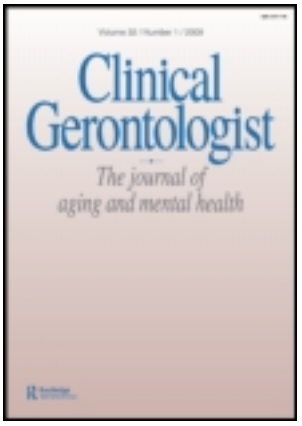

Clinical Gerontologist
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/wcli20

Health Promotion With Older Adults Experiencing Mental Health Challenges: A Literature Review of Strength-Based Approaches

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Published online: 10 Jun 2013.

To cite this article: Sandra P. Hirst PhD GNC(C) , Annette Lane RN PhD & Rebecca Stares RSW MSW (2013) Health Promotion With Older Adults Experiencing Mental Health Challenges: A Literature Review of Strength-Based Approaches, Clinical Gerontologist, 36:4, 329-355, DOI: 10.1080/07317115.2013.788118

To link to this article: http://dx.doi.org/10.1080/07317115.2013.788118

Clinical Gerontologist, 36:329–355, 2013

ISSN: 0731-7115 print/1545-2301 online
DOI: 10.1080/07317115.2013.788118

Routledge
Taylor & Francis Group

REVIEW ARTICLE

Health Promotion With Older Adults Experiencing Mental Health Challenges: A Literature Review of Strength-Based Approaches

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Strength-based approaches may be utilized as a health promotion strategy for older adults with mental health challenges. Within this review, the results of an extensive literature search on strength-based approaches with this population are presented. While early evidence suggests the effectiveness of strength-based approaches, much work needs to be done to evaluate strength-based assessment tools, interventions, and models for older adults with mental health challenges.

KEYWORDS literature review, mental health, older adults, strength-based approaches

The aging of the Canadian population will accelerate over the next three decades, particularly as individuals from the Baby Boom years of 1946 to 1965 begin turning 65. As the number of older adults increases, so does the prevalence of disability in general (Turcotte & Schellenberg, 2007) and mental health challenges[1] in particular. Older adults are particularly vulnerable to mental health difficulties, in part due to age related changes to the brain and also in part because of the multitude of changes that occur with aging, including changes in living environments and family structures.

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Prevalence rates suggest that of the 6.85 million seniors in 2021, up to 4% will have serious clinical depression and as many as 15% may experience depressive symptoms (NICE Depression Tool, 2008). In all age groups, men aged 75+ are likely to retain the highest incidence of completed suicide (Statistics Canada, 2010). Although the prevalence of psychosis in the general population is expected to remain at approximately 1%, within published reports the prevalence of psychotic symptoms in dementia varies, but is as high as just over 70% (Leroi, Voulgari, Breitner, & Lyketsos, 2003). While research has shown that many of the mental health challenges faced by older adults are treatable (Canadian Coalition for Seniors Mental Health, 2009), unfortunately these challenges, especially depression, are often under diagnosed in older adults. Effective treatment and service delivery are essential to address mental health concerns.

An important component of health promotion to address mental health challenges when working with older adults involves utilizing strength-based approaches. A strength-based approach operates on the assumption that individuals have strengths and resources for their own empowerment. Traditional health intervention models concentrate on deficit-based approaches, ignoring the strengths and experiences of the participants. In a strength-based approach, the focus is on the individual and not the problems. Drawing on strength-based approaches does not ignore problems, rather it shifts the frame of reference to define the issues experienced by the individual instead of the deficits, which are often described in negative terms. By focusing on what is working well, informed successful strategies support the promotion of mental wellness in older adults experiencing mental health challenges.

In order to examine how strength-based approaches are utilized with older adults with mental health challenges, an extensive literature review was conducted. The following questions were addressed:

1. How have strength-Based approaches been defined within the context of mental health challenges and have older adults been included?
2. What strength-based research has been done specific to older adults with mental health challenges?
3. What are the implications for those who work with older adults experiencing mental health challenges, and what are the policy and funding implications?

METHOD

We conducted a literature reviewing using the following data bases: ERIC, Social Work Abstracts, SocIndex with Full text, and PsycInfo using the search terms: seniors, aging, mental health, best practices, and strength-based

approaches. Initially, this search yielded 75 articles/research studies, however, we excluded articles or studies that did not overtly state or focus upon strength-based approaches with older adults, those that involved "best practices" that were not strength-based or addressed best practices in health care education. We also excluded studies or articles that focused upon attitudes of older adults towards services, such as mental health services.

