.org/>

iii) QUALITY OF LIFE (QOL)

QOL is a multi-faceted concept, encompassing macro societal and socio-demographic influences and also micro concerns, such as individuals' experiences, social circumstances, health, values, and perceptions. As it is subjective, it needs grounding in people's own values and perceptions. One definition of QOL is offered by the Centre for Health Promotion of the University of Toronto as "the degree to which a person enjoys the important possibilities of his or her life" (<http://www.utoronto.ca/qol/concepts.htm>).

Theory base

QOL has five key elements: (1) a catalyst, (2) antecedents, (3) mechanisms, (4) response, and (5) perceived QOL. The catalyst describes a change in the respondent's health status. The antecedents refer to stable or dispositional characteristics of the individual. Examples of such antecedents include sociodemographics (e.g. gender, education) and personality (e.g. optimism, self-esteem, sense of control, mastery, expectations). Mechanisms describes the behavioural, cognitive, and affective processes to accommodate the catalyst. Examples of such mechanisms include using coping strategies, initiating social comparisons, seeking social support, reframing expectations and engaging in spiritual practice. The working of one's self-evaluation of QOL comes as a result of change in internal standards, values and the conceptualization of QOL. Perceived QOL may be defined as a multidimensional construct incorporating at least three domains: physical, psychological, and social functioning.

Underlying principles

- An interrelationship of objective and subjective elements
- Includes positive and negative features
- A change in one element will influence the others
- Includes a self-evaluation component

Reading suggestions

Brown, I., & Brown, R. (2003). Quality of life: A model for practice. In Brown, I., & Brown, R. (2003). (pp. 98-121). *Quality of life and disability – An approach for community practitioners*. London, UK: Jessica Kingsley.

Netuveli, G., & Blane, D. (2008). Quality of life in older ages. *British Medical Bulletin*, 85, 113-126.

Internet resource

The quality of life model / University of Toronto <http://www.utoronto.ca/qol/concepts.htm>

iv) RESILIENCY

Resiliency is the ability of people to successfully adapt and develop positive well-being in the face of chronic stress and adversity. This ability is highly influenced by protective and supportive elements in the wider social environment.

Theory base

There is no consensus on what pre-conditions are required to support the development of resiliency; however, researchers and theorists agree that some form of protective factors are required to permit an individual to develop in the presence of chronic / severe stress. Resiliency can develop out of experiences that promote self-determination and increase participation.

Resiliency was initially used in reference to adults in the 1970's by researchers. They questioned why some adults who lived in negative conditions were able to thrive and sustain positive outcomes. Researchers described these adults as "invincible". This term was changed to "resilient" when the influence of context was identified. Resiliency is a process rather than a static outcome as an individual's resilience can change and develop depending on context and life experiences. Resilience examples may also be called "buffers".

Underlying principles

- Buffers are more powerful than risks
- The more risks an adult faces, the more buffers are needed
- Is linked to life stress and an adult's unique coping capacity
- Connections/ relationships can promote resiliency
- In identifying an adult's strengths and needs, the contribution and interplay of risk factors and buffers is often undetermined

Why it's a strength-based approach

- Emphasizes Capacity and Intentionality
- Attends to the Context
- Recognizes Interrelationships
- Concentrates on Solutions / Potential

Reading suggestions

Smith, E. J. (2006). The strength-based counselling model. *The Counselling Psychologist*, 6, 34-79.

Internet resources

International Resilience Project: www.resilienceproject.org

Mental Health Foundation of Australia

http://www.embracethefuture.org.au/resiliency/index.htm?http://www.embracethefuture.org.au/resiliency/resiliency_model.htm

v) SOLUTION FOCUSED THERAPY

The defining feature of Solution Focused Therapy (SFT) is its intentional emphasis on constructing solutions rather than resolving problems. The person (child, youth, or adult) is assisted to imagine a preferred future about how things will be different and how to make this happen. The SFT therapist assumes that the person wants to change, has the capacity to do so and, in fact, already has experience with performing elements of the desired change. Working collaboratively, the therapist and person identify those elements of the desired change which are already happening, focus on the person's story, strengths, resources, progress, changes and exceptions to the problem in order to achieve their preferred future (adapted from Gingerich & Eisengart, 2000).

