The Strengths Model in Hong Kong

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INTRODUCTION

Mental health practice involves the continuous process of learning and refinement, especially when practitioners focus on the strengths and aspirations of individuals who are coping with serious mental illnesses (Tse et al., 2016). Cross-cultural considerations include beliefs, language, the role of social support, and the distinctive characteristics of specific communities that require localization in designing and offering mental health services. In this chapter, we describe the experience of adopting the Strengths Model in Hong Kong, starting with an introduction to the mental health system in the city. We then illustrate the development and implementation of the Strengths Model for the Chinese population in Hong Kong. We also briefly review research studies focusing on the Strengths Model in mental health practice in this cultural context (Tsoi et al., 2018; Tsoi, Tse, Canda, & Lo, 2019; Tse et al., 2019). The process of localization described in this chapter required the building of complex relationships among Strengths Model founders, scholars, organizations, caseworkers, and people facing mental health challenges.

THE MENTAL HEALTH SYSTEM IN HONG KONG

Mental health needs

The territory-wide study on Common Mental Disorders (CMDs), the Hong Kong Mental Morbidity Survey (HKMMS) 2010-2013, indicated the clinical diagnosis of

adults aged 16-75 years with a prevalence rate of one week was 13.3% for CMD (Lam et al., 2015) and 2.5% for psychotic disorders (Chang et al., 2015). The highest proportions of diagnoses include depression, generalized anxiety, and mixed anxiety and depressive disorders. The amount of public resources allocated to mental health services is insufficient in proportion to significantly increasing demands in recent years, particularly those associated with the social unrest since June 2019 in Hong Kong (Cheung, 2019; Hong Kong Government, 2013b). Hong Kong has a limited number of psychiatrists; the latest Mental Health Atlas reported that Hong Kong has a ratio of 4.39 psychiatrists per 100,000 population, a low rate compared to that in other countries, such as Japan (10.1/100,000) and England (17.65/100,000). The city's nursing workforce has a ratio of 29.15/100,000, whereas Japan has 102.55 and England has 82.23 (Chan, Lam, & Chen, 2015). Furthermore, Hong Kong has a substantially high caseload rate for community psychiatric social workers of 5.9 social workers per 100,000 people in the population, compared to 17.93/100,000 in the United States (World Health Organization, 2011). According to a survey authorized by the Food and Health Bureau of the Hong Kong Government on access to psychiatric care, the average period from symptom onset to initial psychiatric consultation is 42 weeks (Chan et al., 2012). Increased efforts are thus necessary to develop and retain mental health professionals. In addition, in a study conducted by Lam et al. (2015), it was found that less than 30% of those in HKMMS with CMDs had received professional help during the previous year, suggesting either a shortage of services or barriers to care. All of the above figures reflect the way in which a much larger population suffering from different mental health problems has not received professional services.

Psychiatric and Social Services

The most recent census reported a total population of 7.4 million in Hong Kong (Census and Statistics Department, 2019). Approximately 92% of the population includes people of Chinese nationality and 8% are referred to as ethnic minorities (Census and Statistics Department, 2016). Since 1990, the Hospital Authority of Hong Kong (HA), which is a statutory body, has managed all of the city's public hospitals, including the clinical administration of public mental health services (Cheung, Lam, & Hung, 2010). Regional psychiatric facilities have been expanded to support the growing need for inpatient care and outpatient services. In 2015/16, of the 228,700 Hong Kong citizens who received HA psychiatric services (Hong Kong Government, 2017a), over 60% of the services provided were to people suffering from different types of CMDs.

Overall, the public mental health system in Hong Kong has taken shape with many similarities to community care in the West. A community psychiatric nursing service became available in 1982, followed by community psychiatric teams in 1994. As the services were extended throughout the community, new Integrated Mental Health Clinics came into service in each geographical district in 2012. These clinics are managed by family doctors and are sponsored by the HA's primary care centers. The doctors receive supervision from experienced psychiatrists. To this day, the clinics

are running on a small, experimental scale. All of the above community care has contributed to a gradual reduction in the average length of inpatient stays from over 90 to around 60 days in the past decade. Furthermore, the HA implemented the case management care model (known as the personalized care program, or PCP) in 2010 (Hong Kong Government, 2017b). This model is aligned with similar support for home-based crisis interventions and other assertive treatments used in Western countries. This program allows an assigned case manager to follow up with a person who has a severe mental illness through a close alliance and individual care plans (Hong Kong Government, 2013a). To date, 315 case managers, mainly psychiatric nurses and occupational therapists with knowledge of mental health services, have taken care of more than 15,000 clients with severe mental illnesses, who are being treated in Hong Kong's public sector. The government seeks to improve the ratio of case managers to clients from the current 1:50 to 1:40.

While the HA mainly manages services for inpatients, the Social Welfare Department (SWD) is responsible for carrying out public policies and for developing and arranging social welfare services in Hong Kong. Most notably, the SWD offers an array of services for people affected by mental illnesses, with the aim of enhancing rehabilitation and community reintegration. Since 2010, the SWD has established 24 Integrated Community Centres for Mental Wellness (ICCMW), which are allocated across the region. These centers are recognized as the core providers of community mental health services in Hong Kong (Hong Kong Government, 2013a). In addition, the SWD also provides services for the younger population, children, families, the elderly, and offenders (Hong Kong Government, 2013a). The Disability Discrimination Ordinance (Cap. 487), approved in 1996, is a legal framework for maintaining equal work, housing, and education opportunities, as well as reducing harassment and discrimination toward individuals with disabilities or severe mental illnesses (Hong Kong Government, 2013a).