As our extensive search only yielded 31 articles or studies that fit the above criteria—strength-based approaches with older adults (see Tables 1 and 2), we broadened our criteria to include strength-based approaches with other vulnerable populations, such as children and youth, as these articles and studies might offer information that could be applicable to older adults (see Table 3). For instance, we included strength-based tools such as the Behavioral and Emotional Rating Scale (BERS) (Epstein & Sharma, 1998), or strength-based communities for children and adolescents (Benson, Leffert, Scales, & Blyth, 1998). By expanding our search, we accessed another 16 articles/research studies (see Table 3). Further, we conducted a hand search based upon our knowledge of strength-based approaches, particularly of websites that may offer information on strength-based philosophies, approaches or communities that could apply to older adults. This augmented our search further to yield several more references, for a total of 50 articles.

FINDINGS

How Have Strength-Based Approaches Been Defined Within the Context of Mental Health Challenges, and Have Older Adults Been Included?

A strength-based approach is a perspective. It strives to lead with the positive and values trust, respect, intentionality, and optimism. It is based on the idea that people and environments interact and change each other in the process. It is an alternative to the historical deficit approach found in the fields of mental health and social services where deficits, problem behaviors, and pathologies are the focus. Within the last decade researchers and practitioners within the fields of education, mental health, psychology, social work, and child welfare have begun to question the deficit-based approach and move toward a more holistic model of development (Trout, Ryan, LaVigne, & Epstein, 2003). Rather than focusing on individual weaknesses or deficits, strength-based practitioners collaborate with adults to discover individual functioning and strengths.

Strength-based approaches are described in the literature in the following ways: (a) a perspective (or worldview) used to work with individuals and families; (b) standardized assessment tools; (c) specific interventions

TABLE 1 Strength-Based Approaches for Older Adults With Mental Illness or Dementia

Author(s)	Type of Article	Focus	Results
Braddock & Phipps (2009)	Discussion article Report on case studies	Use of specific activities to enhance or maintain the abilities of older adults with dementia	Offered two case studies to illustrate activity engagement.
Cox, Green, Seo, Inaba, & Quillen (2006)	Discussion article	Addressed development of Care-Receiver Efficacy Scale (CRES)	Scale tested on 177 older adults 55 years of age and older. Researchers determined that scale showed "adequate internal consistency reliability" (p. 645).
Heller, Factor, Sterns, & Sutton (1996)	Research study utilizing interviews, pretest and observations	Tested the effectiveness of Person Centered Later Life Planning for older adults with mental retardation and their family members and staff (42 in intervention group and 38 in control group)	Intervention group showed significant improvement in knowledge of leisure, retirement and work/volunteer opportunities, but did not show improvement regarding making choices and action plans. Intervention group demonstrated a decrease in life satisfaction.
Hung & Chaudhury (2011)	Research study (ethnography) Utilized interviews with residents with dementia, participant observations and focus groups with staff	Explored what supports and undermines personhood in older adults at meal times in long-term care	Following themes emerged from data: outpacing/relaxed pace; disrespect/respect; withholding/holding; invalidation/validation; disempowerment/empowerment.

Judge, Yarry, & Orsulic-Jeras (2010)	Research study Utilized Likert-like evaluation tool	Examined the usefulness of the ANSWERS program with caregiving dyads where one member has dementia (52 caregiving dyads)	Caregivers and care receivers rated program as very helpful.
MacCourt & Tuokko (2005)	Discussion article	Described the Seniors' Mental Health Policy Lens as an analytical tool to identify the negative effects of current and planned policies, programs and practices on older adults with mental illness	Authors noted that this tool can be utilized by those who create policies and those who critique policies and can be utilized to analyze policies and implications of programs at the governmental and nongovernmental level.
Parsons, Harper, Jensen, & Reid (1997a)	Research study 7 older adults (ages 49 to 67) with profound mental retardation	Examined a protocol involving two types of choice presentations for assessing leisure choice-making skills of older adults with severe disabilities	Five older adults made choices based upon the use of objects while the other two used pictures. Researchers noted the importance of assessing choice-making skills prior to presenting choices to severely disabled older adults.
Parsons, Harper, Jensen, & Reid (1997b)	Discussion article	Addressed a system of evaluating leisure choices for older adults with severe disabilities Discussed two methods of presentation for choices: direct and indirect	Suggested that the method of evaluating choices was effective in increasing leisure choice opportunities presented by staff and the choices made by older adults.

