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ORIGINAL ARTICLE

Impact of strengths model training and supervision on the therapeutic practice of Australian mental health clinicians

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ABSTRACT: *This study explored the impact of Strengths Model training, supervision and mentorship on the practice of a group of multi-disciplinary mental health clinicians that included mental health nurses, social workers, psychologists, and occupational therapists. A qualitative approach that combined critical realism and grounded theory was used. The findings demonstrated how a substantive category, Getting to Know Clients Better, facilitated participants' progression through a basic social psychological process, Becoming a Strengths-Informed Practitioner. This process consisted of a discernible and sustained change towards more person-centred, hopeful, and recovery-oriented practice. The findings also described an underlying generative mechanism for this, the Client Becomes Visible, which accorded with theoretical models of empathy, based on enhanced cognitive processing. The strength-based approach to practice facilitated the establishment of a collaborative relationship and a stronger therapeutic alliance between the client and clinician. The research demonstrated that Strengths Model is an effective vehicle for improving recovery-orientated mental health services.*

KEY WORDS: *empowerment, interventions, mental health, Personal recovery, strengths, therapeutic relationships.*

BACKGROUND

The Strengths Model offers a framework for recovery-oriented mental health treatment, based on a refutation of historical, deficit-focused mental health practices (Rapp & Goscha 2006). The model's therapeutic power is based on an overt bias towards the acknowledgement of people's strengths (Rapp & Sullivan 2014). This bias is viewed as a necessary counterweight to traditional deficit-oriented assessment and interventions, which, in combination with the historic social marginalization and depravation of people with mental illness, induce helplessness and therapeutic nihilism for mental health workers and clients alike (Rapp & Goscha 2012) According to Rapp and Goscha (2012), this happens because, in a psychological sense, traditional approaches have rendered the positive possibilities for recovery invisible. Success in strengths practice is defined primarily as harnessing client's goals and dreams to create a basis for achievement (Rapp & Sullivan 2014). The model has six core principles (Rapp & Goscha 2006) underpinning it:

- People with psychiatric disabilities can recover, reclaim, and transform their lives.

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- The focus is on an individual's strengths rather than deficits.
- The community is viewed as an oasis of resources.
- The client is the director of the helping process.
- The therapeutic relationship is primary and essential.
- The focus of our work is in the community.

Strengths Model practice supports clients towards their personal recovery by assisting them to achieve goals that are meaningful to them and build on their strengths and resources (Rapp & Goscha 2012). There are three key elements that are utilized by health professionals to achieve this (Rapp & Goscha 2012). The Strengths Assessment provides insights into an individual's strengths and resources, the Goal Plan structures the individual's goals with a set timeframe, and regular supervision sessions provide a forum for health professionals for discussion and review their practice within the therapeutic relationship (Chopra *et al*. 2009). The Strengths Assessment and Goal plan are collaborative interventions between the health professional and the client. Supervision is provided by a senior clinician in support of therapeutic relationship development (Rapp & Goscha 2006).

The use of Strengths Model in practice has shown positive outcomes for mental health services. Barry et al. (2003) compared outcomes for 81 clients who received Strengths Model follow-up against those of 93 clients who received assertive community treatment from a multi-disciplinary team consisting of medical, nursing, and social work staff. They concluded that 'strengths demonstrated a significantly greater advantage with symptomatology reduced by half' (Barry et al. 2003, p. 269). Fukui *et al*. (2012) examined the relationship between case managers' fidelity to the Strengths Model process and consumer outcomes for 14 mental health teams, within ten agencies, over an 18-month period. They found a statistically significant, positive relationship between fidelity scores, psychiatric hospitalization, competitive employment, and post-secondary education (Fukui *et al*. 2012).

Australia's mental health services have faced sustained criticism, suggesting that they have failed to deliver reasonable services to people experiencing mental illness (Commonwealth Government of Australia 2013; NSW Mental Health Commission 2014; Phipps *et al*. 2019). This has led to a two-decade-long policy emphasis on recovery-oriented service reform (Beckett *et al*. 2017; Morgan *et al*. 2021; NSW Mental Health Commission 2014). In 2015, an Australian public mental health service covering an outer suburban catchment area of Sydney adopted the Strengths Model to align service delivery to a recovery-oriented paradigm. The 2-day training covered the principles of Strengths Model practice. It included practical training on how to conduct an assessment of a person's strengths and support clients to undertake personal recovery planning. It focused on how to participate in Strengths Model group supervision. Post-training, staff were offered the opportunity for individual supervisory support and field mentoring (Carlson *et al*. 2016), whereby Strengths Model supervisors could accompany them into the field to support them directly as they worked with clients. They were also asked to participate in ongoing Strengths Model group supervision, within their local treatment teams.

