EXPLORING COMPLEX STRENGTHS-BASED PRACTICE IN ADULT SOCIAL WORK

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Abstract

It is widely accepted that strengths-based approaches are good practice for adult social work in England, with a particular focus in implementation on community and personal assets.

This study focuses on the underdeveloped area of promoting strengths-based approaches in complex practice. It explores the extent to which strengths-based approaches are understood and embedded in adult social work practice, and how they contribute to positive outcomes for people with care and support needs. Adopting a practice ethnography methodology (Ferguson, 2016), the research engages with social constructs and environmental factors to generate context-dependent knowledge (Floersch *et al*., 2014).

Six social workers, eight people with lived experience, three family carers and range of care providers and health professionals took part in field observations. Data was collected over an eighteen-month period through practice observations, informal conversations, reflective sessions, and triangulation of social care records. Additional insights were gathered via a strengths-based survey completed by twenty-five practitioners, including social workers, occupational therapists, and managers.

Thematic analysis (Braun and Clarke, 2006) identified three themes for discussion:

1. How conversations with people and the subsequent recording of statutory assessments under the Care Act (2014) were impacted by the structure of the forms and the implications of this.
2. How social workers balance strengths versus problematisation in the context of risk.
3. How mental capacity is continuously socially constructed and influenced by a range of factors that both promote and restrict autonomy.

Relational social work was identified as an enabler to strengths-based practice across all three themes. Recommendations for practice are to reconsider the way that interactions are recorded in digital systems to promote strengths and improve statutory compliance and to focus on relational social work to promote strengths for people particularly when there are complexities of risk and capacity.

Glossary of abbreviations

Abbreviation	Full text	What this refers to
AI	Artificial Intelligence	The simulation of human intelligence by machines, especially computer systems. It enables computers to learn, reason, and make decisions
CQC	Care Quality Commission	National regulatory body for social care providers that deliver personal care to adults as well as all NHS services and from 2023 has started to assess local authority adult social care service delivery
GP	General Practitioner	A doctor
MDT	Multi-disciplinary team	Widely used term in adult social care - often used to donate social care and health staff with or without other care providers and people with lived experience working jointly to support a person
MSP	Making Safeguarding Personal	A way of working that considers safeguarding more widely that the process of making a person safe. Based on six principles of: protection, prevention, proportionality, personalisation, empowerment, partnership, and accountability.
PA	Personal Assistant	A person who is employed directly by a person to support with health and social care tasks rather than a service commissioned by a local authority
SMCM	Strengths-Model Case Management	A model of strengths-based practice developed by Rapp and Chamberlain (1984) for use in mental health settings – has key features such group supervision, focus on active support, strengths-assessments
SPA	Single point of access	adult social care contact centre for the host authority

Table of figures

Table of tables

Table of Contents

1. Introduction

The focus of this thesis is how strengths-based approaches are applied within adult social work. This practice ethnography (Ferguson, 2016; 2018) examines how social workers embed strengths-based working into their practice and the factors that affect this. The study was undertaken with social workers employed in adult social care within England. Data was collected over an eighteen-month period and incorporates field observations, review of electronic records, reflective discussions, and survey data. Six social workers, seven people with lived experience, three family carers and a range of care providers and health professionals took part in field observations. Survey data was received from twenty-five participants across adult social care. Data was analysed in relation to statutory duties specifically under the Care Act (2014) and the Mental Capacity Act (2005), and strengths-based theory drawing on the sociological theories of Bourdieu (1991), Bourdieu and Waquant (1992), Goffman (1959; 1961), and Garfinkel (1967).

My interest in this field was partly due to the current prominence and relevance of the concept of strengths-based practice within adult social care. I started my social care career when I was sixteen working in a care home for people with learning disabilities and have subsequently worked in almost every area of adult social care, from front line work to director level posts. My personal philosophy and approach have always been that the role of social care is to support and enable a person to live their life. Over the course of the last thirty plus years the roles I have had in adult social care have changed, but this foundation of my personal and professional practice has not. When I started my doctorate, I was initially thinking of exploring the topic of integrated working and the interface between health and social care. However, I switched towards focusing specifically on strengths, to bring this work back to people rather than professionals. Social work, and social care more generally, are ultimately vehicles for upholding and promoting social justice and human rights (IFSW, 2024).

The statutory drivers that govern adult social care are fundamentally rights-based. The first chapter of the Care Act (2014) sets out a duty to promote wellbeing. This is a broad concept that encompasses:

- control over day-to-day life.
- participation in work, education, training or recreation.
- domestic, family and personal relationships.
- suitability of living accommodation
- protection from abuse and neglect
- and contribution to society.

Whilst the wellbeing principle aligns closely with strengths-based practice, I sought to explore whether this alignment was enacted in a rhetorical or relational way. I hoped to move beyond the well-rehearsed critiques s of managerialism (Matarese and Caswell, 2018; Gillingham and Humphreys, 2009; Harris, 1998; Harlow, 2003; Harlow *et al*., 2013; The social work taskforce, 2009) with a new contribution to knowledge about how, the statutory wellbeing principle was enacted, and the extent to which social work remained relevant within this context. I was also mindful of the potential disconnect between academic and professional contexts in presenting findings and recommendations that were not strengths-based in the context of research specifically focused on this element of practice! Inevitably managerialism emerged as a factor in the findings, with critical factors impacting on social workers' ability to practice in a strengths-based way. My recommendations, where possible, are therefore framed within strengths-based and solution-focused language without tempering the overall messages.

In chapter two I set out my definition of the strengths-based approach:

> ‘An approach that focuses on relationships, practice and empowerment, understanding a person’s individual experience, with co-produced solutions enacted through the consideration of a person in terms of their:
>
> - abilities (i.e. what they can achieve themselves with or without support),
> - assets (i.e. what support they can draw on within their own networks - for example family, friends, and other social and community networks),
> - capabilities (i.e. their personal characteristics – for example humour, patience, confidence, trustworthiness, humility, etc.),
> - and resilience (i.e. how have they survived previous adversity and what are the current, or previous mechanisms that they can draw on in the face of the current situation)’

Chapter two provides a critical examination of the origins and theoretical foundations of the strengths-based approach and how this has been interpreted, adapted, and operationalised within English policy and practice. Foundational work in strengths-based practice originated in the United States during the 1980s within the field of mental health social work, emerging as a deliberate challenge to deficit-led, problem-focused models of care. The central paradigm of the approach is that people who have undergone trauma are inherently strong, possessing capacities, resilience and agency that can be mobilised through collaborative practice (Saleebey, 1996; 2000; 2004; Rapp *et al*., 2006, Weik *et a*l., 1989). Drawing on social constructionism, the strengths-based approach emphasises how realities are shaped through individual and social narratives, requiring practitioners to support a reframing of dominant deficit-laden accounts towards narratives of possibility, competence and hope (Kelly, 1955; Saleebey, 2008).

This theoretical position was developed into a practice model, known as strengths-model case management (SMCM) by Rapp and Chamberlain (Weick *et al.*, 1989) translating it into a structured methodology for assessment, goal setting and partnership working. While SMCM has been widely implemented and evaluated internationally, there is limited evidence to suggest it has been adopted as a discrete practice model within the UK context. Other practice models such as solution-focused social work (Greene and Lee, 2011), which sought to bridge theory and practice, have been suggested to offer structured, relational methods for coproducing goals while navigating organisational and cultural constraints.

Since the Care Act (2014), strengths-based working has become embedded within adult social care in England as a statutory expectation, supported by the Department of Health and Social Care's national strengths-based framework (DHSC, 2019). This positions strengths-based approaches as a philosophy of practice rather than a prescribed intervention. The English interpretation of strengths-based approaches has evolved with a primary focus on one element - the notion of enhancing community and relational assets. This interpretation has inspired both advocates for, and criticism of, the approach. There is a debate around the efficacy of the current evidence base, with multiple references to further evidence needed (e.g. Price *et al.*, 2020; Caiels *et al.*, 2021). However, in this study I take an interpretivist view critically engaging with studies and implementation alongside policy, case law and in the context of strengths-based practice as it is understood, enacted and experienced in everyday adult social work, rather than solely as an abstract or idealised model. Including within this lived experience of strengths-based practice.

In defining the strengths-based approach for this thesis, I draw deliberately on both the theoretical origins and policy implementation, seeking to recognise the narrow focus of implementation on community assets and broaden this to encompass the wider implications for practice. I define strengths-based approaches not as a fixed practice model but as a relational and value-based way of working that seeks to recognise, develop and utilise abilities, assets, capabilities and resilience within the person's lived experience, to enhance their well-being according to their own goals.

In the third chapter I set out my methodological framework and provide a reflection on my epistemological and ontological positions, which shape how knowledge is constructed and interpreted. In line with the interpretivist paradigm guiding this thesis, the study is grounded in an understanding that social work practice is contextually embedded, relational, and meaning-driven. The chapter therefore outlines the rationale for adopting a qualitative ethnographic approach, with particular attention to methods that privilege participants lived experiences and recognise the co-construction of knowledge between researcher and participant. It details the design of the study, including sampling, data collection, and analytic strategies, and considers the implications of these choices for the depth, credibility, and transferability of findings. Attention is also given to the ethical dimensions of the research, including issues of consent, confidentiality, and the power dynamics inherent in researcher–participant relationships, particular in relation to the familiarity problem (Greer, 1964) and the role of reflexivity.

I situated my analysis in the context of the statutory frameworks of the Care Act (2014) the Mental Capacity Act (2005) and theories of risk (Horlick-Jones,2009; Kemshall, 1998; 2002; Lowenstein, 2001) . I drew on three sociological theories as analytic lenses with which to explore the emergent themes around social construction (Kelly, 1955) and framing (Saleebey, 2008; Goffman, 1961) recognising the need for different levels of reflexivity within practice:

- Bourdieu's sociological theories (Bourdieu, 1991; Bourdieu and Waquant, 1992; Bark, 2022; Wolniak and Houston, 2023), are used to understand hierarchies at a meta-level with particular attention to the concept of professional habitus and preconstructed objects.
- Erving Goffman's theories and observations of social behaviours and institutional interactions (Goffman, 1959; 1961; 1963; Goffman and Helmreich, 2007; Smith 2022) are used to explore performance patterns of social workers at individual and organisational levels.
- Harold Garfinkel's (1967) theory of ethnomethodology examines how people create, interpret, and sustain social narrative in everyday interactions.

The sociological theories of Bourdieu (1991) and Bourdieu and Waquant (1992) propose that the way people think, feel, interpret situations, and act are developed through experiences over time. This 'habitus' develops through education, work, and social experience, and therefore becomes an unconscious social norm or common-sense view. The 'professional habitus' is application of this to the institution of workplace routines, training and operational work practices.   Bourdieu (1991) proposed that habitus shapes not only what people say, but how they say it, including tone, vocabulary, confidence, and authority. Some ways of speaking are recognised as legitimate or authoritative because they align with dominant social norms, while others are marginalised. The professional habitus is shaped and reproduced through 'preconstructed objects' which are the institutional categories, tools, and concepts that govern, policy, organisational systems, and professional language. These concepts help explain why professional language often appears neutral or objective, even though it reflects particular social histories and power relations. These theories have previously been applied specifically to the field of social work (Bark, 2022; Wolniak and Houston, 2023).

The impact of professional habitus and the role of preconstructed objects in research is considered further by Bourdieu and Waquant (1992) with a focus on methodology and reflexivity, challenging both sociologists and researchers to question their own categories and assumptions. In social work, examples of preconstructed objects include statutory assessments, risk categories, or notions such as 'need', 'capacity', or 'eligibility'. These objects are not neutral; they reflect historical struggles, professional hierarchies, and policy priorities,

Bourdieu and Waquant (1992) argue that to recognise and challenge the preconstructed objects requires epistemological reflexivity and the absence of this reinforces structural power inequities. In this thesis I reflexively explore preconstructed objects to challenge how they are shaping and, in the case of written records, potentially distorting and undermining strengths-based practice.

Goffman's work examines how social order is created through every day, face-to-face interaction. Rather than focusing on large social structures it explores how meaning, identity, and authority are produced in specific situations.

In ‘The Presentation of Self in Everyday Life’ (1959), Goffman describes social interaction as a form of performance. Individuals present themselves differently depending on the setting. They are actors who, on the ‘front stage’, play a specific defined role which is visible and regulated and, when ‘backstage’, can step away from the role. It helps to explain how practitioners may comply with formal procedures in public settings and express critical or relational perspectives elsewhere. This ‘role difference’ can help to understand how social workers manage tensions between bureaucratic requirements and professional values.

Goffman’s work on behaviours in ‘Asylums’ (1961) sets out how institutional routines can shape identity and restrict autonomy. The power dynamics within the institution are reinforced through documents, decisions and routines with decisions taken by ‘circuits of agents' (Goffman 1961:135). In this context the circuits of agents are professional staff and family members who diagnose, define, engineer and direct the course of action for the person who has little or no power or control over the outcome. The institutionalisation labels people, separating them from the outside world and redefines them primarily in terms of their institutional identity. This is particularly used to understand how the Mental Capacity Act (2005) best interests processes are applied in practice.

In ‘Stigma’ (1963) Goffman broadens his focus beyond institutions to everyday social life. He examines how individuals who possess a socially discredited attributes manage their identities in ordinary interactions. Here, Goffman explores how people anticipate judgement, choose whether to conceal or disclose differences, and manage impressions to avoid discredit. The emphasis is on interactional strategies rather than institutional routines. The impact of this is that individuals become socially discredited through labels and categories applied in social interaction.

Although adult social care is not a total institution, I draw upon both ‘Aslyums’ and ‘Stigma’ as they have both overlapping and contrasting concepts. Both texts examine how identity is shaped through interaction; how social labels can dominate how individuals are seen and treated and the steps people take to manage these threats to their identity. The differences are the way that power dynamics are enacted. In ‘Asylums’ (Goffman, 1961) the focus is on the power of the institution. This is reinforced in the environment limiting the individuals control over their identity. In ‘Stigma’ (Goffman, 1963) the power is more subtle and enacted through everyday social interaction and prejudice. These dynamics are used to explore to explore how assessment processes, risk categories, and eligibility decisions can stigmatise people by emphasising deficits over strengths and shaping how interactions unfold. In this thesis I specifically refer to partners in care; the social worker, other professionals and family or friend carers as a ‘circuits of agents’ (Goffman 1961:135) to consider the extent to which the person has control and autonomy within these interactions.

I draw upon ‘Ethnomethodology’, (Garfinkel; 1967), to examine how social order is produced through the everyday methods people use to make sense of their world. Rather than treating norms and structures as external forces, ethnomethodology investigates how they are achieved in practice.

- Indexicality refers to the context-dependent nature of meaning. Words and actions cannot be understood without reference to the situation in which they occur.
- Reflexivity describes how actions simultaneously describe and constitute social reality. By acting as if a shared order exists, participants reproduce that order.

- Accountability is the way that actions are produced to make them recognisable and reportable as sensible or legitimate. This focus reveals how professional reasoning is displayed and justified.

In this thesis, ethnomethodology informs the close analysis of talk and interaction, particularly in relation to assessments of capacity and risk. It allows exploration of how such judgments are produced moment by moment, rather than assuming they are purely technical determinations. By examining moments of uncertainty, disagreement, or breakdown, ethnomethodological analysis makes visible the taken-for-granted assumptions that usually remain hidden. This is particularly relevant in contexts where capacity, risk, or best interests are contested.

Although these three approaches operate at different analytical levels, they are complementary. Bourdieu foregrounds how power, history, and professional habitus shape what appears self-evident. Goffman illuminates how practice is enacted and negotiated in interaction. Ethnomethodology reveals the everyday methods through which social order is accomplished. Together, these theories support a reflexive analysis of strengths-based practice that attends both to structural constraints and to the situated practices through which social work is done. Familiarity obscures analytic distance (Greer, 1964) and this was a continuous professional challenge for me. Drawing on these theories as analytical lenses supported this challenge to ‘fight familiarity’ (Hammersley and Atkinson, 2019) and its application in practice (Delamont, et al., 2010; 2016(a)(b); Mannay & Creaghan, 2016). Fighting familiarity makes visible the routines, labels, and interactional norms that may otherwise be overlooked, highlighting how institutional categories, deficit framings, and power dynamics are reproduced even within interactions intended to be collaborative or strengths-based.

Chapter four is the first findings chapter. In this the relationship between how social workers interact and communicate with people in practice and how this is reflected in the written forms that are produced is examined. Focusing on the Care Act (2014) assessment process the findings show that in general conversations and interactions are strengths-based. However, written records of these conversations are influenced by structural and hierarchical recording mechanisms that often inhibit recording of strengths. This chapter considers both the conversation and the recording of these assessments as 'preconstructed objects' (Bourdieu and Waquant, 1992). These constructs limit reflexivity and privilege professional hierarchies of knowledge over the lived experience of people (Robinson. *et al*, 2018), fundamentally conflicting with the way social workers operate in practice. The chapter discusses how reflexivity, and therefore control over the written narrative, is improved when the social worker has a relationship with the person as opposed to being a short-term intervention. The chapter uncovers statutory compliance challenges with the assessment document including an inconsistent approach to the application of wellbeing (Care Act 2014:1; The Care and Support (Eligibility Criteria) Regulations 2015:2(1)C) and a confusion of identification of need and determination of eligibility. It also identifies the risks of case management tools that auto populate deficits and the need for further consideration of these as local authorities move towards use of artificial intelligence (AI) to support recording systems. This chapter identifies opportunities to improve Care Act (2014) assessment processes to better capture strengths and outcomes and discusses the challenge of managing the tension between strengths-based conversations and deficit-led recordings.

Chapter five offers a critical examination of the issue of risk in strengths-based practice. The concept and language of ‘problematisation’ (Weick *et al*., 1989; Saleebey, 2004) is utilised to explore how descriptions of risk-related problems identified in the strengths-based survey are navigated within day-to-day practice. There were interesting nuances between these data sources, with survey data articulating problems and observation data demonstrating how social workers navigated risk in action. This, therefore, reaffirms a key challenge in qualitative research – namely that how people say they will act is often different to the reality (Jerolmack and Khan, 2014).

The respondents to the survey highlighted problems in promoting strengths-based approaches. These included the social worker’s ability to build a relationship with the person; organisational and structural factors; and the other partners in care as ‘circuits of agents’ (Goffman, 1961:135) with influence in this space. In field observations social workers used their skills and knowledge as actors within the social space (Goffman 1959; 1961) to actively work within these constraints to understand and support positive risk taking. Strategies with the partners in care included changing the risk perceptions (Slovic *et al*, 2013; Slovic, 2010, Finucane, *et al*, 2000) and working in partnership (Greene and Lee, 2011). Organisational strategies included role distancing - moving from a frontstage to a backstage role (Goffman 1959; 1961). As in chapter four, the ability to promote positive risk taking for individuals was stronger when there was a relational social work approach which supported advocacy. This could be seen with family carers as well as the person supported; however, there were opportunities to improve self-advocacy within these discussions.

Chapter six builds on previous chapters and considers the concept of mental capacity in strengths-based practice. This explores how capacity is not presumed as per the Mental

Capacity Act (2005) definition but rather constructed and understood in the social and professional infrastructure of day-to-day practice. Case law is used to demonstrate the emphasis in law on rights-based practice and self-determination within the context of capacity. Data is analysed through case studies, drawing on techniques of ethnomethodology (Garfinkel, 1967), and using extracts of conversations to demonstrate how social workers embedded consideration of capacity within their practice. This chapter builds on both the concept of risk, and specifically how this links to capacity - and again draws attention to the role of preconstructed objects (Bourdieu and Wacquant, 1992) and how these are used to justify decision making, this time in relation to best interest decisions. As in previous chapters there was a positive correlation between strengths-based approaches and a relational social work approach, but in this chapter further nuance was shown in this area through relational social work not necessarily being about longevity of involvement, but about the type of relationship.

Chapter seven summarises the findings, discusses the limitations of this research, and distils the broader conclusions into four key findings:

- Strengths-based practice was strong when there was a relationship-based approach.
- To ensure statutory compliance and continuous focus on strengths the divide between bureaucracy and practice must be bridged.
- The importance of language in recording cannot be underestimated, and this needs significant consideration with the introduction of generative artificial intelligence.
- In line with other studies, the relationship between risk enablement, risk dignity and strengths is impacted by a range of relationship and organisational factors. Social

workers are good at supporting positive risk taking for people with capacity but, in line with other research, there is further work needed when capacity is a concern.

Each of these findings is discussed, and two recommended areas of practice focus are suggested:

- Implement relational based social work approaches to maximise strengths for people where there is a high perception of risk and for anyone for whom capacity may be a factor in this.
- Restructure the way that the tools used to support and record social work practices are embedded in practice to enable an amplification of strengths.

Further opportunities to embed these in practice are discussed, before final thoughts and reflections are provided.

2. The Strengths-Based Approach

This chapter provides a critical exploration of the origins and development of the strengths-based approach, starting with its theoretical and historical roots in the United States, with particular reference to the work of Rapp, Weick, and Saleebey at the University of Kansas in the 1980s. It examines the adoption and policy integration of the approach in England following the introduction of the Care Act (2014) and addresses the critiques. It then sets out the discussion about the evidence base and the approach to review taken here. The evidence is considered in relation to strengths-based practice and outcomes for people, before a summary of the gaps and the focus for this study is provided.

Approach to the literature review

This literature review took place in two stages: an initial chapter in May 2022, followed by a revised update in August 2025. In 2022, I used broad and focused keyword searches via Google Scholar and Cardiff University Library, which resulted in approximately 200 useable sources. In 2025, I updated the review with further library searches, AI-assisted queries through Elicit software, and targeted searches of major UK model websites, concentrating on studies from 2022 onwards. This added roughly thirty new sources; however, several of the earlier grey literature reports had been superseded. My evidence appraisal method is outlined later in this chapter.

When undertaking the formal literature review in 2022, I began by systematically reviewing my existing reference list and categorising sources into four groups:

- Empirical studies
- Theoretical approaches

- Best-practice guidance
- Grey literature

This process highlighted both the breadth of the material already collected and the absence of a consistent vocabulary used to describe strengths-based practice. Terms such as strengths-based, asset-based, community-led, and person-centred were often used interchangeably, while some UK practice models avoided the explicit use of strengths-based terminology altogether. These observations informed the initial selection of broad search terms, followed by progressively more focused searches.

The first set of database searches was conducted using Google Scholar and the Cardiff University Library search engines. The initial search terms were deliberately broad to test the sensitivity of the search strategy searches and generated several thousand results overall. This was narrowed down to:

- Strengths-based AND social work NOT children (since 2011) – this generated 224 results
- Asset-based AND social work NOT children (title only)- this generated 139 results.

As shown in Appendix one, title screening revealed that the majority were either conceptually unrelated, focused on children's services, or used the term strengths in a generic or non-practice-related sense. From the initial strengths-based search only fourteen articles were accepted as relevant, with 206 rejected and four identified as duplicates. Similarly, the asset-based search yielded 139 results, of which only twelve were accepted. This confirmed findings from earlier reviews that broad keyword searches are of limited use in this field due to inconsistent terminology and indexing.

In response to these limitations, I adopted a more focused search strategy based on the names of specific UK strengths-based practice models, rather than abstract conceptual terms. This decision was informed by my earlier scoping work and by the observation that UK local authorities and practice frameworks often adopt branded models without explicitly labelling them as strengths-based.

Searches therefore included:

- Local Area Coordination
- Community-Led Support

Although these searches produced relatively small useable numbers - fourteen results for Local Area Coordination, nothing for community led support - they were more targeted and aligned closely with adult social care practice in England. In parallel, I undertook direct reviews of UK model websites and associated publications, recognising that much of the relevant material existed outside peer-reviewed journals.

During this period, the Cardiff University strengths-based conference series and associated webinars were taking place. Participation in these events provided access to presentations, emerging research, and discussions with academics and practitioners actively engaged in strengths-based work. These sources contributed additional material and informed further citation tracking and thematic development.

In total, the 2022 literature review included approximately two hundred pieces of literature with specific relevance to strengths-based practice. Acknowledging the methodological challenges identified by Price et al. (2020) and Caiels et al. (2021), I adopted an iterative and inclusive approach to synthesis, drawing on both peer-reviewed studies and grey literature from the UK and, where relevant, international contexts.

Initial attempts to organise the literature involved grouping sources by dominant UK practice models and, subsequently, by the defining features of strengths-based practice identified by Rapp et al. (2005). However, many studies and publications addressed multiple aspects of practice and could not be meaningfully confined to a single category. This led to the development of outcome-focused thematic groupings, which better reflected the complexity and overlap inherent in strengths-based approaches.

The first iteration of the literature search formed a progress review chapter submitted in May 2023, prior to data collection. The second phase took place in August 2025, following completion of the finding's chapters. This timing allowed the literature review to be revisited considering the empirical findings and emerging areas of significance, particularly in relation to safeguarding, risk, mental capacity, and recording practices.

The 2025 update employed a more targeted and selective search strategy, reflecting both the findings of the study and developments in the literature since 2022. Searches were conducted using Elicit, Google Scholar, and the Cardiff University Library, alongside direct reviews of key UK organisational websites.

Key search terms included:

- Strengths-based approaches in adults (since 2022)
- Making Safeguarding Personal in England AND strengths-based approaches
- Strengths-based AND social work NOT children AND adults

As detailed in Appendix one, the Elicit search on strengths-based approaches in adults identified fourteen papers, of which four were accepted. The Making Safeguarding Personal search was more extensive: from an initial pool of approximately 500 items, thirty were analysed in detail, resulting in twelve accepted sources, nine rejected, seven duplicates, and two inaccessible texts. This process involved additional screening for relevance to adult safeguarding practice in England and explicit engagement with strengths-based principles.

The second phase placed particular emphasis on evidence relating to Making Safeguarding Personal, mental capacity, and risk management within strengths-based frameworks. These areas had emerged strongly from the empirical findings but were under-represented in the earlier literature review. As a result, two additional themes were incorporated into the review:

- Mental capacity, risk and strengths-based approaches
- The interface between strengths-based practice, recording systems and digital tools

This refinement ensured closer alignment between the literature review and the analytical chapters, while maintaining transparency regarding the evolution of the review process.

Across both phases, inclusion decisions were guided by relevance to adult social care practice, explicit engagement with strengths-based principles, and contribution to understanding outcomes, implementation, or critique of the approach. The iterative refinement of search terms reflects both the fragmented nature of the literature and the need to balance sensitivity with specificity.

Appendix one summarises the search terms, platforms, screening outcomes, and accepted sources for both phases, demonstrating how key terms were identified, tested, refined, and applied to construct a comprehensive and contextually grounded review of strengths-based practice.

What is a strength-based approach?

Since the publication of the Care Act (2014) a strengths-based approach in adult social work has become commonplace in England. At its core, the approach reflects the inherent capacities, resilience, and agency of individuals, rather than focusing on deficits or risks. The Social Care Institute for Excellence defines the approach as:

> 'a focus on individuals' strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing' (SCIE, 2022)'

Similarly, the DHSC (2019) emphasises it as 'a way of working, not an outcome,' highlighting its status as a philosophy of practice. My working definition of a strengths-based approach for this thesis is:

> An approach that focuses on relationships, practice and empowerment understanding a person's individual experience, with co-produced solutions enacted through a consideration of a person in terms of their:
>
> - abilities (i.e. what they can achieve themselves with or without support)
> - assets (i.e. what support they can draw on within their own networks -for example family, friends, and other social and community networks)
> - capabilities (i.e. their personal characteristics – for example humour, patience, confidence, trustworthiness, humility, etc.)
>
>   and

- resilience (i.e. how have they survived previous adversity and what are the current, or previous mechanisms that they can draw on in the face of the current situation)

Strengths-based approaches differ from traditional care management which focuses on deficits - what is wrong with a person, and whether the person is eligible to receive services or support that can help to compensate for or fix these deficits. Care management is transactional, focusing on compliance and risk management, and the role of the professional is key to directing the intervention or service rather than it being coproduced.