(*Continued*)

TABLE 1 (Continued)

Author(s)	Type of Article	Focus	Results
Peacock et al. (2010)	Research study Qualitative using focus groups and interviews	Examined the positive aspects of caregiving for individuals with dementia Most of the caregivers were below age 60 although 21% were 80 years of age and older	Caregiver responses were more negative than positive. However, identified the following five positive aspects: opportunity to give back; personal growth; discovery of inner strengths; sense of competency and opportunity to develop a closer relationship to the care receiver.
Perkins & Tice (1995)	Discussion article	Addressed importance of using a strength-based perspective with older adults with mental illness	Same as focus.
Yarry, Judge, & Orsulic-Jeras (2010)	Research study Case studies (2)	Presented two case studies demonstrating the use of ANSWERS for caregiving dyads coping with mild to moderate dementia	Offered examples to demonstrate the importance of assessing and utilizing each dyad's strengths and specifically tailoring an intervention to address each dyad's needs.

TABLE 2 Strength-Based Approaches for Well or Physically Frail/Unwell Older Adults

Author(s)	Type of Article	Focus	Results
Campbell & Nolfi (2005)	Research study Utilized surveys	Researchers taught older adults to use the computer to access health information to ascertain whether or not this had an impact on their interactions with health care professionals and health seeking behaviors	While older adults showed a willingness to learn how to use the computer, this training did not significantly change their health seeking behaviors or interactions with health care professionals.
Chapin & Cox (2001)	Discussion article	Compared empowerment based approaches with strength-based approaches in frail older adults	Empowerment-based approaches involve a social justice element, while strength-based approaches examine strengths of individuals and environments.
Cullinane (2006–07)	Discussion article	Addressed how the American Society on Aging (ASA) is committed to strength-based approaches with older adults	ASA involved in educational sessions, promoting diversity and cultural competence and establishment of a civic engagement website.
Dapp, Anders, von Renteln-Kruse, & Meier-Baumgartner (2005)	Discussion article	Discussed program conducted in Germany that focuses on health promotion and prevention for well older adults	Follow-up survey 6 months post-program very positive.
Farone, Fitzpatrick, & Bushfield (2008)	Research study	Addressed hope and internal locus of control on health and well-being of 109 older Mexican women who were diagnosed with cancer	Hope and internal locus of control determined to be a strength-based approach and can be fostered through cognitive behavioral techniques and environmental supports.
Graham & Fallon (2006)	Research study utilizing qualitative methods	Examined psychological strengths in 10 older Australian adults in regards to maintaining physical and mental health	Positive outlook, social connectedness, spirituality, adaptability and receiving support services all determined to be important psychological strengths.

(*Continued*)

TABLE 2 (Continued)

Author(s)	Type of Article	Focus	Results
Greene (2000)	Discussion article	Advocated for use of Functional-Age Model of Intergenerational Treatment as a theoretical framework for social workers working with older adults and families	Model is a strength-based approach that focuses on the functional capacities of older adults and can be used to assess the older adult's environment.
Hwang & Cowger (1998)	Research study Utilized questionnaires with a case study	Social workers (SWs) sent questionnaires and case study of older woman. SWs to prepare an assessment and were evaluated on whether the assessment was strength-based or deficit-based	Concluded that overall, SWs operate from a strength-based approach. However, mental health SWs tended to use a more deficit-oriented approach.
Kivnick & Stoffel (2005)	Discussion article	Discussed Vital Involvement Practice (VIP) model as a strength-based approach to working with frail older adults	Authors presented a case study in which this model was successfully used.
Kivnick & Murray (2001)	Discussion article	Discussed Life Strengths Interview Guide as an assessment tool that can be used with older adults	Authors explained that tool is theoretically supported by Erikson's principles of psychosocial development.
Laforest et al. (2008)	Research study Utilized intervention and control groups Collected information on health behaviors at baseline, 2 months later and following intervention	Examined impact of self-management intervention program for housebound older adults with arthritis (113 older adults) Program included creative problem solving and maintaining positive attitudes	Intervention group had fewer functional limitations and less helplessness than control group after intervention.

Lamb, Brady, & Lohman (2009)	Research study Qualitative methods (12 interviews of women 64–72 years of age)	Purpose of study to provide descriptive data on the biopsychosocial implications of participating in self-managing older adult learning communities	Eleven out of 12 women showed strong similarities in their attitudes towards learning (and its relationship to resiliency). Concluded that lifelong learning resources may be important for underserved older adults.
Mead & Fisk (1998)	Research study Retention performance tested initially after training and one month later (17 older adults in concept group and 18 in action training group)	Examined effects of concept training versus action training in teaching older adults to use a virtual ATM.	Older adults in action group had faster and more accurate performance immediately after training and one month post training.
Moore & Charvat (2007)	Discussion article Utilized a case study as an example	Discussed the Appreciative Inquiry model (AI) and how this can be applied to facilitating individuals' health changes	Offered a hypothetical case study of a 55-year-old woman who had an MI and how the AI model could be applied.
Moyle et al. (2010)		Data analyzed using thematic analysis Strategies for maintaining well being through resilience included: keeping active, relationships, community connections, practical coping, emotional coping and spiritual coping	Noted that major strategies in the maintenance of mental well-being in older adults is to keep mentally active and participate in community and relationships.
Onolemhemhen (2009)	Research study Qualitative	15 poor older women from Detroit (mean age, 68 years) interviewed to examine their experiences	4 strength-based themes emerged: Rebounding from life's adversities; spirituality and commitment to church; making do with current resources; and strong families.