Along with the SWD, the Labour Department, the Employees Retraining Board, and the Vocational Training Council, as well as NGOs, all offer a range of employment support services, such as vocational training and workshops, for the public. Other community-based services include counseling and other resource centers that are largely staffed by health professionals and psychiatric medical social workers

In addition to services directly offered by the government, in an effort to increase residential care, non-governmental organizations (NGOs) provide alternative community-based residential services. These residential services are subvented by the SWD and include halfway houses, supported hostels, and long-stay care homes. These social rehabilitation service options support the re-integration into the community of people with severe mental illnesses after they have been discharged from the hospital (Cheng, 2011).

Prevention and Early Detection

There have been a number of preventive programs in Hong Kong in recent years. The HA collaborated with the SWD to establish community-based programs for the prevention and early identification of mental health issues among various target groups. In 2001, The Early Assessment and Detection of Young Persons with Psychosis (EASY) program was created for individuals aged 15-25 years (extended to 15-64 years in 2011) presenting early symptoms of psychosis. The Elderly Suicide Prevention Programme (ESPP) was established in 2011, assisting adults aged 65 or above with depression or suicidal ideation. In addition, the Child and Adolescent Mental Health Community Support and Community Mental Health Intervention projects provide more focused support for children and adolescents.

THE IMPLEMENTATION OF A RECOVERY-ORIENTED STRENGTHS MODEL IN HONG KONG

Recovery-Oriented Services

The concept of mental health recovery may still be foreign to people with mental illnesses and professionals in Hong Kong (Ng et al., 2008; Ng, Pearson, Chen, & Law, 2010; Davidson & Tse, 2014). However, some progress has been made in the past two decades. As the Mental Health Service Plan for Adults states, "the vision of the future is of a person-centered service based on effective treatment and the recovery of the individual" (Hospital Authority, 2011, p. 5). Even though such principles have been advocated only in recent years, practices promoting people's empowerment emerged as early as the 1980s (Tsoi, Lo, Chan, Siu, & Tse, 2014). Multiple agencies have adopted recovery-oriented practices, such as peer support services, recovery colleges, supported employment, and the clubhouse model, all of which encourage participants to develop and use their strengths. In the area of hospital-based psychiatric care, for example, the regional psychiatric unit in Kowloon Hospital is a place where people with mental illnesses have served as peer specialists on the mental health team and as representatives on the rehabilitation team since 2012. The oldest psychiatric institution in Hong Kong, Castle Peak Hospital, recruits peer helpers for their user-led clinical programs. Within social services, NGOs run peer support groups with participants who share similar struggles in different recovery stages. Peer support workers facilitate these groups, which support members in coping and living with mental illnesses by having them "walk with" one another. Furthermore, the first multi-agency peer support training course was launched in 2012. It is a three-year pilot project funded by MINDSET and involving four NGOs. It aims to facilitate people who have recovered from mental illnesses in helping others on their recovery journey (Davidson & Guy, 2012). The peer support service provided in the social welfare sector was established as a formal intervention in March 2018, with about 50 full-time and part-time peer support positions. As of April 2019, approximately 20 full-time equivalent support workers had been recruited to work in the public hospital sector.

The Journey

The journey to the adoption and implementation of the Strengths Model in Hong Kong is mostly about relationships. It is a story of close collaborations across different cultures, languages, and settings. The use of the strengths-based approach debuted in Hong Kong as early as the year 2000. Professor Kam-Shing Yip from Hong Kong Polytechnic University completed exploratory case studies, applying the strengths perspective to his work with adolescents in the community (Yip, 2003; Yip, 2005; Yip, 2006). Similarly, Kevin Hui (The Society of Rehabilitation and Crime Prevention, Hong Kong) and his team conducted a six-month, single group, pre-post design study on the effectiveness of strengths-based case management (Hui et al., 2015). Nevertheless, the first major systematic development of the Strengths Model Case Management (SMCM) in Hong Kong lies within the collaboration among The University of Hong Kong (HKU) and three leading NGOs.

The year 2003 marked a meaningful encounter between Professor Charles Rapp from the University of Kansas (KU) and Tse from the University of Auckland, New Zealand. Tse attended a mental health conference in Christchurch, New Zealand, where Rapp spoke as a keynote presenter. Rapp is the founding author of SMCM and the seed of implementing SMCM out the United States was sown in their conversation. In 2009, Tse relocated back to Hong Kong and joined the Department of Social Work and Social Administration at HKU after working in New Zealand for over 20 years. As Tse delved into SMCM, he met Dr. Richard Goscha (another of SMCM's founding authors, from KU) and their friendship has borne many scholarly fruits in the years since 2009. In 2012, Tse and his doctoral trainee, Tsoi, implemented SMCM and conducted a non-randomized controlled trial at the residential services of three NGOs: the long-stay care homes of the Tung Wah Group of Hospitals, the halfway houses of Caritas Hong Kong, and the supported hostels of the Baptist Oi Kwan Social Service. Tse has a long history of close partnerships with these agencies' supervisors – Ms. Eppie Wan, Mr. Stephen Wong, and Ms. Chan Sau Kam – who aided the rolling out of the Strengths Model in their supported accommodations. It was with much anticipation that the team invited Goscha to provide training for caseworkers in Hong Kong. Over 100 mental health professionals attended his four-day workshop in April 2012 (Tsoi et al., 2018). As the model took shape at the three residences in 2013, Goscha continued to supervise via monthly video conferences. Tse provided ongoing local group supervision in later years. From 2014-2015, the integrated community centers of the Society of Rehabilitation and Crime Prevention (SRACP) and the Richmond Fellowship of Hong Kong both adopted the Strengths Model. Regular supervision and training were also provided at these agencies by trainers from KU and Australia. In the following year, the Hong Kong Recovery and Strengths Perspective Social Work Association was set up as a division of its Taiwan mother organization, led by Professor Song Li-Yu from National Chengchi University.

