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Strengths-Based Case Management: Implementation With High-Risk Youth

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ABSTRACT

Few effective methods of intervention exist for youth at risk for negative life outcomes. One method used successfully with both adults with chronic mental illness and adults with substance abuse problems is strengths-based case management (SBCM). Based on the principles of strengths theory, SBCM aims to assist individuals in identifying and achieving personal goals, with an emphasis on the case manager–client relationship and client self-determination. In the current study, the authors report findings from a feasibility study that implemented SBCM with adolescent runaways. Challenges to implementation, such as financial status, the role of families, abuse and neglect, developmental issues, education, peer relationships, and transportation, are examined. The current findings suggest that it is feasible to successfully implement SBCM with adolescents, but the challenges to application are different with this group compared with adults, given the developmental differences between adolescents and adults.

There is a growing need to identify effective methods of intervention for youths at risk for negative life outcomes. Those with multiple problems that span different service delivery systems may have difficulty finding the most appropriate type of services or may be frustrated in their attempts to access complicated and fragmented systems. For these youths and their families, the systems of care may become too burdensome to negotiate, and they may simply give up on finding services to meet their needs. Case management is one method of addressing the service of youths with complex needs. Case management services can help individuals negotiate community systems of care when they feel unable to advocate for themselves. Particularly among those who may be ambivalent about receiving treatment or other services, long waiting periods and complex admission procedures may be deterrents (Mejta et al., 1997).

Although case management "is viewed by many as an important service enhancement" that is low cost but can lead to improved short-term outcomes (Shwartz, Baker, Mulvey, & Plough, 1997, p. 1659), there is a paucity of theoretically driven models. One clearly defined and theoretically driven model used successfully with adults is strengths-based case management (SBCM; C. A. Rapp, 1998b). The initial model was developed in 1982, with specific desired client outcomes (e.g., community tenure, independent living, employment, and leisure activities) identified as the focus of the intervention. With their emphasis on linking clients with formal mental health services, the case management approaches at the time seemed

incapable of achieving these outcomes. The strengths model was constructed of elements of practice that were thought to be more effective in achieving these specific outcomes, which were different from the standard practice at the time.

Now several decades later, clinicians and researchers are currently searching for innovative methods of intervention with another population for whom traditional services frequently are insufficient: adolescent runaways. The present study, based on a small feasibility project, reports on the application of the strengths model of case management to youths who have run away from home and are facing a variety of challenges in their lives. As part of a formal feasibility study, we examined challenges to implementation of this model with adolescents, such as financial status, the role of families, abuse and neglect, developmental stage, education, peer relationships, and transportation.

SBCM

Overview

As described by C. A. Rapp (1998b), the strengths model of case management is based on the theory of strengths, which aims to identify the factors that are impacting an individual's life and how they can be changed. The theory states that clients must identify their own desired outcomes in areas such as quality of life, achievement, sense of competency, life satisfaction, and empowerment. The theory posits that the niches in which clients live (e.g., living arrangement, recreation, education) directly impact achievement of these outcomes. In turn, individual (e.g., aspirations, competencies, confidence) and environmental (e.g., resources, social relations, opportunities) strengths directly impact the quality of an individual's niches. By creating enabling niches instead of remaining in entrapping niches, individuals can accomplish their desired outcomes. Thus, the theory is based on internal as well as external factors that impact clients' lives.

The SBCM model is based on six principles (C. A. Rapp, 1998b): (a) The focus is on individual strengths rather than pathology; (b) the community is viewed as an oasis of resources; (c) interventions are based on client self-determination; (d) the case manager–client relationship is primary and essential; (e) aggressive outreach is the preferred mode of intervention; and (f) people can learn, grow, and change. Although the model has been employed in a variety of settings and locations, the model does not focus on labeling individuals by illness or diagnosis, nor does it involve blaming those with specific illnesses (C. A. Rapp, 1998b). In fact, some have asserted that the focus on "problems and pathology is the reality against which the strengths perspective is rebelling" (Cohen, 1999, p. 460).

Another key component of the model is the methods or functions of the model. These include engagement and the development of a relationship with the client, strengths assessment, personal planning, resource acquisition, and ongoing collaboration and gradual disengagement (C. A. Rapp, 1998b). SBCM is not simply making referrals for needed services and waiting for a call from the client if services are not received. Case managers in SBCM must get to know the persons with whom they are working and engage them in a collaborative effort aimed toward accomplishing their goals.