(*Continued*)

TABLE 2 (Continued)

Author(s)	Type of Article	Focus	Results
Orsulic-Jeras, Shepherd, & Britton (2003)	Discussion article	Presented strength-based assessment and intervention model for older adults with HIV	Described the types of questions to ask older adults with HIV under the following headings: physical symptoms, social support, life roles, employment and recreation, history and culture, and coping mechanisms.
Shapira, Barak, & Gal (2007)	Research study Utilized a test and control group	Offered a course to 22 older adults (mean age, 80 years) who attended an adult day center or living in nursing homes Examined the psychological impact of learning to use computers and the internet in older age; researchers hypothesized that this would contribute to a sense of well-being and empowerment in older adults	Computer and internet usage contributes to the well-being and sense of empowerment in older adults and positively impacts interpersonal relationships and a sense of control and independence.
Shearer, Fleury, & Belyea (2010)		Evaluated the feasibility of the Health Empowerment Intervention (HEI) This intervention involves education, but also identification of health goals and recognition of individual strengths	Older adults in intervention group found meetings helpful in identifying resources and making progress towards attainment of goals. Researchers concluded that HEI results in significantly improved health empowerment in older adults.
Tate, Lah, & Cuddy (2003)	Research Questionnaire	Reported on 1996 questionnaire sent to over 2000 aging war vets (Canadian) to determine how they define successful aging and to ask if they consider to have aged successfully.	Over 83% of respondents reported having aged successfully. Successful aging associated with health, keeping active, positive outlook, and having goals or interests.

TABLE 3 Strength-Based Approaches in General, in Other Vulnerable Populations or Communities

Author(s)	Type of Article	Focus	Results
Anuradha (2004)	Discussion article	Discussion of how a strength-based approach uses the concept of resilience and is collaborative with clients	Described the phases in interviewing a family with a mentally ill member and applied the strength-based approach.
DeJong & Miller (1995)	Discussion article	Presented questions, based upon a solution. focused approach, that may help a social worker conduct a strengths-based interview	Concluded that solution-focused interviewing fits with a strength-based approach.
Eheart, Hopping, Power, & Racine (2007)	Discussion article	Described an Intergenerational Community as Intervention (ICI) as an intentionally constructed intergenerational neighborhood where some residents face challenges (such as adolescents with delinquent behaviors)	ICIs are strength-based communities that facilitate and support alliances and relationships.
Epstein (2000)	Discussion article	A description of the BERS is offered	Many assessment scales for children are deficit-based. The BERS assesses for strengths, which can lead to strength-based treatment plans.
Frain, Bishop, & Tschopp (2009)	Research study utilizing standardized tools	Utilized tools to assess self-efficacy, self-advocacy, self-perceived stigma and competence to examine the relationship between quality of life, employment, adjustment to disability and functional status among 114 adults (18 years of age and older)	Concepts of self-efficacy and self-management most important in leading to positive rehabilitation outcomes.

(*Continued*)

TABLE 3 (Continued)

Author(s)	Type of Article	Focus	Results
Knibbs et al. (2010)	Research study Utilized focus groups	Focus groups with public health nurses (PHNs), managers and policymakers to examine positive organizational attributes that contribute to work of PHNs	Strength-based approaches, including an appreciative inquiry approach seen as most useful.
Rapp, Pettus, & Goscha (2006)	Discussion article	Addressed that there is little attention given to strength-based approaches within policy development Offered 6 principles that should be part of a strength-based policy	Offered examples of policies that contain some strength-based characteristics, such as the Americans Disabilities Act and the Social Security Act.
Rashid (2009)	Discussion article	Addressed the importance of psychotherapy focusing on client strengths, not just deficits	A focus on client strengths does not deny weaknesses. Strength-based interventions need to be offered with sensitivity towards how clients may receive them.
Rashid & Ostermann (2009)	Discussion article	Argued the importance of a positive model to assess clients, rather than a deficit-based approach	Strength-based approach changes the relationship between the therapist and client as it balances the power differential.
Russo (1999)	Discussion article	Discussion of how the Person Centered Approach utilized for individuals with mental retardation is similar to a strength-based approach in other populations	A strength-based approach may need to be adapted to clients with mental retardation due to difficulties responding to open-ended questions.
Shapiro (2002)	Discussion article	Discussion of an approach in working with the family of a 13-year-old girl with medical problems and a developmental disability Utilized an approach that promotes family resilience and focuses on family strengths	Same as focus.