Theory base

Steve de Shazer and Insoo Kim Berg (Shazer & Berg, 1986) developed the specific steps of SFT in the mid 1980's. Earlier therapeutic approaches were built upon structural philosophy, the thinking of the traditional scientific method and cybernetics using such questions as "What causes the problem?" And "What maintains the problem?" In comparison, SFT asks the question "How do we construct solutions?"

Underlying principles

- Emphasizes mental health, strengths, resources, and abilities rather than deficits and disabilities
- Works with the frame of reference of the individual(s), not that of the counsellor or the treatment model
- Emphasizes an a-theoretical and non-normative perspective where the individual(s) view of the situation is accepted at face value
- Views change as inevitable
- Provides a present and future orientation where the primary focus is to help the person(s) in the present and future
- Provides a pragmatic orientation focusing on doing more of what works
- Views small changes as generative
- Views meaning and experience as being interactionally constructed
- Understands that the meaning of the message is in the response one receives (adapted from Walter & Peller, 1992)

Why it's a strength-based approach

- Emphasizes Capacity and Intentionality

- Attends to Context / System
- Invites Meaningful Participation
- Recognizes Interrelationships
- Concentrates on Solutions / Potential

Reading suggestions

De Shazer, S., & Berg, I.K. (1986). Brief therapy: Focused solution development. *Family Process*, 25, 207-221.

Kim, J. S. (2008). Examining the effectiveness of solution-focused brief therapy. A Meta-analysis. *Research on Social Work Practice*, 18, 107-116.

Internet resources

Institute for Solution Focused Therapy <http://www.solutionfocused.net/home.html>

4.2 What strength-based research has been and is being done in general and specific to older adults with mental illness and adults with a disability?

While the body of literature examining strength-based approaches is growing, there is still need for much more research. At the present time, some of the reports are case study based, or offer hypothetical case studies, particularly in the area of family therapy work (Shapiro, 2002; Skerrett, 2010) (and this often does not focus on older adults with mental illness or adults with disabilities). There is some research that examines psychological traits that promote strengths and mental well being in older adults (Farone, Fitzpatrick & Bushfield, 2008; Graham & Fallon, 2006) or strategies such as internet training to maintain sense of well-being and empowerment (Shapira, Barak & Gal, 2007). Other research focuses on evaluation of specific interventions, such as computer training to improve health knowledge in older adults (Campbell & Nolfi, 2005), educational sessions that present health knowledge to well older adults (e.g. Dapp, Anders, von Renteln-Kruse, & Meier Baumgartner, 2005), housebound older adults with arthritis (Laforest et al., 2008) or older adults with mental retardation (Heller et al., 1996). There is also research that examines specific techniques to aid choice in adults with severe disabilities (Parsons, Harper, Jensen & Reid, 1997a; Parsons, Harper, Jensen & Reid, 1997b) or to enhance functioning in dementia caregiver-care-receiver dyads (Judge, Yarry & Orsulic-Jeras, 2010).

Overall, there is a dearth of research that examines strength-based approaches with older adults with mental illness or adults with disabilities.

4.3 What does the research say?

While the research indicates that strength-based approaches are effective (Powell et al., 1997), methodologically, there is little ability to compare studies, as research examining strength-based approaches occurs with diverse populations (e.g. families, well older adults, adults with autism or behavioural disorders) and is conducted in various manners (e.g. evaluations of interventions

specific to particular populations; qualitative studies with very small samples; randomized control trials). Research on strength-based approaches with specific populations often is predicated on participants having intact cognitive and communication skills.

Also, the research regarding strength-based approaches with older adults experiencing mental illness is limited. Research tends to focus on well older adults, or those who are housebound with physical illness. There is an intervention program for caregiver-care-receiver dementia dyads described in the form of case studies (one article) and one study (evaluation using Likert like scale) to evaluate effectiveness of program (rated highly by dyads) by the same authors (Judge et al., 2010; Yarry, Judge, & Orsulic-Jeras, 2010).

Similarly, the research examining strength-based approaches with individuals with disabilities is limited. In addition to the study examining later life planning in adults with mental retardation (cited above) (Heller et al., 1996), we located one study that examined the relationship between quality of life, employment, adjustment to disability and functional status among 114 adults (18 years of age and older) with disabilities (Frain, Bishop & Tschopp, 2009). The researchers utilized standardized tools to assess self efficacy, self advocacy, self perceived stigma and competence. The researchers found that empowerment improves adjustment to disability and employment outcomes for those with disabilities, and that the concepts of self efficacy and self management are most important in leading to positive rehabilitation outcomes. They concluded that the study results point to the importance of rehab counsellors' interventions that focus on education to increase clients' control and assertiveness (to help with interactions with medical providers).