This paper reports on the findings from two stages of a four-stage study. The initial two stages focused on the impact of the Strengths Model on individual therapeutic practice, among staff who chose to adopt it. These stages sought to understand firstly, whether Strengths Model training and supervision led to practice change for these staff and, if so, to describe the extent and significance of this. This included a focus on discovering and characterizing generative mechanisms that could explain any change. The final two stages of the study offered a critical realist, retroductive analysis of the place of strengths-informed clinical practice within the broader field of psychotherapy. These findings have been reported separately due to the variation in their focus and scale of their respective findings (Pullman 2022).

METHOD

A qualitative approach, combining critical realism (Bhaskar 1986) and grounded theory (Glaser 1992), was used to explore the impact of Strengths Model training and supervision on mental health clinicians working in a large public mental health service. Grounded theory was utilized as it could produce an explanatory theory of the impact of the training and supervision on professional practice that was grounded in the data (Chun Tie et al. 2019). Critical realist analytic techniques were added to the grounded theory analysis in order to uncover, deeper, more generalizable mechanisms of change that corresponded to and helped explain the grounded, empirical descriptions of therapeutic practice (Kempster & Parry 2014; Oliver 2012). The study included two rounds of interviews and a focus group. Data collection took place between June 2018 and November 2021.

Participants

Study participants were strengths-trained mental health professionals who worked in the mental health service (see Table 1). Ten participants were interviewed initially. Seven returned for second interviews and three for a final focus group, to review the findings, in November 2021.

Data collection

The primary data collection method for this study was semi-structured qualitative interviews with mental health staff. The interviews with all the participants covered a total of 13 hours. The shortest lasted 25 min, the longest 1 hour and 36 min. All interviews took place in a private setting of the participant's choice. The data were collected and analysed by the first author. The second round of interviews and focus group explored participants responses to the initial findings. This allowed for a co-designed, iterative, development of the final grounded theory.

Ethics considerations

This study was approved by the Human Research Ethics Committees of the University of Tasmania and the South West Sydney Local Health District (AU/1/DD01312). All participants were informed verbally and in writing about the purpose and methods of the study. They signed a statement of informed consent.

Data analysis

Initial interviews were analysed using grounded theory techniques, with the intention of discovering significant, empirically derived categories. These categories were then analysed using a combination of the critical realist *context, mechanism, outcome* (CMO) heuristic (Dalkin *et al*. 2015; Emmel *et al*. 2018; Pawson *et al*. 1997) and the classical grounded theory concept–indicator model (Glaser 1978). The CMO heuristic was used to locate these categories, and any emergent core category or Basic Social Process (BSP), within a critical realist, stratified, ontological framework. Retroductive reasoning (Bhaskar 1986) was used to establish and verify the presence of a generative mechanism that underpinned this process.

TABLE 1 *Participant experience and professional discipline*

Participant	Years of experience	Professional discipline
1	6	Clinical psychologist
2	8	Occupational therapist
3	5	Social worker
4	6	Clinical psychologist
5	5	Social worker
6	6	Registered psychologist
7	20	Registered nurse
8	2	Occupational therapist
9	13	Registered nurse
10	18	Occupational therapist

RESULTS

Substantive categories

The interviews generated six, interrelated, substantive categories, *Getting to Know Clients Better, Strengths Work Enhances Treatment Planning, Strengths Work Enhances Quality of Treatment Process, Using Strengths to Mitigate Risks, Necessary but not Sufficient, and Becoming a Strengths Informed Practitioner*.

Getting to know clients better

This category described the qualitatively different information that clinicians had at their disposal once they enacted strengths practice tasks, including the completion of strengths assessments. Often, this information facilitated self-reflection on the part of clinicians in relation to clients. Therefore, it was not simply about information for a treatment process, but also about information for human understanding.