Skerrett (2010)	Discussion article	Discussed positive psychology as complementary to family nursing (with its emphasis on strength-based orientation)	Offered examples of how nurses can integrate interventions from positive psychology into family sessions.
Slocombe (2003)	Discussion article	Addressed how a strength-based approach was utilized by a company in Australia	Offered an example of how this approach was used to bring about a change in the views of those working in a nursing home in Australia.
Sousa, Ribeiro, & Rodrigues (2006)	Research study Qualitative (interviews)	Interviews conducted with 28 families that were considered to be multi-problem and poor	Researchers concluded that a problem-saturated approach to family work still predominant.
Steiner (2010)	Research study Qualitative (3 children and their caregivers)	Compared a strength-based approach with a deficit-based approach in the education of parents with autistic children Examined parents' statements about their child's behavior and parent affection toward autistic child	Concluded that a strength-based approach to parent education improved parent-child interactions.
Trask, Hepp, Settles, & Shabo (2009)	Discussion article	Discussed family-centered approaches to care of ethnically diverse older adults Family-centered approaches involve plans that include family and specifically tailored to each client/family	Family-centered approaches are strength-based as they involve empowerment and elicitation of strengths in family and environment.

targeted to particular populations; and (d) strength-based models. As the terms "approach" and "model" are not often defined by the user, it sometimes is not clear what constitutes an "approach" or a "model." To distinguish between approaches and models, strength-based approaches that focused on individuals are considered to be interventions and those that can be applied to communities as models. Also, while some of these perspectives, assessment tools, interventions, and models are used with older adults facing mental health challenges, not all of the strength-based approaches have been utilized with older adults. Some are specifically tailored to children, youth, or families. However, these approaches are often salient to older adults with mental health issues.

Strength-based perspective

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

A strength-based perspective is collaborative and reduces the power differential between professionals and individuals/families (Anuradha, 2004; Greene, 2000; Rashid & Ostermann, 2009). This viewpoint includes guiding concepts such as empowerment and social justice (Anuradha, 2004; Chapin & Cox, 2001). It recognizes that individuals who have lived through to older age have a lifetime of coping strategies and internal/external resources. While practitioners utilizing a strength-based perspective may refer to the influence of solution focused therapy, positive psychology, or health and human care professionals' emphasis upon individual strengths, their descriptions suggest that they are influenced by such approaches, rather than by actually utilizing the models.

Strength-based assessment tools

In contrast to the ubiquitous deficit-based assessment tools, strength-based assessment tools provide practitioners with positive methods to

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

The majority of validated assessments for adults have relied on a deficit-oriented model. While these tools have proven useful for understanding what is wrong with individuals, they provide little insight to the strengths that clients may have in overcoming some of their problem behaviors.

There are a number of strength-based assessment tools, such as the Strengths and Difficulties Questionnaire (Goodman, 1997), the Child and Adolescent Strengths Assessment Scale (Lyons, Howard, O'Mahoney, & Lish, 1997), Profiles of Student Life: Attitudes and Behaviors (Benson, Leffert, Scales, & Blyth, 1998) and the Behavioral and Emotional Rating Scale (BERS) (Epstein & Sharma, 1998). These tools, however, are developed for children and adolescents, and not older adults. The BERS (Epstein & Sharma, 1998) is perhaps the most documented strength-based assessment tool. It was developed to provide professionals with a reliable, valid, and standardized assessment tool to measure strengths of youth and gradations of improvements over time.

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

Strength-based interventions

Strength-based interventions are designed to enhance the strengths of particular populations. The following interventions were identified for older adults with mental health needs.

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

individuals with mental retardation. This training program involves 15 sessions (2 hours each) and includes information on leisure, work and volunteer opportunities, as well as on how to make choices and plans for the future.