4.4 What evidence based mental health and strength-based best practices are relevant to an examination of older adults with mental illness and adults with disabilities?

An emerging evidence base supports the efficacy of mental wellness interventions for older adults and adults with a disability. There are three primary sources of evidence for clinical practice: evidence-based reviews, meta-analyses, and expert consensus statements. The most extensive research support was found for the effectiveness of pharmacological and psychosocial interventions for major depression in older adults and for dementia. Less is known about the effectiveness of treatments for the other disorders, although emerging evidence is promising for selected interventions. Empirical support was also found for the effectiveness of community-based, interprofessional, geriatric mental health treatment teams.

However, barriers to implementing evidence based practices in the mental wellness service delivery system for older adults and those adults with a disability do exist. Successful approaches to implementing change in the provision of services emphasize moving beyond traditional models of education to include educational techniques that actively involve the learner, as well as systems change interventions such as integrated care management, implementation toolkits, automated reminders, and decision support technologies.

A strong argument can be made for the exploration and implementation of evidence based practices. The anticipated growth in the population of older adults and adults with a disability underscores the need for a strategy to facilitate the systematic and effective implementation of evidence-based practices in mental wellness care.

4.5 What are the implications of this research and related literature findings for Alberta?

There are a number of implications from the research and literature findings that are relevant for Alberta. These implications include the grassroots of practice with older individuals with mental illness and adults with disabilities and extend into the government/policy level. Clearly, there needs to be infrastructure on multiple levels to support the movement toward strength-based approaches.

Practice: To move toward a strength-based approach to working with older adults with mental illness or adults with disabilities, there needs to be education for professionals in community, hospital and long-term settings. With high staff turnover in both populations, education needs to be ongoing in order to sustain the shift in approach over the upcoming years. Education is particularly important, as professionals may presume to be working from a strength-based orientation, and may in fact not be doing so (Hwang & Cowger, 1998). For instance, in examining the approaches of social workers (strength-based versus deficit based), Hwang and Cowger (1998) concluded that those working in the areas of mental health or psychodynamic counselling were less likely to employ strength-based approaches than in other settings. Funding for education is necessary in order to educate staff and concurrently, keep programs running.

Funding: Funding sources need to support strength-based programs (Russo, 1999) within the context of their funding priorities and both short and long term goals. Currently, funding tends to support deficit oriented programs. When clients improve, funding is sometimes reallocated. This approach to assessing worthy proposals needs to be changed so that funding proposals can be written from a strength-based perspective and still elicit attention.

Policy: Policy makers need education on how to write policies that encourage a strength-based orientation. Rapp, Pettus, and Goscha (2006) posit that the ideal strength-based policy would include each of the 6 strength-based principles.

- 1) Strength-based social policy should line up with specific population experience and agenda.
- 2) Strength-based social policy privileges goals. This means that problems are subsumed under goals. They are viewed as barriers to the desired goals.
- 3) Strength-based social policy endorses equal membership (recipients of policy benefits remain regular participants in mainstream society rather than sequestered off) and a strengths-oriented look at the environment. The community is seen as full of resources and helpful individuals and institutions.
- 4) Strength-based social policy is voluntary for recipients. Those who receive benefits can choose to opt for or out of benefits; there is no coercion.

- 5) Strength-based social policy endorses choice. Not only should the client be able to decide whether or not to opt into the policy, but there should be meaningful choices once the client decides to make use of the policy.
- 6) Strength-based social policy ensures a client well-being incentive structure. That is, program providers should be rewarded for producing good client outcomes, rather than being rewarded for doing the minimum for clients (see Appendix 8.3).

Additionally, current policies need to be examined for their impact upon older adults with mental illness (MacCourt & Tuokko, 2005) and adults with disabilities. Are these policies either neutral or positive in their impact upon older adults experiencing mental illness or adults with disabilities?

Research: There needs to be much more research to examine the following questions: a) What are effective strategies to support activities for older adults with mental illness and adults with disabilities living in the community?, and b) How would volunteerism assist older adults with mental illness and adults with disabilities to gain a sense of meaning and purpose (thereby enhancing well-being)?