Research on SBCM

The strengths model was originally designed for use with adults with severe and persistent mental illness. Of previous studies testing its effectiveness, four used experimental or quasi-experimental designs (Macias, Kinney, Farley, & Jackson, 1997; Macias, Kinney, Farley, Jackson, & Vos, 1994; Modrcin, Rapp, & Poertner, 1988; Stanard, 1999) and five used nonexperimental methods (Barry, Zeber, Blow, & Valenstein, 2003; Kisthardt, 1994; C. A. Rapp & Chamberlain, 1985; C. A. Rapp & Wintersteen, 1989; Ryan, Sherman, & Judd, 1994). Overall, social functioning in a variety of life domains (e.g., independence of daily living, vocational, leisure time, and social support) was improved, and symptomatology was reduced. In the experimental studies, statistically significant differences favoring the strengths case management individuals were observed in psychiatric hospitalization (Macias et al., 1994), competence in daily living (Macias et al., 1994), community living skills (Modrcin et al., 1988; Stanard, 1999), use of leisure time (Modrcin et al., 1988), income (Macias et al., 1997), overall physical health (Macias et al., 1994), and symptomatology (Barry et al., 2003; Macias et al., 1994, 1997). In a review of case management research, C. A. Rapp and Goscha (2004) found that, although no differences were found for some variables, in no experiment did the strengths clients fare worse than the control group.

More recently, SBCM was adapted for use with adults with substance abuse problems (R. C. Rapp, Siegal, & Fisher, 1992), based on the similarities between these individuals and persons with mental health problems (Siegal, Rapp, Fisher, Cole, & Wagner, 1993). The National Institute on Drug Abuse-Funded Enhanced Treatment Project demonstrated that the strengths model can be integrated into residential substance abuse treatment and can improve treatment compliance and retention (Siegal et al., 1995). Other data from this project (Siegal et al., 1996) revealed that SBCM impacted participants' employment functioning, and these positive outcomes were correlated with others, including less substance use and better social functioning.

Application of SBCM With High-Risk Youths

Although the existing research has not addressed the use of SBCM with adolescents, the model appears to be a good fit for this population. Similar to the challenges experienced by persons with mental illness, for whom this model was

originally developed, these youths are frequently considered to be difficult or oppositional; thus, finding appropriate and acceptable services may be an overwhelming task for the youths, their families, and others involved. Furthermore, youths involved in risky behaviors, such as substance use or unsafe sexual behaviors, have problems with self-esteem; thus, identification of strengths or positive attributes can be difficult. Many have been labeled as problem teens and have been described by their behaviors (e.g., troublemaker, fighter) or by a psychiatric diagnosis. Their failure to see any positive qualities in themselves relates to a lack of hope for the future.

In recent years, models of strengths-based intervention with youths have begun to emerge. Strengths-based intervention that focuses on belief in the youths' competence and ability to change is an increasingly popular approach for working with youths in criminal justice settings (Clark, 1998). The emphasis of the approach is on culturally sensitive intervention that is not focused solely on problems but also on strengths and past successes that can be used to address the situation at hand (Clark, 1998).

In this study of the implementation of SBCM with high-risk youths, we anticipated that, given the developmental differences between adolescents and adults, the challenges in working with this population would be unique and might impact the way in which case managers implemented the model. Thus, in this phase of our work with SBCM among adolescents, we aimed to address the following questions: What issues must one consider in the application of SBCM with high-risk youths (as opposed to adults with substance abuse problems or chronic mental illness)? Is SBCM an acceptable and feasible model of intervention with high-risk youths? The next stage in our work will include a formal pilot study using a two-group (intervention and standard services) design to test in a preliminary manner the effectiveness of this method of intervention.

The Runaway Youth Research Project

Project Description

The Runaway Youth Project is a feasibility study that focuses on the use of SBCM as the primary method of intervention for an indicated prevention program (Eggert, 1996) for adolescent runaways, a population at risk for a host of negative outcomes. In addition to SBCM, each youth received an individualized education on risk behaviors and was provided written materials on topics relevant to the behaviors in which he or she was engaging. Case management took place mainly in the community or at participants' homes, school, local fast food restaurants, parks, or other locations outside of the case manager's office. The youth was the identified participant, but parents or legal guardians were involved to varying degrees based on the specifics of the situation.

We implemented the SBCM model as described by C. A. Rapp (1998b); only very minor modifications were made to reflect the developmental stage and interests of adolescents (e.g., the term *leisure* was replaced with *hobbies*). Participants who enrolled in this ongoing study receive intensive case management services for 1 year. Although having a determinant endpoint for intervention is not typical in the SBCM model, this was necessitated given that SBCM was used in the context of a feasibility research study.

Case managers who provided the intervention were master's-level mental health clinicians who had experience working with adolescents. Case managers received extensive training in the model. Weekly team meetings were held to discuss cases, and case managers also received individual supervision.

Participants

This feasibility study was conducted in a midsized southeastern U.S. city. Participants ($N = 11$; age range = 12–15 years) were youths who had run away from home and at the time of study enrollment had returned home to live with their parent or legal guardian. The majority of youths were African American ($n = 9$ [82%]) and female ($n = 8$ [73%]). All were enrolled in school. Because this study focused on prevention, we concentrated specifically on those youths who had reported to police as a runaway one to three times as opposed to chronic runaways or homeless youths. Most youths were recruited by means of study informational materials distributed by local law enforcement officers at the time they ran away from home.