2. Acquiring New Skills While Enhancing Remaining Strengths (ANSWERS): This program is for dyads coping with mild to moderate dementia in one member. This program involves six 90-minute curriculum guided sessions (education about dementia and memory loss, communication, recognizing emotions and behaviors, etc.) (Judge, Yarry, & Orsulic-Jeras, 2010). The goal of this program is to provide a set of skills to help caregivers and care-receivers cope with mild to moderate dementia. Judge and colleagues (2010) evaluated the effectiveness of this program with 52 dyads (75% of caregivers were women). Caregivers and care-receivers were asked to complete a Likert-type evaluation. Care-receivers and caregivers rated the program as very helpful and indicated that they would highly recommend it.
3. Functional-age model of intergenerational treatment: This is a strength-based assessment and intervention that focuses on the older adult's functional capacities and looks at how older adults can meet the demands of the environment. This approach can be used to assess the older adult's environment and the interdependence between family members (Greene, 2000). Although this intervention is entitled a model, it is specifically geared for individuals and families, rather than communities, so it is considered an intervention program.
4. Vital involvement practice (VIP): This is a strength-based intervention for working with older, frail adults (Kivnick & Stoffel, 2005). The intervention involves tailoring individual care plans to: a) systematic identification of individual strengths and assets, including the environment; b) consideration of strengths in relation to individual and environmental challenges.
5. Improving mood—promoting access to collaborative treatment (IMPACT): IMPACT is an intervention program for older adults who have a major depression or dysthymic disorder (Centers for Disease Control and National Association of Chronic Disease Directors, 2009). This intervention involves the primary physician and another professional (e.g., nurse, social worker, psychologist) and offers education, treatment with antidepressants (if determined to be necessary), 6 to 8 sessions of counseling, and a relapse prevention plan (IMPACT: Evidence based depression care, 2011).
6. Program to encourage active rewarding lives for seniors (PEARLS): PEARLS is a brief, time limited, and participant driven program, which teaches depression management to older adults with depression. It is offered within the homes of older adults and teaches behavioral techniques

(Centers for Disease Control and National Association of Chronic Disease Directors, 2009).

7. Identifying depression, empowering activities for seniors (IDEAS): IDEAS is a community depression program that is focused at the detection of depressive symptoms in older adults in order to reduce their intensity (Centers for Disease Control and National Association of Chronic Disease Directors, 2009).

Strength-based models

There are a number of strength-based models identified in the literature. These were identified as models, rather than interventions, as they can be applied to communities of individuals, rather than just individuals or dyads. They include: (1) Appreciative inquiry (AI); (2) Capacity-building /asset-based community development; (3) Quality of life; (4) Resiliency; and (5) Solution-focused therapy. A number of these models are not specific to older adults with mental health challenges, but can be applied to these populations. For instance, AI was originally designed to bring about organizational change; it has now been applied to effect individual health changes (Moore & Charvat, 2007).

Appreciative inquiry. The purpose of AI is to focus on the positive aspects of people, organizations, and systems including the potential for meaningful and valuable change. AI is often used for promoting organizational or systems change through group processes involving discussion. Those involved in a system determine what works best within that system and how the system could be improved. The AI process includes a cycle of four inquiry stages: (1) "discover" what works; (2) "dream" or imagine the ideal system and the potential of the system in the future; (3) "design" a plan to achieve that ideal system, and; (4) "deliver" by putting into action the designed process. AI provides the opportunity, through collaborative group discussion, to explore prior success of individuals, organizations or systems, and envisions future potential and action. The belief that change is likely, positive, and possible is important for the success of this process (Moore & Charvat, 2007).

Moyle and colleagues (2010) used the AI model to interview 58 older adults (65 years of age and older) from four countries (Australia, UK, Germany, and South Africa) to explore how they maintain mental health (well being) through resilience. Participants lived in their own home or independently. The following four themes were identified: social isolation and loneliness; social worth; self-determination and security. Strategies for maintaining well being through resilience included: keeping active, relationships, community connections, practical coping, emotional coping, spiritual coping. Moyle and coworkers (2010) noted that a major strategy to maintain

mental health well-being by these participants was to keep mentally active and to participate in community and relationships.

Capacity building. Capacity building is about harnessing the talents and skills of every member of a community, supporting continued skill development, and fostering relationships based on mutual benefit. The concept of capacity building has been applied in the framework of community development. It is based on the work of the Asset-Based Community Development Institute, co-directed by Kretzmann, McKnight, and others. Aspects of this model make it particularly applicable to older adults with mental health challenges. For instance, this model promotes the identification and "giftedness" of individuals who are often marginalized in the community. This model recognizes that social capital and networking are important assets within a community and allows members of the community to take a participatory approach and ownership of their own development (Chaskin, Brown, Venkatesh, & Vidal, 2001).

