Mapping A Pathway For Embedding A Strengths-Based Approach In Public Health Practice

By
A Locally Driven Collaborative Project

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Final Report: Mapping A Pathway For A Strengths-Based Approach In Public Health Practice

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for
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Oxford County Public Health and Emergency Services
Perth District Health Unit
Huron County Health Unit
Leeds, Grenville and Lanark District Health Unit

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The views expressed in this final report are the views of the project team and do not necessarily reflect those of Public Health Ontario.

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There is no doubt that health care’s orientation toward the dominant model of diagnosis and treatment, risk assessment and intervention, to improve health is valuable; however, it often places only a passing consideration to health related goals that focus on emotional well-being and the preservation and promotion of mental health. Working solely from this illness-based approach does not allow public health prevention providers to move beyond the illness paradigm, towards helping those in their care to recover, become stronger, make connections in their social world, and acknowledge that health is much more than the absence of disease (McAllister & Walsh, 2003).

In attempts to find a more comprehensive, holistic approach to health care, the strengths-based paradigm is being proposed as a “game changer” with the potential to transform health care (Gottlieb, Gottlieb, & Shamian, 2012). It redirects the focus from deficits, problems, and weaknesses, to mobilizing, capitalizing and developing an individual’s strengths with the final objective being to promote health and facilitate healing. While many public health staff believe they are working from a more positive or strengths-based perspective, Rapp and Goscha (2006) suggest that few truly know how to incorporate the underlying values, principles and philosophy of strengths-based perspective into their practice. The need to evolve a strengths-based paradigm in health care is important because the ensuing approach provides individuals, and the communities they live in, the opportunity to feel in control. It fosters making personal choices and problem solving, thus decreasing the chances of dependency and learned helplessness in a public health care system with limited resources (Chapin & Fast, 2000).

This current project study explores a paradigm shift; it seeks to better understand how a strengths-based approach can be sustainably embedded into public health care practice. It invites a conversation about potential new and creative ways health care providers might work with people and communities. A strengths-based paradigm offers a different language to describe a person’s difficulties and struggles; it allows public health care providers and those they serve to see opportunities, hope and solutions. It
supports a greater degree of professional satisfaction and work engagement in staff. This project promotes a new strengths-based paradigm that informs and enhances public health care while continuing to address its primary mandate: supporting people and the communities they live in to take control of their own sense of positive health in a meaningful and sustainable way.
2. LITERATURE REVIEW

2.1 The Need for a Paradigm Shift
Traditionally, public health agencies have focused on understanding the biological/psychological and environmental risk factors that increase the likelihood of people developing (or maintaining) health-related challenges; they have also sought to understand the implications for prevention. Interventions and preventative programs based on the deficits, problems, or pathologies of individuals often direct professionals' attention to one view of the person and the communities they live in. The emphasis on deficits, or what a person or community is lacking, leads to a cycle of focusing only on what needs repair followed by a reliance on prescribed resources or assumed solutions. When public health or care provision organizations act as experts on resolving the problems of people, they deny those particular individuals or communities the opportunity to explore what strengths and capacities they have. They deny the opportunity for a process of exploring, participating, taking control and learning (Herman-Stahl & Petersen, 1996).

Lind and Smith (2008) point out that current health care programs and policies directing most nursing practice continue to support deficit-oriented values and practices. This is at odds with the historical notion of health promotion being the mediating strategy between people and their environments – a positive, dynamic, empowering, and unifying set of values include: caring, empowerment, honouring different ways of knowing, social justice, equity, and respect. As a result, this deficit model inhibits the recognition of, and working with, a community’s strengths. The imposed, deficit-oriented language in public health discourse limits the exploration of exciting options for health-promoting practice with partner individuals and communities (Lind & Smith, 2008). For a public health transformation that places people and communities at the center of health care, there needs to be a new approach to public health practice and to professionals’ leadership. Community nursing practice requires a bridge to assist in the paradigm shift from a deficit model of practice to a health-promoting practice consistent with the principles of the primary health care and community health nursing standards of practice (Community Health Nurses Association of Canada, 2003).
2.2 An Alternative Approach - Strengths-Based Practice

If an alternative approach is to work, it will need to be a more balanced and holistic perspective to public health provision. Strengths-based practice has been proposed as a more effective approach. While it does not deny that people experience health-related problems, strengths-based practice proposes that those individuals and their families have strengths and resources that give them the ability to recover from adversity. It is an approach to public health that avoids labeling and assumes power in people, and the communities they live in, to help themselves. It casts health care service providers as partners rather than experts, authorities, and initiators/directors of the change process. This fundamental shift means working with and facilitating (rather than fixing), pointing to signs of health (rather than dysfunction), all while limiting the negative influence of labels on well-being. It invites health care practitioners to ask different questions that are more curious, exploratory and hopeful. In many ways, the strengths-based approach offers a genuine basis to address the primary mandate of community health services: enable people to take control of their own lives in healthy, meaningful and sustainable ways (Gottlier, 2013; Lind & Smith, 2008; Rapp & Goscha, 2006).

Interest in strengths-based practice has increased significantly as practitioners, educators, researchers and public health providers shift their attention from the prevention of specific problems to a more holistic view of individual and community development. Pesut and Herman suggest that the strengths-based approach in public health is less about identifying/developing standardized techniques or prescriptions for care and more about developing the art of creatively working with people’s strengths to find solutions to- or ways of living with- complex challenges (as cited in McAllister & Walsh, 2003). This is also true when considering communities as clients, as is often the case in public health practice. As such, continuing to practice predominantly from a deficit or illness-based approach is only half the story of effective public health care and, if applied alone, can actually leave people more vulnerable. In fact, if used in isolation, an illness-based approach can create a culture of need, deficiency and dependence, on our health care system (St. Luke’s Health Initiatives, 2003). Over time, this approach
may erode personal capacity for drawing upon protective factors and innate capacities (St. Luke’s Health Initiatives, 2003).

2.3 What is Strengths-Based Practice?
The strengths-based approach is not a model for practice. It is an approach to practice based on a philosophy. McCashen (2005) relates that it depends above all else on values and attitudes and it is the underlying values and attitudes (rather than skills and knowledge) that will determine the processes and outcomes to be engaged in. Skills and knowledge are mobilized as resources to serve principles that enable change. What one (or organization) believes (beliefs) and believes in (values) are more influential in determining the ways in which one will work with people (and the outcomes for them), than what one knows or how skilled they are.

As Madsen states:

“The stance we take in relation to others reflects choice. We can position ourselves in relation to others in ways that invite respect, curiosity, and connection. We can also position ourselves in ways that invite judgment, disconnection, and disapproval. The stance we take has profound effects on relationship and is shaped by our values and conceptual assumptions.” (Madsen, 1999, p.15)

A strengths-based approach emphasizes an individuals or community’s existing strengths, capabilities and resources. Those who embrace a strengths-based perspective believe all individuals and their families have strengths, resources and the ability to recover from adversity. This perspective replaces a primary emphasis on problems, vulnerabilities and deficits. A strengths-based approach is developmental and process-oriented. It identifies and reveals a person’s internal strengths and external resources as they emerge in response to specific life challenges. A strength-based paradigm uses a different language (see Appendix A) to describe a person’s challenges and asks different questions to explore struggles. It allows one to see opportunities, hope and solutions rather than barriers, hopelessness and problems.
Taking a strengths-based approach allows for new and creative ways to work with people receiving health care that honour their skills, competencies, and talents as opposed to their deficits. It does not need to be in dispute with, or subscribe to, any particular model or theory of mental health. Rather, the strengths-based approach seeks to answer some very different questions like (McCormack, 2007):

- Why do people survive the problems of life at all?
- What resources do people draw on that would account for their resilience?
- Why do a significant majority of people diagnosed with mental health problems not just survive, but often live well despite their problems?
- What are the protective factors that support positive health and effective recovery?
- What meaning do individuals ascribe to their experiences, their suffering, and their triumphs?

The strengths-based approach involves moving away from a focus on deficits- or in the instance of health care practice, on illness- and therefore represents a paradigm shift. Assumptions on “interventions” or “preventions” are challenged and the role of the health care user is transformed from one of being a passive agent in their health care to that of an active collaborator and participant.

2.4 Principles and Guiding Values of Strengths-Based Practice

Current health care systems tend to be strongly influenced by the mainstream medical model; therefore it is extremely important to have a clear, comprehensive understanding of the values and beliefs underlying strengths-based practice. At the heart of strengths-based practice is the belief in, and valuing of, the person and/or community and their strengths. Laurie Gottlieb (2012) has outlined the following guiding assumptions of strengths-based perspective as it relates to health care:

- Individual, families, and communities aspire to and are motivated to better health and healing.
- Individuals have the capacity to grow, transform and self-heal.
- Every person is unique which is reflected in their responses to health and human challenges.
• People create their own meaning to understand themselves and to make sense of their environments and experiences.
• Problems, weaknesses, vulnerabilities, hardships and suffering, are part of the human condition.
• Strengths are required for health and self-healing.
• Within each person resides the power to self-heal, which is considered a strength.
• Strengths enable people to adapt to different environments and cope with life experiences to meet a wide range of health challenges.
• People reside in environments that range from healthy to toxic.

It is also important to realize that when public health employees are aware of the values that guide their own professional and organizational practice, they are in a better position to answer the following questions (adapted from L. Gottlieb, 2012):

• What are the issues that require my expertise and skills?
• How do I conduct myself as a professional?
• How do I go about creating a meaningful connection with the person or community I’m serving? What should I be observing? What should I be attending to? What should I be listening for?
• What knowledge and skills do I need to have in order to effectively care for this person or community?
• How do I know when the actions and activities that I have taken are right or best for the person, family or community?
• What is the right evidence or outcome indicator that I should be looking for?

The strength-based approach draws one away from procedures, techniques and knowledge as the keys to positive change. Instead, it reminds us that every person and community holds the key to meaningful change and transformation processes. Embracing a strength-based approach involves a different way of thinking about people and of interpreting their patterns of coping with life challenges. With a strength-based mindset, one asks different questions and communicates in ways that invites a curious
exploration based upon a clear set of beliefs and attitudes. This emphasis on strengths is founded on the following beliefs: (McCashen, 2005)

- All people have strengths and capacities.
- People can change. Given the right conditions and resources, a person’s capacity to learn and grow can be nurtured and realized.
- People change and grow through understanding and experiencing their strengths and capacities.
- People are experts of their own situation.
- The problem is the problem, not the person.
- Problems can blind people from noticing and appreciating their strengths and capacity to find their own meaningful solutions.
- People have good intentions and can take charge of their own lives.
- People are doing the best they can in light of their experiences to date.
- The power to change is within us.

The following principles are the foundation for guiding and implementing strengths-based approach into practice (O’Connell, 2006; Rapp & Goscha, 2006; McCashen, 2005):

- An absolute belief that every person has potential and it is their unique strengths and capabilities that will determine their evolving story of health as well as define who they are - not their limitations (not, I will believe when I see – rather, I believe and I will see).

- What we focus on becomes one’s reality – focus on strength, not labels – seeing challenges as opportunities to increase resilience (not something to avoid) and create hope and optimism.

- The language we use creates our reality – both for health practitioners and clients.

- Belief that change is inevitable – all individuals have the urge to succeed, to explore the world around them and to make themselves useful to others and their communities.
Positive change occurs in the context of authentic relationships - people need to know someone cares and will be there unconditionally for them. It is a transactional and facilitating process of supporting change and capacity building–not fixing.

A person’s perspective of reality is primary (their story)—therefore, need to value and start the change process with what is important to the person – their story, not the “expert’s”.

People have more confidence and comfort to journey to the future (the unknown) when they are invited to start with what they already know.

Building people’s capacity is a process and a goal – a life long journey that is ever changing as opposed to static.

It is important to value differences and the essential need to collaborate – effective change is a collaborative, inclusive and participatory process – “it takes a village to care for a person”.

2.5 Implications of a Strengths-Based Practice for Public Health
The strengths-based perspective means working with people without attempting to “fix”, focusing on health rather than dysfunction, celebrating wholeness, successes and well-being while avoiding limiting labels and diagnosis. It also includes asking different questions that are more curious, exploratory and hopeful. Embracing a strengths-based paradigm encourages seeing beyond people’s challenges to the potential of what can be. It supports people taking control of their own lives in healthy, meaningful and sustainable ways. As a result, public health care needs to consider whether its organizational and practice goals facilitate the following (Gottlieb, 2013):

- Places the person and family at the center of care (person/family-centered care).
- Empowers the person/family to achieve their own goals and find new meaning in their lives (empowerment movement).
- Develops an understanding of the whole person and considers human uniqueness from cells to citizens to communities (whole–person care, holistic care, personalized care).
- Knows that issues be understood within their context, taking into account history and circumstances (context – based).
• Encourages the person to take charge of, and be responsible for, his or her own health, recovery and healing (health promotion and illness prevention, self-care).
• Embraces a collaborative relationship between the person/family/community and the health care provider or organization (collaborative partnership).

A shift to the strengths-based paradigm requires careful attention by public health providers to system change processes, evaluation, appropriate research and best practices. Essential to success will be the collaboration between different community care providers embracing the same philosophy of a strengths-based approach, as well as the development of staff skill sets that enable effective engagement, collaboration, facilitating and mentoring. Public health care providers will require more of a person/community-centered and collaborative template that allows for targeted interventions and preventative strategies. These strategies will reflect relationship and capacity building, as well as strengthen key processes for resilience that are meaningful to the intended clients and the community they live in. There needs to be a commitment to work as co-partners with local schools, parents and other significant community supports to develop (informed and evolving) effective practice models. These models will seek to nurture resiliency in individuals, families and communities; helping them to become more resourceful in dealing with crises, weathering persistent stresses, and meeting future challenges, as opposed to developing dependence on the system.

If the strengths-based approach is to be something that truly guides and influences public health practice, it should be evident in: the language of interactions with the people being served, the language of service, team and organizational interactions, and the written documentation of service provision activities – assessment, service delivery, training, etc (Rapp & Goscha, 2006). It lends to the following:

• Seeks to understand the crucial variables contributing to individual resilience and well-functioning families/communities.
• Provides a common language, preventative philosophy, and framework of positive health.
• Sees resiliency and capacity building as a goal that provides a conceptual map to guide prevention and evaluation efforts.
• Intervention strategies are client driven and relationship focused.
• Engages distressed people with respect and compassion.
• Perceives capacity building as a dynamic process that evolves over a life time.
• Affirms the reparative potential in people and seeks to enhance strengths as opposed to deficits.
• Promotes successful change through connecting a person’s strengths and their aspirations.

Developing and sustaining a strengths-based public health care culture requires commitment and leadership that reflects and models its principles. It is about having a strengths-based way of thinking, describing and practicing that is supported by all staff and potential community partners. A strengths-based public health care culture has the following characteristics (Gottlieb, 2013; Lind & Smith, 2008; McCashen, 2005):

• Understands that a strengths-based approach is a philosophy based on values and guiding principles for working with all clients/communities to bring about change.

• Relates to clients/communities in ways that demonstrate positive attitudes about their dignity, capacities, rights, uniqueness and commonalities.

• Creates conditions and unique opportunities for staff and clients to identify value and draw upon their strengths and capacity in ways that creates meaningful and sustainable progression towards change and positive health goals.

• Provides and mobilizes resources in ways that complements a client’s (community’s) existing strengths and resources as opposed to compensating for perceived deficits. It is a holistic approach of combining excellent public health practice with supporting the well-being of a client.

• Acknowledges and addresses power imbalances between public health agencies and clients (e.g., Not – "I’m the professional and your only role is to obey me and follow my instructions.").

• Seeks to identify and address social, personal, cultural and structural barriers to a person’s or communities’ desired goals, growth and self-determination.
2.6 Summary

Although the research clearly indicates a need to re-think the influence of the medical model of public health care and invites consideration of the strengths-based perspective, very little research has outlined a clear model of skills training and implementation practice, particularly in relation to public health practice. Studies are needed to explore the critical aspects of knowledge and skills enhancement, as well as organizational factors that can be implemented in sustainable ways. It is about exploring a view of health care that considers strengths – what is best, what is working and what has potential. It is about embracing a shift from health professional-assessed outcomes to client outcomes. Strengths-based outcomes are concerned with the human spirit and the whole person and would enlarge the focus to include health, healing, quality of life and subjective well-being. There needs to be a path taken, hence, the goal and purpose of the current, proposed project study.
3. PROJECT PURPOSE

The Ontario Public Health Standards (OPHS) and the supporting guidance documents establish requirements for fundamental public health programs and services for Ontario Public Health Units. OPHS include: four Principles (i.e., need, impact, capacity, and partnership and collaboration); the Foundational Standard and Protocols; and the Program Standards and Protocols. The Principles underpin the Foundational and Program Standards and are used to guide the assessment, planning, delivery, management and evaluation of all programs and services. Stated in the Impact Principle, Public Health Units are responsible for improving the overall health, wellness and resilience of the population as a whole, or of priority populations. The concept of resiliency is also embedded in several of the Program Standards.