Results

On the basis of our interactions with study participants, we have identified several areas in which SBCM with youth is complicated by factors that are unique to adolescence. In this section, we briefly outline the complexities and ways in which we have used the existing model to work with youth, who may have very different lives developmentally, socially, and financially than adults receiving case management services. In addition, we address findings related to the acceptability of this method of intervention and incorporate feedback from both case managers and participants.

Financial Issues

Perhaps one of the main similarities between youths and adults involved in SBCM projects is economic deprivation and poverty. The impact of poverty on consumers of mental health services can include challenges in meeting basic needs as well as restrictions on activities and experiences with stigma (Wilton, 2003). Most people with psychiatric disabilities are living entirely off government assistance. Poverty means inadequate housing, reduced mobility, and limited opportunities for recreation, education, relationships, and employment. The hope-

damaging effects of poverty contribute to lethargy and alienation.

Similar to adults with chronic mental illness and/or substance abuse problems, many youths who run away from home come from families in which financial stressors cause numerous problems. These youths may have little control over the situation but still suffer the effects of limited financial resources. As a result, we found that it is important to help youths use naturally occurring resources and free or low-cost activities in the community, such as playing basketball in a city park or walking around the food court at the mall. Simple types of activities available in the community can enhance participants' lives and shift the focus from pathology to the promotion of health and well-being (Sullivan & Fisher, 1994).

For youths who want to work to improve their families' financial situation, child labor laws, which prevent them from obtaining employment until they reach a certain age, create a barrier to employment. Those youths who are employable based on their age tended to seek out part-time employment to help supplement their family income or to have personal spending money. In this study, case managers were actively involved in helping participants obtain work permits and identifying employers willing to hire younger adults. For most of the youths who wanted jobs, case managers were able to assist them in securing part-time employment, mainly in the fast food industry.

Family Issues

Dependence. Family members play critical roles in the lives of many adults and adolescents. The primary difference with adolescents is that they are legally tied to their families (unless emancipated) because of their age. Hence, adolescent participants in this SBCM program were dependent on their parents for a variety of things, including consent to participate, provision of housing and food, transportation to appointments, and overall well-being and safety. In fact, failure to meet youths' basic needs could become problematic and might warrant a mandatory report to child protective services. Parents or guardians could also withdraw children from the study if they so desired, even if the youths did not wish to. By contrast, adult participants in such programs would typically have the legal right to enroll or withdraw themselves from a program unless they had a legal guardian appointed to make decisions for them. In cases in which dependence on parents caused problems for participants, the case managers served as an advocate to help youths meet their basic needs.

Family dynamics and crises. For adults and, perhaps more so, adolescents, family dynamics can dramatically impact the functioning of the person participating in the intervention. Both runaway youths and their parents typically identify family issues as being among the main precipitating problems (Sayfer, Thompson, Maccio, Zittel-Palamara, & Forehand, 2004). Additionally, others have reported that parents of runaway youths have lower levels of parental monitoring and warmth than parents of nonrunaways (Whitbeck, Hoyt, & Ackley, 1997). Thus, in providing intervention to these youths, who have a forced dependence on their families, the staff must take into account the preexisting family dynamics that likely contributed to the runaway behavior and that may inhibit positive change. As noted by Whitbeck et al. (1997), caregivers of these youths do not appear to be "simply beleaguered parents attempting to cope with delinquent, defiant children" but are trying to cope with severe family issues that warrant intervention (p. 526).

One of the most interesting findings in terms of developing rapport and intervening with families is that a great deal of benefit can be achieved by seizing the opportunity to intervene during a crisis. There appears to be a period of parent–guardian receptivity to intervention immediately after the runaway youth returns home. Others have similarly noted a high level of family motivation during this state of disequilibrium, which tends to dissipate when the crisis has resolved (Slesnick, 2001, p. 417). In fact, Slesnick (2001) found that fewer days between the initial assessment and the first session with the family (for those receiving family therapy) predicted participation in a greater number of sessions.

In most situations with study participants, the family conflict was at a level that warranted immediate attention. The challenge for the case managers was to intervene in a manner consistent with the focus of the intervention. Given that this study did not involve the provision of family therapy, case managers would engage in problem solving around specific issues but would refer participants and their parents for family therapy to address other long-standing problems. Some families were receptive to such referrals, whereas others were not interested in receiving family counseling. Among those who agreed to participate in family intervention, most did not remain in treatment and continued to rely on the case manager to assist with crisis situations that arose.

Family views on strengths-based intervention. Although the benefits of strengths-based interventions with at-risk youths have been documented by others (Harvey & Hill, 2004), it is our experience that focusing primarily on the strengths of youths is often inconsistent with the parents' or other family members' beliefs. Specifically, some parents initially reported to staff members that focusing on strengths was contradictory to their belief that youths should experience consequences for negative behavior and be punished when rules were broken. When the theoretical rationale of the study was explained in detail and the messages reinforced over time as part of the intervention, many parents later reported that their own beliefs and the rationale of the study were not theoretically inconsistent. However, we identified several instances in which parents were in need of more one-on-

one intervention to help them better understand the theory behind SBCM. In particular, study staff reported encountering parents who did not practice parenting strategies consistent with the notion of strengths-based practice. In these instances, it was very difficult for the youths to integrate these concepts into their lives.