The Strengths Model – New Era in Asia Symposium was held at HKU in October 2016. Goscha made his second visit to Hong Kong and led the event, together with Song and Tse. The team shared their experiences with SMCM in the United States

and Taiwan. Tse and the three NGO supervisors also shared their learning and the challenges they had faced regarding their work in Hong Kong. Goscha provided training for caseworkers during his visit, conducting a total of 23 supervision sessions throughout those years. The year 2016 continued to be celebratory for the Strengths Model in Hong Kong, as the SMART Institute (Strengths Model Application Research and Training) was also founded that year. A unit in the Department of Social Work and Social Administration at HKU was co-hosted by the Tung Wah Group of Hospitals, Caritas Hong Kong, and the Baptist Oi Kwan Social Service. The institute is dedicated to the evidence-based practice of SMCM and its clinical application, research, and training in the city. Continuing to this day, the SMART Institute has organized a range of events, including conference presentations, seminars, and workshops, to promote and educate people about SMCM. These community activities are targeted not only at mental health practitioners, but also at caregivers, as an introduction to discovering strengths within families. Tse continues to facilitate the training of case managers and peer support workers in the HA, as well as mental health practitioners from different NGOs in Hong Kong and Macau. In addition, Tse et al. have conducted three rigorous research studies for peer-reviewed publications in the local context between 2013 to 2019 (see "Study Results" below). In celebrating the SMCM work at a long-stay care home, the Tung Wah Group of Hospitals published a book entitled 我是資優生 (*A World of Talents*). The book contains stories of residents with mental issues and their recovery experiences with the strengths-based approach at a long-stay home. Besides, since 2016, Caritas Hong Kong has published a series of Daily Planners to promote the Strength Model's concepts. The planners consist of various self-learning exercises, with reference to the Strength Model, and are distributed to frontline workers and service users.

The Process and Elements of Implementation

The adoption of the Strengths Model in Hong Kong has been marked by several milestones, with continuous development in the present day. As illustrated in the above section, its growth has been made possible through the sharing of practical wisdom and goals among scholars and practitioners. It started with Tse's overseas visits, during which he shared his work with recovery-oriented approaches and contributed his new knowledge of the Strengths Model to the field at home. Strong collaborations continued due to the commitment of NGOs, intensive training for caseworkers, trial cases, and ongoing supervision. Once the caseworkers' professional development had been strengthened, they began their SMCM work in residential services. Research studies (for details of these, please see the next section on integrating implementation with research) were carried out to examine the outcomes and process in order to establish a more extensive evidence base for SMCM. These have been followed by continuous training and teamwork as the SMCM service has extended to more homes. The maintenance and growth of this community are guided by a quality implementation framework that includes ongoing professional development, guidance, and support for supervisors and caseworkers, as well as fidelity reviews.

The efficient flow of the service community relies on key components for SMCM implementation. These elements are in place to ensure the quality of services delivered to people with mental illnesses and are characterized by five "Cs" (Wan, 2019).

1. Commitment from senior management not only ensures the leadership of operational functions, but also drives the structural movement. The shift in service direction requires the teams' dedicated efforts in cultivating the community's new culture.
2. Capable staff is a crucial element in executing SMCM. The case managers' values, attitudes, and competence are their fundamental assets when adopting and applying the Strengths Model, given their close engagement with service users.
3. Clinical support ensures the professional development of caseworkers and enhances evidence-based practice. Goscha and Tse provide regular training and supervision, while Tse and his teams learn from and share their research findings. There are also regular fidelity reviews and evaluations on the implementation of SMCM.
4. Continuous training has been emphasized throughout the process of implementation. The regularity of coaching is critical for building up case managers' competence and morale. Ongoing training is given through group supervision, field monitoring, and monthly guidance.
5. Collaboration among organizations has been the foundation of SMCM's adoption in Hong Kong. The community expands due to the collective strengths of the three NGOs and HKU, as well as their continuing efforts in learning from, supporting, and sharing with one another. In summary, the elements of SMCM implementation are based on the values of extension and the constant movement of all involving parties.