> I'd only been working with her for about two months —but she was very quiet and very shy. She would only give me one-word answers. I started doing it [strengths assessment] with her, and that's when I learned so much about her. She opened up. I found out that she was a figure skater, and she did dancing, and she could play the piano, and she could play the flute and she could do them at quite a high grade… I didn't know that for the first couple of months of working with her, because we'd only been focusing on her series of admissions to hospital (Participant 3)

Within a temporal framework, *Getting to Know Clients Better* functioned as a precursor mechanism for subsequent practice change. However, it is not a 'one-off' or time-limited process. Knowledge about an individual client continued to grow, and deepen as time progressed:

> seeing clients think of their own ways to skin a cat, and how it does actually work. I think it builds the capacity

> in which we see our clients … It makes it a much more positive sort of thing, … we had one girl who I don't even think she can remember her name some days, but she wanted to go to uni. We helped her go to uni, and she's receiving distinctions and high distinctions. Everybody was just kind of like, "what?" (Participant 2)

Strengths work enhances treatment planning

Getting to Know Clients Better functioned as a mechanism for three important, subsequent practice changes. The first of these was *Strengths Work Enhances Treatment Planning*. As understandings carried over into treatment planning, clinicians were able to weave in-depth knowledge of a client's interests into a carefully constructed, deeply personalized treatment plan where those skills and interests contributed directly to the treatment process:

> She just lit up and started talking about things. … I learnt that she was in the witness protection program. I learnt that she used to submit poetry, she used to do a lot of gardening and knitting … it gave me the tools to engage her better in future sessions… when … she was getting distressed, I could refer back to one of her interests and really formulate care plans according to what she finds was useful when she needs to wind down. (Participant 5)

In particular, the use of the strengths assessments had the capacity to generate rapport and increased personal understanding between client and treating team. In turn, these factors allowed teams to confidently prescribe less restrictive, more recovery-oriented medical treatments.

> in treatment planning, … strengths has supported, the consideration of transitioning from a depo [intramuscular injection of antipsychotic medication] to oral [client self-administering, antipsychotic tablets] to give someone more autonomy over their medication… it's because there's been a rapport development or a better understanding of the person, and identifying possible strengths that weren't previously seen. (Participant 10)

The use of strengths assessment principles with clients influenced multidisciplinary treatment planning, even where other team members were not trained in the model. Commenting on the impact in a residential mental health setting, one participant noted:

> I was met [by] the staff, … with, "why are you doing this? This is traumatising. These people are best kept here. Institutions basically are the best place for them"… through strengths … I gradually transformed some of the … ideas of some of those people … I haven't done formal strengths training with all the gentlemen in that space [staff], but just looking at a lens as to, "this person loves going out, this person loves going to the footy. Why don't we encourage that?" and it's been working. (Participant 10)

Strengths work enhances quality of treatment process

Over time *getting to know clients better* also acted as a mechanism for another category, that was named *Strengths Work Enhances Quality of Treatment Process*. This mapped the establishment of a more collaborative relationship and a stronger therapeutic alliance between client and clinician. One factor was the time taken listening to clients talk about their lives, which helped them develop confidence in their relationship with clinicians:

> I remember calling him saying, "is there something that you need help with? Is there anything that you want to do that you're not able to do? Can I help you with anything?" and for maybe six months he would say no to me, but instead of making the conversation about his mental health, like directly about it, I tried to make it about his life… eventually he called me, and it was probably the first time he'd ever called me, and he said, "I know I have a mental illness and I need help, but I want a job. Can you please help me get a job?" and then that kind of changed our relationship … he said, "you know, you can come to my house to see me. I don't always have to come to you." He was happy for us to go over. (Participant 8)

Another component was an association between increased collaboration and hope. Clients became more hopeful, engaging more constructively and assertively with their mental health support and in the process of their own recovery. Participants attributed this to the strengths-based treatment process:

> She was just like, "oh, I don't care about mental health, you're just going to put me on a CTO [involuntary Community Treatment Order] you're just going to make me have a needle." She was very negative about mental health, and then she ended up being the person who could call me and say, "I need you to book an appointment with Doctor Stowe [pseudonym]. I'm coming in to talk to him about reducing my medications, and I'm giving it this six months," and it just helped her take control. (Participant 8)

Increased recognition of, and cooperative engagement with, clients' families provided a further component of this category.