The origins and development of the strengths-based approach

Strengths-based approaches originated in mental health treatment in the mid-1980s. Saleebey published multiple editions of The Strengths Perspective in Social Work Practice throughout the 1990s and 2000s, with later versions incorporating redrafts and additional chapters by other authors, responding to feedback for a greater focus on ‘oppressed group [...] and [...] social and economic justice' (Saleebey, 2006:xvii). The central paradigm of the approach is that people who have undergone trauma are inherently strong (Saleebey, 1996; 2000; 2004; Rapp *et al*., 2006, Weik at al., 1989). In this Saleebey and colleagues are not arguing that the person does not need support, rather than the way the support is delivered should be collaborative rather than paternalistic. The social worker’s role is not to ‘fix’ the person, but to partner with them to consider what the solutions could be (Saleebey, 2008). This perspective aligns with social constructionism (Kelly, 1955), supporting the view that reality is constructed by individual and social narratives (Saleebey, 2008, Weik *et al*., 1989; Rapp and Lieberman, 2020). Part of the social worker’s role is to support a 'reframing' (Saleebey, 2008:7; Garfinkel 1967) of the narrative away from deficits towards opportunities, reflecting how a person's individual previous - and current - life experiences have provided them with the tools that will enable them to achieve their goals. It is, however, more than this; Saleebey's message to social workers is to believe in people and believe what they say (2008; 2000). Rapp, *et al*. (2006) summarised the approach into six inter-dependent elements:

- A goal-orientated approach using tools such as the miracle question[1] (Quick, 2008) and solution focused discussions
- A systematic assessment of strengths as opposed to being focused solely on deficits
- Consideration of an environment which is rich in resources, for example local community assets and the role played by family and friends
- Use of explicit methods for goal attainment
- Hope-inducing
- Based on meaningful choices

Greene and Lee's (2011) solution-focused social work built on the work of Saleebey, Rapp and colleagues in a first attempt to bring together social constructionism, social psychology, and postmodernism (Payne, 2014). This was a ten-step approach for solution-focused social work. The first seven steps focused on shifting the power dynamic through collaborative relationships led by the person, definitions of both the problem and the solution, building on what has already worked. The remaining three steps address external factors: navigating deficit-led practices, recognising, and embracing cultural diversity and continuous evaluation (Greene and Lee, 2011). This theoretical and practical application of the strengths-based

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[1] The miracle question is a technique in which the enquiry starts with exploring a future when things are different or a problem is solved. It encourages the person to visualise change, focus on goals and discover strengths or resources they can use to support a change.

approach bridges theories providing practical steps for practice implementation in different settings. There is limited literature to suggest it has been adopted as a practice model, although elements of this do feature in a range of other implementations.

In contrast, the national strengths-based framework (DHSC, 2019) is a policy document. It focuses on five key components: knowledge and co-creation, values and ethics, theories and methods, experience, and skills, with an emphasis on reflective practice, supervision, and quality assurance in the context of the Care Act (2014). It is targeted at social care professionals and uses a range of case studies to link back to practice.

Whilst both frameworks advocate for a strengths-based approach in social work, Greene and Lee's (2011) work offers a broader, integrative perspective suitable for various practice settings, whereas the UK government's framework provides a targeted, policy-aligned guide for adult social care professionals in the UK context.

Strengths-based approaches and problematisation

A key feature of the strengths-based approach is the redefining of problematisation within social work. Weick *et al*. (1989) caution against problematisation as a concept as it focuses on the individual in isolation of other social constructs. The strengths-based movement experienced a backlash amongst other academics with a critique that this was an oversimplification of issues, with the argument made that social work needs both problem solving and capacity building (McMillan *et al*, 2004). Saleebey (2004) responded directly to this challenge, reiterating that the strengths-based approach is not about ignoring the problem, but about framing this holistically in the wider context of the person's lived experience.

Saleebey (2001) suggested positive characteristics such as patience, trustworthiness, insight, and initiative, should be considered alongside deficits when undertaking mental health assessments. He purposefully reframed well-known diagnostic terminology to illustrate his perspectives; one such demonstration was the suggestion of a diagnostic strengths manual (DSM), adopting the nomenclature of the Diagnostic and Statistical Manual (DSM) clinical handbook for diagnosing mental health disorders, (APA, 2025). The strengths manual was proposed to include ‘Estimable Personal Qualities’ in which qualities of 'Trustworthiness’, 'Patience', 'Initiative' and 'Insight' (Saleebey, 2001:185-186) were considered with a range of positive behavioural activities that could influence these traits. Similarly, Saleebey (2000; 2001) coined a 'C-P-R' triangle of strengths, appropriating the acronym for lifesaving care. In this example the three sides of the triangle each provides a description of a strength C – competence, P - promise, and R - resources (Saleebey, 1996; 2001). Saleebey accepted that these examples were perhaps ‘a tad precious’ and ‘frivolous’, noting that this was deliberate (2001:186). The point is that to problematise reinforces power dynamics established in professional hierarchies (Saleebey 2004; Goffman 1961). These can be referred to in sociological terms as a 'professional habitus' (Bourdieu, 1991; Bourdieu and Waquant, 1992; Bark, 2024;) and challenging these reflexively through constructing alternative narratives enables a focus on recovery and goals.

Overall, the debate around problematisation highlights a fundamental tension within social work between deficit-based and capacity-building perspectives. While critics argue that strengths-based practice risks oversimplification, Saleebey’s reframing (Goffman 1961; Saleebey 2004) demonstrates how recognising positive traits and capacities can challenge entrenched professional hierarchies and shift the focus from problems to potential. By disrupting the 'professional habitus' (Bourdieu, 1991; Bourdieu and Waquant, 1992; Bark, 2024) and constructing alternative narratives, the strengths perspective offers not only a critique of traditional power dynamics but also a more recovery-oriented, goal-focused practice that focuses on empowerment and hope.

Strengths-model case management

Strengths model case management (known as SMCM) is one of the original practical applications of strengths-based theory. It has been used internationally since its inception at the university of Kansas, USA, in the 1980s. Initially developed by Rapp and Chamberlain (Weik *et al*., 1989), it remains relevant with studies examining the approach being published up to and including 2025.

The original components of the SMCM focused on both the person and their environment. The person was central to the conversation, reinforced through a strengths-based assessment and targeted supported interventions. Practice was enabled though group supervisions (Rapp and Chamberlain, 1984). A review of implementation (Rapp and Goscha, 2004) identified ten components, some of which are specifically relevant for mental health interventions and share features with assertive outreach interventions. The remaining features are more relevant for social work practice: small caseloads to allow meaningful engagement; continuity of care over time; tailoring plans to individual goals and strengths; coordinating across fragmented service systems; adapting support as needs change; connecting people with a broad range of practical and therapeutic resources; providing timely crisis intervention; supporting skills for daily living; and working from a strengths-based perspective that emphasises resilience and personal capacity (Rapp and Goscha, 2004).

SMCM has a structured implementation and there is broad consensus on critical facets of the approach (Marty *et al*., 2001) as set out by Rapp and Goscha (2004). It combines individual strengths with self-direction, use of informal networks, the development of a relationship between the case manager and the person being supported, and assertive community involvement that is supported by the case manager (Brun and Rapp, 2001). SMCM has been widely implemented internationally, although does not appear to have found traction within UK literature. There have, however, been studies internationally including the USA, Hong-Kong, Taiwan, Canada, and Israel. These are considered further within the evidence section of this literature review.

English context

The introduction of the Care Act (2014) marked a step change for the focus on strengths-based approaches in England (Whittington, 2016; Tarrant, 2024). Whilst the Act itself does not specifically reference the approach, the premise of strengths within the legislative context is consistently reinforced throughout the Care and Support Statutory Guidance (2025), with twenty references to strengths within the text. Several implementation partners have developed offers to support local authorities to develop strengths-based approaches. However, the predominant focus appears to be less about the relational elements and personal strengths of individuals highlighted through the original strengths-based theory, in favour of opportunities to maximise personal and community assets. There are three dominant models used within the sector: Three Conversations (partners4change, 2025), Community Led Support (NDTI, 2025), and Local Area Coordination (LAC)/Community Catalysts (LAC, 2025). Each model has an element of standardisation but is adaptable to local systems - so naturally has variation built in. Some areas have adopted multiple models

(Fawcett *et al*., 2021), and other local authority areas claim to have adopted strengths-based working without reference to a specific model.

Three conversations

The Three Conversations approach is based on three principles; listen and connect, work intensively with people in crisis, and build a good life. It is active in around twenty local authority areas (Partners4Change, 2025). The principles are strengths-based, recognising individuals and families as experts. This approach sets out three conversation stages; the first maximises family and community assets, the second identifies complexity and risk, and the third identifies what additional support is needed to enable the person to live their most independent life (Tew, *et al*., 2019; Parker, 2021).

Local Area Coordination (LAC)

Local Area Coordination (LAC, 2025) is a model that originated in Australia in the 1980s. It expanded into England and Wales in 2009 where it has combined delivery with Community Catalysts. The website lists eleven local authority areas utilising this model within the UK, although references in case studies suggest implementation in around fifteen to twenty areas (LAC, 2025). The premise of this approach is a focus on linking people with locally based resources and building and strengthening natural community assets. The model involves local community-based coordinators working collaboratively with people to identify and build networks and support based on their goals and strengths.

Community Led Support

Community-led support is an approach pioneered by the National Development Team for Inclusion, who are fundamentally a user-led social change organisation. It currently operates across thirty UK areas (NDTI, 2025). It brings together strengths-based practice, outcome-focussed commissioning, and provision and community assets. This approach builds on existing structures to reduce bureaucracy and co-create local arrangements, such as setting up ‘talking cafes’ (CCS, 2022) that move conversations with individuals into local community-based venues to link people up with local communities.

There is a level of similarity across the three models, with maximising existing individual and community resources a dominant feature. This focus has generated a body of criticism that strengths-based approaches are vehicles of neoliberalism to orchestrate a transfer of responsibility from government to communities (Gray *et al*., 2011). Critics argue that the application of strengths-based approaches masks societal inequity and injustice with a smokescreen of person-focused approaches (Gray *et al*, 2011; 2015; Withers and Pollock, 2019), and that this is an active tool of government (Gray, *et al*. 2015). This point is echoed by Withers and Pollock (2020) who, whilst acknowledging a positive impact for individuals, criticise community focused strengths-based models on the basis that they enable society to distance itself from structural injustices. This is the opposite of what the strengths-based approach is about; working at an individual level alone is insufficient to effect real change, and for social workers to work in a strengths-based way requires challenging on a structural, as well as an individual, basis (Saleebey, 2008). The counter arguments suggests that the move towards developing stronger community links to support older people is the only way that social work can move away from an inevitable rationing of resources (Lymbery, 2014; 2017). Other contributions suggest the approach enables a rebalance of power towards the person with care and support needs (Steven, 2007), and that opportunities could be further enhanced with government intervention (Hutchinson, 2019).

UK evidence mainly highlights how managing demand and cost drives change (Tew *et al*., 2019). This is unsurprising as in 2019, 82% of statutory directors of adult social care (DASS) reported asset-based approaches as fundamental to delivering savings (ADASS, 2019), however by 2025 85% of DASSs were predicting that their budgets were insufficient to meet statutory duties (ADASS, 2025).

Statutorily, local authorities can meet eligible needs under the Care Act (2014) in a variety of ways and are not limited to commissioned services. The UK models often emphasise the mobilisation of 'assets' to reduce publicly funded care rather than a broader account of strengths-based practice, aligning with critiques that the rhetoric can mask cost containment agendas (Gray *et al*., 2011; 2015; Withers and Pollock, 2020). Case law ([2019] EWCA Civ 1614) has been cited as a caution for councils implementing the Three Conversations model (Tirraoro, 2020), as a shift of responsibility to carers risks conflicting with statutory duties under the Care Act (2014)—specifically, the duty to provide an appropriate personal budget (2014:26). More broadly, there is an ethical imperative not to 'coerce' carers who are unwilling or unable to provide support (DHSC, 2019:25).

The attention within these arguments to the perceived merits and disadvantages of increased use of community and personal assets focuses narrowly on one element of the strengths-based approach. This singular focus distracts from the fundamental principles of the strengths-based approach which are around relationships, practice, and empowerment, aligning with international definition of social work (IFSW, 2014). The focus within the UK models on those aspects that are about alternatives to traditional services, and the associated financial implications, risk detracting from the fundamental principles of social work practice.

Is there an evidence base?

Over the last five years there has been a concerted effort in England to evaluate the strengths-based approach, through specifically commissioned evidence reviews. The challenge has been agreeing the scope and nature of the approach - to wit: what it is, how is it implemented, and how can you demonstrate and measure effectiveness. Two commissioned literature reviews (Price *et al*., 2020 and Caiels *et al*. 2021) reviewed a limited set of studies from a larger sample.

Price *et al*. (2020) analysed fifteen studies taken from a sample of over 5000. Of the studies appraised, six were assessed as good quality and nine as poor quality. The purpose of the review was to examine implementation and effectiveness, and reviewed studies focused on strengths-based interventions for adults being supported or assessed by social workers, or projects in adult social care teams. The review highlighted the intervention of Making Safeguarding Personal (MSP) as defined in the Care and Support Statutory guidance (2025:14) as a potentially measurable strengths-based intervention. MSP has six key principles: protection, prevention, proportionality, personalisation, empowerment, partnership, and accountability (SCIE, 2025). Price *et al*. (2020) completed a framework synthesis of seven studies specifically on the implementation of MSP which was then further examined by Ajuha *et al*. (2022). Both reviews highlighted the inadequate quality of evidence to support implementation and found that none of the studies were judged to demonstrate effectiveness. The Price *et al*. (2020) review recognised that the exclusion criteria were potentially over restrictive (having been limited to UK-only studies), incomplete searches of grey literature, and a focus on quantitative outcomes statements for effectiveness. The impact being that only fifteen studies in total warranted review.

Furthermore, there was a recognition that the review did not pay sufficient attention to the perspectives of people with experience of these interventions (Price *et al*., 2020).

The second review, by Caiels *et al*. (2021), included 72 studies, theoretical pieces, and reports from a literature sample of 1744. This review set out to examine six questions; what strengths-based approaches are, the evidence, challenges, system requirements, Care Act (2014) impact, and how to evaluate effectiveness. The discussion included support for, and opposition to, the strengths-based approach. Positives included a focus on empowering individuals, fostering collaboration, and promoting wellbeing by focusing on personal and community assets. Criticisms included a lack of evidence, a risk of overlooking structural inequalities, and the risk of it being used as a cost-cutting tool rather than for genuinely improving care. This review offered much more of a discussion of strengths-based debate than the Price *et al*. (2020) study. Findings recognised the policy support for this approach but recommended further development of the evidence base in this area Caiels *et al*. (2021).

The reviews and other similar attempts to synthesise evidence identified that further research is needed to define what is meant by a strengths-based approach (Price *et al*., 2020; Caiels *et al*., (2021), how to capture evidence (Mahesh *et al*., 2024), and how to evaluate its effectiveness (Price *et al*., 2020; Caiels *et al*., 2021; 2023; Tew at al., 2019; Ajuha *et al*., 2022). An earlier systematic review recommended that studies examining SMCM should also provide clear descriptions in line with the standards of randomised control trials (Ibrahim *et al*., 2014), however other analyses recommend ensuring the views of practitioners are not lost (Caiels *et al*., 2024). These discussions reflect the earlier consideration of a lack of a single definition of the strengths-based approach (Caiels *et al*., 2021; 2024; Rapp *et al*., 2006; DHSC, 2019).

Silovara *et al*. (2025) utilised a Delphi study, consensus-style approach to define what could and should be measured as evidence for the strengths-based approach; this identified thirty-two potential areas of evidence, settling on twenty-six measurable outcomes. Many of these are grounded in strengths-based theory and have been categorised under outcomes relevant to the individual, their family or friend carer, community resources, workforce considerations, and timelines for accessing support. The study set out a range of tools that could measure the suggested outcomes. Seven of the twenty-six elements included as feasible were not considered measurable. Key areas in the debate on community assets include the range of available resources, cost effectiveness and preventing or delaying the need for more intensive services. As discussed previously, implementation reports on the English models, often commissioned in partnership with delivery organisations, focus strongly on demand management through community assets. Other evaluations highlight actual or predicted cost savings, cost avoidance, and reduction in referrals as benefits of implementing a particular strengths-based model (Thiery *et al*., 2023). However, there are claims that demand management and cost savings are over reported (Slasberg and Beresford, 2016), with a review of local authority savings suggesting that only 25% of reported savings came from working differently to reduce the need for services as opposed to actual reductions in service levels (Bolton, 2016). Additionally, an overall increase in acuity and demand has placed significant pressures on local authority budgets (Slasberg and Beresford, 2016). Cost savings have been linked to services that promote more choice and control, such as improvements in the use of Direct Payments and reductions in the use of residential care (Fawcett *et al*., 2021). However, there is mixed evidence regarding whether a reduction in funded care is a direct result of increased signposting to community provision as alternative to commissioned services (Prunty *et al*., 2024), suggesting, per Bolton's (2016) argument, that this is not simply about a change in model but a reduction in service provision generally. Generally, upfront costs could be seen as barrier to implementing strengths-based models (Stevens *et al*., 2024).

The attempt to quantitively measure the approach appears to be challenging. Price *et al* (2020) acknowledge a disposition towards a positive, natural science approach to demonstrate the evidence base. Similarly, Caiels *et al* (2021) raised the question of how the strengths-based approach is defined and what is being measured. The Delphi study (Silovara *et al*., 2025) attempts to identify potential measurements but excludes issues that are politically relevant in relation to financial incentives for local authorities to work in this way in the current climate. This study also excludes practice implications - namely paperwork, level of bureaucracy and cultural shift and resilience. This raises the question of whether a focus on standardisation and quantitative measurement is the best way to understand the implementation of a strengths-based approach.

When looking at evidence to consider within this review I focused on eighty-eight studies. This is in comparison to the fifteen articles reviewed by Price at al. (2020) and the sixty-three pieces reviewed by Caiels *et al* (2021). Similarly to Price *et al*. (2020) and Caiels *et al*. (2021), when considering which evidence to evaluate I decided to reject the rigid criteria of quantitative measures drawing instead on my own interpretivist paradigm and recognising the complex social structures and individualised approaches (Bryman, 2016). In contrast to Price *et al* (2020) and Caiels *et al* (2021) I wanted to move beyond measuring to enhancing understanding. There is an argument that there is no evidence that a deficit model is effective (Saleebey, 2004) which raises the question about why there is so much emphasis in the commissioned literature on effectiveness in general. I adopted a more inclusive approach and found there was significant amounts of relevant literature, including some of the individual studies reviewed by Price *et al* (2020) and Caiels *et al* (2021), as well as additional sources. Almost exclusively studies were qualitative and small scale. However, if something is replicated independently within a different context, cultural setting and environment and generates the same or similar interpretations, generalisability could be suggested, albeit cautiously. A summary of the studies included in this review are outlined at appendix two. Furthermore, whilst the issues of cost savings may be seen as politically positive, these are not the only reasons to endorse the approach. There is symmetry between strengths-based practice and the international definition of social work suggesting that this is a positive way to practice.

I experimented with a range of ways to consider the evidence and noted cross cutting findings and recommendations across studies. I initially had seven themes, but I consolidated these into two distinct set of findings: those relevant for practice, and those relevant to lived experience of strengths-based practice.

Practice

Strengths-based relational practice is embedded within the Care and Support Statutory Guidance (2025) underpinning core duties in the Care Act (2014). In this section of the literature review I examine the practice implications that can be drawn from the reviewed studies with a particular a focus on relational social work, risk and capacity, assessment and leadership, and cultural change.

Relational social work

Evidence across service contexts suggests that strengths-based relational work is associated with improved quality of life and wellbeing for the person supported. This could be seen in studies in mental health settings where SMCM has been implemented (Brun and Rapp, 2001; Roebuck *et al*., 2022; Tse *et al*., 2021; Tsoi, 2019; Rapp *et al*., 2015; Chen *et al*., 2021) in other mental health settings (Quinn *et al*., 2023; Tse *et al*., 2021) and working specifically with the families of people with dementia (McGovern, 2015). In these examples the consistency with a type of relational approach was less important than the model itself. However, there was limited reference to the importance of relational-social work in evaluations of the UK strengths-based models.

Risk and capacity

Literature on capacity and risk often overlooked strengths-based principles. Relational social work strengthened risk management but the way that was presented in practice varied (McDonald, 2010). Interventions that focused on risk management and harm reduction were seen as the most important indicators of good outcomes (Robb and McCarthy, 2023). Within the context of safeguarding and risk, practitioners reported that more open conversations enabled the provision of better support leading to more effective safeguarding (Butler and Manthorpe, 2016; Hopkinson *et al*., 2015) although there was a difference in the definition of effectiveness in the two studies. The process of discussing outcomes was key to ascertaining involvement (Lonbay and Brandon, 2017; Lawson, 2014) but relationship building involved more time (Butler and Manthorpe, 2016). Engagement often involved listening to views but did not necessarily lead to increased control for the person, which remained with the professional (Lonbay, 2015; Robb and McCarthy, 2023; Butler and Manthorpe, 2016). Tensions have been identified in balancing personalisation and safeguarding (Manthorpe *et al*., 2022; Aspinal *et al*., 2019) and personalisation, autonomy, and risk more generally (Jepson *et al*., 2016; Symonds *et al*., 2018; Robb and McCarthy, 2023; Aspinwall-Roberts *et al*., 2022). Responses to safeguarding and risk were further influenced by relationships with other professional partners (Price *et al*., 2020; Lawson, 2014) and when decisions were considered risky family views were prioritised (Jepson *et al*., 2016). Other factors identified were ageism (Cooper *et al*., 2018; Lonbay, 2015), with older people often not being involved in safeguarding (Lonbay and Brandon, 2017) and the viewing of the person in the process as vulnerable (Lonbay, 2018).

These issues were magnified further when the capacity of the person in relation to the risk was in doubt (Lonbay, 2018; Price *et al*., 2020). Capacity assessments were manipulated based on circumstances to both demonstrate and refute notions of capacity (Aspinwall-Roberts *et al*., 2022), and as rationale to intervene and restrict choice and control under the pretext of best interests (Aspinwall-Roberts *et al*., 2022; Robb and McCarthy, 2023). External influences, rather than capacity *per se*, were seen as drivers for on-going or cyclical intervention to change behaviour (Keeling, 2017).

Taken together these studies suggest that the focus of engagement within safeguarding and risk management is framed in professional and institutional factors (Beck, 1992; Power, 2003; Perrow, 2011). This construction of risk management (Goffman, 1961) is not necessarily strengths-based. Relational work can improve the quality and ethics of safeguarding processes without necessarily shifting power or risk tolerance. This highlights tensions with defensive practice (Kemshall, 1998; 2002; Manthorpe and Moriarty, 2010) rather than building on strengths, hopes and possibilities (Saleebey 1996, 2006). Prioritisation of risk aversion over autonomy, and assumptions of vulnerability (Lonbay, 2018) can limit the extent to which individuals experience genuine empowerment. This is interesting concept considering that the strengths-based movement started with people drawing on complex mental health support who arguably may present with reduced capacity and increased risks.

Assessment

Assessments are a key feature within practice and strengths assessments, rather than deficit enquiry, remain a key component of a strengths-based approach (Rapp *et al*., 2006; Rapp and Chamberlain, 1985; Weik *et al*., 1989). A range of talking strategies can be used to operationalise wellbeing across social work practice (Payne, 2006). One such strategy is narrative therapy, which provides a structured, reflective space to understand a persons lived experience (Gu, 2018). For example, a study with teenage mothers in Mozambique found that participants mobilised problem-solving, cognitive, and relational strategies to navigate limited access to health and education, low levels of material provision, and conflictual relationships (Hutchinson, 2019). This illustrates how narrative work can reveal and amplify existing resources rather than solely cataloguing need. Other examples are solution focused techniques for assessment such as the miracle question (Quick, 2008) - a technique that supports a person to consider their future when things are better, or their problem is solved. Studies have suggested that formal training in this technique can change the way social workers approach assessments (Toros, 2019a; 2019b), bringing about a distinct shift from deficits to strengths in assessment questions (Toros, 2019b).

Other studies have identified barriers to strengths assessments with professional judgement and autonomy remaining a key feature and, as with other areas of practice, a switch to questioning of competency when decisions appeared risky (Symonds *et al*., 2018). This suggests assessments are not routinely co-constructed. Studies found that more structured forms restrict opportunities for conversations but increase accountability, and that more flexible recording methods led to a more open conversation – however these did provide less transparency around the event (Matarese and Caswell, 2018). Evaluation of community led support found that implementation sites undertook more planned rather than unplanned care plan reviews, suggesting that this was evidence of improved support (Prunty *et al*., 2024). However, this assumption is potentially flawed as it equates increased efficiency of process with better outcomes for people. Similarly, several evaluations report that implementation of strengths-based models require more staff to implement the new ways of working due to the need to work more intensively with people (Caiels *et al*., 2024; Stevens *et al*., 2024). This could potentially be evidence of better outcomes; however, it could also be that attempts to streamline the assessment process, has led to an increase in double recording (Stevens *et al*., 2024). These are attempts to measure outcomes and benefits for workers rather than necessarily for people supported.

Leadership and Cultural Change

There is a consistent theme across a range of literature sources that leadership is viewed as being integral to successful implementation in the UK strengths-based models (Bown *et al*., 2020; Carrier, 2020; Fawcett *et al*., 2021; Duggal *et al*., 2021; Jessop *et al*., 2025; Lunt *et al*., 2021; Miller *et al*., 2024). Leadership was also highlighted as vital to making safeguarding personal (Cooper *et al*., 2018; Lawson *et al*., 2014; Price *et al*., 2020).

Changes in process were identified as requirements for success, including adaptability of IT systems and processes (Caiels *et al*., 2024; Stevens *et al*., 2024), performance management culture (Stevens *et al*., 2024) and system pressure (Caiels *et al*., 2024). Culture changes are also viewed as key, with tools such as supervision being valued by practitioners (Chen *et al*., 2021; Petrakis, 2013; Tse *et al*., 2021). Training and confidence in the approach was seen as essential to support the shift from traditional to strengths-based practice (Stevens *et al*., 2024; Brongers *et al*., 2020; Briand *et al*., 2022; Toros, 2019a; 2019b), with qualitative analysis of narrative of stories and specific examples of individual cases used to provide evidence (Fawcett *et al*., 2021).