Barriers to Care and Challenges

Stigma and discrimination associated with mental health issues remain major barriers for people seeking help from and accessing mental healthcare. Strengths-based interventions are no exception. We conducted a longitudinal, repeated cross-sectional study of self-stigma, social stigma, and coping strategies among people with mental health problems. The baseline survey was completed by 193 participants recruited from psychiatric outpatients in 2001. Another sample of 193 outpatients matched in age, gender, and psychiatric diagnosis was recruited in 2017 for cross-sectional comparison. In addition, 109 of the 193 participants (56.5%) were successfully contacted and re-assessed in 2017 (for further details, see Chung, Tse, Lee, & Chan, 2019; Chung, Tse, Lee, Wong, & Chan, 2019). The major finding of this investigation was that there was only a slight reduction in perceived stigmatization among participants with mental illnesses in Hong Kong from 2001 to 2017. A lower proportion of service users of outpatient clinics interviewed in 2017 agreed

that most people would not marry a person who had a history of mental illness and would not accept someone who previously had mental illnesses as a close friend, but viewpoints regarding untrustworthiness, dangerousness, devaluation, avoidance, and personal failure remained unchanged. Personal experiences of rejection and coping strategies were similar in the two cross-sectional samples. Regarding the longitudinal study, the 109 participants who were re-assessed in 2017 reported similar experiences regarding stigma, compared to their responses in 2001. Although public expenditure on mental health education has grown exponentially in the past two decades in Hong Kong, our findings highlight that the stigma experienced by people facing mental health challenges has not improved proportionally. Fear of stigmatization due to the discouraging levels of community acceptance of mental illness may cause people to be reluctant to seek help when a problem arises (Siu et al., 2012). Government agencies and NGOs must continue their community and education activities in encouraging more positive attitudes. Moreover, sufficient service provision is crucial to proper care for people with mental illnesses at early stages.

INTEGRATING IMPLEMENTATION WITH RESEARCH

From 2013 to 2019, Tse et al. conducted three research studies on SMCM in Hong Kong (2016, 2018 and 2019). They include a non-randomized controlled trial, a randomized controlled study (in progress), and an international comparison of Western strengths-based practices and practices in Hong Kong. These studies suggest the importance of translating the Western approach to fit the needs of a Chinese population. Their results provide insights into the outcomes of current clinical applications and offer directions in which to extend the localized implementation of the Strengths Model.

A Non-Randomized Controlled Trial

A non-randomized study was carried out to evaluate the effectiveness of SMCM for individuals with mental illness in Hong Kong (Tsoi et al., 2018). In the 12-month controlled trial, the effects of the treatment in the intervention group were compared with those in a treatment-as-usual control group. Participants were selected from six residential sites run by the Tung Wah Group of Hospitals, Caritas Hong Kong, and the Baptist Oi Kwan Social Service. These six residential service units were invited to participate in the study, based on their previous experience (or lack thereof) of the Strengths Model. The SMCM intervention or non-SMCM intervention (control group) that each individual received was therefore based on the setting in which he or she resided. Since the allocations of individuals to the intervention or control groups were not random, this is a non-randomized controlled trial. In a sample of 124 participants, over 85% were diagnosed as having schizophrenia and the rest with bipolar disorder. All possessed adequate Chinese reading and comprehension skills. Data were collected at pretreatment and at the fourth and 11th months for comparison. Seven assessment tools (e.g., the Maryland Assessment of Recovery in

people with serious mental illnesses, States of Hope, the Working Alliance Inventory) were used as outcome measures.

The SMCM intervention was provided by caseworkers who were trained by Goscha and his team members. During a 12-month period, individual sessions took place for 30 to 60 minutes every two to three weeks. The caseworkers met with participants at nearby parks and fast food places in the community, following the SMCM's sixth principle (i.e., the primary setting is the community, Rapp & Goscha, 2012, pp. 61-62). The sessions were facilitated with the aim of discovering the individuals' strengths. The Strengths Assessment was used to set recovery agendas and the Personal Recovery Plan was used to align participants' strengths with their desired goals. Fidelity monitoring, including chart reviews of tools, interviews, and the evaluation of group supervision, was conducted. The detailed fidelity report and scores were prepared by Tse and a person with lived experience of mental illnesses and was moderated by Goscha. With everyone's effort, the average fidelity score improved from 2.6/5 before the trial to 3.7/5 during the intervention period. Scores close to 4 out of 5 meant that the interventions provided in the trial had reached the desired features of SMCM practices, such as a good ratio of caseworkers to service users, satisfactory supervision, and clinical support for workers.

To the best of the authors' knowledge, this was the first study with preliminary evidence of high-fidelity SMCM's positive effects on service users' outcomes conducted in a healthcare system structured differently from that of the U.S. The study reported significant differences in outcomes between the intervention and control groups regarding psychiatric symptoms, the achievement of goals by users and caseworkers, and caseworkers' well-being (Tsoi et al., 2018). As for goal achievements rated by caseworkers, the intervention group made better progress in achieving their recovery goals – or, in general, what the literature refers to as "functional recovery" (Leonhardt et al., 2017; Tsoi et al., 2018). In practice, the results suggest that frontline social workers should be empowering individuals with mental illnesses through their journeys of strength discovery (e.g., what are the users' aspirations, talents, and previous/current successes). Ongoing support and stable and trusting therapeutic relationships are critical elements contributing to successful intervention outcomes (Tsoi et al., 2018). The caseworker outcomes highlight the effectiveness of SMCM in reducing caseworkers' emotional exhaustion. It is our understanding that this was the first study involving the influences of SMCM on caseworker burnout. A potential new direction for future research was suggested in regard to considering individual and organizational changes that may affect caseworkers' well-being (Tsoi et al., 2018). Another observation was that the visual plot of the results of the key clinical outcomes across various agencies demonstrated a strong link between higher fidelity settings and better outcomes. This finding regarding fidelity provides the basis for further research on organizational characteristics that may influence fidelity (Tsoi et al., 2018).