Other community models that are based upon drawing forth the strengths of community members include the Intergenerational Community as Intervention (ICI) (Eheart, Hopping, Power, & Racine, 2007). These communities include older adults, as well as residents facing challenges, such as youth who display delinquent behaviors. By forming alliances across intergenerational lines, members of the community can help each other.

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

The quality of life model from the Centre for Health Promotion is believed to be applicable to all individuals, including older adults. This model emphasizes physical, psychological, and spiritual aspects of individuals (particularly those who are facing disabilities or challenges). The model also emphasizes environmental factors, as well as the importance of choice and skill building. As older adults with mental health challenges often lack choice and opportunities, this model may be used to promote health and well-being.

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

There is no consensus on what pre-conditions are required to support the development of resiliency; however, researchers and theorists agree that some form of protective factors are required to permit an individual

to develop in the presence of chronic or severe stress. Resiliency can develop out of experiences that promote self-determination and increase participation. Although resiliency is sometimes viewed as part of individuals' psychological make-up, it is also considered to be a process rather than a static outcome as an individual's resilience can change and develop depending on context and life experiences.

Resilience is now being researched and applied to communities. For instance, the Resilience Research Centre based at Dalhousie University is examining how physical and social contexts—such as neighborhoods and communities—foster resiliency in children, youth and families (Resilience Research Centre, 2011). In order to foster health in older adults with mental health challenges, an examination of the social and community contexts would be useful and health promoting. Research could be conducted on factors in assisted living and nursing home environments that foster resiliency in older adults with mental health concerns.

Solution-focused therapy. Although solution-focused therapy can also be considered a perspective or an intervention, we have also included this as a model. Solution-focusedtherapy was developed by Steve de Shazer and Insoo Berg (de Shazer & Berg, 1986) and focuses on constructing solutions, rather than on dwelling on problems or deficits. This model has influenced such spheres as child welfare, domestic violence offenders, and social policy (Institute for Solution-Focused Therapy, 2011). This model focuses on mental health, strengths, and resources, and so is applicable to a population such as older adults with mental health challenges.

What Strength-Based Research Has Been Done Specific to Older Adults With Mental Health Challenges?

While the literature examining strength-based approaches is growing, there is still need for research. Some of the reports are case study based, or offer hypothetical case studies, particularly in the area of family therapy work (Shapiro, 2002; Skerrett, 2010) and often does not focus on older adults with mental illness. There is some research that examines psychological traits that promote strengths and mental well being in older adults (Farone, Fitzpatrick, & Bushfield, 2008; Graham & Fallon, 2006) or strategies such as internet training to maintain sense of well-being and empowerment (Shapira, Barak & Gal, 2007). Other research focuses on evaluation of specific interventions, such as computer training to improve health knowledge in older adults (Campbell & Nolfi, 2005), educational sessions that present health knowledge to well older adults (e.g., Dapp, Anders, von Renteln-Kruse, & Meier-Baumgartner, 2005), housebound older adults with arthritis (Laforest et al., 2008), or older adults with mental retardation (Heller et al., 1996). Overall, there is a dearth of research that examines strength-based approaches with older adults with mental health challenges.

What does the research suggest? While the research indicates that strength-based approaches are effective (Powell et al., 1997), methodologically, there is little ability to compare studies, as research examining strength-based approaches occurs with diverse populations (e.g., families, well older adults, older adults with severe developmental disabilities) and is conducted in various manners (e.g., evaluations of interventions specific to particular populations; qualitative studies with very small samples; randomized control trials).[2] Also, research on strength-based approaches with specific populations often is predicated on participants having intact cognitive and communication skills.

The research regarding strength-based approaches with older adults experiencing mental health challenges is limited. Research focuses on well older adults, or those who are housebound with physical illness. There is little research that focuses on strength-based approaches for older adults with mental health difficulties.

What Are the Implications for Those Who Work With Older Adults Experiencing Mental Health Challenges, as well as Policy and Funding Implications?

The implications of this literature search involve those who work directly with older adults with mental health challenges, as well as for funders and policymakers. In order to move toward a strength-based approach to working with older adults with mental illness, there needs to be education for professionals in community, hospital, and long-term settings. With high staff turnover, education needs to be ongoing in order to sustain the shift in approach over the upcoming years. Education is important, as professionals may presume to be working from a strength-based orientation, and may in fact not be doing so (Hwang & Cowger, 1998). For instance, in examining the approaches of social workers (strength-based versus deficit-based), Hwang and Cowger (1998) concluded that those working in the areas of mental health or psychodynamic counseling were less likely to employ strength-based approaches than in other settings.