The practice evidence for the strengths-based approach has been considered in the context of relational social work, risk and capacity, assessment and the organisational contexts of leadership and cultural change. Relational approaches have been associated with improved wellbeing and empowerment (Brun and Rapp, 2001; McGovern, 2015; Tse *et al*., 2021) reflecting Saleebey's (1996; 2006) emphasis on recognising and building individuals' capacities, assets, and resilience. Practice is significantly challenged when there is consideration of risks, capacity, and safeguarding (Robb and McCarthy, 2023; Butler and Manthorpe, 2016; Hopkinson *et al*., 2015; Lonbay, 2015). Whilst it is recognised that greater involvement of the person is important (Lonbay and Brandon, 2017; Lawson, 2014; Butler and Manthorpe, 2016) this is primarily linked to risk management (Beck, 1992; Power, 2003; Perrow, 2011; Goffman, 1961) rather than strengths. Strength's assessments are a key component of the overall approach and studies have shown that application of different techniques can enable this way of working (Rapp *et al*., 2006; Toros, 2019b; Gu, 2018). However, structured processes, professional judgement, and accountability requirements can limit genuine collaboration, and increased procedural efficiency does not always translate into improved outcomes for service users (Matarese and Caswell, 2018; Prunty *et al*., 2024). Effective implementation also depends on leadership, organisational culture, and workforce development to embed relational approaches, support practitioner confidence, and sustain change (Bown *et al*., 2020; Fawcett *et al*., 2021; Stevens *et al*., 2024). Training, supervision, and system-level adaptations, including flexible processes and performance management, are critical to fostering a culture that balances empowerment with accountability while keeping service users' strengths and goals central to practice (Chen *et al*., 2021; Tse *et al*., 2021; Petrakis, 2013).

Lived Experience of strengths-based practice

In addition to the focus on practice, the literature considered the experiences of people in receipt of a strengths-based intervention. Increased use of community assets has been found to have positive outcomes for individuals. These include enabling people's voices to be heard (Lunt *et al*., 2021; Bainbridge and Lunt, 2021), building positivity, tackling isolation and loneliness, (Lunt *et al*., 2021), an improved sense of wellbeing (Caiels *et al*., 2024) personal outcomes (Lunt *et al*., 2021), and trust (Mason *et al*., 2021).

Internationally, an Australian small-scale qualitative project found use of community circles of support increased opportunities for people with acquired brain injury to develop relationships and reduce isolation, with the length of the study suggesting that this was a sustainable intervention (Rowlands, 2001). A study of 'care farms' in the Netherlands found that these also provided good outcomes (Hassink *et al*, 2009). The article concluded that these care farms, which are working farms that offer day care, supported working placements and residential placements for individuals, could be considered innovative models of community-based support. Whilst a systematic review of care farms across the UK and Europe concluded that further evidence was needed to evaluate the intervention, it did highlight that across the eighteen qualitative studies people valued the contact, achievement, and sense of belonging and fulfilment they offered (Murray *et al*., 2019), suggesting that these types of provision can add social value on an individual basis.

Earlier intervention also emerged as a positive outcome. Community initiatives were identified as; bridging the gap between formal services and communities (Duggal *et al*.,

2022) and identifying alternatives to provision of services (Bainbridge and Lunt, 2021; Miller *et al*., 2025). This was also seen as simpler as it could happen without needs for referrals (Bown *et al*., 2017). These outcomes could be seen for people who subsequently didn't need social care support (Lunt *et al*., 2021) and as enhancements to formal care services (Bown *et al*., 2020).

Focusing on strengths in rural communities has demonstrated positive outcomes in both the UK (Phillips, 2025) and Canada (Vance, 2017). The literature suggests there should be consideration of rural communities through their assets and strengths rather than deficiencies in comparison to urban settings. Studies highlight rural communities' reliance and responses to challenges (Averill, 2003), different approaches to provision of home care (Sharman, 2014) and different relationships and approaches to technology as enabling resources (Bryant *et al*., 2018; Phillips, 2025). These studies start to look beyond the individual level outcomes to challenge how ways of living and community assets need to be considered in terms of understanding how communities live.

Considering these findings holistically suggests that there is a benefit for enhancing communities in relation to wellbeing, a position that is both supported in the critique of the approach (Lymbery, 2017; Withers and Pollock, 2020; Steven, 2007) and challenged due to the lack of focus on wider structural challenges (Withers and Pollock, 2020). These findings do not substantiate the claim that strengths-based approaches are simply a vehicle of neoliberalism as suggested by Gray *et al*. (2011). However, they do indicate that such approaches could be further improved with additional government intervention, aligning with Hutchinson (2019).

Strengths-based approaches have applications beyond social work. Improvements in wellbeing outcomes were found when strengths-based approaches were included in psychotherapy practices (Flückiger *et al*., 2023). Other considerations of applications of strengths-based approaches in mental health settings suggested participants had 'relational security and hopefulness' (Quinn *et al*., 2023), and in studies with people with drug and alcohol use suggested increased psychosocial function, and improved sense of self awareness, knowledge, and communication (Geyer, 2012). Studies have found SMCM correlates with reductions in hospitalisation (Fukui, 2012; Björkman *et al*., 2002; Ibrahim *et al*., 2014; Teague *et al*., 2012) and in follow up services (Gelkopf *et al*., 2016), but not in reduction of symptoms (Tsoi, 2019; Björkman *et al*., 2002; Fukui, 2012; Ibrahim *et al*., 2014). Xie *et al*. (2013) suggests that identification of character strengths rather than deficits could be beneficial to recovery for people with mental health conditions. There has been improved recovery attitudes including achievement of self-identified goals, (Tse *et al*., 2021; Fukui *et al*., 2010; Tsoi, 2019; 2022; Gelkopf *et al*., 2016), and understanding of strengths and weakness, as well as functional recovery in areas of employment and family relationships (Tse *et al*., 2021; Teague, 2012).

Gaps and areas for further development

In this literature review I took an inclusive – as opposed to an exclusive - approach to inclusion of evidence, including studies drawn from a range of sources. I acknowledge in my approach the shared conclusion of Price *et al*. (2020) and Caiels *et al*. (2021) that further work was needed to establish an evidence base. This message was repeated in other systematic reviews and evidence summaries included in my reading. A call for further evidence was identified in studies in relation to community asset approaches (Murray *et al*., 2019; Bryant *et al*., 2018), measuring preventative impacts (Duggal *et al*., 2021), making safeguarding personal as an intervention (Ahuja *et al*., 2022), the link between personalisation and safeguarding more generally (Manthorpe *et al*., 2009; 2013; 2022; Stevens *et al*., 2018; Aspinal *et al*., 2019), risk aversion and capacity (Price *et al*., 2020; Lonbay, 2018; Cooper *et al*., 2018). Furthermore, this was a recommendation in reviews of strengths-model case management (Teague *et al*., 2012; Tse *et al*., 2016) where, despite the longevity of the model and the structure of the intervention, once exclusion criteria were applied, few studies were seen to provide strong evidence (Tse *et al*., 2016).

Challenges included the lack of a consistent definition of strengths-based practice and an understanding of how to measure this (Price *et al*., 2020; Caiels *et al*., 2021). Attempts to define measures of strengths-based approaches such as the Delphi study (Silovara *et al*., 2025) provide indicators but exclude core concepts such as resilience, cultural change, and preventative impact, reducing the approach to what can be quantified, rather than what is meaningful for practice.

Despite discussion of approaches and attempts to measure these at practice-level, the evidence is limited. Implementation and research in England is heavily focused on community assets and demand management (Tew *et al*., 2019), with less attention to how social workers enact strengths-based practice in assessment, safeguarding, or risk contexts. Where capacity is in question, evidence suggests practice often defaults to risk aversion (Lonbay, 2018; Robb and McCarthy, 2023). The voices of people with lived experience and unpaid carers are underrepresented, while critiques of the approach as a neoliberal agenda (Gray *et al*., 2011; Withers and Pollock, 2020) are political and theoretical rather than evaluated empirically.

Summary and conclusion

The evidence reviewed in this literature review tells a story about the way that strengths-based approaches have been implemented in England and more widely. Certainly, when considering asset-based approaches, there could be support for the hypothesis that increasing people's social and community networks of support delays and reduces the need for formal care services. There is a body of evidence associated with SMCM that suggests strengths-based working can improve outcomes and treatment for mental health conditions, (Björkman *et al*, 2002; Fukui, 2012; Teague *et al*., 2012; Ibrahim *et al*., 2014; Gelkopf *et al*., 2016; Tsoi, 2019; Tse *et al*., 2021) yet studies in England looking at safeguarding, capacity, and risk suggest this is an area of development for strengths-based practice (Manthorpe *et al*., 2009; 2013; 2022; Lonbay, 2018; Cooper *et al*., 2018; Stevens *et al*., 2018; Aspinal *et al*., 2019; Price *et al*., 2020).

There are two fundamental questions for consideration:

1. What are we trying to measure?
2. Why are we trying to measure it?

In relation to the first question there is no agreed definition of strengths-based approaches. Implementation in England appears to be concentrated on community assets at the expense of complex practice. There is also no agreed definition of what should be measured, despite the recent contribution of Silarova *et al*. (2025). Critics, or even other reviewers of the literature (e.g. Price *et al*., 2020; Caiels *et al*., 2021), will continue to argue that there is significant work needed to establish robust evidence-based measures. However, there is also no evidence that suggests the traditional problem-focused approach can be effectively measured either (Saleebey, 2004).

The second question is more philosophical in nature, given that working in a strength-based way with individuals fits with social work values and ethics (BASW, 2021). Rapp *et al*. posited that ‘as we sit here today, it is hard to envision that strengths-based social work will ever be the dominant mode of practice’ (2006:84). However, with the introduction of the Care Act (2014), strengths-based approaches became mainstreamed within legislation through the Care and Support Statutory Guidance (2025). Implementation within the UK is significantly skewed towards the community assets element of the approach at the expense on the relational importance of the social worker in supporting a person to achieve the goals.

In this literature review I have considered the evidence thematically to bring together a range of studies and grey literature which suggest similar outcomes. Focusing on community assets can improve wellbeing, increase connectivity, and reduce and delay care needs. There is international evidence that supports strengths-based practice models and some evidence of practice outcomes in the UK, but these are not embedded and have been identified as underdeveloped when supporting complex social are needs involving risk and capacity. Consistently leadership and culture change is highlighted as a crucial element of implementing changes in approach. The areas for development, particularly within the UK literature, are in how social workers practice in a strengths-based way beyond the focus on community assets and demand management, and how this practice is experienced both by the social worker and person being supported. My interest in the strength-based approach is primarily at the social work practitioner level. The following chapter sets out my methodology in relation to exploring three questions:

- How do social workers define and understand strengths-based approaches in relation their practice?

- How are these interpretations observable in day-to-day practice and what are the factors that influence these?
- How do people with care and support needs experience social work intervention?

3. Methodology

Introduction

As discussed in the literature review the application of strengths-based approaches in England have focused primarily on the developments of community assets with a gap around strengths-based practice, particularly with relation complex risk and decision making. There is a general call for further research on strengths-based approaches (Price *et al*., 2020; Caiels *et al*., 2021; Price *et al*., 2023; Tew at al., 2019; Mahesh *et al*., 2024) including using numerical data (Ibrahim *et al*., 2014), and in ensuring the views of practitioners are not lost (Caiels *et al*., 2024). However, this position does not adequately reflect the volume and diversity of the extensive body of work captured over the last fifty years – or, indeed, acknowledge that there is no evidence that traditional deficit focused approached are effective (Saleebey, 2004).

I was interested in understanding the practice element which naturally led me towards a qualitative approach, emphasising words and actions, rather than numbers, in the collection and analysis of data (Bryman, 2016). This chapter sets out my epistemological position – that knowledge of strengths-based practice can be generated by getting close to practice, and my ontological approach: that practice is shaped through the day-to-day activities undertaken by social workers.

In this chapter I detail my rationale for the use of an ethnographic approach and how this was applied across my research and the practical aspects of my methodology.

Ontological and Epistemological Positioning

My overarching paradigm, the belief system (Guba and Lincoln, 1994) that shaped my research, was an interest in a practice perspective situated within a socially constructed ontology. In this I mean that the world of social work is understood and co-produced through engagement with participants and their social worlds. I acknowledge, per the literature review, that the breadth and complexity of what is encompassed by a strengths-based approach is challenging. Descriptions consist of lists of features and exclusions (Rapp *et al*., 2006; Saleebey *et al*., 2006; Greene and Lee, 2011; DHSC, 2019; Silovara *et al*., 2025) rather than definitions. Strengths-based approaches, like social reality, are not fixed but created and shaped within the contexts of statutory frameworks, organisational culture, and working environments. People with lived experience, their family and friend carers, social workers, and other professionals shape what adult social care is and how it is experienced. I was interested in how social workers practice in a strengths-based way, what influences this, how they navigate it, and, fundamentally, how it affects people's lives. The impact of managerialism and the political arguments around the role and decimation of adult social care is well debated (The King's Fund, 2025; Foster, 2025; Murphy *et al*., 2025; ADASS, 2025), and I was keen not to produce another study that simply replicated these. My interpretivist epistemology follows my ontology of constructionism. The knowledge generated from my data is co-produced, a product of how social workers construct their practice in the context of day-to-day practice. I was interested in how social workers interpret and enact strengths-based approaches in their day-to-day practice, and how these interpretations are shaped by their experiences, values, and the organisational contexts in which they work. This approach privileges qualitative, context-rich inquiry, recognising that understanding emerges through engagement with participants rather than through detached observation. In this knowledge is not simply reflected but created (Braun and Clarke, 2022).

In contrast to a positivist paradigm that assumes reality is objective and measurable, my study embraced complexity, nuance, and subjectivity. I sought to understand not just what social workers do, but how and why they do it — and how their actions are shaped by the interplay of personal, professional, and systemic factors. This philosophical positioning supports the use of ethnographic methods, which allow for deep immersion in practice settings and the co-construction of knowledge with participants.

Ethnography

I was interested in utilising a research method that mirrored the way that social work practice happened (Floersch *et al.*, 2014; Riemann, 2005; Tervo *et al.*, 2005; Shimei *et al.*, 2016), thus exposing a range of environmental factors that go beyond written narratives (Floresch, 2000) and identified as beneficial in understanding social work practice (Breimo, 2016). I read accounts of social work ethnographies (for example, Ferguson, 2014; 2016; Leigh, 2015; Matarese and Caswell, 2017; Cefai, 2015) and I developed a picture of how my research would look and feel.

This approach led me to ethnography, a term that describes both a methodological style and a research outcome or written product (Bryman, 2016). Ethnography is a way of studying the world as it is. For adult social care this takes place within the social constructs of managerialism (Matarese and Caswell, 2018; Gillingham and Humphreys, 2009; Harris, 1998; Harlow, 2003; Harlow *et al.*, 2013; The social work taskforce, 2009), austerity (The King's Fund, 2025; Foster, 2025; Murphy *et al.*, 2025; ADASS, 2025), increasing acuity (DHSC, 2021) and a risk-based society (Beck, 1992). Using these accepted constructs and environmental factors, the aim of this study was to generate context-dependent knowledge (Floersch *et al*., 2014). Ethnography has a strong synergy between reflective social work practice and ethnographic inquiry (De Montigny, 2018; Riemann, 2005; Tervo *et al*., 2005; Sheimei *et al*., 2016) although a key difference is the use of reflective practice to improve outcomes for individuals, whereas ethnographic research aims to use in-depth studies to consider wider practice applications (Shaw and Holland, 2014; Shaw, 2020).

There is no standard method for ethnography, and methodological descriptions can be as vague as a need to 'be there' (Engel and Schutt, 2017:263). Even narrowing the focus to consider ethnography in the field of social work there are significant variations in design in implementation that reflect the diverse nature of the field of work. Institutional ethnographies examine the structural elements of social work focusing on the interactions amongst, and between, social workers and other professionals in office or workplace settings. These studies look at what the social worker does within their day-to-day practice to highlight structural and organisational factors such as the institutionalisation of hospital environments (Burrows, 2020) and the impact of managerialism on social work tasks (Matarese and Caswell, 2018).

Social work ethnographies that focus more closely on the interaction between the social worker and the person they are working with rather than the organisational context in which the work takes place have been termed practice ethnographies (Ferguson, 2016). These studies tend to utilise more mobile methods such as walking tours with people to understand their experiences of marginalisation (Roy, 2016), travelling around with social workers as they undertake home visits (Ferguson, 2016), and accompanying outreach support teams as they engaged with homeless people on the streets of Paris (Cefai, 2015).

Both types of ethnographic approach offer useful contributions to the field; however, I wanted to undertake practice ethnography to understand the dynamic factors on a day-to-day basis that shape strengths-based practice.

My ethnography was grounded in a desire to explore individual approaches to practice; to examine the implementation of strengths-based approaches by considering the perspective of social workers and people who are in receipt of adult social work interventions (people with lived experience); to create a 'context-dependent knowledge' (Floersch *et al.*, 2014:4). I did not have an initial hypothesis but instead used an inductive approach to understand on a day-to-day basis whether, and how, social workers embedded strengths-based approach within their practice, and what this impact was on the person they were working with.

Whilst there is general agreement that ethnography involves long term data collection there is no consistency of opinion about what long term means (Hammersley, 2018). My data collection took place over an eighteen-month period. This is a more extended period than some other social work ethnographies (for example Ferguson (2018) and Burrows (2020)), and longer than I had planned, due to a range of factors including my own work commitments and the availability of participants. An advantage of this elongated data collection period was that it enabled a longevity element, particularly as a review of records took place at the end of the data collection period which allowed for triangulation between what was observed and what was recorded.

One of the key considerations for ethnography is the impact of the researcher within the environment. In my research the impact was expected, and proved to be, manageable within this professional workforce. Adult social services departments are accustomed to engaging with a plethora of professionals in their day-to-day work, so my presence was not unwelcome – however, my challenge was to keep to the observer role rather than segueing into participant observer, as the latter risked the integrity of the data.

Negotiating Access

I was fortunate to be able to identify a research site using my professional networks. The in-principle discussion was supported by the deputy director of the Council, ratified by the director, and honoured for the duration even when this leadership changed. The site was a local authority in England with statutory responsibility for adult social care. Access was granted to approach potential social work participants from all the operational, delivery, and safeguarding teams, providing a wider scope of potential service areas.

I had done a period of contracted work with the site in my non-academic capacity and was permitted to retain an honorary contract. This meant I had access to IT systems such as email and the social care management system, use of which was agreed through the Council's governance process and included within my research protocol (appendix three). This did have an impact on my identity within the field, and this is discussed further in the familiarity discussion.

The research site was situated in an area of England in which population demographics are not representative of England as a whole; white British people are overrepresented compared to the England average, and there is an above average ageing demography. The geography of the areas was predominantly rural rather than urban, and there were pockets both of deprivation and affluence. These features are reflected within my participants – noting that I did not actively collect demographic data. All but one social worker was white, two were male and four female. All lived experience participants were also white, although at least two were of non-British origin. The ages of lived experience participants ranged from early twenties up to participants in their nineties due to the wide variation of teams included within the overall scope of the study. It is recognised that this is not likely to be representative of the wider demographics of adult social care.

Ethical considerations

Undertaking a practice ethnography in this setting brought into sharp focus the difference between how ethical participation is framed within formal governance processes and how consent, capacity, and inclusion are negotiated in everyday social work practice. Because I embedded myself in routine activity and observing practice as it unfolded, inclusion of participants was fluid, shaped by who was present, involved, and affected in the moment.

Approval for research in an adult social care is legislated for in the Care Act (2014) and governed through the Health Research Authority with a requirement for a favourable decision (HRA, 2025) from the Research Ethics Committee (REC). The study received such a favourable decision from the REC and was signed off through the professional governance of the research site (Appendix four). Cardiff University governance was automatically granted alongside the REC decision.

This study raised several key ethical considerations beyond formal regulatory approval, reflecting both the complexity of conducting ethnographic research in adult social care and my dual roles a social care professional and as a researcher.

Most elements of the sign off process were unproblematic, however there were two areas in which further work was required; the management of people who may not have capacity to consent to participation, and the management of record information online.

Capacity Considerations

A key ethical aim was to enable the inclusion of people who might lose capacity over time, rather than excluding them automatically from the research process. However, engagement with the REC on this issue was challenging, with a strong sense of caution and nervousness surrounding the involvement of individuals lacking capacity. I was adamant that I did not want to exclude people who may lack the capacity to consent. A strengths-based approach by its very nature focuses on individuals’ capabilities and assets rather than deficits. This is arguably both more complex and more important for people who are unable to effectively articulate their own strengths, as they are reliant on others around them to enable them to live their most independent lives. Social workers routinely work with people for whom there are queries about capacity, and therefore it is essential that there is a focus on how the strengths of these people are promoted in social work practice and the outcomes that are achieved. The Mental Capacity Act Code of Practice (2020) provides guidance on balancing the benefits and burdens of inclusion of people who lack the capacity to consent to take part in research. For this research, the potential risk was that an individual may become emotional when describing their experiences, they may find understanding or retaining the discussions challenging, and that anonymised details about their lives may enter the public domain. The benefits of inclusion for this cohort of people were at population level in understanding how social workers practice with people who have this range of impairments. I followed guidance for research set out in sections 30-24 the Mental Capacity Act (2005). In practical terms this meant that if any of the participants were likely to lack the capacity to understand the research it was my role to undertake a capacity assessment if appropriate. The determination of capacity was based on the participants understanding of the relevant information about the research. There was only one person who did not have the capacity to consent. The social worker held discussions with the person, with the family, carers, and other interested parties regarding their involvement, and all the observations were of the multi-disciplinary meetings rather than directly with the individual. There were people with lived experience who did participate who were assessed as lacking capacity to make certain decisions, however I was confident through my interactions with them that they had the capacity to agree to take part in the research. I developed a detailed process for this which was set out and agreed as part of the research protocol. This experience reinforced the need for continual ethical reflexivity in the field and shaped my understanding of ethics as something lived and negotiated through relationships, as well as satisfied through prior approval and protocol (Dewing, 2008).

Safeguarding responsibilities, confidentiality, and data protection were crucial to my methodology particularly given the use of observational methods and access to social care records. The study design sought to minimise intrusion and potential harm while ensuring that participants were not excluded from contributing to knowledge that directly concerns them and this was at times challenging when attending meetings in which the person themselves was not present.

I had a clear statement within my research protocol regarding confidentiality and safeguarding responsibilities, and no issues arose with this during the research - however I did experience an ethical dilemma during data analysis when I came across something that made me uncomfortable. My research protocol covered ethical issues that arose at data collection stage but not after field work was completed, so I had no real opportunity to revisit this. I used my university supervision to discuss this and identified that there were evident safeguards built into to address this, and we agreed a plan around further anonymisation within my findings - however the feeling of discomfort remained, providing evidence of my familiarity problem (Greer, 1964).

Identifying Participants

The eligibility criteria for inclusion were adult social workers and people in receipt of adult social work interventions and/or carers (people with lived experience) within the Council's areas of responsibilities. All adult social workers working in the research sites were offered the opportunity to be involved. Social workers were recruited through a direct email via the Council distribution list, and a flyer.

Inclusion criteria:

- Social workers who worked for the Council's Adults services department
- Adults who may have care and support needs who:
    - Were over the age of 18 at the start of the research.
    - Had capacity to give informed consent to involvement in the research or had a willing consultee to support the inclusion.
    - Lived within the boundaries of the research site.
    - Lived in their own home or a care home.
    - Were currently known to a social worker or were waiting social care input.
- Friend and Family carers/unpaid advocates of people with care and support needs who lived within the boundaries of either of the Councils.

Exclusion criteria

My research protocol contained a specific sentence detailing exclusion of participants that exclusively undertook work in the part of the adult social care service that I had been contracted in, to reduce the issue of conflict of interest. Other exclusion criteria were:

- Participants that withdrew consent, objected to participating during the period of the study, became unwell, were experiencing a crisis that would make this inappropriate or harmful (noting that people in receipt of social work involvement may be experiencing significant difficulties in their lives).
- Participants who lacked the capacity to consent and for who there was no consultee available, or the consultee did not agree with inclusion.

Consent

Participant information leaflets and consent forms, designed to be appropriate for the cohort of people, were tailored for the following

- Participant information sheet social worker
- Consent form social work participant
- Participant information sheet person with lived experience
- Consent form person with lived experience
- Participant information sheet personal consultee
- Participant information sheet nominated consultee
- Consultee declaration form
- Participant information sheet general - for other people who may be part of the observation
- Participant Consent form general

An example of the information sheet and consent form proformas can be seen in appendices five and six respectively.

A letter detailing the study, information leaflet and consent checklist was provided to social workers who expressed an interest following informal discussions. All participants were given a minimum of twenty-four hours to consider if they wish to take part in the study and access was arranged based on the social worker availability. Volunteer social workers were asked to identify people from their caseloads, including family and friend carers where appropriate, who may be prepared to take part as participants. Social workers were given copies of the information leaflet and consent checklists. I gained consent directly from the lived-experience participants and recorded this on the consent forms. Other professionals were asked if they consented to involvement during the field work observations and offered information regarding the study.

Confidentiality

All data was anonymised. People with lived experience were provided with pseudonyms, to enable a personalised element of these participants reflecting their characters and strengths. Social workers were identified numerically (social worker one, two, etc.) and described using gender neutral language they/their rather than he/she. This was to aid anonymity for participants, particularly where colleagues may have been aware that they were taking part in the research.

I was conscious of the need to ensure that any safeguarding or ethical concerns that arose would not be compromised through the need for participant confidentiality. To address this my research protocol acknowledged the requirement for cultural sensitivity (Haight, *et al*

2013) in line with role of social work ethics on human rights (BASW, 2014). This did not arise as an issue.

Participants

My plan for research was for up to twenty-seven participants, with up to fifteen social workers and ten to twelve experts by experience. I planned to undertake data collection part time over an 8–12-week timescale. This was an arbitrary figure based on reviews of other similar studies (namely Ferguson, 2014; and Morriss, 2014) and adjusted to the parameters of my research scope. I reached out to identify social workers on five separate occasions over a twelve-month period. Several social workers initially expressed interest and then withdrew due to competing pressures. The final study involved field observations of six social workers and eight individuals with lived experience. Three family carers, and range of care providers, other social care staff, and health professionals were also present and consented to be part of the field observations. I conducted ten face-to-face observations in people's homes, one face-to-face visit outside of the persons home, fifteen days of office-based observations with social workers, and around thirty hours of virtual observations including MDT's, reflective discussions, and supervision observations. Additionally, I reviewed the case records and associated documents for seven people with lived experience. At this stage I had reached a point of data saturation within the confines of the scope of this research as a professional doctorate research project. Discussions with social workers and duty observations captured insights of practice in relation to an estimated twenty anonymised people with lived experience, in addition to the people identified through pseudonyms. Data was collected over eighteen months through practice observations, informal conversations, reflective sessions, and triangulation of social care records. Additional insights were gathered via a strengths-based survey (detailed below). This was completed by twenty-five practitioners, including social workers, occupational therapists, and managers. There is likely to have been an overlap between the respondents of the strengths-based survey and the social workers who were part of the field observations.

An outline of the participants can be seen in figure one.