Randomized Controlled Study

At the time of writing, the latest study protocol is designed for a randomized controlled trial (RCT) to assess the effectiveness of SMCM with Chinese individuals with mental health challenges in Hong Kong. It aims to conduct rigorous research that provides evidence and implications for local strengths-based interventions supported by the ongoing measurement of fidelity scores during the course of study (Tse et al., 2019). In addition to the RCT focusing on outcome evaluation, we will also carry out a qualitative study to examine the therapeutic elements contributing to the intervention outcomes.

Before the trial, the authors made preliminary cultural adaptations according to their best knowledge of SMCM. These were carried out considering cultural sensitivity, which may be weak in previous research in the Western context (Tse et al., 2019). Some adaptations were conducted by clinicians in the years from 2012 to 2013, before we planned to conduct the present RCT. This work included translating the Strengths Assessment and Personal Recovery Plan forms into Chinese, using local terms and providing examples referring to the concept of strengths. This study investigates the compatibility of SMCM with Chinese culture, considering aspects such as Chinese people's views, family traditions, and reservations regarding the expression of their strengths and successes. These cultural values may be influenced by linguistics, folklore, metaphors, icons, and introspection from Taoist philosophy and Confucius's Doctrine of the Mean (Zhongyong 中庸) (Tse, Divis, & Li, 2010; Tse et al., 2019; Song & Shih, 2010). It also examines the structural compatibility of SMCM with aspects such as caseload size and the ratio of supervisors to caseworkers. Mental health services in Hong Kong operate within a different structure compared to the U.S., with higher caseloads, for example; the HA reported a 1:47 ratio of community caseworkers to individuals with severe mental illnesses. The above cultural and community factors provide valuable insights into the best possible SMCM implementation in local Chinese or Asian mental health settings (Tse et al., 2019).

The RCT is making strong progress. A total of 210 participants have been recruited from the ICCMWs of three NGOs in Hong Kong. Participants are randomly assigned to an SMCM intervention group and a control group. The inclusion criteria include: 1) service users of mental health services in ICCMWs; 2) aged 18 years or above; 3) Chinese and can speak Cantonese and read Chinese; 4) diagnosed with a mental illness, including major depressive disorder, anxiety disorder, bipolar disorder, and psychotic disorders, by a psychiatrist; and 5) able to provide written informed consent to participate in the study and agree to be allocated to either an SMCM intervention or a control group (Tse et al., 2019). Data are collected at six and 12 months for comparison between the SMCM intervention and the control group.

The ICCMWs staff are the caseworkers delivering the intervention in the SMCM group. They are required to have received training by Goscha, with ongoing group supervision, in order to deliver the intervention. There are individual sessions of 30

minutes with the participants every two weeks. The Strengths Assessment and the Personal Recovery Plan are used to help users set recovery goals. The Fidelity Scale is also included to monitor the service unit every six months. For the control group, a generic intervention (i.e., treatment as usual) is delivered to the participants. This includes medical appointments, recovery groups, hobby groups, and general community activities. The control group's caseworkers call service users or meet them at center activities as an attention placebo; thus, if there are any differences between the intervention and the control group, we can be certain that the differences are not due to the extra attention individuals receive in the intervention group. Furthermore, this study aims to involve people with lived experience of mental health challenges. Nine people in recovery from mental illnesses provided feedback in regard to revising the Chinese questionnaire in a pilot study conducted in 2017. Individuals with lived experience of mental illnesses are recruited as paid fieldworkers for the data collection process, and the study results will be disseminated among both the participants and the wider public.

The current RCT in progress will increase our understanding of the effectiveness of SMCM on individuals' recovery and any unintended results of strengths-based services for individuals with mental illnesses. The essential therapeutic ingredients and fidelity features of SMCM will be illustrated, along with their effects on recovery outcomes. This research will closely examine enhancements made to SMCM adaptation for the Chinese community, ensuring a culturally responsive practice.

Critical Review and Cultural Considerations

The researchers in Hong Kong led a critical review of the use of strengths-based approaches in mental health services (Tse et al., 2016). The critical review examined the quality of seven selected articles and drew implications for cross-cultural, recovery-oriented practice. The review included peer-reviewed journal articles with quantitative research on strengths-based interventions published between January 2001 and December 2014. From a search of 619 articles, 55 were identified as relevant to the review and seven met the inclusion criteria. The quality of the studies was appraised using the Quality Assessment Tool for Quantitative Studies, with the majority rating from moderate to weak among diverse research designs. The review presented evidence that the strengths-based approach creates positive effects for outcomes including service satisfaction and utilization, hospitalization rates, and educational and employment attainment, as well as multiple interpersonal outcomes, such as a sense of hope and self-efficacy (Tse et al., 2016). The studies confirmed the advantages and feasible application of high-fidelity, strengths-based approaches for clinical settings and in healthcare. The review highlighted the high level of engagement between caseworkers and service users in strengths-based interventions, as well as the benefits of recruiting peer supporters. The lack of routine review and monitoring of users' strengths were discussed, and the discussion suggested that SMCM could improve the monitoring of clinical practice (Tse et al., 2016). Therefore, Tse et al. suggested more high-quality and well-designed clinical studies to further examine the effectiveness of strengths-based approaches (Tse et al., 2016).