Public Health Units use guidance documents to support implementation and help operationalize the Program Standards. Guidance documents outline evidence-informed practices and current research on all program areas. In many of these guidance documents, using a strengths-based approach (or a similar strategy such as resiliency building and/or youth engagement) is recommended (ie: Ontario Public Health Standards pages 18,22,35). Although it is evident that Public Health Units need to adopt a strengths-based approach, after working with the participating Health Units it has become apparent to the group that organizations are at varying stages of integrating this philosophy into their practice.

In addition to the OPHS and guidance documents, there are several other documents that help inform Public Health practice. Some examples of documents that recommend strengths-based practice and/or youth engagement include:

- Ministry of Health Promotion and Sport Youth Engagement Principles
- Registered Nurses Association of Ontario (RNAO) Clinical Best Practice Guidelines – Enhancing Healthy Adolescent Development
- Canadian Public Health Association Public Health - Community Health Nursing Practice in Canada – Roles and Activities
By collaborating with other Public Health Units across the province, this project attempted to explore varying stages of readiness and capacity to integrate a strengths-based approach into Public Health practice. Assessing organizational capacity and implementation strategies to adopt a strengths-based approach are to be proposed to help Public Health Units meet the OPHS and other best-practice publications.

As a result, the objectives of this project study were:

1. To evaluate and outline the crucial factors that contributes to (or hinders) public health staff’s ability to adopt, develop and implement strengths-based principles of practice through the use of questionnaires, focus groups, reflection sessions and expert interviews.

2. To outline a potential roadmap strategy for professional capacity building within Public Health Units that provides a common language and a strengths-based framework for public health practice.

3. To identify the key aspects and guiding concepts that will be required to embed a strengths-based perspective and culture of practice in Public Health Units that reflects the following characteristics:
   - Understands that a strengths-based approach is a philosophy based on values and guiding principles for working with all individuals to bring about change.
   - Relates to individuals in ways that demonstrate positive attitudes about their dignity, capacities, rights, uniqueness and commonalities.
   - Creates conditions and unique opportunities for public health staff and community partners to identify value and draw upon their strengths and capacity in ways that creates meaningful and sustainable progression towards change and positive health goals.
   - Provides and mobilizes resources in ways that complements an individual's existing strengths and resources as opposed to compensating for perceived deficits. It is a holistic approach of combining excellent public health practice with supporting the well-being of people.
   - Seeks to identify and address social, personal, cultural and structural barriers to a person’s desired goals, growth and self-determination.
The intent of the project study was to draw upon several evaluation and educational strategies to address the intent and objectives of this project. Questionnaires, focus groups, reflection sessions and expert interviews were all utilized to evaluate the following:

1) What is the current and required capacity (knowledge, skills, beliefs, current practice and resources) among public health staff (and their organization) to implement a strengths-based approach in their practice?
2) What are the essential steps a Public Health Unit should explore and undertake to embed a strengths-based culture for professional practice?
3) What are some practical strategies for Public Health organizations to nurture strengths-based approaches in the community they serve - effectively integrating strengths-based practices in collaboration with community partners?

The sequence of the project and intervention tasks involved the following phases:

Phase One: Project was approved and project partners collaborated to determine the project tasks, evaluation tools, timeline for project implementation.

Phase Two: The administration of two baseline questionnaires to project participants that would evaluate their personal perception of resilience, understanding of strengths-based practice, current engagement as professionals in strengths-based practice and to what degree their work setting supported strengths-based practice.

Phase Three: The presentation of a full day workshop on the theory, values, principles, strategies and implications of strengths-based practices for public health professions and the organizational systems and policies supporting them.

On the same day, shortly after the strengths-based workshop, a focus group session was performed with a select few participants to explore the implications (personally and professionally); challenges and potential opportunities that a strengths-based approach might have if embraced by Public Health Units.

Phase Four: The administration of one post questionnaire within three weeks of project participants taking the strengths-based training. The post questionnaire was used to assess potential changes in the participants’ understanding of strengths-based practice, current engagement as professionals in strengths-based practice and to what degree their work setting supported strengths-based practice.
Phase Five: Expert interviews were conducted with Public Health staff representing various levels (e.g., administration, frontline, management, senior leadership etc.) and responsibilities within the Public Health Units. The purpose of the interviews was to allow for a more personal and diverse exploration and documentation of the differing (or similar) perceptions of existing challenges, current practices and potential opportunities of Public Health Units supporting and embracing a strengths-based perspective and practice.

Phase Six: A reflection session was performed in each of the participating project partners’ Public Health Units (Oxford County Public Health and Emergency Services, Perth District Health Unit, Huron County Health Unit, and Leeds, Grenville and Lanark District Health Unit). A lead staff at each partnering Public Health Unit was prepared with a similar script of questions to engage their colleagues with the opportunity to share their feelings about how the concepts and principles of strengths-based practice have been impacting them (personally and professionally). The conclusions were documented and set to the project evaluator.

Phase Seven: A final focus group session was held at each partner Public Health Unit by the project evaluator for the purpose of gathering final thoughts, insights and suggestions as to what a strengths-based practice might need to address or could look like if it was to be effectively and successfully adopted by a Public Health Unit – including their own.

The timing of the project phases was:

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<td>Seven</td>
<td>September 2012</td>
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<tr>
<td>Data review and final report</td>
<td>October 2012 to January 2013</td>
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The information and responses gathered from the questionnaires, focus groups, reflection sessions and expert interviews were gathered, reviewed and complied by the project evaluator with the goal of addressing the project objectives:

1. To identify the crucial factors that contributes to (or hinders) public health staff’s ability to adopt, develop and implement strengths-based principles of practice.

2. To propose a potential roadmap strategy for professional capacity building within Public Health Units that highlights a common language and a strengths-based framework for public health practice.

3. To identify the key aspects and guiding concepts that will be required to embed a strengths-based perspective and culture of practice in Public Health Units.
5.1 Ethics and Privacy Considerations

With regards to ethical considerations, participation in this project study was entirely voluntary and based upon informed consent. Informed written consent was obtained from each public health participant prior to completing the questionnaires or participating in the focus group sessions. No form of deception or coercion was used and participants were not compensated. To protect the confidentiality of project participants, responses on the questionnaires and focus groups were reported in aggregated or generalized format and unattributed quotations. The focus group format, however, means that the complete anonymity of the participants was not fully guaranteed to which the participants agreed to before taking part.

Ethics approval was applied for and received from the University of Calgary. Access to the data during the project time frame was restricted to Dr. Wayne Hammond, and research team members when required. Data was and will be stored at a secure site maintained by Resiliency Initiatives. Data was kept by Resiliency Initiatives throughout the project and will be given to Public Health Ontario at the conclusion of the project, along with the final report.

5.2 Study Design

To assess the project participants’ personal perception and capacity to be resilient, the Adult Resiliency: Assessing Developmental Strengths (AD:ADS) was administered (See Appendix C) prior to a one-day workshop on the theoretical principles of strengths-based practice and implications for professional health prevention practice. The results of the resiliency survey were presented at the strengths-based training workshop in aggregated format.
as a way to personalize the importance and inter-relatedness of one’s personal resilience and strengths-based professional practice.

In order to assess the project participants’ current knowledge and beliefs related to strengths-based concepts, as well as their perception of being supported to implement a strengths-based approach in their practice, the Strengths-Based Aptitude Questionnaire (SBAQ) was administered prior and shortly after the one-day workshop. The use of the SBAQ reflects a quasi-experimental one-group pretest-posttest experimental design, as the assessment protocol did not utilize random sampling or a control group design (Shadish, Cook, & Campbell, 2001). It should also be noted that measuring the potential pre-post changes in the project participants’ knowledge, beliefs, skills and perception of being able to embrace strengths-based practice, is challenging in light of the small sample size. Also, internal changes in a person’s beliefs take time paired with continuous training and support – not just a one-day workshop.

To further explore the potential challenges as well as the essential steps and strategies a Public Health Unit should consider in order to successfully embed a strengths-based culture for professional practice, expert interviews and multiple focus groups (two time periods: shortly after then three months after the strengths-based workshop) were utilized. The expert witness interviews were held shortly after the strengths-based workshop with the goal of hearing from a variety of roles in the Public Health Unit about the opportunities and challenges of embracing a strengths-based approach. The project evaluator created a script of questions that were used in the focus group and expert interviews (See Appendix B).

Finally, reflection sessions (See Appendix B) were performed by designated staff at each of the partnering Public Health Units. This encouraged the ongoing internal discussion and reflection process within the partnering Public Health Units leading up to the final focus group sessions. The reflection session facilitators were prepared to record the various concerns and overarching themes presented by their participating colleagues, which were also compared to the themes arising from the focus group and expert interviews (this
represented an additional way to confirm existing themes or detect emerging ones).

Responses on all the questionnaires were collected electronically in a non-identifiable format and inputted into a web-based data site (Assessing-Resiliency.com) created by Resiliency Initiatives. The data site has several reporting options that allows for the creation of aggregated group and comparative reports. These reports indicate degrees of resilience, as well as baseline and potential changes in identified areas related to strengths-based practice. All data collected in this project can be downloaded into an Excel spreadsheet for ongoing assessment purposes by Public Health Ontario. The collection of the data from questionnaires, focus groups, expert interviews and reflection sessions was overseen by Resiliency Initiatives and legally belongs to Public Health Ontario with full control over its use.

The full day strengths-based workshop was provided at multiple locations based upon the geographic location of the partnering Public Health Units. The strengths-based training workshop was provided by Dr. Wayne Hammond and was intended to be an introduction to strengths-based practice that highlighted the following:

1) The theory and history of strengths-based practice.

2) The role of resilience and principles of strengths-based practice.

3) Implications for professional practice and strengths-based capacity building in public health clients (both individuals and communities).

4) The role of organizational culture and leadership support for strengths-based practice.

5) The role of community members and partners in strengths-based practice.
5.3 Recruitment and Demographics

The participants in this project study were recruited from the following Ontario Public Health Units:

- Oxford County Public Health and Emergency Services
- Perth District Health Unit
- Huron County Health Unit
- Leeds, Grenville and Lanark District Health Unit

1) The initial administration of the AR:ADS, SBAQ and participation in the strengths-based workshop involved 261 public health staff participants.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number (N = 261)</th>
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<tr>
<td>Male</td>
<td>25</td>
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<table>
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<tr>
<td>50 to 59</td>
<td>62</td>
</tr>
<tr>
<td>60 plus</td>
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<table>
<thead>
<tr>
<th>Years of Practice</th>
<th>Number</th>
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<tbody>
<tr>
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<td>6 to 10</td>
<td>51</td>
</tr>
<tr>
<td>11 to 15</td>
<td>41</td>
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<tr>
<td>16 to 20</td>
<td>19</td>
</tr>
<tr>
<td>21 plus</td>
<td>52</td>
</tr>
</tbody>
</table>
2) The post administration of the SBAQ included 70 public health staff participants - all of whom participated in the pre questionnaires and strengths-based workshop.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number (N = 70)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>67</td>
</tr>
<tr>
<td>Male</td>
<td>3</td>
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<table>
<thead>
<tr>
<th>Ages</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 29</td>
<td>18</td>
</tr>
<tr>
<td>30 to 39</td>
<td>22</td>
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<tr>
<td>40 to 49</td>
<td>12</td>
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<tr>
<td>50 to 59</td>
<td>14</td>
</tr>
<tr>
<td>60 plus</td>
<td>4</td>
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</table>

<table>
<thead>
<tr>
<th>Years of Practice</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 or less</td>
<td>9</td>
</tr>
<tr>
<td>1 to 5</td>
<td>22</td>
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<tr>
<td>6 to 10</td>
<td>14</td>
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<td>11 to 15</td>
<td>12</td>
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<tr>
<td>16 to 20</td>
<td>1</td>
</tr>
<tr>
<td>21 plus</td>
<td>12</td>
</tr>
</tbody>
</table>

3) Two focus group sessions were performed with each of the partnering Public Health Units and included a total of 40 volunteer participants.

- (N = 10) Oxford County Public Health and Emergency Services
- (N = 8) Perth District Health Unit
- (N = 10) Huron County Health Unit
- (N = 12) Leeds, Grenville and Lanark District Health Unit

4) The expert interviews involved 15 key staff in various professional roles (directors, supervisors, managers, frontline, and administration, etc.) from the partnering Public Health Units. They were individually interviewed to capture the unique perceptions and insights from the various positions within the Public Health Units.
5.4 Measures

Questionnaires:
1) The Adult Resiliency: Assessing Developmental Strengths Questionnaire – AR:ADS
(See Appendix C – Questions 15 to 76)

The AR:ADS is self-report questionnaire developed by Resiliency Initiatives to determine an adult’s perception of their personal resilience and is based upon the 31 developmental strengths framework validated in the established youth resiliency framework model (Donnon & Hammond, 2007a; Donnon & Hammond, 2007b; Donnon and Hammond, 2011). See Appendix D for the Adult Resiliency Framework and Appendix E for review of initial psychometric properties in a draft journal publication being readied for submission entitled “A Psychometric Assessment of the Self-Reported Adult Resiliency: Assessing Developmental Strengths Questionnaire”.

2) The Strengths-Based Aptitude Questionnaire – SBAQ (See Appendix C – Questions 1 to 14)

SBAQ is also a self-report questionnaire that consists of 14 questions developed by Resiliency Initiatives and was designed to determine an adults’ personal and professional engagement in three important areas related to strengths-based practice:

1. **Strengths Orientation** - explores a person’s perception of strengths-based practice and their underlying beliefs of their professional role in nurturing the capacity of those they care for.

2. **Strengths Practice** - explores how and to what degree a person engages in the practices of their profession from a strengths-based perspective.

3. **Strengths Support** - explores whether a person feels supported by their work environment to engage in strengths-based practice.
6. QUANTITATIVE EVALUATION RESULTS

6.1 The Adult Resiliency: Assessing Development Strengths (AR:ADS) was administered to 261 Public Health staff participants prior to participating in the strengths-based workshop. The results of the questionnaires were inputted into a web-based data site created by Resiliency Initiatives that allows the data to be reported in two formats – Degrees of Resilience and Aggregated Developmental Scores:

a) Degree of Resiliency Graph (Figure 1)

The degree of resiliency graph displays four categories of degrees of resiliency determined by Resiliency Initiatives based upon a correlative analysis between degree of resiliency to risk and pro-social behaviours/attitudes in individuals (Donnon & Hammond, 2007a; Donnon & Hammond, 2007b; Donnon and Hammond, 2011). The four resiliency categories of degrees of resiliency are as follow:

**Optimal Resiliency** – Individuals who report having 26 to 31 positive developmental strengths are considered to be experiencing optimal resiliency. Individuals in this category present with a strong understanding of their developmental strength areas and actively draw upon them in collective and constructive ways.

**Average Resiliency** – Individuals who report only having between 21 and 25 positive developmental strengths are considered to be experiencing average resiliency. Individuals in this category indicate that although they understand the developmental strength areas, they are just starting to develop the ability to draw upon the developmental strengths in consistent and constructive ways.

**Vulnerable Resiliency** – Individuals who report only having between 11 and 20 positive developmental strengths are considered to be experiencing vulnerable resiliency. Individuals in this category indicate that although they are aware of the developmental strength areas, they have not developed the ability to draw upon the developmental strengths in consistent and constructive ways.

**Impoverished Resiliency** – Individuals who report only having between 0 and 10 positive developmental strengths are considered to be experiencing impoverished resiliency. Individuals in this category indicate that they are not aware of what their developmental
strengths are and have no experiential understanding as to how they could draw upon them to negotiate and navigate life’s challenges.