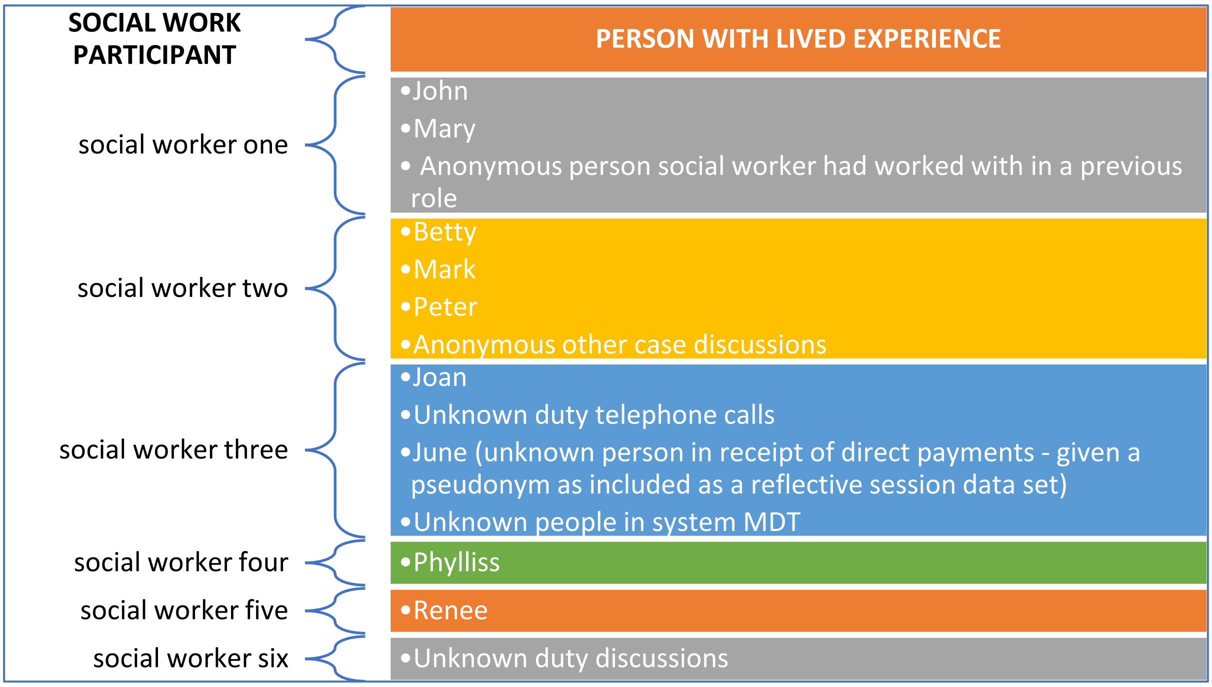


Figure 1: Relationship between social work participants and participants with lived experience

Data Collection

The study followed an ethnographic approach primarily focused on the social worker's interaction with the person with lived experience. The key to successful ethnography is the ability to adapt and be flexible (Hammersley and Atkinson, 2007), and the method of data collection and analysis evolved through the period of the study.

Participant observations

Social workers were observed in day-to-day aspects of practice and interaction; this was a mixture of office-based observations and out of office field observations. The social workers continued to undertake activities of work as usual and agreed which areas could be shadowed. Dates for field observations were prearranged, and often social workers deliberately timed visits and other out of office activities to coincide with these observations, agreeing my attendance with the individuals with lived experience in advance. Field observations included accompanying social workers on face-to-face visits, assessments, joining relevant Teams meetings, observing phone calls, discussions with managers and/or colleagues including the case discussion elements of supervision, reflective sessions, and one-to-one discussions. The wider scope of the approach was to capture as much authentic practice as possible.

Unlike institutional ethnographies (Longhofer *et al*., 2013) this was targeted participant observation in practice settings. Observations provided opportunities to explore what the social worker did, the way that the social worker approached interactions with the people they worked with, how they described these interactions, and the stance they took when talking about cases and talking to people with whom they are working. The observations enabled an understanding of how the social work involvement in an individual's life - and indeed me as the researcher - had an impact.

The plan was to follow this up with discussions through semi-structured interviews to generate knowledge on the impact that this may have through reflection. However, this was not needed as the social workers who took part in the study were comfortable with open reflective sessions. These were essentially conversations about the work that they were undertaking, the cases that were being observed and the factors that were affecting practice. These conversations developed organically and took place in the office, through catch ups on Teams, or whilst travelling to meetings in a true mobile methods style

(Ferguson, 2016; Cefai, 2015). In this way I generated co-produced data with the participants (Bryman, 2016).

Reviewing of records

The request to review records for the person with lived experience was explicitly highlighted as part of the consent process. I was aware that this access would provide significant value to my study. The similarities of social work practice and ethnography can be seen in the ways that social workers record data particularly for assessments (White, 1997). Use of records can offer significant benefit to contextualising ethnographic studies (Bryman, 2016) as the practitioner generates the data on which assessments are conducted (Morley, 2015). The aim of records is to present a factual and literal approach (Taylor and White, 2000). Specifically, use of records as tools for analysing multiple, differing accounts over periods of time is a key element of demonstrating professional judgements (Taylor and White, 2001).

I reviewed records retrospectively, at the end of the data collection period. One participant had subsequently died, so I did not review their information. As I had access to the system directly, I only reviewed records that were related to field work observations. Records included: a range of assessment documentation, copies of minutes for meetings that I had observed, case recordings, and copies of letters from other professionals that had been uploaded.

Interviews and surveys

The plan was to use semi-structured interviews with people with lived experience alongside participant observations to develop a narrative around the individual’s experience of social work. The structure of the interviews was co-produced with representatives from a local carers’ advocacy organisation to create a template and this was included in the t of the REC submission.

Semi-structured interviews were ultimately not pursued; however, I had intended to use these to reach out to people with lived experience of adult social care to ensure that their voices could be captured alongside practitioners. Unexpectedly, the field observations that took place in people’s homes, care homes and out and about in the community provided ample opportunities to hear the voice of the person with lived experience and understand how this was translated and shaped into written records. Participants had control over what they chose to disclose, and those who responded did so willingly, resulting in a diverse and meaningful dataset. Given the depth of insight already available within these responses, it was not methodologically necessary to extend the study to include semi-structured interviews. Therefore, the decision not to use interviews was not due to a lack of value in the method itself, but rather a pragmatic and ethical judgement based on participant burden, organisational context, and the adequacy of the qualitative data already obtained to meet the research aims.

The national framework for strengths-based practice (Baron & Stanley, 2019) was used to develop a baseline questionnaire in the form of a short electronic survey (appendix seven). This was reviewed by an external social work colleague with a solid understanding of strength-based working to review drafts of this survey prior to implementation and was agreed as part of the REC process. The plan was to use this survey to generate interest in taking part in the study, as well as using it reflectively to explore how the social worker understood their own practice in relation to the strengths-based approach. As a guide to the discussions a number of these questions asked participants to rate their views.

Twenty-five people completed the anonymous strengths-based survey. The survey consisted of twenty-four numbered questions. Six of these were open questions. Six questions asked for pictural star rating of one star to five star. Five questions contained a list of statements participants were asked to rate on a Likert-scale five-star rating scale of: agreement/disagreement (two questions), important/not important (two questions), always/never (one question). One question asked for statements to be ranked in order of importance to a strengths-based approach. The final six questions were free text and provided opportunities for participants to comment on the ratings and ranking questions. In total, 224 comments and around 8000 words of text were generated across the six free text questions. Whilst the intention of the survey had not been to generate a data set *per se*, but to engage, encourage participation, and provide a basis for discussion, it provided additional detail and rich context that enhanced the other data sources. I choose to code this data as part of the thematic analysis (Braun and Clarke, 2006; 2022). The inclusion of surveys and interviews often sits uncomfortably with a purist view of ethnography, as these are not true participant observations - although they are frequently used (Bryman, 2016). I am, per the arguments of Jerolmack and Khan (2014), conscious that survey data does not record actions in the way participant observations do, but I was interested in how the anonymised comments could be observed within practice. In using the data in this way, I was able to show the contrast, and the similarities, between what was said and what was observed. This provided additional context and richness regarding talk and actions, and particularly in identifying where comments on areas of practice were observable and interpretable within the field.

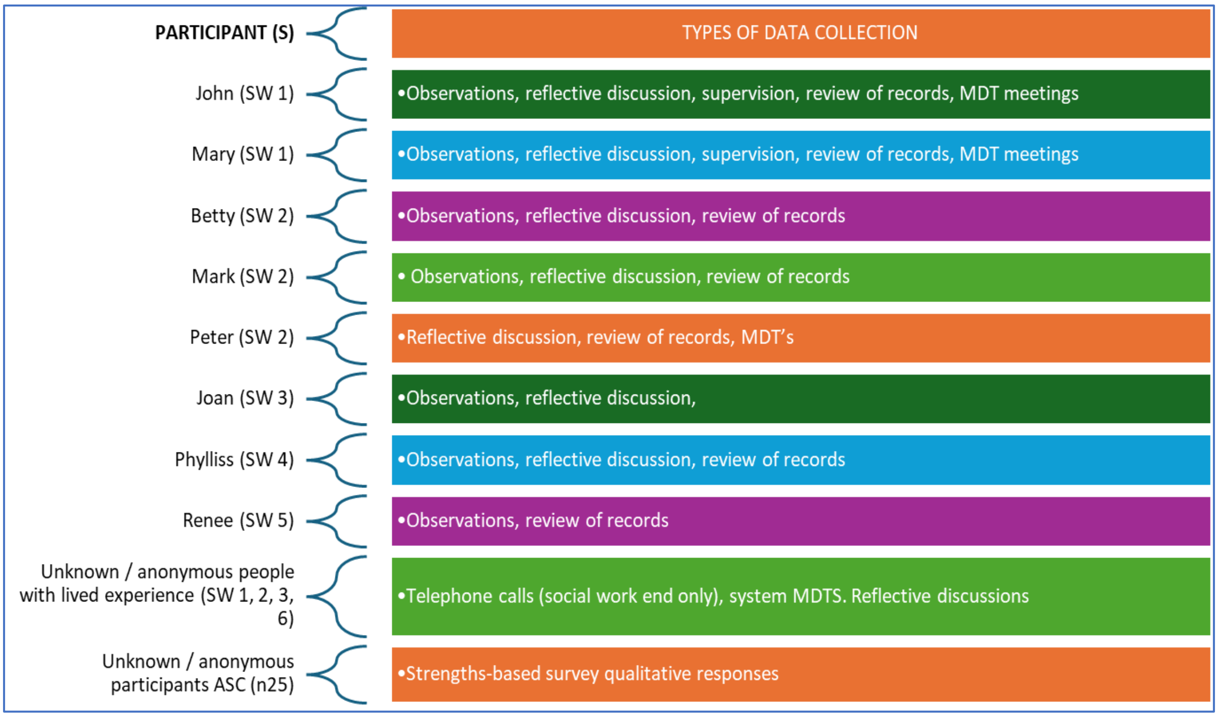
Recording of data

Field data was recorded through a mixture of note taking and audio recording and, where appropriate, recordings of video conferencing and phone calls. In the spirit of ethnography, I also kept a reflective diary, recognising that this could be equally as important as field notes (Delamont, 2106b) and enable me to challenge my own assumptions (Reeves *et al*., 2008; Morriss, 2016; Greer, 1964) and maintain distance. Recording mechanisms were agreed with all participants. I used my own sperate notes and audio recordings in these observations regardless of whether other attendees recorded them. Audio recordings were auto transcribed using Microsoft Word and edited manually.

A selection of case management documentation was downloaded from the Council system. In line with the information governance agreement, this was done using Council IT equipment and stored securely. No documents were printed. Information was transcribed for use to enable pseudonymisation of both the participants and the anonymisation of the host site.

Anonymised data was saved securely on the Cardiff University Research Data store and retained for the purposes of analysis and evidence of data collection.

A summary of the data collected by participants can be seen in figure two:



PARTICIPANT (S)	TYPES OF DATA COLLECTION
John (SW 1)	•Observations, reflective discussion, supervision, review of records, MDT meetings
Mary (SW 1)	•Observations, reflective discussion, supervision, review of records, MDT meetings
Betty (SW 2)	•Observations, reflective discussion, review of records
Mark (SW 2)	• Observations, reflective discussion, review of records
Peter (SW 2)	•Reflective discussion, review of records, MDT's
Joan (SW 3)	•Observations, reflective discussion,
Phylliss (SW 4)	•Observations, reflective discussion, review of records
Renee (SW 5)	•Observations, review of records
Unknown / anonymous people with lived experience (SW 1, 2, 3, 6)	•Telephone calls (social work end only), system MDTS. Reflective discussions
Unknown / anonymous participants ASC (n25)	•Strengths-based survey qualitative responses

Figure 2 Relationship between people with lived experience and types of data collection

Fighting familiarity

As mentioned previously I was aware on commencement of the research that the familiarity problem (Delamont *et al*, 2010) - that is achieving the balance between sufficient knowledge to understand and interpret the social context without presupposing existing views and biases within this, was inevitable. As someone with over thirty-years' experience across the breadth of the adult social care pathway, including insider knowledge of the Council, I was an insider researcher (Chavez, 2008). Familiarity was something I had to recognise, reconcile, and manage on a continuous basis.

The familiarity problem for me was multifaceted. Environmental familiarity (Delamont *et al.*, 2010) was a given - I had been working within the local authority, running the risk that I failed to see what is going on (Becker, 1971). My data collection was elongated and things changed within the Council during the period of my research so conversely, I was also exposed to unfamiliarity during this period. This could have, but luckily didn't, lead to cultural faux pas (Leigh *et al*., 2020).

I needed to build rapport with social workers, so they felt comfortable sharing their practice (Westlake, 2016; Shaw and Holland, 2014), but was also aware that the key to successful participant observations is to adopt a neutral stance and remain vigilant regarding the researcher's position and influence as part of the research process (Greer, 1964). Finding the balance on a continuum of professional distance (Green *et al*., 2007), a concept applied to practice, was equally relevant for my research - rapport needed to be sufficient to enable trust without compromising the integrity of the data.

One technique for fighting familiarity (Delamont, 2010) is to undertake studies in atypical settings; whilst not deliberate an atypical setting presented itself in this case. I commenced the research element of my professional doctorate in September 2020 during the covid-19 pandemic, and the rules and norms of undertaking research, and indeed practicing social work, had changed. Social workers were predominantly working from home. There were no longer an established office culture and the staple of social work practice – visiting people in their own homes, in hospital, day services or places of work - was no longer normal business. Face-to-face research was largely suspended by the university. I managed to identify a potential research site early on. It took two years to gain the approvals and commence data collection. At this point pandemic restrictions were over but the world of social work, as so much of the world, was irrevocably changed, many social workers had not returned to offices and significant amount of work was now online. My vision for data collection, a mobile methods approach (Cefai, 2015; Ferguson, 2014; 2016) was no longer the only reality. The nuances of moving from traditional social work ethnography to a blended ethnography involving both physical and virtual practice naturally provided an atypical setting. Observation within the digital space allows a level of anonymity that is not available in physical interactions, and therefore potentially reduces the impact of the researcher on the field (Cleland and McCloud, 2022), thus potentially helping with the process of blending in (Leigh *et al*., 2020). In the online observations, after initial introductions and consents, I kept my camera off and became a passive observer.

The atypical research environment was circumstantial. I also adopted the strategy of studying other ethnographies (Delamont, 2010) to tackle my familiarity challenges. I noted some researchers could identify both advantages and challenges of familiarity in a variety of settings (Mannay and Creaghan, 2016; Jones, 2004; Wollner *et al*., 2013). This included insider knowledge enabling insight into cultural expectations, and outsider perspectives key to identifying cultural blind spots (Haight *et al*., 2014. Additionally long-term field work created a new level of over familiarity (Hammersley and Atkinson, 2007; Delamont 2016a) although not overtly described as such (Mikkonnen *et al*, 2017). Other ethnographies, albeit reported in journal articles, either did not acknowledge the impact of the researcher's position (Matarese and Caswell, 2017), revealed the personal and political positions of the researcher alongside the research (Westoby *et al*., 2019), or clearly acknowledged the political positioning (Van Maanen, 1991; Greer, 1964).

Techniques for addressing familiarity in other ethnographies included novel data collection such as pictures (Ball, 2005; Robinson, 2016; Leigh, 2015), performance, and art to enable participant expression (Leigh, 2015; Leigh *et al*., 2021; Shimei, 206), and mobile methods (Cefai, 2015; Ferguson, 2016). I adopted the mobile methods within my study by accompanying social workers on visits, joining Teams meetings, attending supervisions, reviewing case notes, and spending time in social work offices. This enabled me to get a breadth and depth of the social workers' practice.

At data analysis stage collaboration, discussion, and revisiting data are reported to provide a lens that can improve objectivity (Greer, 1964; Stanhope *et al*., 2020; Rapport, 2010; Tadd *et al*., 2012). As a single researcher, rather than as part of a team, my route to collaborative challenge and discussion was primarily through my university supervision arrangements and I used these sessions to acknowledge and work through my professional familiarity. I also drew on anonymous discussions with friends and family about my research and position in it, checking and challenging my own assumptions. I revisited data coding and themes multiple times before settling on my areas of analysis.

Use of sociological theories such as Garfinkel (1967) have been used within qualitative research to reflexively challenge familiarity (Morriss, 2016). This is a technique I applied, drawing on the sociological theories of Goffman (1959; 1961; 1963), Bourdieu and Waquant (1992), and Garfinkel (1967) alongside other sociological theories of risk (Perske, 1972; Horlick-Jones, 2005; Horlick-Jones and Prades, 2009). I situated these in the context of the statutory adult social care frameworks and strengths-based lens to challenge my own preconceptions continuously drawing on reflexivity throughout my study.

Reflexivity

Reflexivity has been a key element of understanding and exploring both my epistemological position and my position within in the research process (Probst, 2015). In the context of familiarity (Delamont , 2010; Greer, 1964), and as an inside researcher (Chavez, 2008), I understand this as my awareness of my presence in the research, the effect that this may have (reflexivity), and what I can learn from this (reflection), recognising the symbiotic relationship between research and practice (Floersch *et al*., 2014; Riemann, 2005; Tervo *et al*., 2005; Shimei *et al*., 2016). I reject the positivist criticism of the Hawthorn effect – a phenomenon where people change the way they behave because they know they are being observed and concur with Smith and Coombs (2003) that developing strong social relationships, negotiating engagement, building trust, and establishing an equality of status enables a fuller understanding of the social constructs. The way that field observations were arranged was different for each of the social work participants, both in what was observed and in the time the participant was involved in the study. One social worker picked two people that they worked with, and all field observations related to those two people. Other social workers invited me to observe all their interactions during the prearranged field days, whilst yet others agreed to one off observations. All the social workers agreed to take part in reflective discussions.

I was aware that I needed to act reflexively to challenge my own tacit knowledge and understanding of the situation (D'Cruz *et al*., 2007). I adopted strategies such as maintaining a reflective diary (Braun and Clarke, 2006; 2022), adapting this into reflective pieces that I discussed during supervision and used as part of university progress review submission. I revisited data iteratively to surface and challenge my positions. My supervisors were particularly helpful in challenging my early drafts of findings, questioning whether my knowledge of practice was driving my findings or whether my data was producing the knowledge; at one stage I abandoned writing entirely and focused on revisiting my data.

Reflexivity was also part of the theoretical framework of my analysis; the interpretations of reflexivity were subtly different depending on which theorical lens was applied. I discuss this further within the analysis section.

Data analysis

The study used a qualitative approach to data collection, based on the six stages of thematic analysis adapted from Braun and Clarke (2016; 2022) although this process developed iteratively over time. Initially, I began coding the data using Nvivo (March 2020 release). However, I found that the software created too much distance between myself and the participants' words, limiting my ability to fully engage with the detail of the responses, and created issues with some of the written records that were completed proformas with repeating sections. I therefore returned to manual analysis, which enabled closer familiarisation with the dataset and a more immersive reading of the open-text responses.

Following supervisory feedback on an early findings chapter I revisited the dataset starting from scratch. This was important, as early attempts at coding had potentially been influenced too quickly by pre-existing theoretical ideas. I therefore re-read all responses several times to become fully familiar with the content, noting initial impressions and patterns ensuring deep familiarisation with the data (Braun and Clarke, 2016; 2022).

I then undertook line-by-line manual coding, highlighting key phrases and assigning descriptive codes to segments of text that appeared meaningful in relation to the research questions. These codes were reviewed and grouped into broader categories, allowing potential themes to emerge inductively from the data rather than being shaped by pre-determined labels. This reflected the stages of generating initial codes and searching for themes.

Once provisional themes had been identified, I reviewed them against the full dataset to ensure they accurately represented participants' accounts and refined them where necessary. This stage corresponded with reviewing, defining, and naming themes (Braun and Clark, 2016).

Finally, I integrated these themes into the discussion by linking them back to the research aims and drawing on sociological concepts, such as organisational context, professional roles, and resource constraints. I used the sociological theories of Bourdieu (1991), Bourdieu and Waquant (1992), Goffman (1959; 1961), and Garfinkel (1967) to make the familiar strange (Hammersley and Atkinson, 2019; Delamont, et al., 2010; 2016(a)(b); Mannay and Creaghan, 2016). This moved the analysis beyond description towards interpretation, demonstrating how the findings contributed to a broader sociological understanding of the issue under study while remaining firmly rooted in participants' accounts.

Although I did not undertake any coding during the data collection process one theme became apparent in advance of any analysis or need for coding and remained prominent through each iteration - the issue of mental capacity and its interaction with strengths-based practice. After consideration I chose to analyse these interactions as case studies, to better understand how social workers constructed these in action (see chapter 6). I identified a second prevalent theme of risk being a barrier to strengths-based practice during the coding of the survey comments. This became a more complete summary category focused on problematisation of risk (see chapter 5). The final theme was initially a broader theme, which I initially coded 'the realities of practicing social work'. This focused on the day-to-day interactional elements of the observation. This theme was distilled further to look at the differences between conversations, and subsequent recordings. This developed into a chapter on the difference between what is said and what is written (see chapter 4).

A collaborative approach to data analysis is seen as beneficial in qualitative research (Rapport, 2010; Tadd *et al*., 2012; Stanhope, 2012) but can be difficult to achieve, particularly when specific specialised skills are required (Jones, 2004). In this case, I was a sole researcher with limited opportunities for collaboration. I did utilise colleagues within my own networks to discuss anonymised findings. I also made use of my regular university supervision and progress reviews to discuss emerging themes as part of this process to ensure a level of check, challenge and collaboration, and to explore ideas and thoughts. My data analysis followed the principles of reflexive thematic analysis (Braun and Clarke, 2006; 2022), and the data was analysed using three lenses. Firstly, the theoretical premises of the strengths-based approach and the symbiosis with other studies. Secondly, compliance with the statutory frameworks of the Care Act (2014) and the Mental Capacity Act (2005) and associated case law and legal consideration. And thirdly, drawing on sociological theories. This use of 'multiple reflexive interpretation' (Alvesson and Sköldberg, 2000) provoked considerations of different interpretations of the data, interpretation, and theory.

Reflexive Thematic Analysis and the Use of Sociological Theories

In line with my social constructionist epistemology my analysis was actively generated. I assumed that social workers aimed to practice in a strengths-based way as they had volunteered to be participants on this basis, and therefore I was actively seeking to identify recognisable strengths-based traits. This represented my own position within the research. I drew on sociological theories to deepen my analytical lens. This allowed me to explore what was happening, using social constructionism (Kelly, 1955). I approached this from the fundamental principles of strengths-based practice, considering how framing (Saleebey, 2008:7; Garfinkel 1967) happened in relation to the construction of problematisation and its links to power dynamics and institutionalisation (Goffman, 1961). Each of the findings chapters focus on a slightly different sociological perspective (Bourdieu and Wacquant, 1992; Goffman, 1961; Garfinkel, 1967), but with overlaps. All of these were reflexive but with nuances about the contextual application of this reflexivity from each perspective. I adopted Bourdieu and Wacquant's (1992) concept of professional habitus - to consider the rebalancing of power dynamics through a strengths-based approach and pre-constructed objects - to explore the nature of how assessments were constructed, considering the data at a meta-level. Goffman's concepts (1959; 1961) provided insight into how a range of professional and other interactions follow performance patterns, helping to explain how social workers act in a variety of situations at individual and organisational levels. These concepts can also be linked to Bourdieu and Wacquant's (1992) notion of reflexivity, although Goffman did not use that term directly.

I drew on Garfinkel's (1967) ethnomethodological approach to consider the ways that social workers managed individual conversations and how the interactions that took place were constructed to achieve an outcome. This enabled me to consider reflexivity at an individual level.

Summary

My paradigm was that to understand strengths-based practice, I needed to understand how this was constructed in action by social workers. My research was grounded in a social constructionist ontology and an interpretivist epistemology. This practice ethnography combined in person and digital field observations, examination of written records, reflective conversations, and supplementary qualitative survey data, all collected over an eighteen-month period. This generated a substantial amount of context dependent data.

Ethical considerations were integral at all stages, particularly around informed consent, the inclusion of participants who lacked capacity, confidentiality, and the management of digital data. These challenges required careful negotiation with governance bodies, participants, and my own professional role.

Throughout the research, issues of familiarity, positionality, and reflexivity were central, and I actively engaged with these and challenged these throughout the study. I combined strengths-based theory and evidence alongside statutory frameworks and sociological theories to interrogate my data using reflexive thematic analysis (Braun and Clarke, 2006; 2022).

Overall, this methodological approach generated knowledge that is situated, relational, and theoretically informed. It provides original contributions to the literature through practice-based insights on delivery of strengths-based assessment under the Care Act (2014) and promoting strengths in situations of complexity and risk.

4. The difference between what is said and what is written

Write records in such a way that you would not mind clients reading them; and then invite clients to read them-even amend them. Perhaps recording has to be a mutual undertaking that gives another dimension of relationship and trust. It also makes records reflect family realities and not agency theories (Saleebey, 2008:10)

This chapter focuses on the way that conversations and interactions with people with lived experience are recorded, described, and ultimately written in the form of an assessment under the Care Act (2014) t (the assessment). The online document is used to record assessed need and eligibility under the legislative framework of the Care Act (2014). The analysis focuses on the differences between the conversations that social workers have with people, and the way that this is recorded. Analysis draws on Bourdieu's social theories on reflexivity (Bourdieu, 1991; Bourdieu and Waquant, 1992), its specific relevance and limitations for social work (Wolniak and Houston, 2023), and application to recording systems (White, 1997), as well as theoretical approaches of the strengths-based approach.

I consider assessments as preconstructed objects (Bourdieu and Waquant, 1992), in that they are proformas that must be completed in certain way. They are not neutral tools but instead embed institutional assumptions. These objects steer conversations towards deficit-based categories and professional judgements. The practice of undertaking an assessment, and the written products that are used within a professional habitus (Bourdieu, 1991; Bark, 2024), shape how social worker's practice. Together, these concepts explain the tension observed in my data between strengths-based intentions and deficit-based recording - whist practice interactions often highlight resilience, assets, and relationships, the structure of the assessment reinforces institutional logics that privilege needs and risks.

This analysis combines observations, reflective conversations, survey responses, and electronic records. It particularly focuses on the assessment document using both template and completed assessment information. Discussions with participants and survey data showed that social workers could identify a tension between practice and the assessment -a feature also observed by Caiels *et al*. (2024) and Symonds *et al*. (2020). Observational data highlighted a noticeable difference between strengths-based interactions and the bureaucratic processes used to determine need and eligibility.

The implication of these differences for fully embedding strengths-based practice and the role of language in identity are introduced, and then further analysed against the structure and the function of the preconstructed object itself in relation to the Care Act (2014) legislation under which it is legitimatised.

Conversations between social workers and people with lived experience of social work interventions

One social worker discussed their involvement with June in a reflective session. The social worker did not know June but was undertaking a planned review of her support plan. June had a direct payment, to support her care and support needs linked to her mental health. The original plan included significant support to encourage her to get up, washed and dressed, eat meals and develop a daily routine. June's mental health had improved significantly, and she no longer required the same level of support for personal care. June's personal assistant had requested a review on June's behalf and 'permission' for June to use her direct payment to support her to undertake social activities and engage in her community activities more fully. The social worker initially grappled with how to justify not reducing June's direct payments I followed this up with the social worker in a later reflective session:

> I asked [social worker] about the lady with the direct payments we had discussed a few months back. [social worker] recalled this. The PA has said that it would be better if she could keep the support. [social worker] [..] visited June, who had explained that she was feeling better [..] [was worried] [..] might start feeling unwell again. It was a direct payment and June had already talked to her PA about doing some different things now she was feeling better. [social worker] put all of this in the paperwork and senior management signed off on not reducing the direct payment. [social worker] was pleased. (field notes: SW3/June(1)).