The main discussion in the critical review was directed toward the need to consider cultural nuances when delivering SMCM. First, all studies identified in the review were conducted in the Western context. Culture can greatly influence a person's expressions of feelings and beliefs regarding mental health, strengths, and goals (Tse et al., 2016). The Strengths Model is of Western origin; there are thus many challenges to be faced in the process of ensuring it is culturally adaptable for the Chinese community. Forms of linguistics, metaphors, folklore, and icons are culturally unique, and they all contribute to the perception of strength. In Chinese, the word "strength" can be translated as 優勢 (*youshi* or superiority), 強項 (*qiangxiang* or forte), or 潛能 (*qianneng* or potential) (Tsoi et al., 2019). The interpretation of each term is based on a person's understanding from his or her own cultural perspective. For example, the bamboo is a common metaphor for strength and virtue, given the evergreen plant's ability to grow even in harsh weather conditions. It can be seen across Asia, symbolizing perseverance and tenacity in Chinese, Japanese, and Vietnamese cultures. Moreover, it is important to explore various cultural and philosophical views regarding the concept of "strength". Most Asian communities (namely, Chinese, Japanese, and Korean) are inspired by the teachings of Taoism, Confucianism, and Buddhism (Tsoi et al., 2019). Their philosophy encourages simplicity in life, a clear mind with minimal desires, and a habit of self-transcendence and self-retrospection. Confucianism advocates the ideas of harmony, self-sacrifice, service, and forgiveness (Tsoi et al., 2019). Taoism shares similar roots, placing a great deal of emphasis on modesty (Tse et al., 2010). In light of these considerations, cultural sensitivity and creativity are at the core of mental health practitioners' work with service users in the process of exploring strengths.

Subsequent to the critical review, Tsoi and Tse conducted a small-scale, creative qualitative study using photos as stimuli, with a small sample of Chinese community participants (Tsoi et al., 2019). The participants were presented with different photos, such as a person with a cane, bamboo, and a financially deprived family in a crowded space. They were asked to identify the kinds of strengths they could see in the photos. The questions aimed to encourage the participants to use their own words to describe the strengths pictured. The outcomes revealed the following characteristics of strength, as narrated by the research participants:

1. Strength as a flexible, adaptable capability that may allow a step back at times. This is a Chinese belief stemming from the imagery of a formless flow of water and streams (epitomized by the saying "be water"). It is interpreted as contrasting the Western idea of strength as persistence and force.
2. Strength through relationships. These include support systems from family, friends, and the community, and the empowerment and advantages that flow through relational factors.
3. Strength as a vocational ability. A person's educational advantages and abilities to work represent his or her strengths.
4. Strength in character. A person's qualities, such as a caring spirit, loyalty, kindness, filial piety, and patience, are his or her strengths.

The above findings have two implications. First, they provide valuable information reflecting how Chinese culture may interpret strength differently from Western culture. Second, the findings show the importance of adopting culturally responsive SMCM tools that are endorsed by individuals from non-Western contexts about discovering their strengths. For example, after extensive consultations with individuals with mental illnesses and mental health workers, the English word "strength" is translated to 優勢 (*youshi* or superiority). We emphasize the way in which the concept of strength stretches beyond personal strength and can include one's career, spiritual beliefs, family, and community or relational strength. Hence, further research in non-Western settings is warranted so that SMCM can evolve further, enabling it to cater for users from different cultures.

Discussion

A range of mental health services are available in Hong Kong, including pharmacological treatments, inpatient care, and personalized care programs for community-based services. Strengths-based, recovery-oriented approaches have increasingly been integrated into community-focused services in the past decade (Hospital Authority, 2011). This growing trend warrants more research work focusing on both outcome and process evaluations. Furthermore, our recent study, which included an assessment of staff burnout (i.e., caseworkers involved in the strengths-based intervention reported lower levels of stress, compared to the control group), provided a new direction for further investigations. This brings attention to the urgent need of mental health workers in Hong Kong for support (Tsoi et al., 2018). Future studies are advised to include an evaluation of fidelity reviews and staff burnout in relation to the effectiveness of SMCM for people facing mental health challenges.

The Strengths Model emphasizes the personal strengths and self-defined goals of individuals in the context of their communities (Rapp & Goscha, 2012). It calls for careful consideration of individuals' understanding of strengths on a deep, personal level during the process of therapy (Tse et al., 2016). In recent years, Tse and his team have made diligent efforts to study cultural influences on their implementation of the Strengths Model in Hong Kong. Traditional Chinese beliefs and philosophical values shape people's perceptions of strengths and aspirations, and they have been at the center of the application of SMCM in the city since the beginning. The path to localization requires fundamental steps to be taken in exploring cultural aspects that influence an Asian service user's understanding of strength. The current translated tools confirm the adaptability of SMCM to an Eastern city. The next steps that can enhance the implementation require gaining further insights into metaphors, folklore, and other traditional Chinese family teachings in relation to the concept of strength. Such knowledge can add to the overall strengths-based practice by making it more personalized and relevant for local users. It can also help caseworkers to develop their competence by delivering the intervention more effectively. It is a priority for caseworkers to understand patients' concepts of strength in order to instill hope and self-efficacy; their recovery goals will then become achievable and applicable to their community. In this way, the individuals involved are

empowered in regard to discovering their niche and using the resources available to them. Further research involving high-quality clinical studies is necessary to evaluate the effectiveness of the Strengths Model and its adaptation in these distinctive communities.