Figure 1: The Degree of Resiliency Graph

<table>
<thead>
<tr>
<th>Number of Developmental Strengths</th>
<th>Frequency</th>
<th>Cumulative Frequency</th>
<th>Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>00 - 10</td>
<td>2</td>
<td>2</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>11 - 20</td>
<td>6</td>
<td>10</td>
<td>3.1</td>
<td>3.9</td>
</tr>
<tr>
<td>21 - 25</td>
<td>45</td>
<td>55</td>
<td>17.2</td>
<td>21.1</td>
</tr>
<tr>
<td>26 - 31</td>
<td>206</td>
<td>201</td>
<td>78.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>261</td>
<td>261</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Key
0 to 10 DS = impoverished resiliency
11 to 20 DS = vulnerable resiliency
21 to 25 DS = average resiliency
26 to 31 DS = optimal resiliency

The responses of the Public Health participants on AR:ADS indicate that there are divergent degrees of resiliency capacity. The total number of Public Health staff was N = 261 of which .8% (N=2) reported an impoverished profile, 3.1% (N=8) reported a vulnerable profile, 17.2% (N=45) reported an average resilient profile and 78.9% (N=206) reported an optimal resilient profile.

b) The aggregated developmental strength scores of the project participants (N = 261) based upon the four categories of resilience (Figure 2a and 2b).
Key for categories of resilience:

<table>
<thead>
<tr>
<th>Significant Challenge</th>
<th>Moderate Challenge</th>
<th>Moderate Strength</th>
<th>Significant Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Scores of 0 to 25)</td>
<td>(Scores of 26 to 50)</td>
<td>(Scores of 51 to 75)</td>
<td>(Scores of 76 to 100)</td>
</tr>
</tbody>
</table>

**Figure 2a:** The external resiliency factors recognized as contributing to the protective elements of individual resiliency and the establishment of developmental strengths are family, peer relationships, role (work) and community.

<table>
<thead>
<tr>
<th>External Resiliency Factors and Related Developmental Strengths</th>
<th>Aggregated Scores of the Developmental Strengths for the Four Categories of Resiliency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Factor</strong></td>
<td></td>
</tr>
<tr>
<td>Caring Family</td>
<td>88%</td>
</tr>
<tr>
<td>Family Communication</td>
<td>87%</td>
</tr>
<tr>
<td>Family Role Models</td>
<td>91%</td>
</tr>
<tr>
<td>Family Support</td>
<td>93%</td>
</tr>
<tr>
<td>School Involvement</td>
<td>92%</td>
</tr>
<tr>
<td>High Expectations</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Relational Factor</strong></td>
<td></td>
</tr>
<tr>
<td>Positive Relationships</td>
<td>88%</td>
</tr>
<tr>
<td>Positive Influence</td>
<td>83%</td>
</tr>
<tr>
<td><strong>Commitment to Learning</strong></td>
<td></td>
</tr>
<tr>
<td>Personal Achievement</td>
<td>90%</td>
</tr>
<tr>
<td>Role Engagement</td>
<td>90%</td>
</tr>
<tr>
<td>Balanced Lifestyle</td>
<td>76%</td>
</tr>
<tr>
<td><strong>Role-Work Culture Factor</strong></td>
<td></td>
</tr>
<tr>
<td>Bonding to Role Environment</td>
<td>93%</td>
</tr>
<tr>
<td>Caring Role Climate</td>
<td>80%</td>
</tr>
<tr>
<td>Role Expectations</td>
<td>80%</td>
</tr>
<tr>
<td>Role Boundaries</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Community Factor</strong></td>
<td></td>
</tr>
<tr>
<td>Caring Relationships</td>
<td>63%</td>
</tr>
<tr>
<td>Caring Community</td>
<td>74%</td>
</tr>
<tr>
<td>Community Cohesion</td>
<td>68%</td>
</tr>
<tr>
<td>Shared Common Values</td>
<td>68%</td>
</tr>
</tbody>
</table>
**Figure 2b:** The **internal resiliency factors** that contribute to the protective elements and the youth resiliency developmental strengths framework are cultural sensitivity, empowerment, self-control, self-concept, and social sensitivity.

<table>
<thead>
<tr>
<th>Internal Resiliency Factors and Related Developmental Strengths</th>
<th>Aggregated Scores of the Developmental Strengths for the Four Categories of Resiliency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Control</td>
<td></td>
</tr>
<tr>
<td>Resistance Skills</td>
<td>90%</td>
</tr>
<tr>
<td>Restraint</td>
<td>92%</td>
</tr>
<tr>
<td>Empowerment</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>88%</td>
</tr>
<tr>
<td>Self Concept</td>
<td></td>
</tr>
<tr>
<td>Planning and Decision Making</td>
<td>93%</td>
</tr>
<tr>
<td>Self Efficacy</td>
<td>86%</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>88%</td>
</tr>
<tr>
<td>Social Sensitivity</td>
<td></td>
</tr>
<tr>
<td>Caring</td>
<td>91%</td>
</tr>
<tr>
<td>Empathy</td>
<td>90%</td>
</tr>
<tr>
<td>Equity and Social Justice</td>
<td>94%</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>82%</td>
</tr>
<tr>
<td>Cultural Awareness</td>
<td>78%</td>
</tr>
<tr>
<td>Spirituality</td>
<td>79%</td>
</tr>
</tbody>
</table>

The aggregated results from the AR:ADS responses reveal that as the degree of resiliency decreases, certain developmental strengths start to present as weaker. This trend of certain developmental strengths becoming weaker can be seen in the Average Resiliency category where the external developmental strengths of “Caring Relationships” and “Shared Common Values” present as moderate challenges. In the Vulnerable Resiliency category, it would appear that a number of external developmental strengths (10 of the 19 developmental strengths – all external strengths) are presenting as moderate challenges where the internal development strengths
continue to present as moderate to significant strengths. In the Impoverished Resiliency category, the participants’ responses reveal that all the external and internal developmental strengths are presenting as moderate to significant challenges.

c) The Strengths-Based Aptitude Questionnaire

The questions on the Strengths-Based Aptitude Questionnaire highlight three important areas related to strengths-based practice:

1. **Strengths Orientation** (1,2,3,6,7,9,10) - explores a person’s values and underlying beliefs of their role in nurturing the capacity of those they care for.
2. **Strengths Practice** (4,5,8,11,12,13) - explores if a person engages in a strengths-based manner in their professional practice.
3. **Strengths Support** (14) - explores whether a person feels supported by their work environment to engage in strengths-based practice.

Participants who respond with “Always Like Me” have a **strong aptitude** towards being strengths-based in their thinking and demonstrate a consistent ability to engage in strengths-based practice. Participants who respond with “Somewhat Like Me” may have a **moderate aptitude** towards strengths-based thinking and often demonstrate inconsistency in their practice by defaulting to the more tradition model of care when faced with challenges. Participants who respond with “Rarely Like Me” and “Not At All Like Me” demonstrate a **vulnerable aptitude** towards embracing the strengths-based perspective and tend to default to the traditional illness model of care and practice with clients they are supporting.

The percentage of pre-strengths aptitude of the 261 participants in the three categories were:
**Figure 3:** Pre-SBAQ results indicating the average percentage of how many of the 261 project participants presented as strong, moderate or vulnerable in the three critical areas of strengths-based practice (Appendix F):

<table>
<thead>
<tr>
<th>Category</th>
<th>Strong Average %</th>
<th>Moderate Average %</th>
<th>Vulnerable Average %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths Orientation</strong></td>
<td>56%</td>
<td>42%</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Strengths Practice</strong></td>
<td>50%</td>
<td>44%</td>
<td>6%</td>
</tr>
<tr>
<td><strong>Strengths Support</strong></td>
<td>31%</td>
<td>47%</td>
<td>22%</td>
</tr>
</tbody>
</table>

The participant responses indicate that with regard to the two areas of “Strengths Orientation” and “Strengths Practice” approximately half (56% and 50% respectively) affirmed a strong understanding and ability to engage in strengths-based practice. A slightly smaller (42% and 44% respectively) group of participants reflected a basic understanding and orientation towards wanting to engage in strengths-based practice. A very small percentage of the participants (2% and 6% respectively) reported a clear traditional belief and tendency to default to the deficit model of care practice. It was interesting to note that only 31% of the participants felt supported by their work environment to be strengths-based in their practice with 47% feeling it was inconsistent. But, 22% felt that strengths-based principles were not supported.

To assess potential changes in the three critical areas after the strengths-based workshop, a paired sample t-test was performed on a total of 70 project participants that completed the Post Strength-Based Aptitude Questionnaire (Appendix G). In a paired sample t-test during the time between the survey periods, the project participants did report a significant improvement in their Strengths Orientation ($t(69) = 2.486, p < 0.05$). The analysis indicates that there was a change in the positive direction in the participants’ beliefs and values about strengths-based practice, but not a significant change in their practice or sense of being supported. It was expected that there would be minor changes in the Strengths Practice and Support categories following a one day workshop.
The responses by the participants in the focus groups from the two time periods and the expert interviews were recorded (with permission from the participants) and then transcribed for analysis purposes. Included in this analysis were the observations submitted by the leaders of the reflection sessions at each of the partnering Public Health Units. The analysis protocol drawn upon followed the constant comparison analysis technique (Onwuegbuzie, Dickison, Leech, & Zoran, 2009). The data collected from each of the focus groups, expert interviews and reflection sessions were initially divided into small comments (e.g., need for training, feelings of isolation, frustration with organizational limitations, etc.) that were assigned a descriptor which were, in turn, grouped into categories that developed into several overarching themes (e.g., leadership, policy, management, programing, evaluation, professional development, community relationships, etc.). The resulting themes were compared for continuity or uniqueness from the various focus groups, expert interviews, as well as the reflection sessions, to create the final compilation of results.

The overarching themes and related observations from this evaluation protocol were as follows:

1) **Public Health leadership and organizational policy**
Participants identified a need for a strong leadership role to embrace and support the implementation of a strengths-based perspective and practice in Public Health. It was expressed by the participants that an effective leadership would need:

   a) To become strong advocates for a strengths-based perspective at a government-systems level and in articulating the role of Public Health from a strengths-based perspective in the communities they serve.
b) To take the lead in crafting a mandate and organizational policies that would clearly articulate the vision, mission and goals for strengths-based health care with implications throughout all levels of Public Health.

c) To support an evolving culture of Public Health policy and practice guidelines that are adaptive and responsive to ongoing research evidence, professional expertise within the Public Health Units, and community feedback regarding what is effective and meaningful practice. The emphasis needs to be on fostering a Public Health practice culture of innovation at the management and frontline staff levels.

It was strongly agreed upon that if Public Health Units are going to be successful in embracing and practicing a strengths-based approach, leadership needs to clearly articulate the new vision, mission and goals for public health care with implications throughout all levels of the Public Health Unit. This would need to include clearly outlined and supported practice guidelines and policy development that embraces a culture of strengths-based innovation.

Illustrative quotes from participants:

“If the leadership supported a common language and framework of how we practice that reflects the principles of strengths-based practice, then there would be a stronger coherence and purposefulness in all public health staff being on the same page in embracing a strengths-based approach to health care.”

“It may be a real challenge to embrace a strengths-based perspective since nursing is based upon a medical model; it is about what’s wrong and how do we fix it and as a result, the community sees us as only performing that role.”

“Yes, it is essential that those in leadership understand and are very familiar with the principles of a strengths-based approach. They need to know the research related to it so they know what it means, what it should look like within an organization and supports its practice.”

“Although we are designated providers of care, we have a lot to learn from the individuals and communities we serve; we just need to be receptive to their responses.”
2) **Public Health Unit’s organizational culture and values**
Participants outlined several organizational characteristics considered to be essential for successfully implementing a strengths-based perspective. They identified the following:

a) The need for a shared and clear vision, mission and goals for strengths-based professional practice within the Public Health Unit – supported in the language, documentation and desired outcomes.

b) The need to embrace a culture of creativity and innovation at the management and frontline staffing levels that uniquely adapt a strengths-based perspective to the evolving opportunities of building on the strengths of the clients and the communities they live in.

c) The need to nurture a strengths-based practice that values diverse Public Health roles, demonstrates respect, trust and support for staff working from their strengths; this needs to be reflected and modeled at all levels within the Public Health Unit.

d) That a successful culture shift towards strengths-based practice will take time and there will need to be support for a process of risk-taking, exploring and adapting towards the desired program culture and practice goals.

e) That all the diverse Public Health roles (including administration, etc.) need to be valued and considered as critical to the success of strengths-based practice.

f) The need to put a stronger focus on relational, partnering and facilitating processes by which Public Health supports the community- as opposed to the more traditional model of “just offering services”.

Illustrative quotes from participants:

“In our organization, there would be no challenges to creating strengths-based practice and developing guidelines that are more holistic; we just need to hear it from the leadership and their desire to support it.”

“If the leadership supported a common language and framework of how we practice that reflects the principles of strengths-based practice, then there would be a stronger coherence and purposefulness in all public health staff being ‘on the same page’ in embracing a strengths-based approach to health care.”

“Most of our thinking and practice focus is to prevent chronic disease, reduce injury, reduce substance use and misuse – they are all very negative oriented. As a result, our frame of reference when we do operational planning is to look at the kinds of things we can implement to deal with those negatives.”

“I often feel isolated and disconnected from the larger work or initiatives of my Public Health Unit. I was not even invited to the workshop that started this whole discussion on strengths-based practice.”

“Embracing a culture of strengths-based practice will need to be slow – start with small successes and build upon them”

“All too often, what we offer to the community and what I hear them requesting is different. It creates a big disconnect personally and professionally.”

“The idea of narrowing the gap between how I should treat people and how I do treat people is important. It reignites the reasons I got into nursing in the first place.”

3) Public Health Unit’s program planning and outcome evaluation

Participants clearly indicated the need to align program development with the strengths-based principles of practice. The discussions focused on the following:

a) Effective programming needs to be informed by best practice evidence and to incorporate new learning through the template of a strengths-based perspective as part of an ongoing evaluation. Participants related that staff would need to be involved in, and take responsibility for, the development of programs based upon the expertise they bring from daily practice and feedback from their community relationships and connections.
b) Programming needs to be collaborative with community participation and not solely directed by Public Health. It is not just about counting numbers or what Public Health thinks the community needs—rather, it is also about the perception of how clients’ feel about their own sense of health and how they perceive being heard and supported by Public Health.

c) Current programming goals and outcomes were considered narrow and would need to be more holistic and balanced with the desired outcomes of strengths-based practice. The goal is not just “mitigation or absence” of health risk, but outcomes should also explore and build on the innate strengths and capacities that support sustainable health trajectories and practices in individuals and the communities they live in.

d) Evaluation protocol and outcomes of Public Health Units are primarily about numbers and reducing risk (which are predetermined) rather than a more holistic and client-centred perception of success (which becomes unrealistic given existing demands, resources and time constraints). Conversations explored what would it look like to evaluate a more humane health care system that puts people and communities first and is responsive to their perceived needs (not: this is what we think you need and this is what it will look like). It was proposed that evaluation models would need to include qualitative and quantitative criteria and be reflected in the recording protocols staff are asked to perform.

Illustrative quotes from participants:

“I have often wondered whether the communities we work with know that we actually care or feel safe enough to share their real concerns. Are we responding in ways that they feel part of the process and more hopeful about their health?”

“It’s like we are failing those we are to care for. I’m not sure people experience a sense of hope and confidence based on how we engaged and provided a health care service to them.”

“How can I be expected to work from a strengths-based approach if the data I collect, to determine the success of a program, is based upon the number of
clients served and how often I presented specific information or a pre-determined health intervention? What about whether they felt valued or respected or need other supports to make what we did offer more meaningful? It takes time to listen to what a person or community may need or want, but I’m not asked to collect this type of information."

“We are told that these are the activities we need to complete – not a lot of room for anything new.”

“Although our current guidelines do tell us how the prevention strategies and evaluations are to be carried out, there could be some flexibility on the approach we can take with individuals.”

4. Public Health management practices
Participants spent a great deal of time discussing a number of topics involving the role of management practices in supporting strengths-based practice in Public Health Units. They are as follows:

a) Many of the participants highlighted the belief that managers (and other leaders) play an important role in developing stakeholder understanding and promoting the role of strengths-based health care to other providers, community partners and the general public. It was identified that there is also a need to obtain the support of community physicians in order to effectively implement strengths-based Public Health programming as they are considered an important relational conduit to the public.

b) Participants explored the idea of managers needing to be more supportive of autonomous practice by the Public Health staff. The meaning of autonomous practice was debated with some participants embracing the idea of it being the freedom to be creative and responsive to the needs on a community. Others described autonomy as being the opportunity to be more independent in how they practiced, in not being so closely monitored by managers or physicians. Many stated that their understanding of being autonomous would involve broader job descriptions and that the goals of the program might allow for creativity and the flexibility of using a broad range of health care skills.
c) Participants highlighted the need for management to support public health partnerships and communities in developing a deeper understanding of their important contributions and the essential innate strengths they bring to support the success of developing and maintaining positive health outcomes.

d) Participants commented on the need for management to develop proactive and effective recruitment and retention strategies. Hiring practices should recruit new staff with the appropriate skills, knowledge and attitudes that support and are aligned with the desired professional culture of strengths-based practice. Concern was expressed with the potential lack of qualified staff and numbers of staff to successfully implement programs that will meaningfully meet the diverse needs of the communities being served.