For example, some parents reported that they felt that they had neglected to set up clear rules for their child, so they began to implement a fairly intensive or restrictive structure in the home. The rigid rules went hand in hand with a tough love perspective that they felt was needed. In most instances, this approach was contradictory to the strengths-based model, which would inevitably lead to a conversation about the differences in approaches. Our approach was to try to educate the parents about the model and solicit examples of past successes to provide hope for future positive outcomes. Families were encouraged by the program staff to "hang in there" with the strengths-based perspective and give their child a chance to make positive changes before implementing a punitive approach.

Abuse and Neglect

One of the most important but difficult issues faced in conducting intervention research with adolescent children is mandated reporting of known or suspected child abuse and neglect. Among runaway youths, the rates of abuse are staggering: Some investigators have reported that as many as half of runaway youths have experienced physical abuse and one third were victims of sexual abuse (Tyler & Cauce, 2002). Hence, with any intensive intervention based on developing a therapeutic relationship with the youth, one might expect that previously unexposed abuse might be revealed. The difficulty lies in sustaining the relationship with the family when a report must be made. Relationships can become quite fragile when the alleged perpetrator is the parent or legal guardian. Not only might the adult become angry, putting the child or project staff at risk, but he or she has the legal authority to withdraw the youth from the study.

For these reasons and as a result of our actual experiences with this feasibility project, we learned to be forthright about our legal obligations at the onset of the study. Participants and their parents or guardians were made explicitly aware at the time of the initial screening session of the state regulations to which the staff members were bound regarding mandatory reporting. Specifically, they were informed that any known or suspected abuse or neglect had to be reported to child protective services.

Access to Health Services

Making referrals for needed health services is an important component of case management services. However, one of the challenges in working with adolescents is that state laws vary regarding the type and nature of health services that a minor can receive without parental consent. Many adolescents lack access to confidential health care services. For example, in the state in which the current study took place, minors are allowed to give consent for certain medical services without parental notification. These include, but are not limited to, gonorrhea cultures, genital herpes cultures, pregnancy tests, and Pap smears. Furthermore, state statutes may allow adolescents to confidentially consent to treatment for substance abuse and emotional disturbances.

Unfortunately, few, if any, adolescents have the finances necessary to afford medical care. Although many adolescents have health insurance, which covers significant portions of treatment, receiving statements in the mail from the insurance company or the provider negates the work done to maintain privacy and confidential access to care. Another obstacle many adolescents face involves transportation to the locations to receive services. To address the health care needs of participants, case managers relied on publicly funded or low-cost health services available at no or reduced cost in the local community. In most cases, participants did not receive the same level of care that they would have received through their own medical insurance, but the services were nevertheless received. The most challenging concern was the lack of flexibility among providers of community health services in terms of clinic hours and availability of appointments.

Developmental Differences

Most adults can process issues abstractly and can recognize the consequences of their actions. However, different stages within adolescence exist, characterized by varying levels of comprehension depending on the individual's cognitive development (Elliott & Feldman, 1990). Adolescents, particularly those in early adolescence, often fail to understand potential harmful results of particular behaviors, or they downplay their risk or seriousness (Elliott & Feldman, 1990; Furby & Beyth-Marom, 1990). An inability to comprehend the possible outcomes of engaging in high-risk sexual behavior, using illicit substances, dropping out of school, or attempting suicide can have significant deleterious effects on the adolescents' future. Nonetheless, many of our study participants have improved in their abilities to reason and examine consequences of their behaviors. Because of the negative impact that stress and lack of life experiences can have on adolescent decision making (Leffert & Peterson, 1995; Linn, 1983), the study staff seized on opportunities to educate participants and help them identify goals for their lives. We hope that helping youths to look toward the future with optimism will increase the likelihood that they will make positive choices in the present.

Cognitive development advances rapidly through the adolescent years, but this is also a period characterized by increasing levels of hormones that play a vast, complicated, and not completely understood role in thought processes

and resulting behaviors. Appearance and peer acceptance begin to consume a significantly larger portion of an adolescent's life (Crocket & Peterson, 1993). Physiologic changes alone can cause amazing turmoil and confusion, and the timing of puberty for girls and boys has varied effects on their emotional well-being and psyche (Nottelmann et al., 1987; Simmons & Blyth, 1987; Susman et al., 1987). Furthermore, the adolescent is often caught between desiring additional freedoms and responsibilities but needing parental permission and financial support.