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

Also, current policies need to be examined for their impact upon older adults with mental health challenges (MacCourt & Tuokko, 2005). Are these policies neutral or positive in their impact upon older adults experiencing

mental health concerns? If policies are detrimental to these older adults, what needs to change in order to support older adults facing mental health issues?

DISCUSSION

Findings from the literature review indicate that an examination of strength-based approaches for older adults with mental health challenges is in its infancy. In order to foster health promotion among this population, much more work needs to be done in the areas of strength-based assessments, interventions and models.

Research needs to be conducted in the areas of tool development, interventions and models to enhance strengths in older adults struggling with mental health challenges. For instance, we found only one assessment tool (CRES; Cox et al., 2006) specifically geared to assess for strengths in older adults who are care receivers. Further development of tools is necessary, or, tools utilized with other populations could be tested for reliability and validity on older adults with mental health challenges. While there is beginning evidence of the efficacy of strength-based interventions, methodologically, comparisons cannot be made across studies, as efficacy studies occur with diverse populations. There is need for intervention studies to be replicated. In regards to the identified strength-based models, there needs to be models developed specifically for older adults that are strengths-based. Currently, models that are developed for older adults are usually not strengths oriented (Boult et al., 2009), or, models that are strength-based are tested on other populations, such as children and youth. Could models that work well with other vulnerable or disadvantaged populations be adapted to older adults with mental health concerns?

Further, it is suggested that there should be testing of assessment tools, interventions, and models of strength-based approaches with older adults with mental health concerns of varying degrees and who reside in diverse living environments. Older adults with mental health challenges are a disparate group. Currently, research on strength-based approaches has been conducted mainly with those who can communicate well and who live in the community. Or, if a strength-based approach is used with older adults with dementia, the reports are presented as case studies, rather than an actual study (e.g., Braddock & Phipps, 2009). How might strength-based approaches work for those who have dementia and live within nursing homes? Even though activities to promote health in older adults with severe mental health challenges may look different than those in the community at large, the need for health promotion remains.

Additionally, enhanced partnerships with government (provincial/territorial or national) and service agencies, a standard framework for

describing and developing strength-based services/programs could be developed. This would include standardized elements that constitute a "strength-based" approach and the development of standardized quality improvement criteria, including access and discharge criteria, staffing benchmarks, and outcomes. Having a standardized approach would help to compare types and amounts of strength-based services and client outcomes across the geographical areas.

Policymakers may use the Seniors' Mental Health Policy Lens (SMHPL) (MacCourt & Tuokko, 2005) as a tool to identify negative effects of current and planned policies and programs upon older adults with mental health difficulties. This tool was created in order to: (1) facilitate social environments (including health care environments) that are supportive of the mental health of older adults, and (2) to emphasize mental health promotion and prevention into the way mental health services are delivered and funded.

Implications for Clinical Practice

There are a number of implications for nurses and other health care professionals working directly with older adults to promote mental health, in addition to opportunities for researchers. The cited literature and research speak to the need for professionals to acknowledge the life-impacting challenges of mental illness. Opening one's professional eye to the mental health challenges faced by older adults encourages the health care professional to provide holistic care.

Within their assessment role, health care professionals need to identify the strengths that an older client has to draw upon. In addition, they should ask older adults about the kind of support they need to build upon and reinforce existing strengths. While this process may take time and circular questioning, it may ensure that the older adult "feels heard." Within the assessment, questions about past positive coping experiences are useful as they may help to identify current strengths. The professional could also seek information about past or present issues, which are impacting and hindering the identification and use of current strengths by the older adult. Further, the professional could initiate a new formal program, such as a weekly support group to help promote mental health to focus on exploring and discussing strengths.

Researchers may consider giving further examination to strength-based interventions that are effective in helping to promote the mental health of older adults. The majority of the existing literature on strength-based approaches to interventions appears to draw from childhood and adolescent situations; little research has explored what strength-based approaches are most useful to promote mental health. A qualitative approach, utilizing focus groups or individual interviews, might provide understanding of how older adults understand their strengths and use them in times of need.

CONCLUSION

Health promotion through enhancing strength-based assessment and intervention is in its infancy with older adults experiencing mental illness. Much more needs to be done to develop tools, interventions and models that facilitate the health and development of this vulnerable population.

NOTES

1. The term "mental health challenges" is used to encompass psychiatric disorders as defined by the DSM-IV TR (American Psychiatric Association, 2000), as well as dementias and symptoms of depression and anxiety that may not meet DSM IV TR criteria.

2. Oermann and Floyd (2002) pointed out that it is only when 5 to 10 evaluation studies of an intervention, such as a strength-based approach has been done, that it is possible to begin to synthesize results from across studies.

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