The social worker initially wrestled with how to justify not reducing June's direct payments. However, they actively applied the wellbeing principle (2014:s1) and successfully argued that June remained eligible. In this instance the social worker embodies the principle that June is defined by her capacity and aspirations and can recover (Saleebey 2004; 2006). They provided a successful argument that June would continue to recover if supported appropriately, demonstrating a commitment to hope-inducing interventions (Rapp *et al.*, 2006), and the relationship between these and mental health recovery (Rapp and Gosha, 2006). Legislatively they are promoting wellbeing and prevention in line with Care Act duties (2014 S1).

In the context of significant financial pressures in adult social care (The King's Fund, 2025; Foster, 2025; Murphy *et al.*, 2025; ADASS, 2025) the social worker challenges cost-cutting pressures and empowers June to control her recovery. The focus is shifted from maintenance-based care to recovery, identified as improving outcomes for people with mental health (Xie, 2013; Flückiger *et al*., 2023), with control maximised through a goal-orientated approach (Rapp *et al*., 2006; Saleebey, 2004; 2006). The direct payment enabled June to direct how and where this support is provided.

Assessments as an intervention: the symbolic power of document driven meetings

Examples of strengths-based working were observable throughout the interactions between social workers and people with lived experience and reported in reflective discussions with social workers. In some instances, notable discrepancies existed between the conversations and written recordings. This was particularly prevalent in the completion of the electronic form used to capture statutory assessments of need and determine eligibility for Council arranged support under the Care Act (2014).

When discussing assessments in advance of observations social workers highlighted friction between this assessment form and strengths-based working. One social worker described how they had re-ordered the form and created their own template to capture the conversations:

> Because there's so many pages and even when I highlight stuff [...]I cannot find what page. Whereas while we are talking, I can do this, and I can maybe get it in or anything that I cannot get in [assessment] order. And they have their needs. And then if they start telling me something. They need to be able to do that without me saying can you just stop there because we are not on that subject. (Data Extract: reflection SW4(1))

The social worker is trying to make sense of the conflict between having a meaningful conversation with a person and filling in the assessment. The reordering of the form softens the impact of a form-driven process to try and maximise the opportunity for the person to have their voice heard. This approach allows the social worker to concentrate on the conversation, recognising the importance of listening as a strengths-based tool (Saleebey, 2006; Rapp and Goscha, 2006). Another social worker reflected on an upcoming assessment and noted that this was not naturally strengths-based, and more of a 'functional assessment'. They discussed the intention to adapt the questions to reflect this (Data Extract: reflection SW1(1)).

In these discussions the social workers are acknowledging that there is a tension between undertaking these assessments and strengths-based practice (Caiels *et al*., 2024; Symonds *et al*., 2020). The social workers are recognising that the assessment is ‘document driven’ (Matarese and Caswell, 2018:729). Assessments are instruments of symbolic power (Bourdieu, 1991; Bourdieu and Waquant, 1992) fitting Bourdieu and Wacquant’s (1992) definition of preconstructed objects as socially constructed institutional tools, rather than critically and reflexively constructed by the social worker and the person being assessed. The power is the local authority’s ability to grant or refuse access to services and the assessment is the conduit to this access. The process of undertaking assessment, and the assessment itself, is so embedded and normalised with the social workers’ routine that it is accepted that this is legitimate knowledge (Bourdieu and Waquant, 1992). It is acknowledged that part of the job is to complete the assessment but in describing their approach these social workers recognise that the assessment is not strengths-based. Within the strengths-based survey there were two references the Care Act (2014) having a negative impact on strengths-based practice, with one comment citing 'The Care act can be very disabling for clients' (survey comment 28) and another listing the Care Act as a 'barrier' to strengths-based working (survey comment 210), suggesting that these concerns are shared by other practitioners. In addition, there was a specific reference in the survey that recording requirements are deficit based:

> There has been a propensity that has been created for paperwork, and this focusses a lot on someone’s ability to not be able to do things and make decisions rather than what can be done or decisions made. (survey comment 86)

This respondent is identifying the challenge between 'paperwork' and strengths-based outcomes, highlighting a disconnect between the assessment task (the preconstructed object) to be undertaken and the way they practice. This is surfacing potential epistemic reflexive awareness (Bourdieu and Waquant, 1992) recognising that the document follows a particular agenda that is not strengths-based. This is not sufficiently interrogated to identify how this could be overcome by operating differently (White, 1997), but the social workers adaptation of the form is evidence that they are trying to negotiate and contest power structures (Taylor and White, 2000). This shows recognition of the challenges of being strengths-based when the requirement of the task is to create a set item of data that can be uniformly input into a system (Parton, 2008). This reflexivity is hampered by the accepted legitimacy of the approach as a statutory requirement of the Care Act (2014). The assessment accepted as the necessary ‘professional construct’ (White, 1997:248), and this acceptance inhibits the ability to further consider alternative ways of working.

Understanding the preconstructed object: the assessment form

The assessment document that social workers complete is embedded within the electronic case management system, used by 51% of English local authorities[2]. Understanding the structure and use of this document is important to explore how it influences practice. The form opens with attempts to capture strengths but then moves towards a deficit and eligibility focus. Field observations of an assessment as a specific intervention are that these

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[2] Information taken from Linkedin profile for relevant case management system (20/2/2025) and is not verified it is not referenced to protect anonymity – 51% of authorities may not be 51% of all the adult case management systems as the provide also provides contracting, finance, and children’s services systems.

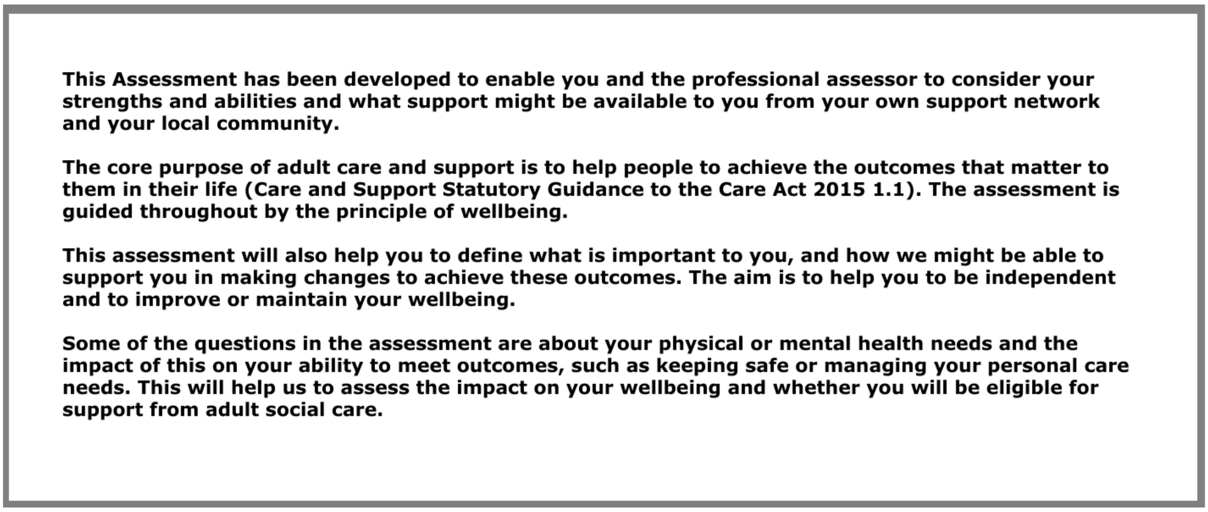
were ‘document driven’ meetings (Matarese and Caswell, 2018:729), and the features of the preconstructed object were observable despite social workers’ attempts to navigate these (White, 1997).

The first three pages of the form collect a range of demographic and contextual information as listed below:

- Personal demographic details including key identifiable numbers and accommodation details.
- Legal, advocacy, mental capacity, risks, involvement, decision making consent, data sharing details.
- Reason for assessment, priority level, and pausing of assessment.
- Information about visits (including when visits took place and who was involved).

These details have been summarised from Assessment CAF1(1)).

This information automatically populates from previous assessments, or contact records held in the electronic system. Within these first sections of the document is a box which describes the assessment as can be seen in figure three.



This Assessment has been developed to enable you and the professional assessor to consider your strengths and abilities and what support might be available to you from your own support network and your local community.

The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life (Care and Support Statutory Guidance to the Care Act 2015 1.1). The assessment is guided throughout by the principle of wellbeing.

This assessment will also help you to define what is important to you, and how we might be able to support you in making changes to achieve these outcomes. The aim is to help you to be independent and to improve or maintain your wellbeing.

Some of the questions in the assessment are about your physical or mental health needs and the impact of this on your ability to meet outcomes, such as keeping safe or managing your personal care needs. This will help us to assess the impact on your wellbeing and whether you will be eligible for support from adult social care.

Figure 3 Screenshot extract from an assessment – introductory text

This extract appears to reflect the six features of a strength-based approach as defined by Rapp *et al*. (2006) and discussed in the literature review. Support from network and your community (figure three) suggests a consideration of an environment rich in resources (Rapp *et al*., 2006). There is a symmetry between the reference to ‘outcomes' (figure three) and goals (Rapp *et al*., 2006), and the statement 'help you define what is important to you, and how we may support you to make the changes' (figure three) suggests explicit methods (Rapp *et al*., 2006) to attain the outcomes. This language would suggest that the assessment has a strengths-based focus.

Certain questions within the scope of the assessments were designed to facilitate personalisation and highlight individual strengths. This section of the assessment was 'about me' and included prompts of:

- My current situation
- What is important to me?
- The people that are important to me are:
- What would I like to change?

- Please tell us about yourself [….] social history…hobbies…interests [...] personal, practical, social, and cultural aspects […] who visits regularly […] what do you do with your time?

(summarised from assessment section about me– CAF1(2))

Discussions prompted and enabled the social workers to focus on strengths; as one social worker stated, 'I would like to get more information about you, who you are, what you can do for yourself, as well as what you cannot do' (Data extract field notes: SW1/Mary (1)).

This framing enabled Mary to talk about the things she enjoyed doing. This initial discussion can be seen in assessment in a section entitled 'important to me' (CAF1(2)). This was recorded on the form as:

> I would like to be able to return home to my house […] I would like to be able to see more of my friends and family. I would like in the longer term to be able to get out of bed more often and for longer periods of time. I would like to continue to be able to read and continue to enjoy literature and quizzes. I also feel it is important to me to get my bowels sorted out. (Data extract record: SW1/Mary (1))

In another person's assessment the 'important to me' description was shorter: 'living here, [daughter-in-law], my friends, and neighbours, and going out to the local club twice a week' (data extract record:SW4/Phyliss(1)). However, in the 'tell us about yourself' (CAF1(2)) section, the social worker expanded on this: 'Phyliss likes to watch the sheep in the field next to her garden [...] Phyliss's friend picks her up and takes her to the clubs' (data extract record:SW4/Phyliss(1)).

These extracts highlight the personalised strengths for the individual based on the concept that the individuals are expert in their own lives (Saleebey, 2006). The recordings corroborated transcripts and reflective notes of the observations. The openness of those questions of 'important to me' and 'tell us about yourself' (CAF1(2)) elicit a strengths-based conversation that would suggest reciprocity between strengths and areas of support need, suggesting the process is a 'systematic assessment of strengths' (Rapp *et al*., 2006), and a joint approach to solutions.

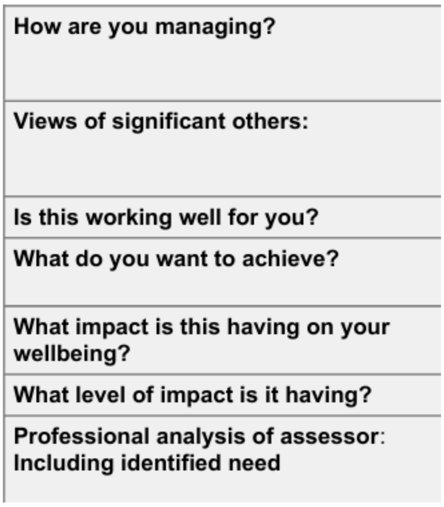
As the assessment progresses the questions are less open and more structured. The next section has a variety of questions structured under twelve areas:

- Keeping you safe- Risk to your wellbeing
- Physical health and wellbeing
- Mental health and wellbeing
- Communication
- Personal care: (washing and dressing, toileting, being appropriately clothed)
- Food and drink
- Financial details
- Property and home
- Relationships and social activities
- Continuing Health Care
- Outcomes and eligibility
- Summary of assessment

(summary from assessment CAF1(3)))

These questions are structured to identify a defined set of needs that can be directly mapped onto the eligibility and outcomes defined in the Care and Support (Eligibility Criteria) Regulations (2015). This step change in approach was observable within the interactions as can be seen as follows: ‘that’s great to hear, ok carrying on with the Assessment, food and nutrition what sort of food do you like to eat?' (data extract Field Notes: SW1/Mary (2)).

The social worker ensured the conversation progressed to cover the requirements for food and drink (CAF4(1)). However, in line with the earlier reflective discussion (Field Notes: SW1/Mary (1)) the question was adapted slightly to put Mary in control. The observation was now unmistakeably a preconstructed (Bourdieu and Waquant, 1992), ‘document driven’ meeting (Matarese and Caswell, 2018:729). The social worker guided Mary through the set of questions (CAF1(3)) - the requirements of the prescribed task (Lipsky, 1983). The social worker ensured the conversation covered the key areas of the assessment, breaking these down into measurable individual items (Parton, 2008) against which a rationale of evidence is required. These can be seen the extract below:



How are you managing?
Views of significant others:
Is this working well for you?
What do you want to achieve?
What impact is this having on your wellbeing?
What level of impact is it having?
Professional analysis of assessor: **Including identified need**

Figure 4: Screenshot extract from an assessment of prompts

These prompts apply to each of the areas of questions. They still appear to still be relatively strengths-based; the focus on 'you' indicates an assumption of ‘client as assessor’ (Greene and Lee, 2011), however for each of these elements the social worker must also clarify if this is stated or observed. Therefore, even though the language of the questioning is personalised the social worker retains a professional view and overall control in determination of the assessment.

For Mary, the worker recorded this in Mary's voice, for example under the question for food and drink 'how are you managing?' the extract reads:

> I like to have pasta…sandwiches and smaller items, my diet is limited due to […] my bowels…[I] like [..] steak [..] chicken […] I would like more pasta dishes […] I need Fortisips […] I can feed myself independently [...] there is no risk of me choking and I don't have any food allergies. (data extract Record:SW1/Mary(2))

This use of the first person indicates that these are Mary's responses which is the foundations of strengths-based working (Saleebey, 2006; Rapp and Goscha, 2006). The written narrative is consistent with what Mary said in the field observation. However, within the observation Mary also raised that in the care home she did not get control over her food and drink in the way that she would at home (data extract: field notes SW1/Mary (2)) This is not reflected in the assessment, as under the prompt 'is this working well for you?' (figure 4) the response is 'yes with support' (data extract: Record:SW1/Mary(3)). This indicates that the social worker's assessment is that needs for eating and drinking are being met, rather than reflecting Mary's view that this is not working well. This is followed up in the professional view of the assessor with a comment:

> Mary needs the support of carers with […] preparation […] capable of feeding herself […] needs support of carers [...] bringing food into the property should she […] return home. (data extract record:SW1/Mary (4))

The disregard of Mary's dissatisfaction with the way her current needs are being met shows prioritisation of compliance with the document and professional expertise (White *et al.*, 2009). The socially constructed picture of what is working well (Hall *et al.*, 2006) ignores

Mary’s expressed views about the control she would have at home, and as such is a false identification of strengths. The observations about Mary and her desire to return home are explored further in chapter six.

The privileging of the professional view of the assessor in the document does not fit comfortably with the strengths-based approach. It displaces the perception of the person as the independent expert. This tension could also be seen in other assessments; comparing conversations in field observations with the written narrative of the assessment form highlighted recognisable similarities in the early part of the assessment. After the initial opening questions, the voice of the person became less prominent and the language more professionalised, although the conversations were still open. For example, in the extract below when Renee is talking about her diagnosis:

> Social worker: so, you have never been married [...] have you always lived alone?
>
> Renee: Alone. Yeah. Yeah.
>
> Niece: You have had a good life, mind.
>
> Renee: Yeah. Until this bloody thing came on from me.
>
> Social worker: What's that?
>
> Renee: This thing [Pause] what they call it.
>
> [Pause]
>
> Niece: Dementia
>
> Renee: Aye. Dementia
>
> Social worker: Right. Right. So, you have got a diagnosis of dementia.
>
> Renee: That's the word. The first time out we found out there was a problem I was in a car and went the wrong way round a roundabout.
>
> Social worker: Ah, right, right.
>
> Renee: Luckily, I did not go into to anybody. Yeah, and that was the start. That is right, isn't it? [looks at niece and nephew]

> Nephew: As far as I know, you did not tell us that at the time. We found out [Pause] later.
>
> [Renee chuckles]
>
> Social Worker: How long ago was that, Renee?
>
> Renee: Well, again, you, [pause] you cannot. I do not.
>
> Neice: about four years ago. (data extract transcript: SW5/Renee (1))

In this conversation it is Renee that brings up her dementia diagnosis, demonstrating that she understands her condition and can exercise control by making the decision herself about giving up driving. The social worker takes a reflective yet passive role, letting the conversation between Renee and her family play out. This recognises the importance of that relationship in building the rapport (Saleebey 2006; Rapp and Goscha, 2006) whilst actively listening and allowing Renee to talk. This approach misses the potential opportunity to strengthen epistemic reflexivity by affirming Renee's emotional insight and resilience in addressing this directly, due to a need to move through the assessment documentation. However, Renee's engagement evidences her resilience and decision-making capacity, providing a strong platform from which to anchor strengths-based interventions that privilege autonomy and partnership.

During the observation, and with the support of Renee's family, the social worker was able to have a conversation that elicited more of Renee's strengths and capabilities. Key to this was Renee's relationship with her niece and nephew who she described as 'my world' (transcript: SW5/Renee (2)). There was discussion about Renee's personal qualities and her life, her engagement in social activities with her friends, her career as a businesswoman, and her involvement in theatre. Renee's humour was evident - she chuckled when she couldn't remember something and her family corrected her, demonstrating her strengths and resilience.

The written description of Renee differed significantly to this interaction. In answer to the question: 'Do you have any mental health problems that impact on your life and wellbeing….can you tell me more about that?' (extract from CAF1(3)). The social workers written narrative was:

> Renee was diagnosed with mixed dementia in 2018 significant decline in recent months [...] no longer able to carry out personal care task [...] no longer able to make drinks [...] Renee thinks she showers daily [...] she does not and no longer knows what to do but refuses support from carers. (data extract record:SW5/Renee(1))

The assessment then repeats each of the identified deficits in the relevant boxes on the form under the heading 'personal care’ (CAF1(3)) and ‘how are you managing' (figure 4) and is further embellished in 'professional view of assessor' (figure 4) which refers to an 'odour' (data extract record:SW5/Renee(2)) being present. In the written assessment the reality of Renee’s situation is not reflective of the assessment discussion but actively constructed (Hall *et al.*, 2006) through a labelling to fit the requirements of the assessment and create a narrative, which is prepopulated into the last section of the document. Unlike Mary’s assessment, Renee’s assessment was written in the third person. This is in part appropriate as she could not articulate all her needs and information is supplemented by the family, but it restricts opportunities for authentic narratives (Matarese and Caswell, 2018), losing the opportunity to demonstrate Renee’s strengths. This is consistent with the concepts of professional constructs that shape deficit-based accounts (White, 1997; Hall *et al.*, 2006), and due to the determination of capacity results in an under recording of personal strengths (Lonbay and Brandon, 2014).

In these recordings social workers are reinforcing unquestioned assumptions, a key aspect of a preconstructed object. Critically they are not recognising the institutional elements of the assessment in shaping valid knowledge. This lack of epistemic reflexivity (Bourdieu and Waquant, 1992), or simply an acceptance that this is the way to get services in place, leads to a picture of Renee that is deficit based. This is a divergence from the observed interactions within the assessment meeting, which was strengths-based, and covered: Renee's life, her relationships, and what was important to her. Renee was able to partly describe her needs with clarity from her family, whom she clearly trusted. There is an attempt to capture these strengths in the earlier, more open part of the document, where the strong family relationship is recognised in that 'Family are trying to keep her in the home for as long as possible [...] Family are important to Renee especially her Neice and Nephew in law' (data extract record:SW5/Renee(3)).

These strengths are lost when forced against the specific questions within the assessment. The need to identify deficits and provide a professional judgement creates a scholastic bias (Bourdieu and Waquant, 1992) that leads the social worker to erode the focus on strengths. Control over the process is with the social worker as assessor, rather than the client (Greene and Lee, 2011). The definition of needs is mandated by the assessment form and creates a negative picture within the written assessment, creating a disconnect between the way that social workers interacted with people and the way that assessments were recorded.

Renee's assessment occurred during a duty visit; the social worker arranged it by phone but had never previously met or spoken to Renee or her family in person. The voice of the person in the assessment appeared stronger when the social worker had a more established relationship with the person. When examining these assessments, it was not possible to triangulate back to a particular observed field work conversation, as the assessment is constructed based on ongoing interactions. For example, in one assessment under the heading 'who was involved and where did it take place' (summarised in CAF1(1)), the social worker recorded dates, times, and people present, with face-to-face meetings taking place on:

> meeting with Peter at [rehab unit / date] his support worker [...] OT also present [...] there has since been regular MDT meetings with [names/profession of five MDT members] since Peter has been having extended visits home [...] further assessed by [name] OT [...] detailed reports of visits [...] follow up visit to Peter 14th July [...] mental capacity assessment in relation to […] decision regarding where he should move to [...] Peter supported in the assessment by [Name, speech and language therapist] [...] please see separate mental capacity assessment. (data extract record:SW2/Peter(1))

This shows the assessment was part of a broader intervention and essential for securing support services, not just based on a single meeting. The more in-depth understanding enabled a more strengths-based approach for, and about, Peter, rather than a set of processes to be followed (Parton, 2008; White *et al*., 2009). The document reflected on Peter’s life and circumstances through the involvement of his wife, consideration of his children, independent advocacy, and other members of the multi-disciplinary team, as well as what Peter was communicating both verbally and non-verbally. The strength-based model (Saleebey, 2004; 2006; Rapp and Goscha, 2006) was embedded. The features of a goal orientated approach, explicit methods to attains these goals, systematic assessment of strengths, a consideration of an environment rich in resources, hope-inducing, and based on meaningful choices (Rapp *et al*., 2006) are clearly identifiable. This assessment, spanning thirty-seven pages, offered comprehensive narrative history and context (Taylor and White, 2000), and notably avoided certain preconstructed elements of the format (White *et al*., 2009; White, 1997). It was an account of the journey Peter had been on, including his life before his accident, a considered view both of what he would have been likely to want, and how he was currently presenting, the views of his family, and the work that family and professionals were doing to try and get him home. This assessment was a product of an on-going relationship between the social worker and the person supported, rather than a one-off conversation. The needs aligned well with the eligibility criteria; however the assessment drew out the needs that were associated with each of the questions as they related to Peter, and the focus on wellbeing was continuously embedded within the plans. The extract below shows how wellbeing is considered under the domain 'being able to make use of the home safely':

> Peter is happy, safe and settled [at his rehabilitation placement] but the plan will need to acknowledge the need for positive risk-taking and supporting his move home [...] likely to be the best option [to] allow him to resume a family life, and would support his independence, even though this may cause disruption to his emotional wellbeing and orientation in the short term. A phased transition will [...] allow him to go home. (data extract record:SW2/Peter(2))

In this assessment the social worker can successfully identify wellbeing outcomes, including his rights under article 8 of the Human Rights Act (1998), providing a much more strengths-based narrative. The intensive work that had gone on as part of an enhanced multi-disciplinary engagement (data extracts MDT:SW2/Peter(1); Case:SW2/Peter(1)) enabled the social worker to better navigate the assessment process, providing a more rounded picture. The assessment is appropriately written in third person. Peter did not describe his needs or outcomes - those were expressed through the voice of family, advocacy, and the multi-disciplinary team. Despite this, the assessments offer a strengths-based narrative reflecting the benefit of the relationship that the social worker had developed with Peter and his network of support.

A less strengths-based lens could have resulted in the view that Peter was unable to return home, and the alternative would be an intensive residential care placement away from his family. The language used when describing Peter was key to understanding the most appropriate way of supporting his independence.

Another example of relational social work is in John’s assessment. John’s desired outcomes are clearly stated as ‘To be able to have my care needs met. To be able to remain independent. To be able to get out of my flat more often' (data extract record:SW1/John(1)). Furthermore, under 'what I would like to change' the statement was ‘To be able to get out more. To be able to resume night support. To be able to continue to get the support I need to stay independent' (data extract record:SW1/John(2).

The social worker was extensively involved with John over an extended period and knew him well. John had care and support needs around his physical care needs, but like Renee there were challenges around his willingness to accept this. For John’s assessment the social worker was able to provide a better articulation of his voice than would have been possible on a single visit. This can be seen when examining extracts of the same assessment element from both forms (see table one).

Topic: Managing personal hygiene	John and social worker one (data extract record:SW1/John(3))	Renee and social worker six (data extract record:SW5/Renee(4))
What do you want to achieve?	I don’t want to be at risk of self-neglect I don’t want to be at risk of sepsis.	Renee is unable to attend to her personal care herself but has declined any support from carers

Table 1: Comparison of assessment information for John and Renee under the topic managing personal hygiene and prompt of what do you want to achieve?

The difference between the two interpretations of the question is based on the voice of the person within the assessment. The social worker, who had a relationship with John, has clearly had a conversation about the risks of not accepting support, and in writing this part of the assessment in the first-person John is identified through his personal narrative (White, 1997; Taylor and White, 2000). For Renee, the social worker assessment is based on a single interaction, which was focused on increasing support in response to a request. The narrative replaced what Renee wants to achieve with a professional judgement of declining personal care and essentially constructing (Hall *et al*., 2006) a problematised view. For John, there is evidence that the social worker has discussed his reluctance to accept personal care and constructed this in what John does not want, setting up the opportunity to negotiate with John. The professional view of the assessor is therefore written in the third person, indicating a difference between John's views and those of his social worker:

> John's resistance to personal care administration is considerable [there is] friction between him and the carers [and] risks his care package ending [and he is] at risk of self-neglect and infection. During the recent meeting John agreed to allow the carers to shower him twice a week moving forward and, in the morning, to have his back cleaned. (data extract record:SW1/John(4))

The distinctive styles adopted by the social worker differentiates between John's voice and the social work voice, showing that they are jointly constructing the narrative. Whilst the conversation referenced in the extract was not observed, another similar conversation was. The social worker's approach to John in field work observations and reflective supervisions was honest and pragmatic, as can be seen in the following extract in which the social worker talks through the issues with John and the care provider:

> **Social worker:** They all [care workers] could have to give notice. They [care provider] wouldn't be able to cover the calls. And the only other options are sort of direct

> payments and things where you manage the care yourself. You bring people in yourself, you know.
>
> **John**: Not a chance in Hell, no
>
> **Social worker** Because we commissioned [provider] and if [provider] hands the package back, and obviously they put the package out again…
>
> **John**: Red herring…I'm a bad lad, bad lad.
>
> **Care Provider**: Sometimes (laugh)
>
> **Social Worker**: Yet here now in when you're calm, you have insight. You know, I can talk to you now about the next parts of the of…
>
> **John**: To me, this having this conversation the crack as it were. It's... It's hitting home properly and it's... I can understand it better and properly. Because when I am short fused and the blue tip [...] blue touch paper goes up, everything goes out the window. If you if you have argued with you guys and then […] down the line…. I then realise damn that's dumb. (data extract transcript: SW1/John(1))

This observation takes place after the date on the assessment but is demonstrative of the open conversations that the social worker can have with John. During this exchange there is a frank conversation about the reality of losing his care provision and the other options. John's response of this 'hitting home' (data extract transcript: SW1/John(1)) is enabling him to reflect and recognise whilst he is calm (Rapp and Goscha, 2006) highlighting the importance of resilience, reflective conversations, and the quality of the relationship between the social worker and John (Brun and Rapp, 2001; Tse *et al*., 2021). This reflection enables the social worker to frame him as having 'insight' (data extract transcript: SW1/John(1)) when he is calm, acknowledging he can be in control and can manage the situation (Tew, 2011). John is clearly stating he does not want to lose his support, and this links back to the outcomes captured in 'important to me' (data extract record:SW1/John(1); record:SW1/John(2)).