Education

Adolescents have far more involvement in the educational system than adults, which results in a greater social and developmental impact on their functioning. Additionally, for most youths, school success is the foundation for future triumphs. Gleaning the strengths or positive aspects of their school experience is essential to fully empower youths through the use of the strengths model. Teachers and school administrators can be either conduits for empowerment or barriers that derail momentum gathered through SBCM. School social workers, counselors, and attendance clerks have thus far been collaborative and cooperative in working with project staff to help youths achieve their goals. Many participants identified improved attendance, better grades, healthier peer relationships, and more effective communication with their teachers as primary goals. These school goals are similar to the school goals that runaway youths have identified in other studies (Lindsey, Kurtz, Jarvis, Williams, & Nackerud, 2000). In several instances, school administrators provided scholastic updates and vital collateral information (always with consent), which contributed to the case manager's ability to assist youths with their school goals.

The absence of parental involvement in school-related activities and assignments can serve as a potential barrier to the achievement of identified goals. Many parents of runaway youths, most commonly single mothers, have a very difficult time assisting their children with schoolwork because of the strain of living in an impoverished environment and their own negative experiences with school (Riley, Greif, Caplan, & MacAulay, 2004). Mothers may project their own angst and frustration about past school failures onto their runaway child (Riley et al., 2004). Similarly, some mothers expressed feelings of inadequacy and frustration about helping their children with schoolwork. In the vein of SBCM, case managers must not blame mothers for the children's poor school performance. Conversely, staff members provided support but also assisted parents in obtaining needed academic assistance for the youths, such as tutoring or additional assistance from teachers at school.

Bullying or harassment from peers can be an obstacle to school success and was also a problem experienced by many participants in the program. According to Smokowski and Kopasz (2005), bullying is the most ubiquitous type of youth violence. Project staff work collaboratively with school counselors and social workers to solve bullying-related issues. Strategies to help youths cope with bullies and navigate school system policies and procedures regarding resolution of these issues were developed in collaboration with school administrators. Similar to Beale's (2001) findings, participants in our study who had been bullied exhibited an increase in school absenteeism, poor school performance, and loneliness. Underscoring strengths in the face of constant and vicious bullying has been essential in helping participants maintain a consistent pattern of school attendance.

Peer Relationships

Runaway youths are under even more pressure to fit in than nonrunaways (Lindsey et al., 2000). These youths must use their resourcefulness and ability to adjust to new and stressful situations in order to cope with pressures to conform to the social norms of their peers. Many youths must also use their charisma and friendliness to engage peers in friendship when they lack visible tokens of conformity (e.g., wearing jewelry and nice clothes).

Although most adults have goals and aspirations of having certain material things (e.g., televisions, nice clothes, cars), not having these items does not usually equal social isolation or rejection. SBCM must be sensitive to the complexities of peer pressure and the high stakes involved with peer acceptance. In the life of an adolescent, the need for material things is amplified by the constant and intense social pressure of fitting in with peers. For example, outward symbols of "being cool" (e.g., designer shoes, jewelry, acrylic nails, and expensive hairstyles) are a ticket into desired social circles and groups. Without these items, many youths are ostracized and shunned by others.

Case managers should be cognizant of adolescents' sense of urgency to possess these material attributes. Youths and their parents commonly clash over the need for such possessions; case managers may be thrust into the middle of this clash and must work to strike a balance between the competing values of the parent and the youth. By facilitating discussions between parents and participants, case managers were able to help the parent and youth communicate their needs or concerns to each other. In some instances, children were able to negotiate with their parents to get items that they wanted if they, in turn, performed household tasks or improved their grades in school.

Furthermore, youths in our feasibility project are faced with other difficult decisions. They may be under peer pressure to engage in certain risky behaviors, such as drug use, sex, or gang membership. These decisions are confounded by the strong drive to be popular and accepted by their peers. Many youths ask the project staff how to handle pressure to have sex or use drugs while still being perceived as "cool" by their peers. Assisting youths with

finding appropriate mentors or role models in their community to help answer these questions has been an important role of the case manager. This was accomplished by identifying individuals in the community who had life experiences in the area in which the youth was struggling.

Empowering youths through SBCM must take into account how certain decisions and activities will affect youths' peer relationships. For example, if a project staff member refers a youth to an Alateen meeting or to another community service, it is important to consider how the youth's peers will perceive this. If the youth receives negative attention from peers for going to a particular agency or activity, he or she may fail to follow through with the service. In addition, youths may be criticized by their peers if they are seen with the project staff member. This issue arises often because the project is predicated on going to the youths' neighborhoods and schools. Some youths in the project report that they feel proud to be in the study, whereas others seem to feel embarrassed or self -conscious about the project. It is critical to discuss with all youths, in advance, how they each want to handle public interaction with peers. In our experience, having this discussion, respecting the youths' wishes, and letting them take the lead goes a long way toward developing trust and rapport.