As the Strengths Model continues to extend toward new communities in Hong Kong, its implementation components follow the principles of the co-construction of goals. Chan (2019) from the Baptist Oi Kwan Social Service proposed a future SMCM plan that consists of four main directions:

1. Platform – the development of a digital platform. Community resource libraries, chatrooms, and strength assessments will become available online. This digital approach will connect case-workers more closely with service users and raise awareness of the services available.
2. Leadership – training individuals in recovery to become peer support workers. This aligns with current peer support worker recruitment processes at psychiatric facilities and NGOs.
3. Setting – implementing SMCM in hospital-based acute services and vocational settings. This is a natural extension of the model from community settings to hospitals and reflects the Hong Kong people's pragmatic view of "recovery" in regard to the way in which healing and the installation of hope should begin as soon as a person becomes unwell.
4. Target – identifying more target groups that can benefit from SMCM. Strength discovery is a favorable method that can be used to support people with learning disabilities, autistic features, or multiple physical disabilities (i.e., verbal and behavioral challenges). Caregivers are also in need of personal recovery and wellness; strengths-based approaches can create protective factors, especially in Chinese communities, which have a strong family orientation. Finally, strength exploration and self-motivation are needed for the elderly population. "JC JoyAge" is a holistic support project for elderly mental wellness. It constitutes a collaboration between The Hong Kong Jockey Club Charities Trust and HKU's Department of Social Work and Social Administration, as well as other NGOs. The project supports elderly people suffering from depressive symptoms and the project is in the process of adopting the Strengths Model.

CONCLUSION

The story of the Strengths Model in Hong Kong is encouraging. The Strengths Model focuses on facilitating the re-integration of people with mental illnesses into their communities and so its local adaptation focuses on the distinctive strengths and

goals of these communities. Following the strengths-based beliefs of progress and movement, the implementation of SMCM continues to strengthen meaningful relationships in different roles and to extend to a wider range of services. The clinical practice of the Strengths Model in Hong Kong ensures its fidelity standards of ongoing training and supervision, the commitment of management, and the collaboration of organizations. The exploration of unique cultural influences and the refinement of its application will continue with rigorous research. This journey has involved discovering people's strengths, as well as the strengths of recovery-oriented mental healthcare in Hong Kong.

END NOTES

Acronyms Used in This Chapter	
CMDs	Common Mental Disorders
EASY	Early Assessment and Detection of Young Persons with Psychosis
ESPP	Elderly Suicide Prevention Programme
HKMMS	Hong Kong Mental Morbidity Survey
HA	Hospital Authority of Hong Kong
ICCMW	Integrated Community Centres for Mental Wellness
NGO	Non-Governmental Organizations
PCP	Personalized Care Program
RCT	Randomized Controlled Trial
SWD	Social Welfare Department
SRACP	Society of Rehabilitation and Crime Prevention
SMART	Strengths Model Application Research and Training
SMCM	Strengths Model Case Management
HKU	University of Hong Kong
KU	University of Kansas

REFERENCES

Census and Statistics Department. (2016). *Thematic Report: Ethnic Minorities.* Hong Kong Special Administrative Region, China: Author.

Census and Statistics Department. (2019). *Mid-year population for 2019.* Retrieved from https://www.censtatd.gov.hk/hkstat/sub/so20.jsp

Chan, S.K. (2019, June). The future plan of Strengths Model Case Management in Hong Kong. Presentation at the *International Conference on Change and Innovation for a Better World: The future of the Social Work Profession*, The University of Hong Kong, Hong Kong.

Chan, W. C., Chow, P. P., Lam, L. C., Hung, S. F., Cheung, E. F., Dunn, E., Ng, R. M. & Fu, J. (2012). *Mental health problems in community: A study of the pathway to care in Hong Kong. Final report*. Hong Kong Food and Health Bureau, Hong Kong Government.

Chan, W. C., Lam, L. C.W., & Chen, E. Y.H. (2015). Letter from Hong Kong: Recent development of mental health services, *Advances in Psychiatric Care,* 21, 71-72.

Chang, W. C., Wong, C. S., Lam, L. C., Lee, E. H., Chen, E. Y., Chan, W. C., ... & Chiu, H. F. (2015). Prevalence, psychosocial and physical health correlates of psychotic disorders in Hong Kong: the Hong Kong Mental Health Morbidity Survey. *Schizophrenia Bulletin, 41*(1), S135.

Cheng, I. (2011). *Mental health services in selected places*. Hong Kong: Legislative Council Secretariat: Research Division.

Cheung, E. (2019, July 11). Nearly 1 in 10 people in Hong Kong likely to have depression, according to HKU survey conducted during extradition bill crisis. South China Morning Post, Retrieved from https://www.scmp.com/news/hong-kong/health-environment/article/3018237/nearly-1-10-people-hong-kong-likely-have

Cheung, E. F. C., Lam, L. C. W., & Hung, S. F. (2010). Mental health in Hong Kong: Transition from hospital-based service to personalised care. *International Psychiatry, 7*(3), 62-64.

Chung, K. F., Tse, S., Lee, C. T., & Chan, W. M. (2019). Changes in stigma experience among mental health service users over time: A qualitative study with focus groups. *Community Mental Health Journal, 55*(8), 1389-1394.

Chung, K. F., Tse, S., Lee, C. T., Wong, M. M. C., & Chan, W. M. (2019). Experience of stigma among mental health service users in Hong Kong: Are there changes between 2001 and 2017? *International Journal of Social Psychiatry, 65*(1), 64-72.

Davidson, L. & Guy, K. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2), 123-128.