There are similarities between the needs of both Renee and John, in that they both require support and are not always accepting of this, albeit for different reasons. John's social worker can provide a less deficit-based articulation; the outcomes stated are clearly John's, there is evidence of the work that the social worker has been doing with John around accepting personal care, and this triangulates with field observations and conversations. The assessment for Renee does not contain these nuances. There is a consideration of capacity in both instances; the assumption was that Renee did not understand that she was refusing care or the implications of this, but there was insufficient time or attention enabled to explore this. John is assumed to understand as the social worker discusses this with him, as can be seen in the previous extract. Specific discussions on assumptions of capacity and risks are considered further in subsequent chapters.

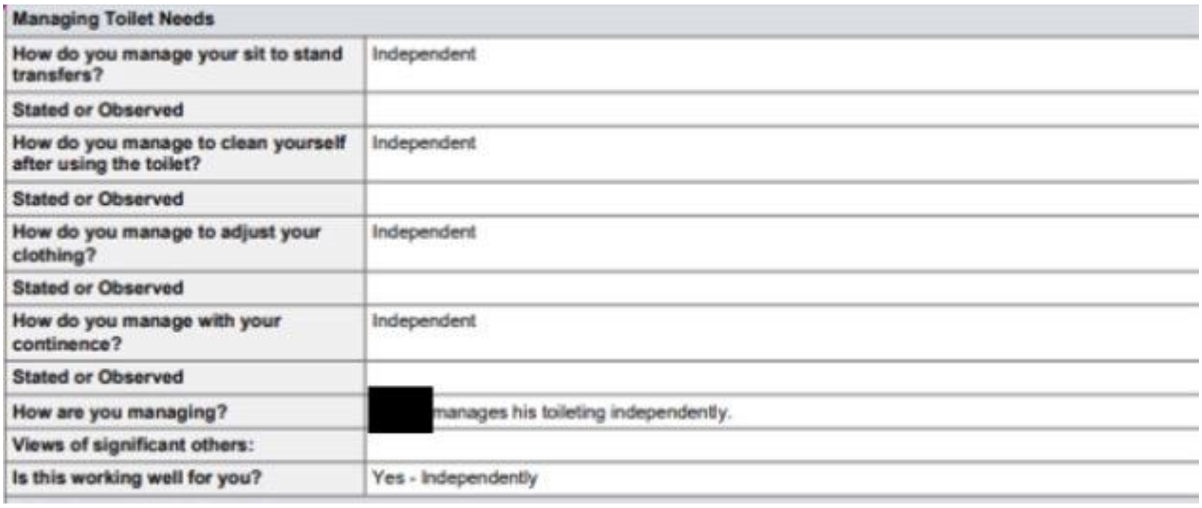
Although the narrative discussion for John is written in a more inclusive way, the challenge of the preconstructed object is that it still focuses on behavioural elements and risks, rather than relationships and opportunities. John's documentation lists eleven separate risks and related behaviours. However, during reflective sessions, the social worker acknowledged John's strengths and resilience and highlighted the difficulty in balancing these with risk management, stating 'John has lots of strengths. I am determined and will not give up on him' (data extra reflection:SW1(2)).

The construction of assessments produced through relational social work, such as John's and Peter's, are longer and contain more detail about the person, a product of the increased knowledge of the person and the outcomes that they wanted to achieve. This naturally enables a better reflection on strengths, albeit hampered by the deficit nature of the assessment structure. When considering strengths in these settings there are case notes on the system and minutes of meetings, as well as field observations that add context that enable a corroboration of the information presented.

A similar triangulation can be seen in Mark's assessment under the heading 'who was involved and where did it take place' (summarised in CAF1(1)). The social worker recorded:

> On 1st March 2023 […] Follow up meeting at Costa Coffee 31st March [...] On 27th April […] and on 7th June [social work student] also present […] I also attended a homeless appointment […] 22nd June […] there have been multi-agency meetings. (data extract record:SW2/Mark(1))

Marks assessment was a product of multiple different interactions rather than a one-off assessment. In Mark's assessment the 'about me' (CAF 1(2)) section was significantly longer than in any of the one-off assessments, running to almost three pages of detail describing his life. Naturally, this enabled more strengths to be explored. However, despite this the features of the preconstructed object (Bourdieu and Waquant, 1992) can still be observed. There are parts of the document that are irrelevant to Mark, but they are still completed see in figure five).



Managing Toilet Needs	
How do you manage your sit to stand transfers?	Independent
Stated or Observed	
How do you manage to clean yourself after using the toilet?	Independent
Stated or Observed	
How do you manage to adjust your clothing?	Independent
Stated or Observed	
How do you manage with your continence?	Independent
Stated or Observed	
How are you managing?	[redacted] manages his toileting independently.
Views of significant others:	
Is this working well for you?	Yes - Independently

Figure 5: Redacted screenshot from Mark's assessment

These sections of this form are not applicable to Mark but cannot be excluded. Minimal attention is paid to the 'descriptive demands' (White *et al*., 2009), contrasting with the significant detail in the other more relevant sections of the assessment. The social worker is delivering the 'input/output' (Parton 2008:263) to complete a transaction that does not meaningfully relate to Marks' needs (Payne, 2014). These questions are a mandatory part of the preconstructed object, and link to the eligibility domain of managing personal care (Care and Support (Eligibility Criteria) Regulations (2015)). This is irrelevant for Mark whose needs do not relate to personal care, and the social worker knows this so pays perfunctory attention to the irrelevant questions and thus does not engage with the problematisation phenomenon (Saleebey, 2006). The social worker was reflexively managing and mediating the constraints of the preconstructed object (Taylor and White, 2000).

Wellbeing principle in the context of the preconstructed object

The term wellbeing is continually referenced within the assessment template both as specific questions and as prompts to consider impact on wellbeing. This was observable in the assessments, however there was significant variations in interpretation.

In one example the social worker linked directly back to wellbeing principles as they are set out with the Care Act (2014:s1) as 'Phyliss [sic] inability to independently access the community significantly impacts upon her personal dignity, personal control, safety, physical mental and emotional wellbeing' (data extract record:SW4/Phyliss(2)).

However, this assessment does not resonate with the conversation that took place between the social worker and Phyliss describes in which she describes going to club:

> **Social worker**: And that is one a week, is it?
> **Phyliss**: Yes, every Tuesday.
> **Social worker**: And how do you get there?
> **Phyliss:** A friend takes us. (data extract transcript: SW4/Phyliss (1))

Phyliss also talked about her friends taking her out shopping and other friends coming to visit, suggesting she could access the community and there was not a significant impact on her wellbeing. The social worker was recognising that without support of friends Phyliss would be unlikely to manage these tasks independently, but Phyliss did not define this. Moreover, the social worker used almost identical language when describing Phyliss's wellbeing in relation to other areas of the form - for example in 'ability to manage home independently' (CAF1(3)) the assessment states:

> Phyliss's inability to maintain her home independently significantly impacts upon her personal dignity, personal control, safety, physical mental, and emotional wellbeing and leaves her susceptible to self-neglect. (data extract record:SW4/Phyliss(3))

The social worker purposefully uses the Care Act (2014:s1) definition of wellbeing domains to ensure that Phyliss meets the eligibility threshold (2015:s 2(c)). These generalised wellbeing outcomes are not defined by Phyliss, and therefore they read as repetitive, particularly as they are pre-populated from the assessment into the eligibility section. The social worker is not arguing for increased services, so this repetition is likely to be arising from habit and a performative need, rather than risk aversion, but it does reinforce the concept of the symbolic power of the form.

Another social worker interpreted the questions on wellbeing as a feeling and combined this with a description of the associated need as 'Betty is happy where she is, although she needs support with accessing the community by public transport as she would get confused' (data extract record:SW2/Betty(1)).

This approach did not reference the Care Act descriptors of wellbeing (2014: S1), but the description of 'happy' does map to the outcome of emotional wellbeing. For Betty, this description provides context that relates back to the assessment observation, in which Betty's son described how she was supported to visit her family by train, with assistance from family and friends to get on and off the train, and support from the train company whilst she was travelling (data extract field notes: SW2/Betty(1)). Additionally, in Betty's assessment, unlike Phyliss's, Betty was clear within the observed assessment that she was happy where she was. The social worker adopts a similar approach across each of the wellbeing questions, describing how Betty feels and what her needs are in relation to the specified question. In this respect it is less repetitive, so appears more personalised.

Another approach taken by a social worker was to simply state that the impact on wellbeing would be significant without support, linking wellbeing to the impact of unmet needs. The three statements in the example below illustrate this:

> Significant if I don't have the support I currently have or need moving forwards […] I would not be able to manage this element of my care myself […] If I did not have support it could be an issue as I would not be able to prepare food and drink for myself due to my lack of mobility and ability to be able to hold utensils properly. (three data extracts record:SW1/Mary(5))

In this the social worker does not attempt to link back to Care Act (2014:s1) wellbeing outcomes *per se*e, or to what Mary has said directly, but makes the connection to the assumption of support needed. The assumption is that this support will meet the wellbeing outcomes of physical health and personal dignity (Care Act, 2014:S1). A similar approach is taken by Renee's social worker who in the specific question on physical and mental wellbeing states that 'Concerns that due to cognitive decline Renee's wellbeing is being impacted on due to her reliance on others' (data extract record:SW5/Renee(5)). This is then reiterated under each of the relevant questions in which there is significant impact on wellbeing due to 'cognitive impairment [...] double incontinence [...and not] engaging with care staff' (data extract record:SW5/Renee(6)), leading to 'unintentional self-neglect' (data extract record:SW5/Renee(7)).

In these examples each of the social workers have interpreted both the principles of wellbeing, and the impact of this, differently - and most importantly in each case this is the social worker's judgement, not the person with lived experience, expressing the wellbeing impact. The assessment is prescriptive - the meaning of impact on wellbeing is open to interpretation, but the way that it is recorded with the assessment is pre-defined. The divergence between the field work interactions, the written documentation, and the variation between interpretation of wellbeing suggest a disconnect between the way social workers interact with people and the construction of the written assessment. The interactions are generally strengths-based and the language is inherently deficit based. The extracts considered suggest that the assessment of the impact on wellbeing is constructed to meet the requirement of the form (a feature of preconstructed object), but the variance between the approaches of the different social workers in how they categorise wellbeing impacts suggests there is not a shared understanding of this. The wellbeing principle is clearly defined in the Care Act (2014:S1) but not consistently applied in this way in the assessment. In this context wellbeing, which should be a strengths-based tool, is reinforcing scholastic bias (Bourdieu and Waquant, 1992) – it is being used to demonstrate eligibility and secure services, rather than empower the person to explore their own outcomes.

This may explain in part the disconnect described by the social workers in the reflective discussions in advance of both Phyliss and Mary's assessments, and the comments made in the strengths-based survey. The result of poorly defined wellbeing outcomes is an over emphasis of deficits for Renee, a reinforcement of need for Mary, and a general repetition of a standardised set of wellbeing principles for Phyliss. The example that most authentically resembled the field observation was Betty's, and that is likely because this interpretation is a response to how Betty described her life within the observed assessment visit.

Pre-population of information and the replication of deficit language

The analysis to this point has highlighted that the assessment documentation which proclaims to be strengths-based focussed (CAF(1)) creates an environment for deficits. This was better managed where there was a relationship between the social worker and the person with lived-experience, but there was a common challenge of presenting strengths with the preconstructed object. The language used to describe people was not routinely strengths-based, and often focused on problematisation (Saleebey, 2004).

This deficit language is not just a one-off phrase in an assessment. The auto population function replicates this throughout the entirety of the person's case records, as I will detail in the next examples. The electronic system is specifically designed to reduce unnecessary administration; it automatically populates demographic and contextual needs, any previous assessments, and certain items and questions into the assessment – and, therefore, into the resulting support plan. The social worker can choose to change this information if required, however with the assessments reviewed this did not happen. There is significant learning here, particularly as Councils move into use of generative artificial intelligence to support practice. Auto-population is an electronic solution to multiple recommendations on reducing bureaucracy and improving social work practice (e.g. Harlow, 2003; Harlow *et al*., 2012; Harris, 2008; Munro, 2011; Social Work Taskforce, 2009). The system supplier claims that these features reduce social worker administration time, with case studies claiming time savings of between 22% and 46% for social workers[3], although this may be linked to a wider range of recording activity and not limited specifically to assessment completions.

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[3] Information taken from the website for the case management system used by host authority, not referenced to protect anonymity for host organisation.

During field work observations it was apparent social workers valued previously gathered information when undertaking assessment. One social worker described how they proactively used this information as part of their preparation before undertaking an assessment visit to make sure they had a good picture:

> I really need to know that at the beginning. Because if they really could not engage because of the hearing and I would have to stop it [the assessment] and we do have a piece of equipment in there [...] which I have had some really good results with. (data extract reflection: SW4(2))

Whilst another social worker referred to a lack of previous history in conversation, stating 'There is not a lot on the system about what you like and how you feel' (data extract field notes: SW1/Mary (3)).

In the first extract the social worker is using the information to prepare and ensure that they can engage the person fully, whereas in the second it is used to introduce the 'about me' question (CAF1(2)). There are clearly benefits to having this previous information. Conversely, the auto-population caused an enhanced focus on deficits for Renee's assessment, as there is a reference to an 'odour' being present and this phrase is repeated three times in the document (data extract record:SW5/Renee(2)). This included in the outcomes and eligibility (CAF1(2)) section, which pre-populate the support plan, although the support plan was not reviewed so the language may have been altered by the social worker at this stage. Each assessment contributed significantly to identifying the care and support needs and highlighted the importance of professional judgement, particularly regarding its representation. Terms like risk of ‘self-neglect' (data extract record:SW5/Renee(7)data extract record:SW1/John(3)(4)) and repeated listings of health

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conditions were noted in multiple assessments. The automatic transfer of eligibility criteria from the assessment to its conclusion, and then into the support plan, streamlines administrative tasks for social workers; however, this process also places greater emphasis on areas of need. This structure may influence how information about a person is documented and utilised in subsequent assessments and interventions.

The importance of assessment from a strengths-based perspective is that it is not simply a functional task, but the telling of a story in a way that supports an authentic narrative and description of strengths and possibilities (Rapp *et al*., 2006). White (1997) summarises the three elements of a rigorous and useful assessment; be reliable and valid including measures of frequency where possible, be understandable to the person, and/or their family or friend carers (in White's examples parents), and accept that it is not always possible to ascertain simple cause and effect within human and social interactions moving away from a 'mechanistic technique' (White, 1997:751).

The challenge is whether social workers can demonstrate these facets without using language or labels that create negative connotations. They must actively ensure that negative language does not impact on how a person is viewed by people reviewing future information. This is important, since it is widely accepted that social constructs of language can create negative connotations (see, for example, Foreman's (2005) explanation of the use of language in relation to disability). Labels that have legitimacy at a certain time and place can, in retrospect, cause 'shock and horror' (Duffy 2017:271). The Gloriously Ordinary Lives campaign suggests five tests for which all care and support interactions should be considered through. The second of these tests is language. It includes both jargonistic language (much of which can be seen in the eligibility domains) but also cites ‘dehumanising’ language with examples such as ‘complex case’ and ‘non-compliant’ (Gloriously Ordinary Lives; 2025:test two). Similar language could be seen in both Renee’s and John’s assessments. Where the language of recording is negative, the approach cannot be truly strengths-based. The challenges to strengths-based practice are whether a person would recognise or be comfortable reading that statement about themselves. Saleebey (1992) cautions that labels should only be used when necessary, based on a full consideration of how and why they are determined, and considering the impact that these have on people’s sense of self and identity. For Renee, she knew she was living with dementia, she was accepting of it and choose to use this language herself - but the label of 'cognitive decline' was not how Renee described herself. Saleebey (2006) points out that the label is how outsiders, in this case the social workers, view the person. These labels then become a permanently perpetuating feature of a case management system that impacts not just on the immediate view of the person, but on future views a social workers may form about a person.

Analysis and discussion: Challenging the preconstructed object

Throughout this analysis I have referred to the assessment in sociological terms as a preconstructed object (Bourdieu and Waquant, 1992). This form delivers the Council’s duty to assess need and determine eligibility under the Care Act (2014), in line with the legislative framework for England. Social workers recognised the tension in this role but accepted this in their roles as street level bureaucrats (Lipksy, 1980).

The way language is used in the assessments does not adequately reflect the social worker’s practice. In all four field observations of Assessments the voice of the person and families was listened to, time was taken to listen to the person’s story, and the outcomes and options discussed. When social workers had a more established relationship the assessment documentation better demonstrated strengths. If the job of the social worker is to ensure that the person’s voice is heard (James *et al*., 2019) the challenge is that the assessment is anti-emancipatory, compelling the social worker to ignore reflexivity and distilling the knowledge generated through these interactions into a set of predefined domains. It could be argued that this is a means to an end - a necessary part of an inherently managerialist structure.

The examination of the assessment itself formed part of the data analysis, and in doing so each section of the assessment was subjected to significant scrutiny. It was during this analysis that something interesting emerged; in the preconstructed object (the assessment) lies the legitimate knowledge (Bourdieu and Waquant, 1992), and therefore the unquestioned assumption is that the eligibility domains are the needs. However, there is no standardised definition of need. It should be the individual, with support of others including an assessor, who identifies what the needs are, and the local authority who assesses the impact of this need. Eligibility must only be determined after the assessment is completed (Care and Support Statutory Guidance, 2025). However, the assessment structure sets out the eligibility as if this is the complete list of needs a social work must consider. Furthermore, it is the social worker who defines wellbeing; hence it is not an authentic assessment of strengths. This highlights something significant in **that the assessment, the preconstructed object designed to assess needs, is not compliant with the statutory framework it is designed to implement.**

The Care Act (2014) sets out a duty to assess need in sections 9 and 10, with a requirement to determine eligibility at section 13. Local authorities may use an 'assessment tool' (Care and Support Statutory Guidance, 2025:6.43), yet the statutory guidance also makes clear that the identification of eligibility takes place after the assessment of needs, whereas the assessment used by social workers combines these throughout the form and summarises at the end to determine eligibility - making the eligibility domains *de facto* needs.

However, if the individual does not define their own needs and outcomes then, by definition, it cannot be 'client led' (Greene and Lee, 2011). If needs are defined by eligibility, then they are not naturally goal orientated, or solution-focused. If the purpose is to highlight deficits, then there will never be systematic assessments of strengths, and if wellbeing is not understood and defined then it will never be hope-inducing or based on meaningful choices. In short, the only one of the six features of a strengths-based approach (as defined by Rapp *et al.*, 2006) present within the assessment structure is an environment which is rich in resources. This supports the findings in the literature review that the English implementation of a strengths-based approach is concentrated primarily on community and personal assets.

This approach to assessing needs worked for Peter, who was unable to articulate his own needs - but in other assessments a greater focus on the person identifying the needs would have elicited a more strengths-based approach and felt less forced. Examples include Phyliss, whose wellbeing was not at risk because she had good informal support to help her maintain relationships, and Mark, for whom several aspects of the assessment were completely irrelevant as his needs were not related to personal care. As for Renee, had there not been such a focus on deficits within the template, the resilience she demonstrated during the observation could have been reflected and led to a different and less restrictive service outcome. A more flexible approach to identifying needs by linking these to wellbeing and then applying eligibility, would orient the assessment away from a deficit-led judgement towards a more holistic understanding of the person. Wellbeing, as defined within the Care Act (2014), requires practitioners to consider areas such as personal dignity, control over day-to-day life, participation in work or community, and relationships. This wider framing encourages social workers to explore what matters to the person and what they can do, rather than concentrating solely on limitations or risks. In this way, the concept of wellbeing provides space for a strengths-based conversation, where existing capabilities, informal supports, and personal resources are recognised alongside identified needs.

The findings indicated that when practitioners focused heavily on eligibility criteria, there was less opportunity for this broader discussion, and assessment could become procedural and form-led. By contrast, when needs were discussed in relation to wellbeing and outcomes, there was greater scope for reflective, strengths-based practice. This shifts the emphasis from determining service entitlement to understanding how individuals can maintain or improve their quality of life using a range of personal, social, and community resources. This would elicit a more strengths-based approach as well as being more compliant statutorily.

Summary

This chapter has focused on the way social workers interact with people and the way this is translated on onto an assessment document. The data highlighted multiple examples of social workers' skills in promoting strengths within both their observed interactions and reflective discussions about their work. Analysis of the electronic assessment, however, highlighted a tension for social workers between identifying eligibility and promoting strengths, described by Bark (2024) as a professional habitus. The impact of the preconstructed object is that the person’s strengths can be diluted through socially constructed, deficit-based language (Hall *et al*., 2006), and the impact of this is exacerbated by automatic population of forms that replicates this language and shapes future interactions. The data showed that social workers can better manage the preconstructed object reflexively in situations where the assessment is not a one-off intervention and there is a relationship between the social worker and the person. However, even in these circumstances, the ability to navigate the preconstructed object varied.

The data also suggested that despite the structured nature of the form, the application of the wellbeing principle was inconsistent. The eligibility criteria were utilised as a description of needs, undermining the ability of ‘client as assessor’ (Greene and Lee, 2011), a key feature of strengths-based assessments. This approach conflates the duty to assess and the application of eligibility which is not in line with the statutory requirements of the Care Act (2014). The implications of these finding are considered further in chapter seven.

5. When the ‘problem’ is risk

> Many writers of an apparent strengths persuasion […] have made abundantly clear that they believe that people have problems. But the problem is - what do you do with problems? What is it about problems that we must address? After the problem, what then? Those are serious questions […] listen for hints and murmurs of strengths. If I had my druthers, the balance […] would be clearly tipped in the direction of the discovery, promotion, and honoring of strengths and consorting with the possible
>
> (Saleebey 2004:590)

This chapter focuses on the specific concept of risk and its place within strengths-based practice. The previous chapter highlights instances of problematisation in constructing assessments. Risk was a prominent concept within the strengths-based survey responses, as well as being observable within observations, conversations, and written records. The data highlighted a complex and nuanced relationship between promoting strengths and perceptions of risk. The concept of the ‘problematisation’ (Rapp *et al.*, 2001; Saleebey, 2006) of risk – that is, the framing of a person in deficit terms rather than focusing on innate strengths and resilience, was prevalent through survey comments. Overall, both survey and observed data demonstrated that social workers understood ‘dignity of risk’ (Perske, 1972) - the concept that to keep a person safe and avoid risk can reduce opportunity for autonomy and growth and be a negative intervention. The data also highlighted the importance of risk dignity in rights-based practice (Mitchell and Kumara, 2009). There were interesting nuances between the survey data and the field observations. The survey data attributed problems with risk aversion to external factors such as relationships with partners in care, and organisational factors. Field observations demonstrated how social workers navigated risk in action. Taken together these demonstrate the recognised tensions in qualitative data collection - what how people say they will act is often different to what happens (Jerolmack and Khan, 2014).

The data is considered through the lenses of strengths-based approaches and risk theory, with considerations of the different problems identified in the survey data. It draws specifically on Goffman’s (1959) dramaturgical framework - the concept that people in social situations, in this case social workers, are actors using techniques of role distancing to mark differences between their own positions and the social positions that they occupy (Goffman, 1961). This impacts on power dynamics (Goffman, 1963; Goffman and Helmreich, 2007) in the context of partners in care as 'circuits of agents' (Goffman 1961:135) around the person.

Positive risk taking as an approach

Within the survey comments the data suggested that respondents recognised positive risk taking as a key element of the strength-based approach, with specific comments such as ‘People should be allowed to live their lives… everyone should be given the opportunity to have their say' (survey comment 114), and '[social work] role regarding advocating for customer [sic] rights and autonomy support positive risk taking' (survey comment 120).

In both these comments the respondents are linking positive risk taking with rights-based practice (BASW, 2021) and the ability for people to self-determine their own outcomes, however they have a slightly different focus. The first comment reinforces the concept that people know themselves and are inherently strong (Saleebey, 1996; 2000; 2001; 2004; 2006), ensuring that the persons voice is heard in relation to this. This recognises the ‘dignity of risk' (Perske, 1972). The second comment also promotes risk dignity but recognises the social worker's role in honouring self-determination (Cowger *et al*., 2006) and inclusion when people need support in this area. Both comments recognise that risk taking is a key part of rights-based practice (Mitchell and Kumara, 2009), and similarly other comments highlighted the importance of 'living life with some risk' (survey comment, 125).

Examples of these approaches can be seen in practice through field work observations, for example with John. During a fieldwork observation a neighbour knocked on the door to check if John needed anything from the shop (data extract transcript: SW1/John(2)). In later discussions the social worker described that John had developed a range of friendships with his neighbours, however expressed concern both about the impact that these relationships were having on John, and the impact that John was having on other people within the block. This 'social network' (Gitterman and Germain, 1976) was serving to both meet John's need for relationships and, in the eyes of the social worker, creating risks. John was lending money to his neighbours that was not repaid, resulting in John being unable to pay his own debts, and at the same time encouraging another neighbour to make calls to the ambulance service on his behalf[4]. This concept of being both 'at risk' and 'a risk' was observed by Stanford (2010). It is intertwined with a strengths-framing of a person as resilient and resourceful despite the conflicts of risk (Saleebey, 2006). The complexity of balancing the benefit for John of developing relationships with his neighbours, and the risks that he is being exploited and, in turn, exploiting others, is an interesting dynamic to explore through a strengths-based lens. As the social worker articulated:

> It is similar to the chap I used to work with in [other local authority]. He was vulnerable and he thought these people where his friends, but they were

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[4] John's calls to the ambulance services are discussed further in chapter six.

> coercing him. On the one side it is great that [John] has built these friendships, but I think he is both open to being influenced and negatively influencing others. (Data extract reflection: SW1(3))

In this the social worker is articulating the importance of the benefits of this social network as part of John's assets. Part of the strengths-based approach is for social workers to know how the person they are working with has developed their own networks of support (Saleebey, 2000). However, the complexity is that that these relationships are not necessarily affirming and supporting John's resilience.

The relationship between John and his social worker was evident through observations and reflective discussions. It was also consistent in the electronic case file history, including copies of emails, safeguarding minutes, letters, and risk assessments. This enabled the social worker to advocate on his behalf as the following as this extract from a safeguarding meeting demonstrates.