Transportation

A key ingredient in the administration of SBCM to youths and adults is the successful procurement of transportation. When working with adult clients, case managers can commonly assist the adult with obtaining their own personal mode of transportation (getting a car for them to drive) or assist them with accessing public transportation (i.e., public bus, Medicaid transportation, taxi; C. A. Rapp, 1998a). Securing transportation for youths is much more difficult because many are not old enough to have a driver's license. For others public transportation is not feasible because of safety concerns. Therefore, the onus of transporting youths to appointments frequently falls on the case manger or the parents. Unfortunately, however, many parents do not have the financial resources to provide transportation for their children. Benway, Hamrin, and McMahon (2003) found that African American children and those from low socioeconomic status families (SES) did not attend their mental health appointments as frequently as other children. It is plausible that poverty influences access to transportation and thus service attendance. Parents who do have their own cars may frequently feel overburdened by constant requests from their children for transportation to appointments and other events. This increasing burden frequently contributes to youths missing their appointments or meetings. Thus, the project staff member plays a critical role in youths' ability to access much-needed services and resources.

Although adolescents typically enjoy a broad spectrum of interests, the types of activities in which they are engaged are highly predicated on access to the particular activity (McMeeking & Purkayashtha, 1995). We found that the majority of youths in this study were limited in the type of hobbies in which they could participate because of lack of financial resources as well as lack of transportation. Thus, youths may be forced to find hobbies that do not require much money or transportation. Participants reported that they were commonly engaging in free after-school activities, playing basketball, listening to music, watching television, or hanging out in the neighborhood with friends. Case managers built on youths' interests or hobbies to engender confidence in areas where they felt challenged (i.e., school performance). Commonly, a case manager would participate in a youth's hobby to build rapport during the initial phase of SBCM. For some youths, the weekly case management session was one of the only times that they were afforded the opportunity to engage in a fun activity outside of the home.

Conclusion

In this feasibility study, we have learned many lessons about the intricacies and challenges of implementing SBCM with high-risk adolescents. Perhaps the most surprising finding was that the SBCM model required few modifications for this population. However, its application is quite complex, because the lives of youth today are complicated by stressors unique to their developmental stage in life. Their choices are influenced by many people in their lives, and they lack the societal power to do certain things for themselves, characteristics inherent in being an adolescent.

Despite these unique potential obstacles, we also have seen firsthand the many positive opportunities that these youths have created by trusting the project staff to assist them in developing their goals. Regardless of their situations, many of these youths took assertive means to try to improve their lives, including finding employment, tackling challenging school issues, and communicating openly with parents and others in their lives about what they felt that they needed to change. The continual struggle for the case managers was to stay strengths-focused even when things did not fall easily into place for many of the participants. As noted by C. A. Rapp (1998b), "too often environmental factors are taken as given or fixed and therefore the options offered to clients are narrow. The lack of options is de facto disempowering" (p. 101). Because the SBCM model focuses on helping participants obtain their goals, the tribulations along the way were not viewed as insurmountable. Participants had the support they needed to believe that their lives could improve, which in many instances was novel.

In implementing SBCM with adolescents, we operated under the same assumption that underlies SBCM with adults: that those with whom we work want information and support, and their goals should drive the focus of the

intervention (C. A. Rapp, 1998b). It is this focus that made this pilot project unique and presented us with hope that youths, even those with multiple problems and life stressors, are receptive to assistance efforts in taking a new direction with their lives. In describing the use of SBCM in adults with substance abuse problems, Siegal et al. (1995) asserts that "much of what is labeled client denial or resistance to treatment may result from activities based on the disease concept's unremitting focus on pathology, clients' lack of meaningful input into the direction of their own treatment, and a therapeutic regimen that is often oblivious to larger social and environmental concerns" (p. 72). Thus, it is entirely possible that the conclusions drawn about difficult adolescents not wanting help may not be completely accurate.

Nonetheless, implementing SBCM with adolescents can be a challenging endeavor. Perhaps the main challenge is to persevere with these youths, even when they may doubt their own abilities to accomplish the goals that they have set for themselves. This process involves helping them develop achievable and realistic goals and then supporting them through the process when the road to accomplishment is not smooth or unexpected events transpire. Goals may not always be supported by family members, especially when they relate to choices that go against family expectations. Respecting the family's culture and preferences while empowering the youths to reach desired goals can be a difficult balance to achieve.

Despite these challenges, there are several key strengths of the model, particularly when implemented with adolescents. First, the model is theoretically driven with clear guiding principles, yet it allows for individual flexibility. The types of goals that are meaningful for one person may not be relevant for another, and SBCM allows for these differences by letting participants select their own goals. In addition, almost all of the work with participants is done in the community as opposed to an office setting. This allows the case manager to experience the youths' niche and culture firsthand and reinforces that SBCM is different from other interventions that he or she might have received in the past. Making this distinction is very critical because most of the participants in this feasibility study had tried other services and were initially not very optimistic about trying something else.

Although these findings are preliminary and are based on one program's experiences with a small number of youths, we believe that our initial work in this area supports the notion that SBCM can be implemented successfully with adolescents who have run away from home. Although these youths are at risk for a variety of negative outcomes, prevention through intensive case management based on the principles of participant strengths may be an alternative method of intervention for this population.