Davidson, L., & Tse, S. (2014). What will it take for recovery to flourish in Hong Kong?. *East Asian Archives of Psychiatry, 24*(3), 110-116.

Hong Kong Government. (2013a). *Fact sheet - Rehabilitation*, Hong Kong: Information Services Department.

Hong Kong Government. (2013b). *Hong Kong 2012. Hong Kong Government yearbook*. Hong Kong: Information Services Department.

Hong Kong Government. (2017a). *Legislative Council 2016-17: Number of persons receiving psychiatric services provided by the Hospital Authority (HA).* Health Services Research Office. Retrieved from https://www.legco.gov.hk/research-publications/english/1617issh29-mental-health-services-20170626-e.pdf

Hong Kong Government. (2017b). *Mental health review report*, Hong Kong: Food and Health Bureau.

Hospital Authority. (2011). *Mental health service plan for adults 2010-2015*, Hong Kong: Author.

Hui, K. Y., Leung, C. W., Ng, M. C., Yu, W. C., Lau, E. K., & Cheung, S. K. (2015). Effectiveness of strengths-based case management for people with mental health problems in Hong Kong. *Advances in Social Work, 16*(2), 323-337.

Lam, L. C. W., Wong, C. S. M., Wang, M. J., Chan, W. C., Chen, E. Y. H., Ng, R. M. K., ... & Lam, M. (2015). Prevalence, psychosocial correlates and service utilization of depressive and anxiety disorders in Hong Kong: the Hong Kong Mental Morbidity Survey (HKMMS). *Social Psychiatry and Psychiatric Epidemiology, 50*(9), 1379-1388.

Leonhardt, B. L., Huling, K., Hamm, J. A., Roe, D., Hasson-Ohayon, I., McLeod, H. J., & Lysaker, P. H. (2017). Recovery and serious mental illness : A review of current clinical and research paradigms and future directions. *Expert Review of Neurotherapeutics. 17,* 1117-1130.

Ng, R. M., Pearson, V., Lam, M., Law, C. W., Chiu, C. P., & Chen, E. Y. (2008). What does recovery from schizophrenia mean? Perceptions of long-term patients', *International Journal of Social Psychiatry, 54*(2), 118-130.

Ng, R. M., Pearson, V., Chen, E. E., & Law, C. W. (2010). What does recovery from schizophrenia mean? Perceptions of medical students and trainee psychiatrists. *International Journal of Social Psychiatry, 57*(3), 248-262.

Rapp, C. A., & Goscha, R. (2012). *The strengths model: A recovery-oriented approach to mental health services*. New York: Oxford University Press.

Siu, B., Chow, K., Lam, L., Chan, W., Tang, V., & Chui, W. (2012). A questionnaire survey on attitudes and understanding towards mental disorders. *East Asian Archives of Psychiatry, 22*(1), 18-24.

Song, L.Y., & Shih, C.Y. (2010). Recovery from partner abuse: The application of the strengths perspective. *International Journal of Social Welfare, 19*(1), 23-32.

Tse, S., Divis, M., & Li, Y. B. (2010). Match or mismatch: Use of the strengths model with Chinese migrants experiencing mental illness: Service user and practitioner perspectives. *American Journal of Psychiatric Rehabilitation*, *13*(3), 171-88.

Tse, S., Tsoi, E., Hamilton, B., O'Hagan, M., Shepherd, G., Slade, M., & Whitley, R. (2016).

Uses of strengths-based interventions for people with serious mental illness: A critical review. *International Journal of Social Psychiatry, 62*, 281-291.

Tse, S., Ng, S. M. C., Yuen, W. Y. W., Fukui, S., Goscha, R. J., & Lo, W. K. I. (2019). Study protocol for a randomized controlled trial evaluating the effectiveness of strengths model case management (SMCM) with Chinese mental health service users in Hong Kong. *BMJ Open,* 1-10.

Tsoi, E. W. S., Tse, S., Yu, C., Chan, S., Wan, E., Wong, S., & Liu, L. (2018). A nonrandomized controlled trial of strengths model case management in Hong Kong. *Research on Social Work Practice, 29*(5), 540-554.

Tsoi, E., Lo, I., Chan, C., Siu, K. & Tse, S. (2014). How recovery-oriented are mental health services in Hong Kong? Snapshots of service users' perspectives. *Asia Pacific Journal of Social Work & Development*, 24(1-2), 82-93.

Tsoi, E., Tse, S., Canda, E., & Lo, I. (2019). Recovery-oriented, strengths-based practice in non-Western culture: Madness, meaning and modesty. Manuscript in preparation.

Wan, E. (2019, June). The key components for implementation of Strengths Model Case Management (5Cs). Presentation at the *International Conference on Change and Innovation for a Better World: The future of the Social Work Profession*, The University of Hong Kong, Hong Kong.

World Health Organization. (2011). *Mental health atlas: 2011*. World Health Organization. https://apps.who.int/iris/handle/10665/44697

Yip, K. S. (2006). A strengths perspective in working with an adolescent with self-cutting behaviors. *Child and Adolescent Social Work Journal, 23*(2), 134-146.

Yip, K. S. (2005). A Strengths Perspective in Working with an Adolescent with Depression. *Psychiatric Rehabilitation Journal, 28*(4), 362-369.

Yip, K. S. (2003). A strengths perspective in working with an adolescent with dual diagnosis. *Clinical Social Work Journal, 31*(2), 189-203.