Illustrative quotes from participants:

“It is not about dictating to community – they are come with strengths and goals for their own community that is unique and we need them to be successful.”

“This would require time for staff to develop the trust and respect with clients, community groups and other community stakeholders – for them to become active partners in the facilitating process.”

“I know how I would want to be cared for personally and its not how I’m being asked to practice.”

“If we hire, we should screen for the skill sets needed for strengths-based practice- not train for them after the fact.”

5. Professional practice, learning and support:
Although the initial training workshop was well received, it was more of an introduction to ‘what strengths-based practice is’ as opposed to an extended, in-depth training that would lead to practical and contextualized practice by Public Health staff. If strengths-based practice is to be embraced, then participants addressed the idea that enhancing
the theoretical and practical skills of current staff would be critical. A number of related ideas were shared:

- Have advocates and champions of strengths-based practice within each sector of a Public Health Unit

- Promote effective practice with a train-the-trainer approach; develop continuous learning and educational opportunities to enhance professionalism and evolve shared learnings

- Take a collaborative Public Health Unit approach to programming with clear accountability, based upon celebrating successes and shared learning with all staff

- Put a strengths-based lens on Public Health documentation, educational practices and teaching models (e.g., wording of documentation, hiring protocols for new staff, community engagement and language of communication, focus of program outcome and evaluation protocol, etc.)

- Review quality assurance and accountability processes, asking what are we doing well, what should we adapt and what should we let go of (e.g., highlighting expectations and successes through a monthly newsletter)

- Become more transparent and holistic in practice with an emphasis on being person, family and community focused, on being inclusive and participatory

- Develop continual invitations to support strengths-based practice as a way of working: cheat sheets, visual reminders, opportunities for shared conversations within and between sectors, etc.

- Develop effective ways to translate new ideas into meaningful practice; create a clear process and implementation model of practice supported by all levels of Public Health Units that prevent ideas getting lost in bureaucracy

- Place a stronger emphasis on the importance of knowledge exchange including the provision of educational tools and access to specialized professions for expert advice.

- Ensure a healthy workplace that reflected family-friendly policies, job sharing, flexible work hours, etc.
Illustrative quotes from participants:

“At the end of the day, it is important that we connect evolving practice of staff at the Public Health Units with the larger mandates…”

“Developing ways to hear what other staff are experiencing and what has worked for them would certainly help my ability to be strengths-based in my role.”

“If we are going to be asked to be strengths-based in our roles, I will need further training and want to know that it is being fully supported by my managers – will really know if I actually experience it first hand by the way I’m supported.”

“If the leadership supported a common language and framework of how we practice that reflects the principles of strengths-based practice – Then there would be a stronger coherence and purposefulness in all public health staff being on the same page in embracing a strengths-based approach to health care.”
The purpose of this project was to explore the current and required capacity of Public Health staff to embrace a strengths-based approach in their practice. Its objective was to understand: what are the essential steps required for Public Health to embed a strengths-based culture? And, what practical strategies can be adopted by Public Health Units wanting to embrace a strengths-based approach?

The initial evaluation results indicate that a majority of the project participants (N = 261) from the partnering Public Health Units presented with average (17.2%) to optimal (78.9%) resilience. The concept of resilience and strengths-based practice are very much intertwined; research indicates that resilience is an essential trait for understanding and engaging in strengths-based practice – you cannot embrace or give away what you are not experiencing personally (Bertolino, 2010; Reivich & Shatte, 2002). With such a strong indication of personal resilience among the Public Health staff, the capacity to implement a culture of strengths-based practice in Public Health is enhanced. There were some project participants, however, that reported a vulnerable (3.1%) and impoverished resiliency profile (.8%) suggesting that one must not assume that all Public Health staff will be prepared to step outside their professional and personal comfort zones.

Some Public Health staff will need to be supported and given permission to explore their sense of personal resilience and professional purpose. In the focus group sessions and expert interviews, many Public Health staff talked about not feeling confident in having the right knowledge, skills and systems support to fully practice from a strengths-based perspective. In many ways, the idea of engaging in a strengths-based practice created a potential dilemma and, as noted in the survey results, a large number of project participants were not confident that they would be supported to engage in strengths-based practice by their work environments. Although many participants were receptive to the idea of focusing on strengths as a starting point for promoting positive health,
Embedding a Strengths-Based Approach

seriously working from the underlying values, principles and philosophy of strengths-based practice was seen as a potential challenge – but not insurmountable.

It was generally agreed that current Public Health practice is strongly influenced by the medical model with an emphasis on problems or potential risks as a starting point. When the problem becomes the only starting point - when the emphasis is on what is lacking in the person or community - this can lead to simplistic and narrow solutions, which may not address the real issues in the long term. This, in turn, has the potential to develop a narrow public perception of what health care is, as well as a dysfunctional dependency on the helping profession.

In response to this challenge, many of the participants saw the value of embracing a more balanced and holistic perspective based in a strengths-based approach. The participants agreed that strengths-based practice does not deny that people experience problems that need to be taken into consideration. Rather, the strengths-based perspective holds the belief that those individuals and their families have strengths, resources, and the ability to recover from adversity. It is an approach to health care that avoids labeling and assumes power in people, families and the communities they live in, to help themselves. It casts health care service providers as partners rather than experts, authorities, initiators and directors of the change process. This fundamental shift was appealing to the project participants as it means working with and facilitating rather than fixing, pointing to signs of health rather than just dysfunction, limiting the negative influence of labels and diagnosis to wholeness and well-being. It invites asking different questions that are more curious, exploratory and hopeful. In many ways, the conclusion embraced by the participants was that the strengths-based approach offers a basis for addressing the primary mandate of community health services: people taking control of their own lives in healthy, meaningful and sustainable ways.

When the participants were asked about the steps Public Health Units need to take to successfully embrace a strengths-based practice, they identified the following areas:
1. Leadership that understands, articulates, facilitates and champions, a shared vision for strengths-based practice within and outside the Public Health Units.

2. Policy and practice guidelines that support a purposeful, strengths-based vision reflecting the guiding values and principles of a strengths-based approach to health care practice and evaluation.

3. Commitment to strengths-based professional development and learning that values all staff roles (not just nurses) and supports innovative and responsive care practices. It cultivates effective program planning, based upon outcome driven evidence (qualitative and quantitative), with an attitude towards learning that continuously incorporates the results of ongoing evaluation, program learning and feedback from clients.

4. Effective human resource planning where new recruits are hired based upon having the right knowledge and aptitude for supporting a culture of strengths-based practice. Existing staff are supported in ways that values open communication (not restricted to hierarchy), nurtures a strengths-promoting workplace environment, provides adequate staff (both nursing and support) for engaging in relationship building with clients and community partners, etc.

5. Supported Public Health partnerships and community development that allows for the integration of initiatives and services, across disciplines and agencies. Essential to this concept is support for Public Health staff to perform facilitation and support roles in community, the goal being to explore, identify and enhance innate resources and sustainable capacity building.

A shift to the strengths-based paradigm would require careful attention to system change processes, evaluation, and appropriate research and best practices. If the strengths-based approach is to be something that truly guides and influences the practice of Public Health Units, it would need to be evident in: the manner of interactions with the clients and communities they serve, the language of service, team and organizational interactions, the written documentation of service provision activities (assessment, service delivery, training, etc.). It would reflect the following:

- Seek to understand the crucial variables that contribute to individual resilience and well-functioning families/communities
- Provide a common language and preventative philosophy
- See resiliency and enhancement of innate strengths (that reflect positive health) as goals that provide a conceptual map to guide prevention and evaluation efforts
- Intervention and prevention strategies would be client driven and relationship focused
- Start with achieving small things, then build upon successes
- Engage distressed people and families, as well as the communities they live in, with respect and compassion – it starts with their story
- Perceive capacity building as a dynamic and experiential process that evolves over a lifetime with multiple partners in the community – it “takes a village”
- Affirm the reparative potential in people and communities and seek to enhance strengths as a starting point (as opposed to deficits or illness)
- Promote successful change through connecting a person’s strengths and their aspirations

Participants recognized the need for a shared public health vision that is linked to clear goals and roles, and informed by evidence and community needs. In light of the complex nature of Public Health, however, it was suggested that staff resource planning needs to provide the required time, support and flexibility for building partnerships, assessing community needs and strengths, nurturing client participation, development of new program opportunities and ongoing professional development. If resourced, supported and effectively aligned to their strengths, staff retention and recruitment of new Public Health staff could be enhanced.

Participants identified the need for flexibility and autonomy in their roles within the Public Health Units. It was pointed out that management should build relationships with staff that encourages innovation, risk-taking and responsiveness to community needs. Public Health practice needs to be flexible, creative and open to change based upon the needs of the community being served. It was also emphasized that management needs to take a lead role in promoting the role of Public Health and strengths-based practice within the organization and publically to community partners. Leaders needs to be
knowledgeable advocates to support effective strengths-based practice in a health care system dominated by an illness paradigm.

Finally, participants reiterated that effective Public Health is collaborative and involves multiple partners. Developing collaborative partnerships takes time and resources, but lends to building sustainable health and sense of confidence and respect by those community members involved. It starts with doing small things together and then building upon the successes experienced. Participants also valued the need for ongoing training and professional development that would support mentoring initiatives, in-house knowledge exchange, technology infrastructure and training/educational workshops or just the opportunity to share success stories between peers.

The strengths-based approach in Public Health is about expanding the mandate and service provision of staff and leadership. It requires a new set of values that invite innovative solutions to long-standing challenges. It values strengths as the starting point in exploring what is best, what is working, and what has potential. In contrast to the current problem-based model of health care, strengths-based practice requires a shift in focus from health professional-assessed outcomes to client outcomes that include health, healing, quality of life and subjective wellbeing. It is about working with people, teams and systems to enhance the greatest potential of experiencing what is important and meaningful to them. It is about keeping the primary focus on the health provider-client relationship in order to promote health and, in so doing, enhance the professional practice of Public Health. Just as Public Health staff need to create environments conducive to helping people take control of their own healthcare, Public Health leadership needs to enable staff to become empowered to practice with a strengths-based perspective.
With its focus on concepts of strengths-based practice and the potential implications for professional best practices/directions of Public Health, the current project explored a potentially novel paradigm shift in public health care policy and practice. While the results of the study highlighted the potential capacities for, strategies to embrace and essential areas to explore in order to embed a strengths-based perspective in Public Health practice, it should be noted that certain limitations were the data collected and evaluated in this study involved a relatively small number of project participants from the four partnering Public Health Units. As a result, the changes in personal perception and capacity to be strengths-based as well as perceiving to be supported to engage in strengths practice were not expected to be significant as changing and solidifying beliefs and institutional practices is a long term process requiring a number of strategies.

This study was a pilot project involving a small number of participants and results should be interpreted with caution and further explored with a larger sample size in more diverse Public Health and community contexts. Also, this study was not a pure research study and did not reflect an experimental design with a control group. However, there was a strong receptiveness to the concepts and potential of engaging in strengths-based practice by the participants in Public Health that could be actualized through a larger collaborative initiative that explored implementing the identified strategies and focused areas requiring change in ways that will enhance the opportunity for strengths-based practice.
As stated earlier, a shift to the strengths-based paradigm requires careful attention by Public Health staff and organizations on: system change processes, intervention and prevention practice, client (community) rapport and evaluation, and appropriate research and best practices. If the strengths-based approach is to be something that truly guides and influences practice, it should be evident in the language of interactions with the people served, the language of service, team and organizational interactions, and the written documentation of service provision activities – assessment, service delivery, training, etc. (Rapp & Goscha, 2006). Embracing a culture of strengths-based practice in Public Health will be a gradual and purposeful process that needs to give consideration to the following areas:
1) Embedding a Strengths-Based Philosophy:

Developing and sustaining a strengths-based culture requires commitment and leadership that understands, reflects and models its principles. It is about having a strengths-based way of thinking, describing and practicing consistently in ways that are and purposefully supported by all staff and community partners (McCashen, 2005; O’Connell, 2006).

A strengths-based organization will ask the following questions:

- Do we understand that a strengths-based approach is a philosophy based on values and guiding principles for working with all clients to bring about change?
- Do we relate to clients in ways that demonstrate positive attitudes about their dignity, capacities, rights, uniqueness and commonalities?
- Do we purposefully create conditions and unique opportunities for care providers and clients to identify value and draw upon their strengths and capacity in ways that creates meaningful and sustainable progression towards change and positive health goals?
- Do we provide and mobilize resources in ways that complements a person’s or community’s existing strengths and resources as opposed to compensating for perceived deficits? Is it a holistic approach of combining excellent health care practice with supporting the well-being of those we serve?
- Do we acknowledge and address power imbalances between care practitioners and clients (e.g., Not: “I’m the healer and your role is to obey me and follow my instructions.”)?
- Do we seek to identify and address social, personal, cultural and structural barriers to a person’s desired goals, growth and self-determination?

A strengths-based culture supports building the capacity of people in proactive and sustainable ways. Not only are the various types of support resources important - how they are offered to complement a person’s existing strengths and goals is just as important. Using services to complement a person’s existing capacity is different than trying to find ways to repair perceived deficits by just adding knowledge and skills. If external resources and supports are not offered in the context of what is meaningful, and do not build upon the person’s existing strengths and resources, the whole experience can undermine the person’s ability to learn and be self-determining. It can
send messages that say to the person: “You have no strengths that are relevant” or “You cannot cope or change your life,” or “You need our expertise.”

Strength-based organizations are unique in that they promote what McCashen (2005) calls a “parallel practice”. McCashen (2005) relates that parallel practice is the action of bringing the principles, processes and skills of the strengths-based approach into organizational contexts, processes, decision-making, direction and policies – both internally and externally. How an organization values and works with its clients needs to be the same process it embraces with it own staff and internal interactions. Strengths-based organizations take a strengths-based approach to decision-making, meetings, planning, supervision, administration, responses to internal and external issues, and relationships with their communities and other organizations. It is always concerned with the political, structural, cultural context of the individuals and teams in the organization itself, as well as with the society in which it exists.

Although what a strengths-based culture looks like varies according to the unique circumstances of the organization, there are common features that are recognizable.

It exists when one sees (McCashen, 2005):

- A clearly articulated mission and vision of strengths-based practice that is embraced at all levels of the organization and supported by leadership
- Strengths-based skills and questions being used in informal and formal contexts in an organization: in supervision, in meetings, in hallways, in annual reviews, in strategic planning, etc.
- Staff members have a sense of belonging and ownership of decision-making and change processes along with a high level of participation and a feeling of being valued
- Staff supervision uses strengths-based processes and skills to review practices and support staff practice
- Staff are supported and encouraged to take the initiative to explore new ground and test new ideas
- Staff deemed to have done the wrong thing are seen as having good intentions and affected by constraints rather than seen as the problem
- Records of meetings, supervision, and decision-making are transparent and owned by the participants
- Affirmative action and just, equitable working conditions
A strengths-based culture is one where leadership, staff, families, and community partners are supported and invited into open and honest communication. Expectations about all aspects of role, performance, attitudes and behaviours are clear, as are everyone’s rights and responsibilities. There is a shared vision and responsibility for achieving the desired health care vision. Success is celebrated and good practice acknowledged.

**Suggested Reading Resources**


2) Embedding Strengths-Based Leadership:
Developing and sustaining a strengths-based approach by organizations requires the creation of a strengths-based culture. This requires commitment and leadership that understands, reflects and models strengths-based values and principles. Essential to a strengths-based organization will be leadership that reflects the following (Gottlieb, 2013);

1. Strengths-Based leaders have a clear vision and through communication and actions, know how to help the organization’s staff to understand how their unique contributions are essential to the success of the larger picture and goals of the organization. Strengths-based leaders are continuously taking stock of the
organizations strengths: what strengths are present, where to build strengths, how strengths in one area can be used to scaffold, complement, or compensate another.

2. Strengths-based leaders recognize and validate the uniqueness of staff at all levels as well as the organization itself. Strength-based leaders understand that they are creating and building a community requiring professionals with different expertise, knowledge and skills to meet the complex needs of the clients and communities being served. It is the leader’s responsibility to bring individuals to work together with the right mix of strengths to realize their vision and effectively meet client needs. To accomplish this, leaders need to know the existing talents of their staff and identify potential abilities that can be developed into strengths through training, education and experience. It’s about respecting and valuing the organization’s staff, treating them with dignity and providing positive feedback about what they are doing best and how to do better.

3. Strengths-based leadership support creating healthy work environments that promote staff’s health and nurtures their development. They treat staff as assets to be developed, not managed. They encourage relationships and create experiences that nurture staff to do their best. It is about investing in people and relationships and securing the resources to make it happen.