We have demonstrated that SBCM can be implemented with very few modifications. However, many intricacies unique to adolescents exist, and staff must take these into account. Additionally, one must be sensitive to issues of culture and gender. In this study, our sample was primarily African American and female, and we must continue to evaluate the application of this model with non-African Americans and male adolescents.

Another critical component of successful implementation of this model with adolescents is that staff must be familiar with the youths' needs, have strong assessment and interpersonal skills, and follow through with commitments made to youths involved in the intervention. These skills are critical to successfully engaging and retaining these youths. The relationship component of the intervention was noted by participants as one of the factors that was most important to them; without a strong connection to the staff, it is likely that many youths may have chosen to drop out of the study.

The next stage in our work is conducting a formal pilot study using a two-group (intervention and standard services) design to test in a preliminary manner the effectiveness of this method of intervention. We believe that the important lessons we have described here will be invaluable in helping us achieve this goal. Most importantly, our work suggests that SBCM is feasible with high-risk youths for whom other models of intervention may not have been effective. Although SBCM is intensive and requires a long-term commitment to participants, the value of focusing on strengths, as opposed to deficits, was reaffirmed.

References

Barry, K. L., Zeber, J. E., Blow, F. C., & Valenstein, M. (2003). Effect of strengths model versus assertive community treatment model on participant outcomes and utilization: Two-year follow-up. *Psychiatric Rehabilitation Journal, 26,* 268–277.

Beale, A. V. (2001). "Bullybusters": Using drama to empower students to take a stand against bullying behavior. *Professional School of Counseling, 4,* 300–306.

Benway, C. B., Hamrin, V., & McMahon, T. J. (2003). Initial appointment nonattendance in child and family mental health clinics. *American Journal of Orthopsychiatry, 73,* 419–428.

Clark, M. D. (1998). Strength-based practice: The ABC's of working with adolescents who don't want to work with you. *Federal Probation, 62,* 46–53.

Cohen, B. Z. (1999). Intervention and supervision in strengths-based social work practice. *Families in Society, 80,* 460–466.

Crocket, L. J., & Petersen, A. C. (1993). Adolescent development: Health risks and opportunities for health promotion. In S. G. Millstein, A. C. Petersen, & E. O. Nightingale (Eds.), *Promoting the health of adolescents: New directions for the 21st century* (pp. 13–37). New York: Oxford University Press.

Eggert, L. L. (1996, September). *Reconnecting youth: An indicated prevention program.* Paper presented at the National Conference on Drug Abuse Prevention Research, Washington, DC.

Elliott, G. R., & Feldman, S. S. (1990). Capturing the adolescent experience. In S. S. Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (pp. 1–14). Cambridge, MA: Harvard University Press.

Furby, L., & Beyth-Marom, R. (1990). *Risk-taking in adolescence: A decision-making perspective.* Washington, DC: Carnegie Council on Adolescent Development, Carnegie Corporation of New York.

Harvey, A. R., & Hill, R. B. (2004). Africentric youth and family rites of passage program: Promoting resilience among at-risk African American youths. *Social Work, 49,* 65–74.

Kisthardt, W. (1994). The impact of the strengths model of case management from the consumer perspective. In M. Harris & H. C. Bergman (Eds.), *Case management: Theory and practice* (pp. 112–125). New York: Longman.

Leffert, N., & Petersen, A. C. (1995). Patterns of development during adolescence. In M. Rutter & D. Smith (Eds.), *Psychosocial disorders in young people: Time trends and their causes* (pp. 67–103). Chichester, UK: Wiley.

Lindsey, E. W., Kurtz, D., Jarvis, S., Williams, N. R., & Nackerud, L. (2000). How runaway and homeless youth navigate troubled waters: Personal strengths and resources. *Child and Adolescent Social Work Journal, 17,* 115–140.

Linn, M. (1983). Content, context and process in reasoning during adolescence: Selecting a model. *Journal of Early Adolescence, 3,* 63–82.

Macias, C., Kinney, R., Farley, O. W., & Jackson, R. (1997). Case management in the context of capitation financing: An evaluation of the strengths model. *Administration and Policy in Mental Health, 24,* 535–543.

Macias, C., Kinney, R., Farley, O. W., Jackson, R., & Vos, B. (1994). The role of case management within a community support system: Partnership with psychosocial rehabilitation. *Community Mental Health Journal, 30,* 323–339.

McMeeking, D., & Purkayashtha, B. (1995). "I can't have my Mom running me everywhere": Adolescents, leisure, and accessibility. *Journal of Leisure Research, 27,* 360–378.

Mejta, C. L., Bokos, P. J., Mickenberg, J., Maslar, M. E. & Senay, E. (1997). Improving substance abuse treatment access and retention using a case management approach. *Journal of Drug Issues, 27,* 329–340.

Modicrin, M., Rapp, C., & Poertner, J. (1988). The evaluation of case management services with the chronically mentally ill. *Evaluation and Program Planning, 11,* 307–314.