> … her life completely turned around, and the other important part of that was to be really communicating

> to her family about what we were doing and why we were doing it, and the purpose of what we were doing. Not that I think that they had any issues because they were just so grateful that someone was actually doing something that looked like it could possibly be working. (Participant 9)

A final component, identified by several participants, was the way that use of the Strengths Model helped the treatment process move forward when it had become 'stuck'.

> ... motivating this young person, who is a 14-year-old boy, to change, there was nothing that we could do. He didn't want to stop self-harm or attempt[ing] suicide ... having that conversation around clinically from what I've learned before, wasn't going to work with him. But once we started to have this conversation around his strengths, his ideas about the future, it opened up this new area. He had never had that conversation ... he constantly told me this was a new way of talking ... so that's how it unstuck in terms of moving to a different avenue but exactly doing the same kind of work in terms of keeping him safe, in motivating him to change around his own safety and future. (Participant 6)

Using strengths to mitigate risks

This category described the positive impact use of the Strengths Model could have on mitigating clinical risk. In combination, the quality of information brought forward in the strengths assessment process, the client-centred, optimistic, therapeutic stance that participants adopted and the enhanced acknowledgement of and relationship with clients and their 'natural supports', offered an effective means of mitigating risk associated with psychiatric relapse and social vulnerability. This applied particularly around identifying and mobilizing social support from family and friends. It also applied to the interweaving of safety and relapse prevention strategies such as assertive follow-up, early warning signs monitoring and psychotherapy to address self-harm, with clients' own preferences and goals, to maintain their motivation to engage in treatment.

> Our medical goals for him are that he's not going to have relapses of psychosis. He's not going to have any more suicidal thoughts, and his risk are going to be low. I guess, in terms of looking at his strengths, he's done one that has told us that he's often lonely and he wants to have more people in his life, and that's going to be something that, for him, that's going to help him stay well, because he's going to have more support ... he's going to have more interactions with other people, he's going to have more people that can support him if he does have a relapse in the future, but also to prevent him from having a relapse in the future. (Participant 3)

Necessary but not sufficient

This next category to emerge described some limits to the model's utility, capturing a view that strengths will often need to be used in conjunction with other treatments and techniques. All participants were clear that the strengths model process is necessary, because a strengths approach provides the central basis for recovery-oriented, person-centred mental health treatment.

> It's the skeleton of the work that I do. It's more than just being person-centred, but it is person-centred. ... and it gives you permission to really initially always explore and understand the person first before you start applying tools that might be useful in helping (Participant 9)

However, the Strengths Model process was seen to be insufficient on its own, by some practitioners:

> I've been aware of the Strengths Model for 20 years and I have reservations about how a strengths assessment and model of care can adequately cover the clinical risk ... the idea is to keep people alive first and then provide care after that. There's no point in providing care if somebody's expired ... so safety, diagnosis, physical things, and then I go into the psychosocial. (Participant 7)

Core category and basic psychological social process

Becoming a Strengths-Informed practitioner

Becoming a Strengths-Informed Practitioner mainly described the internal, cognitive and emotional changes participants experienced. Enacting the Strengths Model brought forward new, surprising, even profoundly confronting personal information and generated unexpectedly good client outcomes. At times, it helped clinicians achieve a sense of shared humanity, based on mutual personal interests or goals. All of this triggered an emotional response from participants as they processed such information. It was in this space that self-reflection and development in therapeutic practice took place.

A common response from participants was an acknowledgement of what they did not know about their clients prior to starting a strengths assessment:

> She talked more about what her goals were, and her goals were completely things that I never thought for her. (Participant 3)

For some experienced clinicians, this provoked a productive cognitive dissonance about their therapeutic practice and its connection to recovery-oriented, person-centred mental health care.