4. Strengths-based leaders understand that people create their own reality and tend to find different ways to find meaning in the work they do. Staff will hold different viewpoints and values, which in turn often affect how issues are framed, decisions made and solutions determined. Effective leaders are aware of this aspect of human development and strive to understand multiple positions, find common ground in differences and make a concerted effort to consider multiple viewpoints. They are comfortable holding contradictory perspectives because they understand that opposing ideas can result in creative and innovative solutions.

5. Strengths-based leadership values and supports self-determination in the organization’s staff. When staff have the ability to choose without coercion, they
are more likely to be motivated to do their best. Their desired organizational culture is one where conditions exist to further develop skills of autonomy, competence, and relatedness by providing positive and meaningful feedback and opportunities to exercise and engage in choice.

6. Strengths-based leadership strives for “goodness of fit” between staff and the work environment where strengths are capitalized. Purposeful efforts are taken to create opportunities for staff to be in positions that align with their passions and skills as well as supported with resources to realize their potential.

7. Strengths-based leaders place a strong emphasis on environments that promote continuous learning and recognize the importance of readiness and timing. They understand the importance of transforming their departments into learning environment where knowledge, information, self-awareness and research are valued activities. Strength based leaders also recognize that staff need mentors and preceptors. It is about creating a coaching model so that younger staff will profit from what others have learned and to assist them to acquire the knowledge and skills needed to develop expertise in a given field and to benefit from learning from mistakes.

8. Strengths-based leaders place a high priority on collaborative partnerships within and outside the organization. Effective partnerships are built on negotiated goals shared power, openness and respect. It is built on the strengths that each partner brings to the table, their respective talents and expertise used in ways to meet goals and to work with purpose and intention in meaningful ways. Consistent with the strength-based approach, collective partnerships focus on what each partner does best. It involves helping the other partner models respectfully, inclusive, collaborative, transparent practice maximize his or her talent and potential. It is an approach that engenders confidence by promoting competence.

In general, strengths-based leadership is an approach to management that uses the principles, processes and skills of the strengths approach to lead and develop effective organizations with the following qualities (McCashen 2005):
• Models respectful, inclusive, collaborative, transparent practice
• Enables the sharing of power and responsibility for service delivery, internal decision-making and operations
• Provides leadership in initiating, developing and sustaining strength-based practice
• Enables staff participation in, and shared ownership of, visioning processes
• Focuses on the strengths and resources of staff
• Acknowledges power imbalances in the organization and works to address them
• Encourages and supports participation in decision-making
• Is mindful of cultural and personal constraints and how dominant stories and ideas can constrain change and learning and is attentive to addressing them
• Is committed to transparent practices and processes
• Is clear about bottom line and accountability
• Enables the development of a clear picture of the future and measurable goals
• Keeps a focus on exceptions and strengths stories
• Sees the problem as the problem

Strengths-based leadership and management assumes good intentions, recognizes that people bring many strengths and skills, and values these by becoming appreciative audiences to their efforts.

Suggested Reading Resources


3) Embedding Strengths-Based Professional Development:

If we are going to ask staff to practice from a strengths-based perspective, Public Health needs to support its workers in developing a personal and professional world view that sees “the cup as half full”. In addition, they will need resources that nurture and reinforce that perspective. The characteristics and beliefs of strengths-based practitioners can be enhanced when they are supported by colleagues and administrative staff in the following ways (McCashen, 2005):

a) Provide opportunities for staff to reflect on and discuss their personal beliefs about resilience and strength-based principles: What does it mean in our professional relationships and intervention programs if people are resilient and at potential? Answering this question as an individual and then coming to a consensus on the answer as a team is the first step towards creating intervention programs or care environments that taps into their client’s strengths and capacities.

b) Form a strength-based practice study group: Provide opportunity and resources to learn about strengths-based practices, the role of “signs of health” development and resilience. Share personal stories of individuals who successfully overcame the odds. Who was the person in our lives that demonstrated resilience? What was it about that person that made the difference? Polakow (1995) stated that, “It is important to read about struggles that lead to empowerment and to successful advocacy, for resilient voices are critical to hear within the at-risk wasteland.”
c) **Focus on the care provision climate:** Care programs and interventions that have strength-based cultures and capacity building experiences are often described as being like “family,” “a home,” “a community I belonged to.” Creating a safe haven is just as important for care providers as it is for the people they serve. It is about being inclusive, respectful, encouraging, honest, socially just and supportive.

d) **Foster community collaboration to coordinate services needed by community members and their families:** If one is to be strengths-based, the needs of the whole person must be considered and may require the support of family and other community resources in collaborative ways. These supports may include professionals, organizations, information, knowledge, material resources and decision-making resources.

e) **Building Staff Capacity:** Nurturing and sustaining a belief in a strengths-based perspective is not only the critical task of staff, it should be a primary focus of administration. Public health unit staff need the same concepts and resources as their clients: caring relationships with colleagues; positive beliefs, expectations, and trust on the part of administration; and ongoing opportunities to reflect, engage in dialogue, and make decisions together. It is critical that the culture be supportive of creative care practitioners who are attempting to respond to a client’s stories, create opportunities for further training, devote time for staff to request support and share successes, and, finally, create opportunities to be mentored by other seasoned practitioners who have embraced a strengths-based perspective.

Public Health workers become facilitators of the change process as opposed to drivers of change. This is accomplished with a range of skills that need to be adapted by Public Health staff and are complementary to the strengths-based approach. These skills are not just another technique, but are based on a belief about people and are best understood as more like a process. They include:

a) **Acknowledging and validating** people as we listen to the problem, identify it and understand its context and impact. The process of validation involves exploring the social, cultural and structural context of experience. Identifying external factors that impinge on experience and behavior can help remove self-blame and alter the way we perceive ourselves. Normalizing enables people to see that others have such experiences and respond in similar ways in similar circumstances.

b) **Developing a concrete description** simply involves having a conversation and describing events, behaviors, experiences, strengths, goals and plans in specific and concrete terms. Concrete descriptions help clarify a person’s experiences and issues
they are confronted with. It challenges beliefs and perceptions that have their roots in generalizations. Some examples of questions are:

- What’s happening? What are people doing?
- Where is it happening and when?
- How often does that happen?
- How intense or powerful is the experience, feelings or behavior?

Concrete description of goals and plans do enable people to see specifically what they are aiming for and this makes achieving the goal more likely and easier to measure. It can lead to, however, an oversimplification of issues, goals and solutions – people’s feelings can be ignored.

c) Identifying and mobilizing strengths, resources and exceptions. It is important to understand that strengths are a person’s or family’s special and unique qualities and resources that define their personhood. Strengths are needed to meet goals, develop health, meet challenges, facilitate and promote healing. Strengths are a person’s capabilities and they come in many forms including assets, capacities, competencies, resources, skills, talents, and gifts. Strengths are the key to health because they are the building blocks of criticalness. They become the key that enables a person to take charge, find solutions to their problems, deal with hardships, overcome vulnerabilities, and find meaning in life. There are three sources of strengths:

1. **Existing strengths** are those capabilities and resources that are an integral part of a person and their environment. These strengths are readily available and easily mobilized to meet the person’s needs and to help them cope with both small and large challenges.

2. **Potential strengths** refer to something that is possible, as opposed to something that is already developed. At the right time and with the right resources, potentials can become a strength. Potentials often come in the form of a capacity.

3. **Deficits that can be turned into strengths**: in one circumstance, a behavior can be a deficit, but when the context, environment or circumstance changes the same behavior can be seen as a strength.

4.
Some examples of questions for identifying strengths and exceptions are as follow:

- What do you do well?
- What do you consider as your strengths? What do others consider as your strengths?
- What was happening before these difficulties arose?
- What have you done that has made a positive difference?
- Are there times when the problem isn’t there?
- What does this say about you? What is it about you that enables you to do this?

Reframing helps people think differently about themselves and the problems they’re facing. It involves exploring alternative perspectives on the same event or experience and creating a possible positive description. A conversation that explores and validates good intentions is more respectful than one that focuses on blame or what people are doing wrong.

Reframing can be assisted through:

- Exploring strengths and exceptions
- Inviting reflection on other possible perspectives – what do the special people in your life say about you and the way you’ve coped?
- Questions that presuppose good intentions – what were you hoping to achieve when you did that?
- Exploring the wider social and cultural context – how many others do you know who have a hard time bringing up kids on their own?

Normalizing is a process of reframing problems by identifying the commonalities between people’s experiences, feelings and responses to problems, and the meanings they give to them. Normalizing enables people to view the problems they face as understandable.

Developing a picture of the future and goal-setting. One’s strength and capacity are the fuel used to get to where one wants to go, but without aspirations and dreams one’s direction can be unclear and motivation diminished. The picture of the future is a
person’s vision of what they want things to be like. It is as it is, a description of what will be happening when the issues are resolved.

Some good questions for exploring the future are:

- What do you want to be different?
- What will make that difference?
- What do you want for yourself and your life?
- How would you be feeling if these issues were not in your life?
- If you could change one thing what would it be?
- If there were a miracle and things were different what would you be doing?

Drawing upon these processes with an emphasis on strengths contributes to creating the required conditions for positive change and empowerment. No matter what your technique, people change when they experience the following:

- Feel safe, confident and hopeful
- Share their stories and experiences, and feel heard and validated
- Have a picture of where it is they want to go: the picture of the future
- Be sufficiently motivated and able to address the cultural and structural constraints that get in the way
- Be aware of, appreciate and to be able to mobilize their strengths, capacities and resources
- Know what to do and how to do
- Be a full participant in the process of change
- Be connected with others who will support and appreciate their efforts and progress

The importance of questions is a critical aspect of successful strengths-based practice. Questions that presuppose a person’s ability to find their own solution are extremely powerful. Strengths-based principles and frameworks rely primarily on finding the right
questions as opposed to knowing the answers. Strengths-based questions are characterized by the following:

- Not knowing - suspending assumptions and using open questions
- Curiosity about appreciation of experience, context, constraints, strengths, exceptions and aspirations
- Open invitations to share stories and explore values
- The belief that people are their own experts
- The belief that people can change and grow
- Expansiveness – room to move from specific descriptions to exploring the context of experience, feelings and meanings
- Concrete descriptions – clearly and specifically describing the issues, strengths and aspirations
- Positive framing
- Respectful and context-friendly language

Laussel (2001) points out that there are some key considerations that Public Health staff need to be purposeful in and implement in their planning and decision-making, at all levels and interactions of an organization.

- Does our decision build the spirit of hopefulness and optimism – with everyone?
- Is our communication open, transparent and respectful?
- Is our language empowering, respectful, nondiscriminatory and free of stereotypes and labels?
- How does our decision recognize and value people’s strengths and capacities?
- Have we identified and valued people’s aspirations and dreams?
- Has our process been respectable of everyone?
- Is anyone being disempowered or diminished by our decision or the process? Have we listen to, heard and respected minorities and quiet voices?
• Is our decision open, public, able to be scrutinized and able to be challenged by anyone?
• Is our decision and decision-making process legal, ethical, accountable and defensible?
• What action do we need to take to ensure that people have maximum say over their own lives?
• Is our decision-making process disempowering of any individuals or groups?
• How can our decision open up new possibilities and choices for those who are affected?
• Who needs to be consulted?
• Have values of social justice, respect, empowerment and self-determination informed our decision?
• Have our discussions been active, challenging and robust?
• What are the alternative stories and viewpoints? Have we really heard them?
• Does our decision build on commonality between people?
• Will anyone be disadvantaged by our decision? How have their views been taken into account?
• Is our decision-making process based on generalizations that ignore unique experience and contacts?
• Does our organizational culture contain blind spots that we are ignoring?
• Is our decision-making limited because of our personal agendas?
• Is there any labeling or categorization that blames people and reframes them as the problem?
• Are there social or organizational structures in place that maintain or contribute to inequalities and exclusion?
Suggested Reading Resources


4) A Strengths-Based Approach To Service Provision:

People often need supports and resources that may include other people, organizations, information, knowledge, material resources and decision-making resources. For many in human health services, their values and identity are often reflected in the approach they take. This can be a challenge if their approach does not fit with the expectations, needs and wants of the person they are supporting.

In a strengths-based approach, the approach taken has to be inclusive and complement the person’s strengths and goals. This is different from attempts to make up the difference of perceived deficits. If the support offered does not consider and adapt to what is meaningful to the person and builds on the person’s existing strengths and
resources, it can undermine their ability to learn and be self-determining. As opposed to “what’s wrong with you”, the starting point for positive change is “what’s right with you”. External resources are added when required and result in change that occurs in ways that are purposeful and complementary to a person’s strengths and goals.

**Figure 4: A Strength-Based Engagement Process** (McCashen, 2005)

Person’s strengths and capabilities are supported by resources in their natural networks.

- If necessary,
- commonly used community resources are added and,
- only if necessary,
- specialized resources are introduced.

**Resilient Coping and Empowerment**

The strengths-based culture supports building the capacity of people in proactive and sustainable ways. Not only are the various types of support resources important, how they are offered to complement a person’s existing strengths and goals is just as important. Using services to complement a person’s existing capacity is different than trying to find ways to repair perceived deficits by just adding knowledge and skills. If external resources and supports are not offered in the context of what is meaningful, and do not build upon the person’s existing strengths and resources, the whole experience can undermine the person’s ability to learn and be self-determining.

A strengths-based perspective starts with exploring the degree to which a person understands and is able to draw upon their resilience. In areas they see as needing to
be supported, external resources should be added when required, in ways that are collaborative and strength-based and are complementary to a person’s existing strengths and perceived goals (Appendix H). When resilience is identified and supported through a strengths-based perspective of care support, knowledge and skills become purposeful tools to support and sustain the journey of embracing a healthy lifestyle. If knowledge and skills are the starting point, there is a danger of creating dependency on others and systems for help, as well as a perspective that one needs to fix something in order to get better.

People need to be perceived as the experts about themselves and their situations. Although problems tend to rob people of the ability to see their strengths and resource options, they are the ones who hold the essential knowledge required for meaningful and sustainable change.

- People make sense of their experience in their own way.
- People know themselves better than anyone else.
- People’s knowledge of their strengths and capacities, aspirations, experiences, and beliefs are within them.
- People know best what helps them change and what stops them.
- Nobody can really know how others feel.
- People know best why they do what they do.

5) Putting the Strengths-Based Approach Into Practice:

Building a relationship of trust is the foundation for all respectful and constructive helping processes. This is created with a genuine interest in and validation of people’s experiences, strength, capacity and aspirations. It is also facilitated by transparent practices and assisting people to take ownership of their own change process.

The strengths-based approach invites us to not only listen well, but to listen for three essential things:

1. People’s lived experience
2. People’s aspirations, preferences and goals
3. People’s strengths and capacities and the stories behind them

To facilitate this process, a useful framework has emerged from solution-focused ideas. It consists of the following six stages for reflection, planning and action:

1. Listening to people’s stories, exploring the context and meaning they give to their experience, identifying the core issues (including cultural and structural constraints)
2. Developing a picture of the future and setting goals through exploration of people’s aspirations
3. Identifying and highlighting strengths and exceptions to the problems
4. Identifying additional resources that complement people’s strengths and goals
5. Mobilizing strengths and resources through a plan of action
6. Reviewing and evaluating progress and change

<table>
<thead>
<tr>
<th>Stories and Challenges</th>
<th>Picture of the Future</th>
<th>Strengths and Exceptions</th>
<th>Other Resources</th>
<th>Plans and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that invite people to share their stories and enable them to clarify the challenges.</td>
<td>Ask questions that help people explore their aspirations, dreams, interests, and goals.</td>
<td>Ask people then help people explore their strengths and the exception to the challenge.</td>
<td>Ask questions that help the person identify resources that might help them reach their goals.</td>
<td>Ask questions that enable people to specify concrete steps towards their goals.</td>
</tr>
<tr>
<td>What’s happening? How do you feel about this? How long has this been a concern for you?</td>
<td>What do you want to be happening instead? What will it look like when this challenge is addressed?</td>
<td>What strengths do you have that might be helpful? What do you do well? What is happening when the challenge is not present?</td>
<td>Who else might be able to help? What other skills and resources might be helpful?</td>
<td>What steps can be taken given your picture of the future, strengths and resources? Who will do what? When? How? By when?</td>
</tr>
</tbody>
</table>
There are a number of strength-based models of practice that would be a complement to the professional development of Public Health staff. They include the following (Hirst, Lane & Navenec, 2011):

1) Appreciative Inquiry
2) Capacity-building / Asset-based community development
3) Resiliency
4) Solution-focused

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

1) 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 design 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 strengths-based approach**

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

**Reading suggestions**


**2) 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 strengths-based approach?

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

Reading suggestions

3) RESILIENCY

Resiliency is the ability of people to successfully adapt and develop positive wellbeing 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 strengths-based approach

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

Reading suggestions
4) 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 that 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 strengths-based approach

- Emphasizes Capacity and Intentionality
- Attends to Context / System
• Invites Meaningful Participation
• Recognizes Interrelationships
• Concentrates on Solutions

Reading suggestions


Although the strengths-based approach does involve an emphasis on strengths and capacities, it also integrates the principles of social justice: inclusion, collaboration, self-determination, transparency, respect, the sharing of resources, and regard for human rights. Just practice embraces the following:

1) The right of individuals to genuine ownership and participation in the process of change they are engaged in.
2) Enabling people to engage in strategies, relationships and reflection where they (and not others) identify and define their strengths, capacities, aspirations and goals.
3) To embrace the sharing of power and resources and to ensure that power imbalances between mentees and mentors are acknowledged and addressed fairly. All practice needs to be open, transparent consultative, inclusive and collaborative.
4) Recognizing and taking steps to address structural and cultural dimensions of a person’s life that limits their ability to control their own lives. Recognizing and concerned with ways that dominant culture and beliefs potentially constrain growth, choice and change.