> [Social Worker] explained that [John] has told him that he would like to live debt free and to stop the harassment from the individuals concerned. [Social Worker] noted that it is believed that there is a further unnamed perpetrator [...][chair] asked if [John] would consider moving and [Social Worker] explained that [John] is adamant that he does not want to move, and he would likely struggle to find a suitable ground floor flat. (data extract MDT:SW1/John(1))

The safeguarding function was attempting to keep John safe by asking him to move. The social worker's support of John's refusal highlights the 'dignity of risk' (Perske, 1972), avoiding the trap of undermining strengths-based practice by considering risk management linearly as avoidance of harm (Carroll and McSherry, 2020). As John would not move, alternative strategies were needed. The social worker negotiated with John, his support staff, and advocacy services, to reduce financial exploitation while enabling John to retain control of his finances. This reflected a contextually appropriate response (Ungar, 2004) in promoting John's strengths while managing risk. The consequences of maladaptive relationships (Gitterman and Germain, 1976) are recognised, and a solution-focused approach (Weik *et al*., 1989) informed the safeguarding response to neighbours borrowing money. Ultimately, John's outcomes - remaining at home and ensuring safeguarding was personal - were upheld through the social worker's advocacy (Cooper *et al*., 2018; Lonbay, 2018; Price *et al*., 2020). These interactions are underpinned by the concept that risk is not fundamentally a negative to be removed, but part of life to be understood and managed. The role of the social worker was to support this.

Other survey comments suggested that there were times when practitioners were less confident in this approach (survey comment 118; 124), and factors were highlighted such as not having a relationship with, or knowledge of, the person; as highlighted in chapter four, there was a strong relationship between John and his social worker. This relational approach enabled risk through; goal setting (Brun and Rapp, 2021), negotiation about choices about risk and the support in place (Roebuck *et al*., 2022) and enabling safety through a structured support system (Tsoi, 2019: Tse *et al*., 2021; Björkman *et al*., 2002) - all of which share features with the strengths model case management approach (SMCM).

Generally, survey participants claimed that they promoted positive risk taking and as demonstrated with John, this could be seen in field observations. The survey data also provided a range of commentary on the 'problems' (Saleeby, 2004; Weik, *et al*. 1989) encountered and field observations provided a different context on how these challenges manifested and were managed in practice.

Family and friend carers

The role of family and friend carers was one area where the differences in data was apparent. Survey data referenced families' 'concern' about risk (survey comment 113); the 'what if' (survey comment 208) and being 'less confident' than the social worker (survey comment 116). In these comments, social workers are reflecting 'affect heuristics' (Slovic *et al*., 2013; Slovic, 2010; Finucane *et al*., 2000) which is the process in which emotions shape decision making by creating a mental shortcut - the results of which include the impact of risk perception potentially being stronger than the risk itself. Fundamentally the way risk feels emotionally shapes the cognitive interpretation of its severity (Loewenstein *et al*., 2001). Studies on the impact of caring highlight complex interactions between caring responsibilities and emotions such as guilt (O'Rourke *et al*., 2011), loneliness (Victor *et al*., 2020), exhaustion (Czaja *et al*., 2009) and grief and loss (Holley and Mast, 2009) - which naturally create circumstances that could amplify affect heuristics.

Whilst the survey responses recognised these impacts, the field observations showed something slightly different. Renee's family were supportive of trying to maintain her independence, but the emotional impacts of caring were evident in the narrative and the observed demeanour:

> Niece: So, the history [...] my Mam, had dementia [...] and [husband's/nephew's] Mam had Alzheimer's dementia [...] it was just as me Mam passed away in 2020 and then we found out about me Aunty Renee having it [...] at Christmas time, was it 2019?
>
> Nephew: Yeah, yeah [...] I think it was [...] there's been a little bit of history of it, but we've been kept in the dark. Things have been going on, and we didn't know about it [...] other folks have been saying, ohh, this has been happening, that's been happening, [...] one of her friends had got adult social care involved [...] brought carers in which she didn't want, wasn't happy with it, so she was very

> resistant to it. So, we stepped in, and it went from there basically. (data extracts transcript: SW5/Renee (3))

The extract highlights the affect heuristics that could be at play, particularly the grief and loss of losing other family members and realisation the same will happen to Renee (Holley and Mast; 2009), and the guilt (O'Rourke *et al*., 2011) as they stepped in because Renee did not want to accept care. The description and their demeanour during the observation showed a level of exhaustion (Maslach and Jackson 1981; Czaja *et al*., 2009):

> Niece: its Yeah, it's getting harder [...] though
>
> Nephew: Yeah, yeah. (data extracts transcript: SW5/Renee (4))

The sense of inevitability within this extract underscores this emotional impact. There is an argument that Renee's family are not averse to risk, they have managed as best they can and have only requested support when the situation has escalated beyond what they feel is manageable. The social worker is listening to this and giving the family time to talk this through as part of the assessment discussions, but this is a one-off intervention so whilst they are listening, the support they can offer is service led rather than relationship led.

Survey comments indicate that social worker's approaches to working with family and friend carers to support a strengths-based approach cite a need for mediation 'offering the right level of oversight and contact to allow them to observe strengths' (survey comment 146). In this the respondent is describing working with the family and/or friend carers as the person's assets (Saleebey, 2006; Rapp and Goscha 2011) but also striving to change the heuristics to become less emotionally based and more cognitive based (Finucane *et al*., 2000). The social worker is addressing the emotional elements of the perceived risk. Other survey responses described similar approaches such as 'involving family' (survey comment 135), 'facilitate a conversation with the person and their carer' (survey comment 161), and 'listen to what is wanted [from carers] and see if there is a compromise' (survey comment 158). In these comments the social workers are indicating that to change the risk perception, they are actively working to promote solutions. This could be seen in the conversation that the social worker has with Joan about going home from the nursing home, discussed further in chapter six:

> **Social Worker:** So, when you were unwell, before you came here [...] I think that your home was a bit neglected, so there was a... I know you were having a lot of health problems and so from what [son] said, it would need new carpets, some pieces of new furniture, things like that. Now that's not out of the question. You know, they're not impossible tasks…We just need to work out how to do it if that was what you wanted to do. [Son] has said he doesn't want to be involved. In, in sorting the house out. But that's also OK because he doesn't need to be. We can help with that [...] If you go home. How do you see yourself living? do you feel like you would need any help? (data extract transcript:SW3/Joan(1))

Joan’s son is not present, but the social worker has had conversations, they are aware of his concerns and provided reassurances about the steps they will take to support this (reflection:SW3(2)). The social worker is acting as a mediator, acknowledging the son’s concerns whilst remaining focused on what will work for Joan. This supports the narrative reported in the survey comments. As was the case with John, this social worker is acting as an intermediary rather than supporting a direct conversation between Joan and her son.

All these approaches are fundamentally strengths-based in nature, involving and working with families as partners in care (Saleebey, 2006; Rapp and Goscha 2011), and engaging and acknowledging the emotions and position of carers rather than just communicating based on facts. This strategy is actively challenging the potential affect heuristics in a strengths-based, meaningful way to enable a proportionate approach to risk.

Affect heuristics could also be seen with carers within the field observation – interestingly with the opposite effect. Anna was determined that it was her responsibility to care for her husband Peter when he returned home from the rehabilitation unit, viewing her role as carer as an extension of her marital role (Lloyd *et al*., 2016). The social worker, and the wider multi-disciplinary team, were concerned that Anna was not aware of the level of support Peter needed and how she would balance this with the needs of two young children (summarised from minutes of MDT, fieldwork discussions, case notes). An extract from the Assessment recorded:

> Anna is more optimistic about her ability to manage on her own with Peter than professionals are [...] Anna would like to take responsibility for Peter's care during the day [...] it is recognised that Anna feels it is her responsibility [...] also conscious about the financial impact of Peter paying for care [...] important for Peter's advocate to listen [to] her views as well. (data extract record: SW2/Peter(3))

The social worker is describing Anna's 'affective forecasting' (Wilson and Gilbert, 2005) – in their view her optimism is masking the support she will need when Peter comes home. The MDT's view is that Anna's emotional response is underplaying the risk to her own wellbeing, to Peter, and to the children. The level of support Peter needs both physically and psychologically is substantial. The data from field observations of multidisciplinary team meetings, and copies of observations undertaken by staff saved on the electronic case record, reveal the social worker's approach. This was to work with Anna, the advocate, and the wider multi-disciplinary team, to reduce the impact bias, namely Anna's underestimation of the impact this role will have on her (Wilson and Gilbert, 2005). The social worker is actively working with Anna in a strengths-based way, recognising her commitment and resilience (Saleebey, 1996; 2000; 2001; 2004; 2006) but actively intervening and negotiating a solution to enable Peter to receive the support he needs, and some support for the children to allow Anna and Peter some time together.

Care Providers

In the example of Anna and Peter the role of the multi-disciplinary team was crucial in shaping the practical support needed and building a consensus. Survey data, however, suggested that promoting positive risk taking was often challenged by providers of care (survey comments 84; 113; 192; 220). One respondent provided a solution focused approach:

> Perhaps stronger links with commissioning and providers would help further foster and develop the resources and understanding needed. There can often be a risk averse culture and approach adopted by Providers (but not always). (survey comment 84)

The risk aversion of care providers is a complex issue to unpack, reflected in the comment of 'not always' risk adverse. Social care providers are predominantly regulated by The Care Quality Commission (CQC, 2025a) against The Health and Social Care Act 2008 (Regulated Activities) Regulations (2014). This legislation includes a duty to assess and mitigate risk (S12(2b)), support ‘autonomy, independence, and involvement in the community’ (S10:2(b)) and seek consent for provision of support (S11). These regulations can conflict with each other when applied to positive risk-taking approaches.

As with affect heuristics, observations showed that risk aversion was not always prevalent, and social workers worked with care providers to manage risk based on existing established relationships. As one social worker said in a conversation before attending an assessment visit:

> The care agency reported that [Phyliss] is [...] not eating [...] believe she forgets to eat. She's looking very thin [...] I spoke to this lady's ex daughter-in-law; she has no concerns at all. Does [...] shopping [...] leaves it there? Doesn't observe her eating but doesn't think there's a problem. So, I'm hoping that [care agency] invited that lady [daughter in-law] and then we'll see how the two marry up [...] [provider] has been around a long time and if she's telling me all that [...] And the daughter-in-law is

> telling me something different. I'm going to go with what the agency tells me. (Data extract: reflection: SW4(3))

The social worker is drawing on both the formal paid elements of the persons support, the care provider, and the family to be part of the assessment to understand the risks involved (Graybeal, 2001). This technique of sharing risk with people with different perspectives helps to triangulate and support the social worker to understand the risk to be managed (Manthorpe and Moriarty, 2010), enabling the social worker to focus on the strengths of the person. This raises an interesting ethical issue about the privileging of hierarchies of knowledge (Robinson *et al*., 2018) and the value of the professional carer voice compared to the daughter-in-law (Houghton *et al*., 2008; Rose, 2003; Huby *et al*., 2004; Fricker., 2007).

For John, the care provider and the social worker worked closely together to try and positively manage multiple risks. One example can be seen in a field example in which the social worker and care provider discuss the implication with John of not being able to provide his support:

> Care Provider: while you're screaming and shouting at [the support workers], John, they're not going to want to work with you.
>
> Social Worker: you've got understanding around where you want to go [and do] [...] You are able to articulate yourself very, very well. And it's around now [your] [...] ability to be able to speak to people in the correct manner. To enable them to give you the care that you need [...]
>
> John: Could be [...] better.
>
> Social Worker: Well, everything could be better, but you do have strengths. At the moment you have the ability here to sit here and have insights into what's going on […] So, with that in mind, I speak with [care provider] regularly. I think in two weeks time we will come back again and have another meeting […] because there are a lot of risks if you don't have care. And I think you know the potential outcome already, so.
>
> John: Basically, [John makes a noise and gestures finger across his throat]

> Social Worker: Do you have anything else, [care provider]?
>
> Care Provider: No, just that you need to try and keep controlling your temper John […] I'm trying to be as patient as I can […] but there's only so much of this [support workers] can take. (Data extract: transcript SW1/John(3))

In this observation, the social worker and care provider discuss managing risks with John. The conversation addresses John's insight, communication, and understanding, referencing his capacity and resilience in the current context (Saleebey, 1996; 2006). John's statement that it 'could be better' (data extract: transcript SW1/John(3)) demonstrates his awareness of the situation. The problem and the solution are reinforced by both the social worker and the care provider as combined partners in change with John (Graybeal, 2001). The arrangement to come back in two weeks gives John time and space to take control over his behaviour and shows a collaborative approach (Rapp and Goscha, 2011) and to gain control over the problem rather than allowing this to control him.

In both these examples the relationship with the support provider is vital to the social worker's ability to support positive risk taking (Teater, 2014). The social workers are recognising that the care providers know the individuals much better and are using their relationships and knowledge of individuals to support an overall strengths-based approach.

Other professionals

Respondents used the term 'other professionals' when referring to risk within the survey comments, with comments particularly mentioning health being 'risk adverse' (survey comment 113; 132; 215) and highlighting the difference between the medical and social model (survey comments 122; 215).

As with other comments the strategies for managing these problematisations were evident in the field observations. One example was a monthly multi-disciplinary meeting that took place between the social work team and the community health teams to discuss people known to the health teams that might benefit from social work involvement. The structure of these meetings was to highlight issues and maintain an open communication to respond to local need (MDT:SW3(1)(2)) as an addition to formal referral processes. Additionally, multi-disciplinary work in relation to assessing and managing risks was observed via Teams meetings in relation to: John, in which the ambulance service, care provider, social worker, and psychologist met to discuss John's continuous calls to the ambulance service during the night (MDT:SW1/John(2)); Peter (MDT:SW2/Peter(2)(3)), in which the therapist, advocate, and social worker met to progress plans to support Peter's long term care needs; and Mary (MDT:SW1/Mary(1)) in which the discussions between the social worker, the speciliast nurse, hospital staff, and advocacy were focused on her request to return home from the nursing home and her capacity regarding this decision. These examples are covered in other chapters. In these contexts, assessments, support plans, strategies, and risk assessments were completed in partnership between the social worker and health professionals, identified as key strategy in the promotion of strengths over deficits (Greene and Lee, 2011). Data revealed that this supported a joint narrative to justify decision-making to maintain accountability (termed micro-politics by Horlick-Jones (2005)). For the social worker, there is a perceived power imbalance (Foot *et al*., 2014), driven by hierarchical health structures (Cootes *et al*., 2022.), which is discussed further in the chapter on capacity.

The voice of the person in this space was often provided by the social worker, or where present, the advocate, which is a feature of a strengths-based approach (Graybeal, 2001). However, the strengths-based approach would have been more authentic had the person themselves been invited to the meeting as an equal partner in the decision-making process (Joseph-Williams *et al*., 2014).

Constraints of timing and resources to being strengths-based when managing risk

In addition to the complexities of promoting dignity of risk with partners in care, data revealed that social workers identified immediacy of risk as a barrier to working in a strengths-based way. One comment from the survey stated:

> Most [people] will request support at a point where their needs can no longer be safely met based on their strengths, and when those that have some willingness to rely on their strengths are identified, there is always a risk aversion. (survey comment 25)

This comment was received in the context of ability to practice in a strengths-based way. The phrase 'needs can no longer be safely met' is a direct reference to Care Act (2014) terminology and refers to the shift in approach from former legislation which focused on provision of services (NHS and Community Care Act, 1990) rather than the more general approach of meeting need (Care and Support Statutory Guidance, 2025). This comment infers that the strengths-based approach can only work until a certain point, after which risk, or risk aversion, prevents this approach being embedded, which is in line with other studies (Caiels *et al*., 2024; Jessops *et al*., 2025). Other survey comments also suggested that this timing issue created a challenge of ‘fixes to [...] ensure basic needs are met and risks are mitigated' (survey comment 34), 'volume of work' (survey comment 37), 'demand outstripping capacity' (survey comment 32), delays in getting support in place (survey comment 47) and lack of money (survey comment 48). Taken together these comments highlight a pattern of reactive, crisis-focused responses that practitioners feel impedes their ability to work in a strengths-based way when managing risk. All these comments support the well-rehearsed challenges experienced in adult social care due to austerity (The King's Fund, 2025; Foster, 2025; Murphy *et al*., 2025; ADASS, 2025), increasing acuity (DHSC, 2021) and a risk-based society (Beck, 1992).

Despite this, evidence of managing immediacy of risk in field observations, particularly as part of a duty response, showed that social workers' skills and abilities did enable them to promote a strengths-based approach. For example, one social worker took a telephone call from a family who had contacted to discuss their father, whose needs had changed. The family were concerned about leaving him alone over the weekend and were requesting reablement. The social worker advised reablement would be unable to start before the weekend and enquired about whether she could speak to the person:

> Is your Dad in-bed now? [Pause]. Is he able to speak on the phone? Can I have a chat with him later? Ok I will speak to you in a bit. (data extract transcript:SW3/annon(1) -only social worker end of the conversation audible)

In this the social worker is attempting to ascertain the position from the person's view. They are aware from the notes on the system that the person was recently fully independent following a period of reablement, and that at this time there was no concerns about his ability to communicate. The social worker then contacted the GP and arranged a same day appointment, and when they rang the person back discussed getting care in:

> Can you get your Dad to the GP at 4:00? The duty worker will call back tomorrow and see what next steps might be [...] If he has over that amount [of money] he will have to pay for care. Yes, we can help arrange it, but we wouldn't have to wait for an assessment if you know about resources. It is about £21 an hour for care. (data extract transcript:SW3/annon(2) -only social worker end of the conversation audible))

In this the social worker is talking candidly to the family explaining that they can arrange for a care provider to be in place for the weekend if they are willing and able to pay for this. The alternative would be a wait, either for a reablement service or for an assessment. Following the phone call the social worker explained that they were able to increase existing care packages on an emergency basis without a new assessment, but they couldn’t commission new care, other than reablement, without an assessment. Additionally, sourcing care locally was far easier for people who funded their own care as the providers had different rates. In this reflective discussion (reflection:SW3(3)) the social worker stated they were aware that the local authority has a duty to assess regardless of financial resources (Care Act, 2014:S9), but that they would be able to support the sourcing of support in time for the weekend if the family were paying. In this the social worker is undertaking a 'backstage' role, distancing themselves from their 'frontstage' statutory duty to provide a workable solution but this is not what they are supposed to do (Goffman, 1959).

In this scenario the social worker adopts a dynamic approach to risk management, contacting the GP, discussing options for getting care in place quickly, and balancing the assessment requirements and the outcome of ensuring safety and support. The social worker is presented with a range of problems which are structurally based and require a quick resolution. The social worker can see from the case management system the person had a successful reablement episode recently, so wants to check there is not a health reason for the change that may be resolvable. Intervening as partners in care and contacting the GP directly, they secure a same day appointment. The request to speak to the person themselves shows professional curiosity, and the conversation with the GP enables a safety net, as the GP knows to come back to the social worker if there are any concerns. The social worker’s focus on solutions is apparent through the entire observation. The framing of 'we can help arrange it… we wouldn’t have to wait for assessment' (data extract transcript:SW3/annon(2)) is not emphasising the problem, which is that to assess in time is not possible, but the solution: 'if you know about resources' they can come up with a collective solution. The social worker’s narrative is not about these deficits *per se*, but the solutions - a key tenet of strengths-based working (Rapp *et al*., 2001).

The social worker is compensating for the deficits within the system rather than dealing with the structural challenges; response times for reablement, inability to complete an assessment and get support agreed before the weekend, and knowledge that the local providers are more inclined to accept people quickly when they are funding their care directly. The social worker is transparent about these system limitations, offering realistic alternatives, and informing of options as part of an ethical risk management approach (BASW, 2021). These work arounds to circumvent the systems, reduce the risks for the person of not having care, and effect change on an individual basis, rather than tackling the deficits in the system is a position that has also been observed in other ethnographies (Burrows, 2022). The alternatives to not acting may be increased pressure on carers, or temporary admission to more restrictive care such as residential care or hospital. Support at home is likely to be the best option in the short term. However, there is an inequity in place between people who can afford to pay and those who cannot pay, leaving the issue about structural inequity and injustice unchallenged and echoing some of the critique of a strengths-based approach as a vehicle for transferring responsibility from the state to individuals (Gray *et al*., 2011; 2015; Withers and Pollock, 2019).

Building on this critique, survey comments also cited a lack of resources more generally as barrier to strengths-based working for example:

> The impact of austerity needs to be taken into account when considering a strength-based approach. A reduction in community assets and resources does directly impact on a strength-based approach. (survey comment 42)

Other survey comments highlight barriers such as lack of funding (survey comment 48) and community resources (survey comment 41), which practitioners see as limiting their ability to work effectively. Whilst not explicitly mentioning risk, these issues represent practical challenges when supporting people who may be left without care. Reduced community resources hinder strengths-based practice (Clarke and Newman, 2012) and make it harder for social workers to maintain strengths and collaborate proactively to manage risk.

Organisational and systematic factors

Linked to the resourcing challenges and late involvement impacting on ability to manage risk in a strength-based way, wider organisational and system approaches to risk also featured strongly within the survey data. This was not a universally consistent theme, with one respondent reporting that the organisation has 'a good philosophy' (survey comment 128), and others reporting a less positive approach in relation to positive risk taking. These comments referenced 'systemic risk aversion' (survey comment 31), 'systems and culture (survey comment 35) citing fear as a 'barrier to fully embracing the approach' (survey comment 117) with decision making 'based on the agenda of the organisation' (survey comment 70). One respondent cited their own approach to risk within this hierarchy as: ‘I operate quite corporately which can be quite risk averse' (survey comment 119).

In each of these comments there is a reference to the systemic nature of risk aversion and its impact on a strengths-based approach, in relation to the approach the institution, or the system. These institutional priorities override the response to individuals (Goffman, 1961), symptomatic of the 'risk society' (Beck, 1992) in which a reflexive approach to understanding risk is required, and in which organisations increase levels of control to manage the impact of risks. The specific reference to operating 'corporately' indicates what Goffman would define as 'role distancing' (1959; 1961) - that is, the respondent recognises that this is not the right approach but is compelled to work in this way.

Examples of the impact of this phenomenon could be seen in the field observations. One social worker discussed a new process that has been introduced by senior management to manage the risk of waits for care. The process had just been implemented the week before and consisted of twice daily meetings between adult social care teams:

> So, there was backlogs being created […] they [senior managers] have categorically said no cases at the end of the day to be left in a customer service tray […] we [social workers] think it must be CQC related […] as opposed to anything else […]. These [cases] are from last week, so these are all triaged […] I just actually need to do the work on them […] But I'm prioritising, as we all are, every time SPA case notes us, because what we don't want to do is be brought in to an 11:00 and 3:00 meeting and sit in front of senior management who are saying, can you tell us why you've not given us decision on this? and then you're having to triage it in front of everybody. (data extract reflection:SW3(4))

Multiple layers of reflexivity and power dynamics are at play in this extract. Social workers apply role distancing (Goffman, 1959; 1961; 1963; Goffman and Helmreich, 2007), by complying with the new system but indicating scepticism not just about the process but about the rationale behind it – i.e. having an audit process in place for the Care Quality Commission Assessment (CQC, 2025b[5]). The organisational response to backlog risk fosters defensive practices, forcing social workers to prioritise compliance over individual need (Kemshall, 1998; 2002; Manthorpe and Moriarty, 2010). The total institution approach (Goffman, 1961) means the social worker is unable to do the work with the people they have already triaged because they are prioritising responding not based on need but based on organisational accountability and compliance. The culture of risk audit (Power, 2003) and

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[5] The period of data collection predated the roll out of CQC local authority assurance, although this process had started.

institutional risk management (Perrow, 2011) is viewed by the social worker as overriding their own professional judgement in this space. The social worker described the impact on their ability to support people:

> It's not like it takes me ages to go through somebody's history and look at all the other stuff it it's not an appropriate place to do it in the meeting, in my opinion […] so you're trying to get them done […] whatever it might be, they [people who have requested support] don't need to wait. I can support them with that 'cause I've got enough resources in my knowledge and whatever to do it there and then…so there is…extra delays happening it's just moved [...] so it's not improved the outcome. (data extract reflection:SW3(5))

In this the social worker is reiterating their own confidence in understanding how to manage the workload and reiterating that the new process is not improving the outcomes for people. The focus is on the institutional elements of managing the risk (Goffman, 1961), rather than using the social workers skills and resources to manage this.

The context of adult social care within the period of this study (2023 to 2024) needs to be understood in relation to the pressures on the adult social sector at this time, and the impact that this is likely having on the structural motivators. Reports indicated that nationally the requests for adult social care increased by 11% between 2015/2016 and 2022/23, whilst the number of people in receipt of adult social care was 2% lower in the latter compared to the former period (Bottery and Jefferies, 2025). This tightening on resources creates organisational pressures to demonstrate that they are meeting statutory requirements. Strengths-based approaches are synonymous with reducing need and risk, but this can only happen with the right interventions. In this context, waits for care and a political framework of new regulation means the organisation is increasing operational control to manage the risk (Kemshall, 2002).

As discussed in the literature review a critique of the strengths-based approach is that essentially it is a vehicle to transfer responsibilities away from statutory bodies to informal support mechanisms, supporting a neoliberalist agenda that uses choice as vehicle for reducing state support (for example Garrett (2010), Gray (2011), and others). Survey comments suggest that almost the opposite is the case - working in a strengths-based way is not a driver for neoliberalism but is stifled by it (Clarke and Newman, 2012). The overall reduction in resources, combined with the increase in demand, means that when things are considered risky, strengths-based approaches cannot be fully embraced because the focus is on resources dealing with demand rather than supporting the outcome for the individual.

Analysis and discussion: when the problem is risk

Application of a strengths-based approach to risk uses individuals' resilience, capability, and natural assets (Saleebey, 1996; 2000; 2001; 2004; 2006). This naturally enables a positive risk approach (Rapp *et al*., 2006). The survey comments provided a useful source of data for surfacing these issues. Field observation data with social workers highlighted examples of how social workers used their skills and capabilities to build relationships with other partners in care to manage this problematisation and promote dignity of risk (Perske, 1972), and to both identify and navigate structural and organisational issues that arose in management of risk.

The identified key barriers to fully embracing dignity of risk were identifiable in two main sub themes: the first was the interface with a range of partners in care, particularly family and friend carers, paid care providers, and health colleagues; the second was structural and systemic functions, which related to the timing and availability of resources and processes within the organisation.

This analysis considers the ways social workers promoted dignity of risk with three identified groups of partners in care; family and friend carers, care providers, and health professionals, and there were synergies and differences within these cohorts. For family and friend carers the data revealed the evidence of 'affect heuristics' (Slovic *et al*., 2013; Slovic, 2010; Finucane *et al*., 2000), and the survey comments demonstrated that they recognised the complexity of the caring role and the interplay between this and risk. For providers of care regulated by the CQC, professional bodies, and, in the case of health professionals, a range of NHS regulators, there are significant additional organisational risks (Dash, 2024). These influences lead to the concept of 'defensive practice' (Kemshall, 1998), reflecting a culture focused on compliance and dominated by risk aversion rather than enablement of strengths (Manthorpe and Moriarty, 2010).

The data has focused on the social work role in relation to each of these dynamics and identified a negotiation and collaboration role with these partners in care to promote ‘dignity of risk’ (Perske, 1972). This is important in relation to rights-based practice (BASW, 2021) and a strengths-based approach. Through the survey data participants recognise the institutional power that the expert 'circuit of agents' (Goffman, 1961) - in this context the other partners in care - have on enabling or restricting positive risk taking. In field observations the strategies for managing this were to shift from collusion to collaboration, recognising the motivation is different for each of the partners. The interventions aimed to, and were often successful in, navigating these tensions. Often the voice of the person in the discussion was absent - even with John, his voice was articulated by the social worker rather than him being at the meeting. This is an area for development. It is essential to move the conversations away from protection towards involvement to enable a reflection on hope and capabilities (Rapp and Goscha, 2006; Graybeal, 2001), as this is diminished within risk circumstances (Kemshall, 2002). Studies into safeguarding have suggested people want to be involved in management of their safeguarding plans (Mahon *et al*., 2024). Including the voice of the person has been found to improve safeguarding outcomes (Lonbay, 2015), and involvement and preferences should not be used as vehicle to exclude risk-based discussions (Baye and Preston-Shoot, 2020). It is difficult to embed a true ‘dignity of risk’ (Perske, 1972) unless the person can be involved and actively engaged within the process (Marsh and Kelly, 2018).