5. DISCUSSION OF FINDINGS

A discussion of the findings has been presented as the answers to the questions that underlie the purpose of this background document have been answered. However, there are a few noteworthy comments that may be useful

One underlying theme in the literature, while often subtle and not voiced, is the need to establish or change practices to support strength-based models. Often lack of funding, inequities in emphasis between acute and long term care, and lack of expertise in strength-based assessment and related interventions underlie a lack of health and human service implementation of such models.

It is assumed that while services and programs should provide evidence of quality and effectiveness, there is no one best strength-based model that is appropriate for all older adults with mental illness or adults with a disability. Local and provincial resources, demographics, geographic location (urban / rural) differ across the province.

There is a classic phrase, attributed to Confucius: "Give a man a fish, feed him for a day; teach him how to fish, feed him for a lifetime". This is commendable, but any strength-based approach has inherent challenges. Any such approach does not help to teach seniors and adults with a disability how to fish when they are denied equal access to the resource base. Consequently, advocacy efforts focused on a more enabling environment, become a necessary extension of development practice. In addition, what if those of us who claim to do the teaching or the implementation of a strength-based approach do not know how to fish? This is not at all far-fetched.

There is one limitation that needs to be identified. The evidence that underlies this background document is drawn from both the research and theoretical literature, and is often based with the context of children, adolescents, and family members. There is little evidence that speaks to the use of strength-based models for the subpopulations of interest. Oermann and Floyd (2002) point out that it is only when 5 to 10 evaluation studies of an intervention, such as a strength-based approach has been done, that it is possible to begin to synthesize results from across studies.

6. RECOMMENDATIONS

6.1 Recommendation:

Develop and adopt, in partnership with government and health and human service agencies, a standard framework for describing and developing strength-based services / programs. This would include:

- Standardized elements that constitute a “strength-based” approach; and
- The development of standardized quality improvement criteria, including access and discharge criteria, staffing benchmarks, and outcomes.

Rationale: A standardized approach would help to compare types and amounts of strength-based services and client outcomes across the province.

6.2 Recommendation:

Encourage and support research on strength-based approaches in assessment, intervention, programs and service delivery to promote mental wellness for older adults and adults with disabilities.

Rationale: Although there has been considerable research on the role of strengths, resilience, and coping, most of this research has focused on intra-individual strengths. Although this research is relevant to the development of strength-based approaches, the growth of strength-based approaches specific to the treatment of older adults and adults with a disability can be facilitated by the development of comprehensive strength-based assessment tools. In addition, there has been only limited research on the relationship between strength-based approaches and clinical outcomes. Further research on strength-based approaches could inform our understanding of who has what strengths, how the presence of strengths is related to mental wellness and functioning, and which strengths can be developed in the course of services delivery.

6.3 Recommendation:

Consider a re-examination of the funding system so that strength-based proposals are given due consideration.

Rationale: Strength-based funding is consistent with health promotion practices.

6.4 Recommendation:

The selection of any strength-based model(s) should be based upon the characteristics (p. 5) that the health care delivery organization believes are consistent with its own mission and mandate.

Rationale: Such a strategy would promote consistent of service delivery.

7. CONCLUSION

Preliminary data indicate that there are improved outcomes for older adults and adults with disabilities who have completed strength-based programming. Early research suggests that community-based approaches can be effective and economical.

Appendices

Appendix 8.1: References

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Appendix 8.2: SWOT Analysis Template

Criteria Advantages? Capabilities?	STRENGTHS	WEAKNESSES	Criteria Disadvantages? Gaps in capabilities?
Criteria Scope?	OPPORTUNITIES	THREATS	Criteria Costs?

Appendix 8.3: Rapp, C.A., Pettus, C.A., & Goscha, R.J. (2006). Principles of strengths-based policy. *Journal of Policy Practice*, 5 (4), 3-18.

Abstract

“While there has been considerable attention devoted to developing strengths-based approaches to individual, family, and community organizing practices, much less attention has been paid to social policy. This article proposes six principles of strengths-based policy. It argues that a strengths-based approach to policy is a more perfect reflection that social work values may lead to more effective social policies.”

Keywords: Social policy; strengths; social integration; client choice; incentives

Appendix 8.4: PPT

(separate file)