Principles of just practice invite the exploring and addressing of ideas and beliefs that define people, as well as what is possible for them.

6) Embedding a Strengths-Based Program Evaluation

Noticing and measuring change are central elements of strengths-based work. They involve an active process of observation and reflection through which people see, value and appreciate exceptions, positive differences in their realities, and progress towards change. For example, self-esteem and confidence increase when people notice what it
is they did that made a difference to their reality. This can bring about a consciousness in people of their power to make a difference. People begin to experience themselves as their own solution-finders.

The purpose of program evaluation must stay focused on the aspects that are most meaningful. All too often, the real benefits of a program cannot be realized with a cursory look at the program data. The deeper the analysis, with client input and participation, the more likely you are to understand all the real and meaningful benefits of the program. Also, successful program evaluations do not generally happen by accident; they are purposeful and timely. Noticing change can be observed through several processes – qualitative and quantitative. Examples of qualitative evaluation processes would be shared observations and feedback, recorded achievements through journaling, and self-reflection scaling questionnaires. Quantitative evaluation processes would include more formal standardized testing.

Three excellent program evaluation resources are:


Doing strengths-based work means creating environments in which people can grow, learn and try. If a health unit employee, however, is putting in more effort for change in the person they are providing service to, it is certain that empowerment is not happening. Although there might be circumstances when the person is experiencing a trauma and they are immobilized to some degree, if the health unit staff member continues to work harder once the person is strong enough to take responsibility, the
staff member can get in the way of empowerment and self-determination by creating a reliance on the “expert”.

If change is not happening, these questions can be asked:

- Has the problem been defined in a helpful way?
- Is the problem manageable; are the steps small enough?
- Do the issues arise from personal or structural constraints - or both?
- Are we working on the right issues?
- Are we clear about who is responsible for what?
- Has change occurred that we haven’t noticed?
- What have you tried before that has worked in the situation and similar ones?
- Have we focused enough on exceptions and strengths?
- Are we doing too much for the client?
- Are we expecting too much?

7. Embedding a Strengths-Based Approach to Partnering

Essential to a strengths-based perspective is the collaboration among different community care providers. Ideally, all organizations will embrace the same strength-based paradigm and will strives to develop staff skills in effective engagement, collaboration, facilitation and resiliency-building of individuals and their families. Community agencies and partners will require more of a person-centered and collaborative template. This allows for targeted interventions based on relationship and capacity building while strengthening key resilience processes that are meaningful to the person and the community in which they live.

There also needs to be a commitment from community health practitioners, and programs, to work with other significant community partners in developing informed and evolving, effective practice models that nurture resiliency in all individuals and their families. In doing so, individuals and their families become more resourceful in dealing
with crises, weathering persistent stresses, and meeting future challenges as opposed to developing dependence on the system (Taylor, LoSciuto, & Porcellini, 2005).

A strengths-based collaborative approach to community capacity building will reflect the following (McCashen, 2005):

- Seeks to understand the crucial variables contributing to individual resilience and healthy-functioning families/communities.
- Provides a common language and preventive philosophy.
- Sees social capacity building and healthy behaviours as common goals that provide a conceptual map to guide prevention and evaluation; intervention strategies are client driven and relationship focused; and the person’s story determines the resources to be introduced and drawn upon.
- Engages all individuals and their families with respect and compassion.
- Perceives capacity building as a dynamic process that evolves over a lifetime.
- Affirms the reparative potential in people and seeks to enhance strengths as opposed to deficits.
- Promotes successful change through connecting a person’s strengths and their health aspirations.

The difference between “Community Planning” and “Community Capacity Building” (Beilharz (2002)):

<table>
<thead>
<tr>
<th>Community Planning</th>
<th>Community Capacity Building</th>
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<tbody>
<tr>
<td>Expertise lies with specialists</td>
<td>Expertise lies with the community</td>
</tr>
<tr>
<td>Expertise is about issues and solutions</td>
<td>Expertise is about the community</td>
</tr>
<tr>
<td>Planning involves a small team who make decisions about</td>
<td>Planning involves discussion</td>
</tr>
<tr>
<td>the community on the basis of research and practice</td>
<td>between many people and includes identification of what would work in</td>
</tr>
<tr>
<td>decisions</td>
<td>that community</td>
</tr>
<tr>
<td>Planning includes consultation with specialists</td>
<td>Planning includes consultation with specialists</td>
</tr>
</tbody>
</table>
community members
- Goals are developed and known by only a few
- The planning group retains and builds on planning information and skills
- The primary goal is risk prevention
- The process is quick and limited

- Many people contribute to a shared vision of a preferred future for their community
- Skills and specialist information is transferred to community members
- The primary goal is social capacity and strengths development
- The process is relational and evolves over time

Stages and processes for community engagement and building (McCashen, 2005):

1) Starts with building relationships and exploring individual concerns, interests and aspirations.

2) Brings people together, sharing stories, and experiences and “naming” the common interests

3) Establishes a common vision or “picture of the future” and develops concrete and specific descriptions of the vision.

4) Explores strengths and exceptions in the past and present.

5) Establishes a structure to support the process.

6) Identifies and explores additional resources that need to be added, in ways that complement existing strengths.

7) Mobilizes strengths and resources to begin experiencing the vision.

8) Develops networks, sustainability and infrastructure.

A community-focused approach facilitates the opportunity for community members to be the driving force of action and change with health providers assisting people to recognize and mobilize their strengths and resources towards their vision. It is about facilitating, advocating and treating community members as the experts of their own lives. The process involves perceiving the community as “at potential”, engaging in ways that nurtures respect and trust, facilitating capacity building and strengths-oriented
processes: all evolving towards the goal of sustainable empowerment. It is about individuals and the communities they live in owning their own path towards healthy and positive lifestyles.

Suggested Reading Resources


Kretzmann, J.P., & McKnight, J.L. (1993). Building communities from the inside out: A path toward finding and mobilizing a community’s assets. Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University.


The strengths-based approach is not a model for practice; it is an approach to practice based upon a philosophy and depends on values and attitudes. Strengths-based values and attitudes are the primary drivers of the intervention process and its outcomes, rather than skills and knowledge. The strengths-based approach has a contagious quality and makes deep, intuitive sense to those who reflect a “cup half full” attitude in life. It is a profound philosophy for practice that has the power to transform and build both the lives of those being cared for and those facilitating the care process. For many, it is not only a philosophy of educational practice but also a philosophy for life because it is based on attitudes and values reflecting a deep respect for the value of others.
REFERENCES


Kretzmann, J.P., & McKnight, J.L. (1993). Building communities from the inside out: A path toward finding and mobilizing a community’s assets. Evanston, IL: Center for Urban Affairs and Policy Research, Northwestern University.


Glossary of Strength-Based Terminology

**Advocacy:**
Speaking, writing or acting in favour of a certain issue or cause, policy or group of people. In the public health field, advocacy is assumed to be in the public interest.

**Assessment:**
A formal method of evaluating system or a process that often includes both qualitative and quantitative aspects in the process.

**At-Potential:**
The human potential for growth, development and/or change. Meant to counter the still popular focus on deficits and risk, this term re-orient focus on the great potential of children and youth, including those viewed as “at-risk”.

**Client:**
May refer to an individual, family, group, or community; the way the term is used depends on the context in which it is used.

**Collaborative:**
A philosophy and practice of working together toward a common goal.

**Community:**
A group of people who share a common territory and/or characteristics (i.e. age, culture, religion, sexual orientation, language, interests).

**Community Development:**
Is the process of involving a community in the identifying and strengthening those aspects of daily life, cultural life, and political life which support health.

**Capacity-building:**
An approach focused on the enhancement of individual and/or community capacity.

**Core competencies:**
Essential skills, abilities and knowledge that are central to health, well-being and success in life.
Developmental Strengths:
The 31 research validated child and youth developmental sub-factors related to resilience and protective factors.

Empathy:
The ability to accurately understand the experience and perspectives of others.

Empower:
To give power and/or authority to another through insight and opportunity.

Engagement:
The degree to which one bonds and builds rapport with another. Research supports this as the most important factor in developing relationships that influence positive growth and change. It also counters the traditional expert driven model of intervention.

Inclusiveness:
A philosophy and practice of being non-discriminatory – To include all.

Health Promotion:
The process of helping people to increase control over and to improve their health. It is also aimed at changing social, environmental, political, and economic condition so as to reduce their impact on the public and individual health.

Influence:
The degree to which one affects the thoughts and actions of another. A positive outcome of meaningful engagement and relationship.

Leadership:
Leadership is described in many ways. In the field of public health it relates to the ability of an individual to influence, motivate, and enable others to work towards greater success in their community and/or the organization they work for. It involves inspiring people to create and achieve their vision and goals. Leaders provide mentoring, coaching and recognition. They encouraged empowerment, allowing other leaders to emerge.

Participatory-approach:
A philosophy and practice of inclusiveness and collaboration with individuals, families, groups other “community” stakeholders.
Partnerships:
Collaboration amongst individuals, groups, organizations, government, or sectors for the purpose of joint action to achieve a common goal.

Persistent:
Diligence and determination toward the object or activity of focus. Countering the traditional deficit based perspective as seeing others as resistant, this is seen as a strength that can be engaged in constructive ways through meaningful relationship and activities.

Person-centred:
An evidence informed approach first developed by humanistic psychologists to engage people in positive development through authentic relationships and client-directed activities.

Policy Development:
The process of putting health issues on decision-makers’ agenda. It involves having a plan to solve the problem and setting out what resources are needed.

Process-focused:
An approach that honours human growth and development as a process that may not appear to be linear in nature.

Protective Factors:
The positive relationships, resources, activities and internal characteristics that enhance well-being and insulate individuals and/or communities from harm.

Public Health:
And organized activity of society to promote, protect, improve, and when necessary restore the health of people, specific groups, or the entire population. It is a mix of sciences, skills, and values that function through programs, services and institutions aimed at protecting and improving the health of all people.

Relationship-based:
A research validated approach that holds the quality of relationship and engagement as central to positive growth, development and/or change.
**Resilience:**
Traditionally viewed as the ability to overcome adversity, research links the development of resilience with internal characteristics and the presence of important relationships, resources and activities.

**Resiliency Factors:**
The 10 research validated child, youth, and adult factors related to resilience and core competencies.

**Strengths:**
Inner characteristics, virtues and external relationships, activities and connections to resources that contribute to resilience and core competencies.

**Strength-based approach:**
Focus on individual and/or community strengths that place emphasis on meaningful relationships and activities.

**Sustainability:**
The ability to maintain the positive benefits, growth, development and capacity of an initiative when the temporary components of the project have expired/been removed.
# Strength-Based and Deficit-Based Concepts: A Comparison

<table>
<thead>
<tr>
<th>Strength-Based Concepts</th>
<th>Deficit-Based Concepts</th>
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<tbody>
<tr>
<td>At-Potential</td>
<td>At-Risk</td>
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<tr>
<td>Strengths</td>
<td>Problems</td>
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<tr>
<td>Engage</td>
<td>Intervene</td>
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<tr>
<td>Persistent</td>
<td>Resistant</td>
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<tr>
<td>Understand</td>
<td>Diagnose</td>
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<tr>
<td>Opportunity</td>
<td>Crisis</td>
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<td>Celebrate (i.e. successes)</td>
<td>Punish (i.e. non-compliance)</td>
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<td>Time-in</td>
<td>Time-out</td>
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<tr>
<td>Adapt to</td>
<td>Reform</td>
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<td>Empower</td>
<td>Control</td>
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<td>Process-focused</td>
<td>Behaviour-focused</td>
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<td>Dynamic</td>
<td>Static</td>
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<tr>
<td>Movement</td>
<td>Epidemic</td>
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<tr>
<td>Unique</td>
<td>Deviant</td>
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<tr>
<td>Avoids imposition</td>
<td>Dominant knowledge</td>
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<tr>
<td>Validates people’s experience</td>
<td>Diagnoses based on norms</td>
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<tr>
<td>People’s context is primary</td>
<td>Professional’s context is primary</td>
</tr>
<tr>
<td>Identifies and builds on strengths</td>
<td>Minimizes people’s strengths</td>
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<tr>
<td>Client-centred</td>
<td>Mandate-focused</td>
</tr>
<tr>
<td>Professionals adapt to clients</td>
<td>Clients expected to adapt</td>
</tr>
<tr>
<td>Meet clients in their environment</td>
<td>Clients always go to professionals</td>
</tr>
<tr>
<td>Flexible</td>
<td>Rigid</td>
</tr>
<tr>
<td>Focus on potential</td>
<td>Focus on problems</td>
</tr>
<tr>
<td>People are inherently social/good</td>
<td>People are inherently selfish/bad</td>
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<tr>
<td>People do the best they can</td>
<td>People do as little as possible</td>
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<tr>
<td>Support</td>
<td>Fix</td>
</tr>
<tr>
<td>Client-determined</td>
<td>Expert oriented</td>
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<tr>
<td>Inclusive</td>
<td>Exclusive</td>
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Focus Group Sessions

The purpose of the focus group sessions is to create an opportunity for selected staff from public health units to explore and share feelings about the implications of strengths-based concepts and principles of practice based upon their current experience as a public health staff. Dr. Hammond will be guiding the conversations with a primary focus on gathering responses in the following areas:

1) How do the concepts of strengths-based practice align with the focus group participant’s personal and professional values. Do they need to align and what are the potential outcomes if they do not.
2) To what degree do the focus group participants feel qualified and prepared to engage in strengths-based practice. What kind of skills/experiential training or administrative support resources may be required. What are the potential barriers that hinder effective strengths-based practice.
3) To what extent do the focus group participants feel supported by the public health administration and current guiding policies for Public Health care practice.

Each area will be explored using the following thought process:

1) What is currently meaningful and working well.
2) What could be built upon or adapted in order for more meaningful and effective practice.
3) What needs to let go of as it acts as a barrier or is just not effective.
Public Health Unit Reflection Groups

*Participant’s Protocol*

The purpose of the reflection group sessions is to create an opportunity for you to share your feelings about how the concepts and principles of strengths-based practice have impacted you (personally and professionally). The facilitator will use the following questions to guide the reflection session.

1) How have the concepts of strengths-based practice impacted your personal and professional values? – why or why not.
2) Have you changed the way you do things, the way you perceive your clients and what you consider to be important in your professional role and practice? – why or why not.
3) Do you feel the need for further skills/experiential training or support resources?
4) What has changed in you (and in your staff and public health unit) as a result of the strengths-based training workshop?
5) What potential barriers do you feel will hinder your ability to effectively engage in strengths-based practice?
6) What is changing or what does it need to look like to be supported in embracing a strengths-based perspective by the public health administration and current guiding policies for Public Health care practice?
Public Health Unit Reflection Groups

Facilitator’s Protocol

The purpose of the reflection group sessions is to create an opportunity for staff from the participating public health units to articulate insights and share feelings about how the concepts and principles of strengths-based practice have impacted them (personally and professionally). The goal is to guide the conversations with a primary focus on gathering responses in the following areas (please just record the various ideas, concerns, insights or themes):

1) How have the concepts of strengths-based practice impacted your personal and professional values? – why or why not.
2) Have you changed the way you do things, the way you perceive your clients and what you consider to be important in your professional role and practice? – why or why not.
3) Do you feel the need for further skills/experiential training or support resources?
4) What has changed in you (and in your staff and public health unit) as a result of the strengths-based training workshop?
5) What potential barriers do you feel will hinder your ability to effectively engage in strengths-based practice?
6) What is changing or what does it need to look like to be supported in embracing a strengths-based perspective by the public health administration and current guiding policies for Public Health care practice?