Nottelman, E. D., Susman, E. J., Inoff-Germain, G., Cutler, G. B., Jr., Loriaux, D. L., & Chrousos, G. P. (1987). Developmental processes in early adolescence: Relations between adolescent adjustment problems and chronologic age, pubertal stage and puberty-related serum hormone level. *Journal of Pediatrics, 110,* 473–480.

Rapp, C. A. (1998a). The active ingredients of effective case management: A research synthesis. *Community Mental Health Journal, 34,* 363–380.

Rapp, C. A. (1998b). *The strengths model: Case management with people suffering from severe and persistent mental illness.* Oxford, UK: Oxford University Press.

Rapp, C. A., & Chamberlain R. (1985). Case management services for the chronically mentally ill. *Social Work, 30,* 417–422.

Rapp, C. A., & Goscha, R. J. (2004). The principles of effective case management of mental health services. *Psychiatric Rehabilitation Journal, 27,* 319–333.

Rapp, C. A., & Wintersteen, R. (1989). The strengths model of case management: Results from twelve demonstrations. *Psychosocial Rehabilitation Journal, 1,* 23–32.

Rapp, R. C., Siegal, H. A., & Fisher, J. H. (1992). A strengths-based model of case management/advocacy: Adapting a mental health model to practice work with persons who have substance abuse problems. *NIDA Research Monograph, 127,* 79–91.

Riley, D. B., Greif, G. L., Caplan, D. L., & MacAulay, H. K. (2004). Common themes and treatment approaches in working with families of runaway youths. *The American Journal of Family Therapy, 32,* 139–153.

Ryan, C. S., Sherman, P. S., & Judd, C. M. (1994). Accounting for case manager effects in the evaluation of mental health services. *Journal of Consulting and Clinical Psychology, 62,* 965–974.

Sayfer, A. W., Thompson, S. J., Maccio, E. M., Zittel-Palamara, K. M., & Forehand, G. (2004). Adolescents' and parents' perceptions of runaway behavior: Problems and solutions. *Child and Adolescent Social Work Journal, 21,* 495–512.

Shwartz, M., Baker, G., Mulvey, K. P., & Plough, A. (1997). Improving publicly funded substance abuse treatment: The value of case management. *American Journal of Public Health, 87,* 1659–1664.

Siegal, H. A., Fisher, J. A., Rapp, R. C., Keliher, C. W., Wagner, J. H., O'Brien, W. F., & Cole, P. A. (1996). Enhancing substance abuse treatment with case management: Its impact on employment. *Journal of Substance Abuse Treatment, 13,* 93–98.

Siegal, H. A., Rapp, R. C., Fisher, J., Cole, P., & Wagner, J. H. (1993). Treatment dropouts and noncompliers: Two persistent problems and a programmatic remedy. In J. A. Inciardi, F. M. Tims, & B. W. Fletcher (Eds.), *Innovative approaches in the treatment of drug abuse: Program models and strategies* (pp. 109–122). Westport, CT: Greenwood.

Siegal, H. A., Rapp, R. C., Kelliher, C. W., Fisher, J. H., Wagner, J. H., & Cole, P. A. (1995). The strengths perspective of case management: A promising inpatient substance abuse treatment enhancement. *Journal of Psychoactive Drugs, 27,* 67–72.

Simmons, R. G., & Blyth, D. A. (1987). *Moving into adolescence: The impact of pubertal change and school context.* Hawthorne, NY: Aldine de Gruyter.

Slesnick, N. (2001). Variables associated with therapy attendance in runaway substance abusing youth: Preliminary findings. *American Journal of Family Therapy, 29,* 411–420.

Smokowski, P. R., & Kopasz, K. H. (2005). Bullying in school: An overview of types, effects, family characteristics, and intervention strategies. *Children & Schools, 27,* 101–110.

Stanard, R. P. (1999). The effect of training in a strengths model of case management on client outcomes in a community mental health center. *Community Mental Health Journal, 35,* 169–179.

Sullivan, W. P., & Fisher, B. J. (1994). Intervening for success: Strengths-based case management and successful aging. *Journal of Gerontological Social Work, 22,* 61–74.

Susman, E. J., Inoff-Germain, G., Nottelmann, E. D., Loriaux, D. L., Cutler, G. B., Jr., & Chrousos, G. P. (1987). Hormones, emotional dispositions, and aggressive attributes in young adolescents. *Child Development, 58,* 1114–1134.

Tyler, K. A., & Cauce, A. M. (2002). Perpetrators of early physical and sexual abuse among homeless and runaway adolescents. *Child Abuse & Neglect, 26,* 1261–1274.

Whitbeck, L. B., Hoyt, D. R., & Ackley, K. A. (1997). Families of homeless and runaway adolescents: A comparison of parent/caretaker and adolescent perspectives on parenting, family violence, and adolescent conduct. *Child Abuse and Neglect, 21,* 517–528.

Wilton, R. D. (2003). Poverty and mental health: A qualitative study of residential care facility tenants. *Community Mental Health Journal, 39,* 139–156.

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