> It gave me something that I didn't realise I was missing, if that makes any sense? Which is a little bit embarrassing, I think, when you think that you're a really skilled clinician and then all of a sudden you realise, "OK, I've been missing this all along." (Participant 9)

No participant found their practice unchallenged or unchanged. Over time, those who consistently used strengths tended to make the practice increasingly central to their work. Their commitment to enacting the model deepened, and their confidence in strengths as a therapeutic stance grew. They became more optimistic about their work and found a renewed energy towards working in the mental health field:

> I believe it will always support me, personally, in preventing burnout (laughs) because I think, particularly in mental health there's a high burnout rate of clinicians in general, and I think this is a way of keeping yourself current, yourself hopeful, because we do work with severe and complex consumers, which can be quite challenging. (Participant 10)

Becoming a Strengths-Informed Practitioner emerged as the unifying, core category of the analysis. It mainly described the internal, cognitive, and emotional changes participants experienced once they began using the model. Over time, these internal changes drove and sustained the practices described in the other substantive categories. Therefore, *Becoming a Strengths-Informed Practitioner* met the grounded theory criteria, as a basic social psychological process that 'explains a considerable portion of the action in an area and relates to most categories of lesser weight used in making the theory work' (Glaser 1978, p. 5).

Becoming a Strengths-Informed Practitioner started with an acknowledgement from participants that they (usually) knew too little about their clients to be truly effective in their work. This led to determined and systematic efforts to find out more about their clients and to understand them more clearly:

> … once you've got the principles of strengths. You're going back, you're getting more in-depth information, you're reviewing the file in a slightly different way, you're gathering the nuggets versus glazing over… (Participant 10)

Over time, participants adopted a set of beliefs that allowed the client take centre stage as the director of the therapeutic process. They believed that they needed to know their clients as unique and fascinating human beings. They believed that their clients' goals and wishes were to be honoured in every way and circumstance possible. In keeping with Snyder's Hope Theory (Snyder 2000), they believed in and practised hope, walking alongside clients, seeking pathways, and encouraging agency. They believed in recovery-oriented practice, and they found themselves delivering this, as strengths-based treatment proved to be central to the effective delivery of a wide range of evidence-based mental health treatments.

Generative mechanism

Critical realist analysis seeks underlying generative mechanisms to explain temporal social processes. In the case of *Becoming a Strengths-informed Practitioner*, an underlying generative mechanism was identified, *The Client Becomes Visible*. This consisted of an interaction between the enhanced client information, provided using the Strengths Model and a response from the participant that moved from curiosity about, to recognition of, and empathy for their client. This process underpinned the adoption of beliefs that made up the components of *Becoming a Strengths-Informed Practitioner*. Importantly, this process can be explained with reference to more general theories of human empathy such as the Organisational Model of Empathy (Davis 1994).

> I'd already had an idea of who she was in my head, and she wasn't anything that I was thinking (Participant 3)

> … with trauma clients, it makes you realise that this person is a survivor, not a victim (Participant 5)

Limitations

A limitation of this research was, while it captured the direct experiences of mental health clinicians, it was not able to incorporate direct client experience of service into the analysis. Also, although four different mental health disciplines were represented in the participant sample, no psychiatrists or mental health peer workers chose to participate.

DISCUSSION

There is a specific difference between the North American context, where the Strengths Model developed, and the Local Health District context in Australia where this research took place. In North America, the Strengths Model has mainly been delivered by services contracted to provide 'case management' psychosocial support to people experiencing major mental illness, separate from other services they may receive, such as psychiatry, clinical psychology, or inpatient treatment (Rapp & Goscha 2012). In the Local Health District setting, such services were usually provided 'in-house', in keeping with standard Australian practice for public mental health services. Standard mental health teams in the service consisted of a mixture of multidisciplinary staff. These teams provided the case management, psychosocial support, and specialist treatment functions in a single integrated entity. Despite these variations, the Strengths Model was found to be an effective approach to assist clients to achieve meaningful recovery goals, and, when the principles were applied in the Australian context, this maximized the services' capacity to align service delivery to a recovery-oriented paradigm.

Poor outcomes for mental health clients remain an urgent problem, in Australia and worldwide (Isobel 2021). In part, this study was an exploration of how the Strengths Model might help overcome this within a public mental health setting. To that end, it demonstrated that Strengths Model training and supervision can enhance recovery-orientated mental health care, where clinicians seek to integrate it into their ongoing practice. Importantly, and perhaps in counterpoint to common perceptions of the purpose of recovery-orientated techniques, it also offers a platform for effective mitigation of clinical risk. The changes achieved can support the reform of treatment models to be responsive in working with individuals towards a meaningful and socially inclusive lifestyle (Slade 2009). The use of the strengths assessment helps create a different lens for clinicians to view practice, leading to an acknowledgement of personhood within professional's approach (Beckett *et al*. 2013). They become sensitized to interpreting assessment information in a hopeful, constructive, ambitious, and recovery-oriented manner. Treatment plans evolve to reflect an optimistic and client-centred therapeutic stance. Working together, clinician and client construct a recovery-oriented treatment plan that promotes hope, independence, and personal recovery (Andresen *et al*. 2011; Rapp & Goscha 2012). Therefore, the Strengths Model offers a foundation for recovery-oriented mental health services that actively empower clients to establish and strive for individual goals, improving mental health outcomes (Fukui *et al*. 2012).