Each area will be explored using the following thought process:

1) What is currently meaningful and working well?
2) What could be built upon or adapted in order for more meaningful and effective practice?
3) What do we need to let go of as it acts as a barrier or is just not effective?
Strengths-Based Practice in Public Health

**Partners:** Resiliency Initiatives and the participating Public Health Units (Oxford County Public Health & Emergency Services (Project Lead), Huron County Health Unit, Perth District Health Unit, Leeds, Grenville & Lanark District Health Unit, Thunder Bay District Health Unit and Niagara Region Public Health).

Thank you for participating in this research project that is exploring the role and implications of embedding a strengths-based approach in Public Health practice.

**What is a strengths-based approach?**

A strengths approach is a specific method of working with and resolving problems experienced by the presenting person. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person’s resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems.

- Focus on trusting and workable relationships
- Empowering people to take a lead in their own care process
- Working in collaborative ways on mutually agreed upon goals
- Drawing upon the personal resources of motivation and hope
- Creating sustainable change through learning and experiential growth

**In order to better understand the role of resilience and how a strengths-based approach to public health practice can be supported, we hope you will fill out the survey to tell us what helps you to cope with the personal and professional challenges we often experience. We need your perspective and experience.**

**PLEASE NOTE:**

- Answer all questions honestly – not in ways you think others would want to hear, but rather using your true feelings and current experiences.
  - The survey will take about 30 minutes to complete.
  - This data is not a test and all answers are completely confidential.
  - Data collected is only used for the sole purpose of informing and developing a strengths-based model of Public Health practice.
  - All data results will be reported in group or aggregated format.

If you have questions about the survey, please contact your Public Health Unit representative.

Thank you for your work on this survey.

**Please check the box below if you agree to participate in the survey. If you do not wish to participate please exit. Thank you for your consideration.**

☐ I Agree
Adult Resiliency & Strength-Based Aptitude Questionnaire

PRE

Birth Date: (mm/dd/yyyy)

Public Health Unit:

Today's Date: (mm/dd/yyyy)
ADULT RESILIENCY: Assessing Developmental Strengths
Your information is very important to us. This survey is about measuring your strengths to tell a story about how you cope with adversity. There are no right or wrong answers. The results will help us to understand your needs and strengths so youth, families, and educators will be in a better position to build upon these. Thank you in advance for completing this survey.

On-line Survey: Use the mouse to select the circle that best describes you.
Hard Copy Survey: Use a pencil or ball point pen. Select the circle using an X or a check mark.

Please answer all of the following questions.

What is your gender?

☐ Male
☐ Female

How old are you today?

☐ 18-19
☐ 20-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ 60 or older

What is your current role in or with the Health Unit?

☐ Public Health Nurse
☐ Management
☐ Administration
☐ Supervisor
☐ Volunteer
☒ Public Health Promoter
☐ Public Health Inspector
☐ Other, please specify ____________________

How long have you been practicing with Public Health?

☐ 1 year or less
☐ 1 to 5 years
☐ 6 to 10 years
☐ 11 to 15 years
☐ 16 to 20 years
☐ 21 years plus

Which of the following reflects your practice?

☐ Direct client service
☐ Indirect client service
☐ Both
If you engage in direct service, please check off the main clients you work with (please check more than one category if relevant)?

- Infants (aged 0 – 12 months)
- Pre-School (ages 1 – 6)
- Children (ages 7 – 12)
- Youth (ages 13 – 18)
- Young Adult (ages 19 – 25)
- Adult (ages 26 – 65)
- Older Adult (ages 65+)

As part of your staff development, are you connected to another staff person who purposely coaches you in your professional development?

- Yes
- No

What type of support do you experience at work from your management? (Check all that apply)

- personal
- professional knowledge
- no support at all
- Other, please specify

What levels of support do you experience at work from your colleagues? (Check all that apply)

- personal
- professional knowledge
- no support at all
- Other, please specify
Strength-Based Aptitude Questionnaire

The following questions were designed to self-assess the degree of engagement in strength-based practice. Please choose the most appropriate answer for each of the following questions:

1 I have an absolute belief that every person has the potential to be successful and do well.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

2 I believe that all people can change – given the right conditions and resources, a person’s capacity to learn and grow can be harnessed and mobilized.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

3 People’s unique strengths and capabilities help define who they are...not their limitations.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

4 I believe that what we focus on becomes one’s reality so I choose to focus on strengths, not labels.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

5 I take the perspective that the language I use creates one’s experience of reality – so I choose to speak in ways that honour people’s strengths and potential.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

6 I believe that all individuals have the urge to succeed, to explore the world around them and to make themselves useful to others and their communities.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me
7 I work from the belief that positive change occurs in the context of authentic relationships and therefore make it a priority to engage the people I work with in respectful and meaningful ways.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

8 I focus primarily on enhancing people’s existing and emerging strengths and capacities and view challenges as opportunities.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

9 I believe that each person’s perspective of reality is important. I therefore take the time to hear their story (perspective) and understand what is meaningful to them as the starting point of our collaboration.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

10 People have more confidence and comfort to journey to the future (the unknown) when they are invited to start with what they already know. As such, I always start with what is known and comfortable for people.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

11 I work from the standpoint that building capacity is a process and a goal – and I see it as an honour to support others during part of their life journeys.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

12 It is important to value differences and the essential need to collaborate – effective change is a collaborative, inclusive and participatory process – e.g. “it takes a village to raise a child”.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

13 I have a strong understanding of strength-based principles of practice and apply them on a regular basis in my professional practice.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me

14 I experience a work environment that supports me in putting strength-based principals into practice.
- Almost always like me
- Somewhat like me
- Rarely like me
- Not at all like me
## Adult Resiliency: Assessing Developmental Strengths in your community

This is **not** a test. There are no **right** answers or **wrong** answers. Please take your time and respond to each statement truthfully.

Select the circle as in the example below:

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>15</strong> I believe it is important to help others.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>16</strong> My friends behave responsibly.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>17</strong> I believe my life has purpose.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>18</strong> I am capable of planning ahead.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>19</strong> My spiritual beliefs/values play an important role in my life.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>20</strong> My partner (or family) encourages me to do the best I can.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>21</strong> I care about my work/role.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>22</strong> I believe it is important to be fair to others.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>23</strong> I feel comfortable asking my neighbours for help.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>24</strong> My neighbours have clear expectations of others in my community.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>25</strong> There are clear consequences for poor behaviour in my work/role.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>26</strong> I am encouraged to set goals and work hard to achieve them in my work/role.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>27</strong> My partner (or family) is interested in what I have to say.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>28</strong> I try to avoid unsafe situations.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>29</strong> I feel positive about my future.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>30</strong> I am in a caring environment in my work/role.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>31</strong> My colleagues/friends encourage me to do the best I can.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>32</strong> I can trust my friends.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>33</strong> I try hard to get the best results I can in everything I do.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>34</strong> I am able to do many different things well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td><strong>35</strong> I respect the beliefs of different cultures.</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
How much do you agree or disagree with the following? Choose one answer for each.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>My partner (or family) accepts the work/role that I have chosen.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>I can rely on my friends.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>My partner (or family) supports me in being successful in my work/role situation.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>39</td>
<td>My neighbours care about how others behave in our community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>I believe that I can do things as well as other people my age.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>41</td>
<td>My partner (or family) treats me with respect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>I am interested in learning about the cultures of other people.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>My partner (or family) encourages me to set goals and work hard to achieve them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>I try to say things in a way that will not hurt people's feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45</td>
<td>My partner (or family) values my opinion.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>46</td>
<td>I believe it is important for me to not engage in harmful behaviours. (e.g., drugs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>I am able to say &quot;no&quot; to my friends when they want me to do something I think is wrong.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>48</td>
<td>I believe it is important for me to change my behaviours when they place me at risk.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>49</td>
<td>My family often tells me how important I am to them.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>50</td>
<td>I feel safe in my work/role.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>I am interested in what I have to learn in my current work/role situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>I am able to balance the demands in my life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>I am concerned about other people's feelings.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>54</td>
<td>Adults in my neighbourhood make an effort to get to know each other.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>55</td>
<td>My work/role situation has clear rules about what is acceptable performance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How much do you agree or disagree with the following? Choose one answer for each.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>56</strong> The people in my work/role situation really care about me as an individual.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>57</strong> I always try to do the best job I can in my work/role situation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>58</strong> I have a good understanding of other races or cultures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>59</strong> Neighbours in my community make me feel like I am important.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>60</strong> My partner (or family) respects my feelings.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>61</strong> Adults in my community care about the people that live there.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>62</strong> I try to be successful at whatever I do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>63</strong> My neighbours make me feel like I am part of the community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>64</strong> I know that I can count on my friends to do the right thing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>65</strong> I feel that I have strong spiritual beliefs and values.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>66</strong> I am pleased to live in a community that has people from many different cultures.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>67</strong> My colleagues and friends treat me with respect.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>68</strong> My family gives me a lot of love.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>69</strong> I like to take on new challenges.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>70</strong> I live in a very caring community.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>71</strong> I am concerned about helping others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>72</strong> I feel safe even when I am at home by myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>73</strong> I feel badly when people I know are sad.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>74</strong> I believe it is important that all people are given equal opportunities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>75</strong> I know I can trust my partner (or family) to be there when I need them.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>76</strong> My partner (or family) always praises me when I have done something well.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX D

Adult Resiliency Framework

PROMOTING DEVELOPMENTAL STRENGTHS THROUGH RESILIENCY ASSESSMENT & DEVELOPMENT

The foundation of the Adult Resiliency Framework is based on the child, youth and adult resiliency assessment and development protocols which promote a strength-based approach and holistic framework for understanding the major components that contribute to individuals becoming both productive and responsible.
# Adult Resiliency Framework – I

**Understanding Adult Resiliency in your Community**

<table>
<thead>
<tr>
<th>Resiliency Factor</th>
<th>Developmental Strength</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Support</td>
<td><strong>Caring Family</strong></td>
<td>Family provides a nurturing, caring, loving home environment</td>
</tr>
<tr>
<td></td>
<td><strong>Family Communication</strong></td>
<td>Can communicate with family openly about issues/concerns</td>
</tr>
<tr>
<td></td>
<td><strong>Family Role Models</strong></td>
<td>Family provides responsible role models</td>
</tr>
<tr>
<td></td>
<td><strong>Family Support</strong></td>
<td>Family provides trust, support, and encouragement regularly</td>
</tr>
<tr>
<td>Family Expectations</td>
<td><strong>Involvement of Family</strong></td>
<td>Family is active in providing help/support with role</td>
</tr>
<tr>
<td></td>
<td><strong>Family Expectations</strong></td>
<td>Family encourages person to set goals and do the best he/she can</td>
</tr>
<tr>
<td>Relationships</td>
<td><strong>Positive Relationships</strong></td>
<td>Friendships are respectful and viewed positively</td>
</tr>
<tr>
<td></td>
<td><strong>Positive Influence</strong></td>
<td>Friendships are trustworthy and based on positive outcomes</td>
</tr>
<tr>
<td>Community</td>
<td><strong>Caring Community</strong></td>
<td>Live in a caring and friendly neighbourhood</td>
</tr>
<tr>
<td>Cohesiveness</td>
<td><strong>Shared Common Values</strong></td>
<td>Adults in the community respect each other and their opinions</td>
</tr>
<tr>
<td></td>
<td><strong>Common Relationships</strong></td>
<td>Neighbours try to get to know each other</td>
</tr>
<tr>
<td></td>
<td><strong>Neighbourhood Cohesion</strong></td>
<td>Neighbours have clear expectations of each other</td>
</tr>
<tr>
<td>Commitment to Learning</td>
<td><strong>Personal Achievement</strong></td>
<td>Works hard to do well at all tasks</td>
</tr>
<tr>
<td></td>
<td><strong>Role Engagement</strong></td>
<td>Is interested in learning new things and working hard</td>
</tr>
<tr>
<td></td>
<td><strong>Balanced Lifestyle</strong></td>
<td>Works hard to improve self</td>
</tr>
<tr>
<td>Role Environment</td>
<td><strong>Role Boundaries</strong></td>
<td>Role environment has clear rules and expectations for appropriate behaviors</td>
</tr>
<tr>
<td>(Work, Home, or School) Culture</td>
<td><strong>Bonding to Work</strong></td>
<td>Cares about and feels safe in their Role environment</td>
</tr>
<tr>
<td></td>
<td><strong>Caring Climate</strong></td>
<td>Role environment and supervisors provide a caring climate</td>
</tr>
<tr>
<td></td>
<td><strong>Role Expectations</strong></td>
<td>Environment encourages goal setting and achievement</td>
</tr>
<tr>
<td>Cultural Sensitivity</td>
<td><strong>Cultural Awareness</strong></td>
<td>Has a good understanding and interest in other cultures</td>
</tr>
<tr>
<td></td>
<td><strong>Acceptance</strong></td>
<td>Respects others beliefs and is pleased about cultural diversity</td>
</tr>
<tr>
<td></td>
<td><strong>Spirituality</strong></td>
<td>Strong spiritual beliefs/values play an important role in life</td>
</tr>
<tr>
<td>Self-Control</td>
<td><strong>Restraint</strong></td>
<td>Believes that it is important for him/her to restrain from substance use</td>
</tr>
<tr>
<td></td>
<td><strong>Resistance Skills</strong></td>
<td>Is able to avoid or say “no” to people who may place he/she at-risk</td>
</tr>
<tr>
<td>Empowerment</td>
<td><strong>Safety</strong></td>
<td>Feels safe and in control of his/her immediate environment</td>
</tr>
<tr>
<td>Self-Concept</td>
<td><strong>Planning &amp; Decision Making</strong></td>
<td>Is capable of making purposeful plans for the future</td>
</tr>
<tr>
<td></td>
<td><strong>Self-Efficiency</strong></td>
<td>Believes in his/her abilities to do many different things well</td>
</tr>
<tr>
<td></td>
<td><strong>Self-Esteem</strong></td>
<td>Feels positive about his/her self and future</td>
</tr>
<tr>
<td>Social Sensitivity &amp; Empathy</td>
<td><strong>Empathy</strong></td>
<td>Is compassionate with others and cares about other people's feelings</td>
</tr>
<tr>
<td></td>
<td><strong>Caring</strong></td>
<td>Is concerned about and believes it is important to help others</td>
</tr>
<tr>
<td></td>
<td><strong>Equity &amp; Social Justice</strong></td>
<td>Believes in equality and that it is important to be fair to others</td>
</tr>
</tbody>
</table>

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**Resiliency Initiatives**

"Their Potential – Our Passion"

[www.resiliencyinitiatives.com](http://www.resiliencyinitiatives.com)
Title:

A Psychometric Assessment of the Self-Reported Adult Resiliency: Assessing Developmental Strengths Questionnaire

TYRONE DONNON

and

WAYNE HAMMOND
Summary. As opposed to the problem-based approach of dealing with specific at-risk behaviors, the objective of the self-reported Adult Resiliency: Assessing Developmental Strengths (ARADS) questionnaire is to provide a statistically sound and research-based approach to understanding the factors that contribute to the development of adult resiliency. The study of protective factors, or the more recent attempts at conceptualizing the phenomena of individual resiliency, has been prevalent in the social and health sciences research for decades. In this present study, we present the psychometric characteristics of the Adult Resiliency questionnaire based on a large urban sample of senior adults (n = 949). The findings from this study present a potential framework for understanding the construct and function of resiliency as it pertains to both the extrinsic and intrinsic factors of adult development.
As such, the literature outlines sufficient support for two broad sets of factors that are related to a general framework for understanding the development of resiliency: (1) intrinsic strengths – personality characteristics or attributes of the individual (e.g., empathy, self-esteem, self-efficacy), and (2) extrinsic strengths – interpersonal settings or environments (e.g., supportive family, positive peer influence, and community environments).

In general, adult resiliency can be defined as the capacity of adults to adapt successfully in the face of high stress or adversarial conditions. The ability of adults to negotiate risk during stressful situations has shifted the focus of research from the identification of protective factors to an understanding of how resiliency strengths and processes allow some individuals to cope more effectively than others. As variations in resiliency are a function of the individual, the identification of resilient adults is largely defined by the effectiveness of adaptation outcomes to the severity of risk exposure. As such, efforts in developing a framework for the construct of resiliency will be hampered to some degree by the heterogeneity of resiliency functioning across different conditions or settings.

From an applied research perspective, the focus on a comprehensive framework for understanding the development of adult resiliency has enabled community stakeholders to focus on a strength-based approach to addressing adult developmental issues. Finally, there appears to be a consensus that a framework for understanding resiliency must be comprehensive and contextually relevant to the ever-evolving changes that occur in individual and collective developmental progressions. The purpose of this present study was to investigate the psychometric properties of the Adult Resiliency: Assessing Developmental Strengths (AR:ADS) questionnaire as a viable, self-reported research tool for measuring adult seniors resiliency factors. In addition, a theoretical framework for understanding the factors that promote the
development of adult resiliency is presented in this study to illustrate the potential utility of the survey from a community well-being and health-based perspective.

**METHOD**

All of the items that were developed for use in the Adult Resiliency: Assessing Developmental Strengths (AR:ADS) questionnaire were primarily drawn and formulated from the research literature on resiliency, protective factors, prevention, and adult development. For example, the major family-related strengths identified that were found to contribute to the development of resiliency were related to having a caring and supportive family, effective family communication, high parental expectations, active involvement in the adult’s life, and family members as role models. The questionnaire was designed to allow for flexibility of use in various applied and scientific studies. In particular, the questionnaire consists of 94 items used to measure the 10 factors or 31 specific strengths subscales associated with the resiliency framework. In other resiliency questionnaires, the ability to manipulate the demographic and behavioral indicators has been attractive to other researchers interested in studying the relationships between the resiliency framework and the specificity of other conditions (e.g., gambling, addiction) or concepts (e.g., attachment, self-concept).

**Procedures and Participants**

In this present study, 949 adult seniors from the Aging Adult Project provided by the Alberta Health Services in Calgary participated voluntarily in the completion of the AR:ADS questionnaire. Working in collaboration with the health region and the administration at each adult care facility, seniors were provided with informed consent forms and local centres administrated the questionnaires. The descriptive analysis of the data showed that there were
just over three times more women (716, 75.6%) and men (233, 24.4%). The difference in ages
categories, work situation, highest level of education and health concerns.

RESULTS

Validity and Reliability

As there is a considerable research and literature that supports the factors identified above,
the configuration of the resiliency framework is based to some extent on the face and content
validity of the items or variables. An exploratory factor analysis on the 94 strength-related items
was conducted using the principal components method of extraction with an orthogonal varimax
rotation. As selection of the number of factors is a critical phase of the analysis, the following
criteria were utilized: eigenvalues greater than 1, a scree test of eigenvalues plotted against factors,
review of the residual correlation matrix, and the performance of several factor analyses. As the
number of factors was uncertain and the scree plot is not an exact measure, we perform several
factors analyses. Each time a different number of factors was specified, the scree test was repeated,
and the residual correlation matrix examined for any large residuals (i.e., >.10) that would suggest
the presence of another factor. The resulting 10-factor solution accounts for 54% of the variance and
the salient loadings for the items assigned to one of the 10 factors were found to range from 0.33 to
0.79 (Table 1). The internal reliability coefficients (Cronbach’s alpha) of the 10 resiliency factor
subscales are: family, \( \alpha = 0.96 \); community, \( \alpha = 0.91 \); peers, \( \alpha = 0.88 \); work (commitment to life-
long learning), \( \alpha = 0.80 \); work culture, \( \alpha = 0.85 \); social sensitivity, \( \alpha = 0.85 \); cultural sensitivity, \( \alpha =
0.76 \); self-concept, \( \alpha = 0.79 \); empowerment, \( \alpha = 0.74 \); and self-control, \( \alpha = 0.75 \).

[Insert Table 1 About Here]

Understanding Resiliency Factors Relationship to Demographic Variables
DISCUSSION

In this present study, an exploratory factor analysis of the YR:ADS questionnaire showed support for a 10 factor model of adult resiliency based on a framework of both intrinsic and extrinsic factors. The resiliency factor subscales shown moderately strong to strong internal reliability coefficients. From a theoretical perspective, there is support for the use of the identified resiliency factors as a framework to predict adults potential ... From an applied perspective, the use of the AR:ADS has practical implications for health advocacy and community stakeholders advocating for comprehensive and strength-based approaches to addressing adult-related mental and physical health concerns. The inference being that an environment that promotes all of the resiliency factors will result in an overall enhancement of adults’ resiliency profile. In turn, this will lead to a reduction in the engagement of at-risk activities and corresponding increase in more prosocial or constructive behaviors.

Grounded in research on resiliency and protective factors, the AR:ADS questionnaire introduces a multidimensional framework for understanding the function of resiliency in human development. The findings are presented in a comprehensive developmental strengths framework to assist practitioners in articulating and advocating for conditions that promote the health and well-being of all children, youth and adults. This strength-based approach highlighted through the use of the AR:ADS questionnaire reflects a shift from the problem-focused approach traditionally used to address specific at-risk behavior issues. Recognizing the importance of finding solutions to an individual’s inappropriate behavior, the emphasis of the resiliency or developmental strengths framework is placed on resolving more systemic issues in the way we nurture and interact with family and persons at home, school, and the community at large.
Further exploratory studies will be required to enhance the existing measures and ensure that all other factors related to the development of resiliency are adequately represented or considered in future research. Correspondingly, future understanding of the function of resiliency and the influence it has in human development will require frameworks or models that include all age groups from infancy and well into the later stages of geriatrics. In addition, the use of the AR:ADS questionnaire and strengths framework has yet to be tested specifically with individuals as a practical tool for addressing low resiliency profiles scores (i.e., that group of adults that score in the lowest quartile of resiliency strengths and engage in the greatest number of self-reported at-risk behaviors). As such, there are currently studies that are exploring the use of the AR:ADS questionnaire to generate individual resiliency profiles and corresponding strength-based treatments plans with sample populations of at-risk adults in care.
Table 1. Factor Analysis Item Loadings and Internal Reliability Coefficients for the Adult Resiliency Questionnaire

<table>
<thead>
<tr>
<th>Factor (Cronbach’s alpha)</th>
<th>Extrinsic Factors</th>
<th>Intrinsic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Factor 1</td>
<td>Factor 2</td>
</tr>
<tr>
<td>1. Family Support/Expectations (α = .96)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring Family 1</td>
<td>.71</td>
<td></td>
</tr>
<tr>
<td>Caring Family 2</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>Caring Family 3</td>
<td>.78</td>
<td></td>
</tr>
<tr>
<td>Caring Family 4</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>Family Communication 1</td>
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<td>Family Communication 2</td>
<td>.74</td>
<td></td>
</tr>
<tr>
<td>Family Communication 3</td>
<td>.71</td>
<td></td>
</tr>
<tr>
<td>Family Communication 4</td>
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<tr>
<td>Family Communication 5</td>
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<tr>
<td>Family Members As Role Models 1</td>
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<td>Family Members As Role Models 2</td>
<td>.74</td>
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<td>Family Members As Role Models 3</td>
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<td>High Expectations 1</td>
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<tr>
<td>High Expectations 2</td>
<td>.35</td>
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</tr>
<tr>
<td>2. Peer Relationships (α = .88)</td>
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</tr>
<tr>
<td>Quality Peer Relationships 1</td>
<td>.35</td>
<td>.65</td>
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<tr>
<td>Quality Peer Relationships 2</td>
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<td>Quality Peer Relationships 5</td>
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<td>Positive Peer Influences 1</td>
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<td>Positive Peer Influences 3</td>
<td>.37</td>
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<tr>
<td>Positive Peer Influences 4</td>
<td>.57</td>
<td>.34</td>
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</table>

Adult Resiliency: ADS Psychometric Summary 8
### Table 1 (…Continued). Factor Analysis Item Loadings and Internal Reliability Coefficients for the Adult Resiliency Questionnaire

<table>
<thead>
<tr>
<th>Factor (Cronbach’s alpha)</th>
<th>Item</th>
<th>Extrinsic Factors</th>
<th>Intrinsic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Community Cohesiveness (α = .91)</td>
<td>Caring Neighbourhood 1</td>
<td>.59</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caring Neighbourhood 2</td>
<td>.73</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caring Neighbourhood 3</td>
<td>.61</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Values Adults 1</td>
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</tr>
<tr>
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<td>Community Values Adults 2</td>
<td>.74</td>
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<td></td>
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<td>Adult Relationships 1</td>
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<td></td>
<td>Adult Relationships 3</td>
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<td>Neighbourhood Boundaries 1</td>
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<td></td>
<td>Neighbourhood Boundaries 2</td>
<td>.51</td>
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<tr>
<td>4. Commitment to Learning (α = .80)</td>
<td>Achievement 1</td>
<td>.41</td>
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<tr>
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<td></td>
<td>Work Ethic 1</td>
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</tr>
<tr>
<td></td>
<td>Work Ethic 2</td>
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</tr>
<tr>
<td>5. Work Culture (α = .85)</td>
<td>Work Boundaries 1</td>
<td>.51</td>
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</tr>
<tr>
<td></td>
<td>Work Boundaries 2</td>
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<td>Bonding to Work 1</td>
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<tr>
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<td>Caring Work Climate 1</td>
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<td>Caring Work Climate 2</td>
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<td>High Expectations 1</td>
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<tr>
<td></td>
<td>High Expectations 3</td>
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<td>.46</td>
</tr>
<tr>
<td>6. Cultural Sensitivity (α = .76)</td>
<td>Cultural Awareness 1</td>
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<td></td>
<td>Cultural Awareness 2</td>
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<td>Acceptance 1</td>
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<td>Spirituality 1</td>
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</tbody>
</table>
### Table 1 (…Continued). Factor Analysis Item Loadings and Internal Reliability Coefficients for the Adult Resiliency Questionnaire

<table>
<thead>
<tr>
<th>Factor (Cronbach’s alpha)</th>
<th>Item</th>
<th>Extrinsic Factors</th>
<th>Intrinsic Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Factor 1 (Family)</td>
<td>Factor 2 (Peers)</td>
</tr>
<tr>
<td>7. Self-Control (α = .75)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Restraint 1</td>
<td></td>
<td></td>
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<td>Restraint 2</td>
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<td></td>
</tr>
<tr>
<td>Restraint 3</td>
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<td></td>
<td></td>
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<tr>
<td>Resistance Skills 1</td>
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<td></td>
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<tr>
<td>Resistance Skills 2</td>
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<tr>
<td>Resistance Skills 3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Empowerment (α = .74)</td>
<td>Safety 1</td>
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<td>Safety 2</td>
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<td>Safety 3</td>
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<tr>
<td>Safety 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Self-Concept (α = .75)</td>
<td>Planning and Decision-Making 1</td>
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<td>Planning and Decision-Making 2</td>
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<td>Self-Efficacy 1</td>
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<tr>
<td>Self-Esteem 3</td>
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<tr>
<td>10. Social Sensitivity (α = .85)</td>
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<td></td>
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<tr>
<td>Empathy 2</td>
<td></td>
<td></td>
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<tr>
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<td>Caring 2</td>
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<td>Caring 3</td>
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<tr>
<td>Equity and Social Justice 1</td>
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</tr>
<tr>
<td>Equity and Social Justice 2</td>
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</tr>
</tbody>
</table>

Note: (n = 949), only factor loadings greater than |.32| are shown.
### Pre Strengths-Based Aptitude Questionnaire – Aggregated Responses (N = 261)

**Response Key:**
- A - Always Like Me
- B – Somewhat Like Me
- C – Rarely Like Me
- D – Not At All Like Me

<table>
<thead>
<tr>
<th>Questions</th>
<th>Responses (% of N = 261)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have an absolute belief that every person has the potential to be successful and do well.</td>
<td>A: 60%  B: 39%  C: 1%  D: 0%</td>
</tr>
<tr>
<td>2. I believe that all people can change given the right resources and support.</td>
<td>A: 60%  B: 38%  C: 2%  D: 0%</td>
</tr>
<tr>
<td>3. People's unique strengths and capabilities help define who they are … not their limitations.</td>
<td>A: 61%  B: 38%  C: 1%  D: 0%</td>
</tr>
<tr>
<td>4. I believe that what we focus on becomes one's reality so I choose to focus on my strengths, not labels.</td>
<td>A: 51%  B: 46%  C: 3%  D: 0%</td>
</tr>
<tr>
<td>5. I take the perspective that the language I use creates one's experience of reality.</td>
<td>A: 55%  B: 44%  C: 2%  D: 0%</td>
</tr>
<tr>
<td>6. I believe that all individuals have the urge to succeed.</td>
<td>A: 57%  B: 36%  C: 6%  D: 1%</td>
</tr>
<tr>
<td>7. I believe that positive change occurs in the context of authentic relationships.</td>
<td>A: 72%  B: 28%  C: 0%  D: 0%</td>
</tr>
<tr>
<td>8. I focus primarily on enhancing people's existing strengths and view challenges as opportunities.</td>
<td>A: 49%  B: 48%  C: 2%  D: 0%</td>
</tr>
<tr>
<td>9. I believe that each person's perspective of reality is important and needs to be heard.</td>
<td>A: 61%  B: 38%  C: 1%  D: 0%</td>
</tr>
<tr>
<td>10. People have more confidence when they start with what they already know and can be successful with.</td>
<td>A: 56%  B: 41%  C: 3%  D: 0%</td>
</tr>
<tr>
<td></td>
<td>Statement</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11.</td>
<td>Building capacity is a process and a goal.</td>
</tr>
<tr>
<td>12.</td>
<td>It is important to value differences and to collaborate.</td>
</tr>
<tr>
<td>13.</td>
<td>I have a strong understanding of strengths-based principles and know how to apply them.</td>
</tr>
<tr>
<td>14.</td>
<td>I experience a work environment that supports me in putting strengths-based principles into practice.</td>
</tr>
</tbody>
</table>
Strength-Based Aptitude Questionnaire

POST

Birth Date: (mm/dd/yyyy)

Public Health Unit:

Today's Date: (mm/dd/yyyy)
Strength-Based Aptitude Questionnaire

The following questions were designed to self-assess the degree of engagement in strength-based practice. Please choose the most appropriate answer for each of the following questions:

1. I have an absolute belief that every person has the potential to be successful and do well.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

2. I believe that all people can change – given the right conditions and resources, a person’s capacity to learn and grow can be harnessed and mobilized.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

3. People’s unique strengths and capabilities help define who they are...not their limitations.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

4. I believe that what we focus on becomes one’s reality so I choose to focus on strengths, not labels.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

5. I take the perspective that the language I use creates one’s experience of reality – so I choose to speak in ways that honour people’s strengths and potential.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

6. I believe that all individuals have the urge to succeed, to explore the world around them and to make themselves useful to others and their communities.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me
7 I work from the belief that positive change occurs in the context of authentic relationships and therefore make it a priority to engage the people I work with in respectful and meaningful ways.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

8 I focus primarily on enhancing people’s existing and emerging strengths and capacities and view challenges as opportunities.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

9 I believe that each person's perspective of reality is important. I therefore take the time to hear their story (perspective) and understand what is meaningful to them as the starting point of our collaboration.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

10 People have more confidence and comfort to journey to the future (the unknown) when they are invited to start with what they already know. As such, I always start with what is known and comfortable for people.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

11 I work from the standpoint that building capacity is a process and a goal – and I see it as an honour to support others during part of their life journeys.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

12 It is important to value differences and the essential need to collaborate – effective change is a collaborative, inclusive and participatory process – e.g. “it takes a village to raise a child”.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

13 I have a strong understanding of strength-based principles of practice and apply them on a regular basis in my professional practice.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me

14 I experience a work environment that supports me in putting strength-based principals into practice.
   - Almost always like me
   - Somewhat like me
   - Rarely like me
   - Not at all like me
A Strength-Based Exploratory Process

<table>
<thead>
<tr>
<th>Stories and Challenges</th>
<th>Picture of the Future</th>
<th>Strengths and Exceptions</th>
<th>Other Resources</th>
<th>Plans and Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask questions that invite people to share their stories and enable them to clarify the challenges.</td>
<td>Ask questions that help people explore their aspirations, dreams, interests, and goals.</td>
<td>Ask people that help people explore their strengths and the exception to the challenge.</td>
<td>Ask questions that help the person identify resources that might help them reach their goals.</td>
<td>Ask questions that enable people to specify concrete steps towards their goals.</td>
</tr>
<tr>
<td>What’s happening? How do you feel about this? How long has this been a concern for you?</td>
<td>What do you want to be happening instead?</td>
<td>What strengths do you have that might be helpful? What do you do well?</td>
<td>Who else might be able to help? What other skills and resources might be helpful?</td>
<td>What steps can be taken given your picture of the future, strengths and resources? Who will do what? When? How? By when?</td>
</tr>
<tr>
<td>How is it affecting you and others?</td>
<td></td>
<td>What is happening when the challenge is not present?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>