The grounded theory *becoming a strengths-informed practitioner* has been able to establish that Strengths Model training and supervision can support effective, recovery-orientated treatment within a multidisciplinary context. The transformation nurtured a curious, holistic exploration of client's activities, motivations, experiences, and opinions. The approach represented a holistic, fundamentally person-centred therapeutic practice. A major threat for this practice development and its sustainability is the hegemony of the deficits-focused biomedical model of mental illness. Gillon (2013, p. 410) notes a fundamental challenge of operating as a person-centred practitioner in a mental health field is that it is dominated by 'medicalized perspectives that view distress in terms of specific "disorders" that may be distinguished and classified'. This creates a fundamental tension between the philosophical position assumed in the person-centred approach and more 'problem-focused' clinical practices within which an expert-oriented case formulation plays a central role. The findings highlight that effective, sustainable, and systematic mental health reform is possible in the discipline of psychiatry and the mental health field more generally, but requires a person-centred understanding of mental health treatment and care. While biomedical hegemony continues within Australia's mental health services, attempts to improve service provision would seem superficial at best (Molloy *et al*. 2018).

The research findings add depth to our understandings of how Strengths Model training and supervision can shape therapeutic relationships between clinicians and clients within mental health services. This includes how strengths-based practice potentiates important psychological processes, such as empathy. Davis's organizational model of empathy (1994) demonstrates that empathy is enhanced when simple cognitive processes are supplanted by more advanced ones. Once study participants enacted the Strengths Model, they shifted from a less empathetic therapeutic stance, marked by the practice of stereotyping and therapeutic pessimism, to a more empathetic therapeutic stance, marked by client-centred practice and optimism. Participants identified that access to increased personal information

about clients, their struggles, personal strengths, and fascinating goals gathered, through strengths-based practice, enhanced their empathy for clients, highlighting advanced cognitive processing (Davis 1994). This experience of enhanced empathy facilitated a commitment to a 'real relationship' (Wampold & Imel 2015). That is, an intimate, emotional, yet professional relationship between health professional and client, driven by empathy, and known to contribute to successful psychotherapeutic outcomes (Wampold & Imel 2015). Clinicians began using the strengths assessment to have in-depth conversations about their client's dreams and goals. Wampold and Imel (2015) have linked the specific ingredients of psychotherapies back to the general positive effects of psychotherapy. It is claimed that all bona fide psychotherapies induce the client to do 'something salubrious', and that these salubrious actions tend to generalize throughout the client's life – hence the generally positive effects of all psychotherapies (Smith *et al*. 1980). The generation of salubrious actions leading to more generalized positive effects on mental health and quality of life was a strong and consistent effect described by study participants.

CONCLUSION

This study has demonstrated that Strengths Model training and supervision is a potentially effective vehicle to improve the recovery-orientated practice of mental health clinicians, in a multi-disciplinary treatment context. It does so by fundamentally enhancing clinicians' knowledge about, and empathy for clients, which proves a robust therapeutic foundation for subsequent treatment processes.

IMPLICATIONS FOR CLINICAL PRACTICE

This research has demonstrated that good-quality Strengths Model training and supervision can enhance clinicians' therapeutic practice, as described in the grounded theory becoming a strengths-informed practitioner. However, systemically successful mental health reform will require a far more significant body of work; one that addresses the deep-seated philosophical, epistemological, technical, political, and social forces that combine to hold mental health systems, mental health staff, and mental health clients within an unproductive, deficit-focused and sometimes nihilistic malaise. Without such work, we can predict that any potential benefits accruing from introducing a recovery-oriented practice, such as the Strengths Model, will be effectively nullified.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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