Summary

This chapter has focused on the problematisation of risk within strengths-based practice. It incorporates survey comments, which are descriptions of how this is perceived with field examples and written records. In all these data sets there was a strong concept of risk dignity (Perske 1972). The survey data highlighted perceived problems associated with applying strengths in the context of risk. These were associated with family and friend carers, and the result of affect heuristics (Slovic *et al*., 2013; Slovic, 2010; Finucane *et al*., 2000). For care providers and health colleagues this was linked to hierarchies of knowledge (Robinson *et al*., 2018), role formats (Horlick-Jones, 2005) and cultural differences - particularly between health and social care (Foot *et al*., 2014; Cootes *et al*., 2022; Joseph-Williams *et al*., 2014). The field data, however, showed how the social workers actively navigated these potential issues through relationship building with these 'circuits of agents' (Goffman, 1961), referred to in this study as partners in care. As observed in the previous chapter, having a relational based approach supported navigation of more complex risk scenarios in a strengths-based way. Social workers did advocate for people in these contexts, but often the person was not included directly in the discussion and there are opportunities to strengthen this area further.

Organisational, structural, and system constraints in promoting strengths in the context of risk was also prevalent in both survey data and field observations, and in this respect there was alignment in the data. The problems surfaced were sufficiency of time and resources to work with people, and the organisations response to risk. The field observations showed that social workers used work-arounds to circumvent the structural issues and improve the support available to people, but the impact of organisational control actively undermined their ability to promote positive risk taking. This was considered in relation to Goffman's (1959) dramaturgical framework in which the social workers distanced themselves from these organisational constraints and found practical workarounds to circumvent these structures (Goffman, 1959; 1961; 1963; Goffman and Helmreich, 2007).

6. Constructions of capacity: The fragile ground of strengths-based practice

'Believe the client and believe in the client. Social workers are sometimes encouraged by our own experience or by the expectations of others to disbelieve… But, until proven otherwise, believing the client and believing in the client are two of the most powerful tools. '

Saleebey (2000:133)

This chapter uses case studies to explore the data to show how social workers construct an understanding of capacity in day-to-day interactions. This enables a detailed analysis of a theme that was prevalent across multiple data sources yet assessed and interpretated differently in each of the case studies considered. Building on the theme of risk discussed in the previous chapter these case studies examine the application of the Mental Capacity Act (2005), drawing on an ethnomethodological framework (Garfinkel, 1967) and strengths-based lens to consider how interactions are used professionally to understand issues of capacity. The case studies concern Joan, Betty, Phyliss, Mary, and John.

Capacity assessments are embedded within day-to-day interactions and considered dynamically. Understanding of capacity is socially and professionally constructed. As in the risk chapter, the role of family and friend carers and other professionals featured within this interpretation and supports the construction of capacity. The data builds on previous studies showing that social workers take a rights-based approach when a person is deemed to have capacity (Burrows, 2022; McDonald, 2010), but that this is less evident when the person is viewed to lack capacity (Lelkes *et al*., 2021; Symonds *et al*., 2018; Price *et al*., 2020; Lonbay, 2018; Cooper, 2018) and can even lead to use of capacity assessments to override choices (Aspinwall-Roberts *et al*., 2022; Robb and McCarthy, 2023; Jepson *et al*., 2016).

Field observations revealed a dynamic and context-dependent approach to assessing capacity in a strengths-based way, as can be seen with Joan, Betty, and Phyliss.

Joan: a conversational approach to capacity

The social worker knew Joan well. Joan had cyclical involvement with adult social care due to issues of self-neglect and alcohol use. She had recently received a diagnosis of terminal cancer and was temporarily living in a nursing home around an hour drive away from her home. On the way to the visit, the social worker explained that at the last meeting Joan had agreed she needed nursing care, and they were actively looking for a home closer to her friends and family but were having limited success. Joan asked why she could not just go home. The social worker moved into a subtle and on the spot capacity assessment that would not have been immediately obvious but followed the steps of ascertaining Joan's ability to understand the decision, retain the information, and balance the risk (Mental Capacity Act , 2005). The social worker started with a discussion about the previous visit:

> **Social Worker**: So [...] the first plan was to move into a care home in [place] and then from there you'd be closer to friends and family and then you can make [...] arrangements with regards to [...] your property. And do [...] longer-term care planning [...] the last time I came to see you [...] we talked about it [...] I remember asking you if you were sure because I would need to let the housing association know [...] I did let them know because you said you were [sure]..they actually need it in writing [...] So, your property is still standing in your name. It needs an awful lot of work doing to it. (data extract transcript:SW3/Joan(2))

It is not obvious that the social worker is undertaking a capacity assessment at this stage. They are applying indexical expressions (Garfinkel, 1967), which is the concept of using language deliberately to ascertain a particular meaning (Lynch, 1983). Discussions have different context dependent meanings, and this conversation is the start of an exploration of capacity. The decision is whether Joan moves to a care home permanently or goes home. The social worker is clear it is a real decision as the property is still available. The fact that it needs 'an awful lot of work' (data extract transcript:SW3/Joan(2)) allows the social worker to explore the complexities of the decision. The conversation continues:

> **Joan**: Can I see how it does?
>
> **Social Worker:** So, when you were unwell, before you came here […] I think that your home sort of [pause] was a bit neglected […] If you go home. How do you see yourself living? do you feel like you would need any help?
>
> **Joan**: I maybe need a carer in, in the morning.
>
> **Social worker**: Yeah. What? What sort of things would you need a carer for?
>
> **Joan** Washing in the washer. [conversation interrupted by a member of staff from the nursing home entering the room]. (data extract transcript:SW3/Joan(3))

The social worker is discussing with Joan options for support, engaging Joan as a partner in her care rather than a recipient. The conversation sequence is 'co-constructed' (Heritage and Maynard, 2006) with the phrases 'We can help with that' and 'what sort of things would you need a carer for?' (data extract transcript:SW3/Joan(3)). The conversational approach is a tool; it is strengths-based and solution-focused (Greene and Lee, 2011) to enable Joan to demonstrate she understands the implications of her decision.

The conversation was interrupted which gave the social worker a chance to revisit the discussion:

> **Social worker**: so, can you remember what we were just talking about? I've just forgotten [slight laugh and pause]. What were we discussing sorry?
>
> **Joan**: About getting it done.

> **Social worker**: Getting what done? Sorry.
>
> **Joan:** The house before I move back in.
>
> **Social Worker:** And then, oh yeah, and then we were talking about carers. So, you would need some help with your? Did you say your washing? laundry?
>
> **Joan**: mmm...
> **Social Worker**: Yeah is there anything else?
>
> **Joan:** I wouldn't need any err help, I don't think, with personal hygiene.
>
> **Social Worker:** Ok. (data extract transcript:SW3/Joan(4))

The natural break is used as an opportunity to subtly assess Joan's ability to retain the information (Mental Capacity Act, 2005). This is achieved using conversational repair (Hayashi *et al*., 2013) in which the social worker claims they do not recall the discussion to confirm Joan does. Having established this the social worker moves onto discuss Joan's need for support, prompting her to describe how her care needs were met in the care home and how this was different to at home – this was something that Joan struggled to explain clearly. The social worker reminded Joan that in the past she had received care, and she had reduced this and ended up back in hospital again:

> **Social Worker:** Do you feel that [reducing care and being admitted to hospital] is something that could happen again?
>
> **Joan:** I shouldn't maybe have done it so quick.
>
> **Social Worker**: Done what so quick?
>
> **Joan:** Reduced Me care.
>
> **Social Worker**: What? So what? When you reduced your care, what do you think went wrong?
>
> **Joan:** I think I needed a bit more care.
>
> **Social Worker:** Yeah
>
> **Joan:** Bloody Hell. (data extract transcript:SW3/Joan(5))

This reflective approach of the social worker asking 'what do you think went wrong? (data extract transcript:SW3/Joan(3))' is not accusatory, it is passing the control over to Joan reflect on this. It enables Joan to acknowledge that had she not reduced her care 'so quick' (data extract transcript:SW3/Joan(3)) she might not have ended up in hospital. It is framed in a way that enables Joan to indicate that reflexively she does understand this, with the response of 'Bloody Hell' (data extract transcript:SW3/Joan(3)) she is showing her acknowledgement of this. The social worker then moved on to ask what Joan thought her sons' views of her going home where and why, as well as a conversation about alcohol use.

> **Social Worker**: Has [son] spoken to you about his thoughts about you going home?
>
> **Joan:** He doesn't want me to, I don't think.
>
> **Social Worker**: Yeah. What's he said? Why?
>
> **Joan**: He thinks I'll [pause] relapse with being on my own […] and [pause]
>
> **Social worker**: With alcohol?
>
> **Joan**: Alcohol? No, no, I don't drink alcohol now.
>
> **Social worker:** Right [pause] Because in previous
>
> **Joan:** Yes I did before
>
> **Social Worker**: Yeah.
>
> **Joan:** I don't deny that.
>
> **Social Worker:** Yeah. And that's what's led to I think the cycle of ending up back in hospital. Do you feel like that's a risk?
>
> **Joan:** No. [pause] Not whatsoever, not interested in it.
>
> **Social Worker:** Right ok. So do [interrupted by Joan]
>
> **Joan:** Not from now on. I just want somewhere comfortable to sit. (data extract transcript:SW3/Joan(6))

In these conversations the social worker is taking an agile approach to assessing Joan's ability to balance risk within her decision making (Mental Capacity Act, 2005: 3(1)). The social worker maintains the approach of co-constructing (Heritage and Maynard, 2006) the narrative as a conversation that contextualises the implications of going home but also does not shy away from discussing the previous issues with alcohol and reducing care. The social worker pays particular attention to Joan's history of reducing care within this discussion. There is a delicate balance between paternalism and risk enablement with the reference to hospitalisation, recognising that the social workers role is not to fix Joan but to partner with her to consider solutions (Saleebey, 2008). The extract reflects high quality strengths-based practice familiar in the relational approach discussed in previous chapters.

The social worker explored Joan's concerns with the existing care home and then talked about the possibility of moving to another home. Joan was adamant that this was not what she wanted.

The social worker then explained that she was doing a capacity assessment and why:

> **Social Worker**: Right. So, one of the reasons why I'm asking you a lot of questions is because the decision that you're making is […] a complex one because there's lots of things that you've got to consider. And as part of my job […] Because you in the past had some difficulties with your memory and bits of confusion. I have to do something what we call mental capacity assessment […]
>
> [distraction in conversation to another topic before returning]
>
> **Social Worker**: And that's to see if you are able to make that decision yourself completely, or to see if you might need support to make that decision, or to see if you might need people to make that decision for you in your best interests. To do that, what the decision that we're doing is just basically about your accommodation […] where you want to live. So, from what I know of you when you were home previously. I know […] You're not drinking now. But you were in a bit of a cycle of. You'd […] go home, you'd have. You'd have care in place, you'd have support, but

> then eventually that you'd reduce that package of care. And as a result of that and increased alcohol intake. You would, after a period of time. You were struggling then to maintain your home. And also, you weren't looking after yourself, so you weren't eating and drinking very well. And your skin was getting quite sore. So, you're getting, like, fungal infections and skin sores. And with your mobility? You were struggling to get around a bit more. And you had a bit of incontinence as well, so that was an issue for you. And what would happen is you would then go into hospital. You would get good level of care and support, and you'd recover. And you'd go home with care. And you'd be OK. And then when the care stopped, your health would start to deteriorate again. So that's [your son's] worry. That is that that cycle would happen again.
>
> [carers from the home entered the room again, brief break from the conversations]
>
> **Social Worker**: So, and I think I would share those concerns.
>
> **Joan**: Yeah, I understand.
>
> **Social Worker:** You being at home without support, and what that might lead to so if you go home. You've got you've got sort of three. Well, there's three options about your accommodation and care that I can see. (data extract transcript:SW3/Joan(7))

Whilst the style of the discussion remains conversational the social worker is explaining the legal basis of the capacity assessment, referring to memory issues as evidence of the diagnostic test (Mental Capacity Act, 2005:2(1)), followed by straightforward summary of steps needed for the functional assessment and introducing best interest (Mental Capacity Act, 2005). Greene and Lee (2011) posit that, in practical terms, to undertake a solution-focused assessment it is virtually impossible to ignore the entrenched deficit model, but unpacking these problems into smaller more manageable elements can help focus on solutions and this is what the social worker is doing with Joan. The adaptation of institution talk (Drew and Heritage, 1992) into a conversation integrates the formal assessment of capacity into a generalised discussion with Joan. Unlike the Care Act (2014) assessment processes (discussed in chapter four), this is not simply the application of a preconstructed object (Bourdieu and Waquant, 1992) but a use of praxeological reasoning – in other words, it is not what Joan says that is being considered, but how she is able to relate this back to ordinary activities of life (Lynch, 1993). This naturally creates space to explore strengths by embedding the elements of the mental capacity assessment into a more general discussion.

The social worker then went through the three options with Joan: move to another care home, go home with care, and go home without care. The only option Joan was prepared to discuss was going home. Although she did concede that she was getting support from the carers within the nursing home, Joan remained insistent that she would not need care once home. Case law cautions against professionals demanding a credible description of care needs as determination of capacity ([2012] EWCOP 2136) or setting the bar higher than would be expected for someone whose capacity was not in doubt (Essex Chambers, 2025(a) on case [2013] EWHC 3230 (Fam)).

Having gone through this in detail the social worker returned to the question of ability to retain the information:

> **Social Worker**: OK, so sorry I know this is a really long-drawn-out conversation. So, we would have just said the three options. Can you remember what the three options I said were?
>
> **Joan:** Moving. [pause].
>
> **Social Worker**: Moving?
>
> **Joan:** Having care. More care.
>
> **Social Worker**: The first one was moving?
>
> **Joan:** to [place] or [hometown]
>
> **Social Worker**: Nursing home. Yeah. Yeah. Moving to another nursing home. And the second one was? Option was.
>
> **Joan**: Moving to [this] nursing home.

> **Social Worker**: So that was the first option. The second option we talked about was moving home with a package of care. And the third option was moving home without any care.
>
> **Joan**: But it's up to the kids as well you know.
>
> **Social Worker**: Yeah, we will ask but, first and foremost, it's your decision. And that's why we're having this discussion, because we need to try and work out whether you might need some support to make that decision or, or you don't need any support, or if you might need professionals and family to make that decision in your best interests.
>
> **Joan:** umhum
>
> **Social Worker**: So, if there's maybe things that you're missing or [pause] because of your…
>
> **Joan**: Well, I'd have to bring [friend] into the decision, I think.
>
> **Social Worker**: Yeah
>
> Joan: Which is only right, I think. All right?
>
> **Social Worker**: Yeah. Yeah, I mean. I think so. I think it's good to have people around you that love [...] and care for you and to hear what their thoughts are as well. (data extract transcript:SW3/Joan(8))

In this part of the conversation the social worker is returning to the decision and checks that Joan can retain the information (Mental Capacity Act, 2005:3(1a)). The social worker is not testing Joan; they support her with the recall but were assuring themselves that Joan did understand the options.

The social worker constructed this management of risk directly with Joan, and unlike the scenarios in the previous chapter there is no MDT involvement. Joan's son does not want to be involved, but the social worker is keeping lines of communication open, recognising the importance of these relationships no matter how strained. Joan references 'the kids' data extract transcript:SW3/Joan(8)) but the social worker is clear – the family and friends views are important and may be needed to help Joan make the decision, but it would be made by

Joan or taken in her best interest. The social worker is reinforcing the dignity of risk (Perske, 1972) and this is applied regardless of capacity.

The social worker concluded by arranging a follow up in two weeks (they were on leave the following week), allowing time for fluctuation and review on the decision. Afterwards the social worker reflected that Joan often changed her mind between going home and changing care home. The social worker did not view this as evidence Joan didn't have capacity, rather that Joan may not be sure of what she wanted given she was approaching end of life. The social worker also reflected that what Joan had said in the meeting was not, in reality, what had happened when she was at home. Regardless of the outcome of the capacity assessment the social worker said she would try and get Joan home if this was consistently what she said she wanted. Unfortunately, Joan died shortly after this meeting so there was no opportunity to follow this intervention through to a conclusion, or to review whether this conversation was recorded as a capacity assessment on the electronic case management system.

Betty: Assuming capacity

Betty was in her early nineties and lived in a caravan on the site of a hotel owned by her son. The social worker had been involved with Betty previously when there had been a request for support to keeping the caravan clean. At the time Betty had not met the eligibility criteria under the Care Act (2014). Betty's situation had subsequently changed, her son had been jailed, and Betty, along with her daughter-in-law and grandchildren who lived in adjacent caravans, were being evicted as the hotel had been sold. The field observation was a meeting between the social worker, Betty, and another son who was open about the situation and shared all the relevant paperwork with the social worker. Betty remained largely silent during the meeting while her son was primarily responsible for leading the discussion, talking about his concerns for his mother and how she was deteriorating, both physically and cognitively, and in his perspective the high level of care that she now needed: a typical deficit approach. The social worker asked pertinent strengths-based questions about what was important to Betty and what was important for Betty. Betty was quiet; however, she interrupted and challenged her son when he said something she did not agree with, particularly around her capacity and ability to understand what was going on.

The social worker made sure they asked Betty what she wanted. Her views were consistent, articulate, and in keeping with the narrative from her son. I asked the social worker what their views on her capacity were following the discussion. Although it was clear that Betty was starting to experience difficulties sequencing, which meant she sometimes forgot how to undertake day to day tasks such as making a cup of coffee or getting dressed, the social worker felt there were no concerns in relation to the decisions Betty was making. Although she wasn't happy about moving, Betty understood that to be near her family would require living in residential care, and was prepared to accept that level of support:

> As Betty's son explained what had happened within the family she looked blankly ahead, as if she was not listening and was opting out, a weary resignation of what had happened. As her son explained in his words about the support Betty needed the social worker attempted to steer this to her strengths and assets, and to the conversation they had the year before, when her needs had been far less. Betty clearly was listening though, as when her son said, '**she really doesn't understand much of what was going on**' she interjected quite firmly with a slight laugh and said, '**yes I do!'.** At this stage, her son backtracked '**yes, Mum, but you are a bit more forgetful than you used to be'** to which she replied, '**I am 92 you know'**. The social worker took this as the opportunity to engage Betty more fully in the explanation of her needs, but she seemed content to let her son speak. She was consistent in her message '**I want to be near to my family'.** (Data extract field notes:SW2/Betty(2))

For Betty there is no capacity assessment completed; despite the detailed description her son is giving about the amount of support she needs, the social worker's assumption of capacity is based on what they can observe within the interactions. Despite the descriptions that Betty is experiencing loss of sequencing and that she is forgetful, she is rational about what is happening, is clear she will accept support, and that she is willing and wants to move closer to her family to receive support. The social worker is 'believing in' Betty (Saleebey, 2000:133). Considering this through an ethnomethodological lens, Betty's capacity to understand is evidenced and interpreted by the social worker, not just through her assertion that she wanted to be near her family, but also by the challenge to her son about her awareness. In response to 'she really doesn't understand' (data extract field notes:SW2/Betty(2)) Betty's interruption is clear 'yes, I do', which demonstrates a reflexive resistance (Garfinkel, 1967). Furthermore, Betty challenges the notion that she is 'forgetful' with the phrase 'I am 92 you know' (data extract field notes:SW2/Betty(2)), contextually framing forgetfulness as a natural feature of her age, not a demonstration a lack of capacity. In this the social worker can ascertain from the ordinary nature of the conversation that there are no concerns with Betty's understanding, and that a capacity assessment is therefore not necessary as it is assumed. Although the social worker did not have an on-going relationship with Betty, they had met before (field notes:SW2/Betty(3)), so the social worker was able to use this prior knowledge to support the assumption of capacity. The fact that Betty remembered the social worker suggested there were no issues with her memory retention.

Phyliss: confusion on meaning triggers concerns about capacity

Phyliss had been referred for an assessment by her current care provider. The local authority did not currently provide any support, and the agency was commissioned by the NHS to support with medication management. The provider had been concerned about an increase in needs. The purpose of the visit was to undertake an assessment under the Care Act (2014).

Phyliss was hard of hearing but was able to engage in the assessment and articulate her own needs effectively. She clearly expressed a desire to be as independent as possible. At one stage she mentioned to the social worker that she was cross with herself when she had forgotten that the oven was on and burned the sausages. The care provider stated that all food was preprepared by Phyliss's daughter-in-law, a fact she confirmed herself. Yet Phyliss insisted she cooked sausages weekly. Concerned about Phyliss's capacity (transcript:SW4 (3)), the social worker considered reframing assessment questions. Eventually, it was clarified that Phyliss received sausages from a friend at a lunch club and cooked them herself:

> **Social Worker:** So, Phyliss maybe you don't get your sausages anymore?
>
> **Phylliss:** I don't get sausages. Yeah, when I go to the club on a Tuesday they always go butchers.
>
> **Daughter-in-Law:** Ah yes they do sometime go butchers for her, but I have just tried to keep it simple for her eh.
>
> **Social worker:** Yeah. Yeah. So, I'm just thinking about, you know, risk of fire and Phyliss did say she's left it on all night.
>
> **Phyliss:** [Chuckles]
>
> **Daughter-in-law:** Eh?
>
> **Social Worker:** Her oven

> **Daughter-in-law:** I have never known that
>
> **Care worker**: No, I have never known that.
>
> [discussion about timers and oven checks between the care provider and the daughter-in-law. Phyliss agreed to using a timer]
>
> **Phyliss**: [firmly] I like to cook my own sausages. In the oven and then make a sandwich
>
> [more discussion between care provider and daughter-in-law about Phyliss eating habits, discussion about the care provider checking the oven, etc]
>
> **Phyliss:** you'll have me stop eating at this rate! (Data extract transcript:SW4/Phyliss (2))

Phyliss' tone in the extract was clear; she did not feel she should have to account for wanting to eat the sausages. Although Phyliss clearly had capacity, she was hard of hearing so had communication difficulties. This case raises the concept of 'common sense' (Garfinkel, 1967), with a focus on how assumptions are made based on what is being said in everyday routines. The conversation shows the different contexts in which the narrative is understood. This indexicality (Garfinkel, 1967) causes confusion. The statement 'I like to cook my own sausages' makes sense to Phyliss, but it is different to how her daughter-in-law and care provider have arranged her meals. It links backs to concerns about her not eating the ready meals – part of the reason for the review in the first place. The dominant narrative, or the socially constructed order, was that the daughter-in-law provided all meals. As these were not always eaten the common-sense approach was that Phyliss was not eating. This links back to Saleebey's (2000) concept of the importance of believing in the person. There is a risk in this context that Phyliss could have been marginalised. The social worker's reflection was that this triggered a potential concern - that Phyliss was confused about what was going on. Phyliss, however, asserted her own autonomy with her firm response 'you'll have me stop eating at this rate!' (data extract transcript:SW4/Phyliss (2)). This scenario mirrors enquiries undertaken by Garfinkel (1967) regarding challenging and then repairing social constructs. The challenge is where the sausages came from, and the repair is the discovery that this is something Phyliss manages independently – and she is clear about it 'you'll have me stop eating at this rate!' (data extract transcript:SW4/Phyliss (2))

In Phyliss's case, although she had some memory retention issues and hearing difficulties the social worker had no doubts about her capacity; however, this could have been swayed had the mystery of the sausages not been resolved. Had the social worker not explored this further, Phyliss might have been assessed inaccurately as lacking capacity and unsafe to cook, reducing her autonomy. Psychology experiments in the 1960s and 1970s describe that once a person is labelled as having an issue that impacts on their mental health, it is difficult to reverse that conclusion (Rosenhan, 1973), and this can lead to self-stigmatisation (Corrigan *et al*., 2012), and is not always received positively (Sims *et al*., 2021). The impact of receiving a diagnosis has been linked to a range elements that can impact on independence, including type of support needed and expected behaviours (Sims *et al*., 2021). The power dynamic and responsibility for determining Phyliss future would no longer have been hers to make (Series, 2015). In this context, the importance of resolving the misunderstanding about the sausages was vitally important; it was a misunderstanding of context rather than assuming Phyllis had fabricated the sausages.

The previous examples show positive framing of capacity to support a strengths-based approach. As in previous studies (Aspinwall-Roberts *et al*., 2022; Robb and McCarthy, 2023) there were examples of capacity assessments being used in a less strengths-based way. This could be seen with Mary.

Multidisciplinary consensus silences Mary's wishes

Mary was articulate, educated and cognitively extremely alert; she had previously held an academic job. Mary had a known degenerative physical health condition. Although she required significant physical support, there was no doubt in my mind, or indeed the social worker when he first met her, that Mary was fully capacious. Mary had been active in her own community as a member of her local tenants' association, having provided feedback on behalf of the community on the accessibility of a proposed supported housing development. The first field work observation was a Care Act (2014) assessment via Teams. Mary was in a nursing home, discharged there temporarily from hospital. She had regular contact with friends through a range of social media that she managed herself. Mary also discussed her regular television scheduling of quiz shows to keep her brain active, talking with disdain about people who went on to television and did not know the answers, when she often did! Mary was incredibly alert, clearly intelligent and expressed she was just waiting to be able to go home. She had significant physical health needs which she was able to describe in detail. Mary was clear in her view she had agreed to the nursing care as a short-term arrangement to enable time to arrange care at home. In an MDT meeting to discuss plans (at which Mary was not present), a specialist nurse who had known Mary for several years stated that '[Mary] hasn't got capacity. People who meet her at first thinks she has but she fools them!' (data extract MDT:SW1/Mary(3)).

The statement that Mary 'fools' people (data extract MDT:SW1/Mary(3)) is specific account (Garfinkel, 1967) designed to label Mary in relation to a functional decline, certainly not a premise of belief in the person (Saleebey, 2000). As a specialist practitioner, the view of this nurse would seem to suggest that Mary's condition would meet the first criteria for determining capacity, however it is primarily a physical disability. A letter outlining a cognitive assessment for Mary undertaken by a clinical psychologist assessment concluded:

> Mary is a lady with [….] progressive [condition] […] Formal testing showed […] average ranges […] perceptual, language, learning, recall, attention and executive skills [….] observational evidence suggested […] mild but clinically significant […] executive changes […] verbal disinhibition, perseverance on topic/task […] poor problem solving in daily life situations […] I am of the opinion […] likely attributable directly to [condition] progression […] Capacity will best be supported by […] opportunities to experience options available to her […] feedback […] risk issues and solutions as the arise'. (Data extract LET:Mary(1))

In this letter each of the functional tests is set out with a score and grading, indicating Mary is in the average range and there are no cognitive concerns. However, the reference to discussions that the psychologist had had with Mary, and the feedback from the care home, was that there was a continuous reference to challenges with her bowels leading the psychologists 'observational evidence' of 'verbal disinhibition' (data extract LET:Mary(1)). This observational evidence is reflected in the social worker's own recordings a year later, and can be seen in the conclusion of the mental capacity assessment:

> Having met with Mary on many occasions and despite attempting to explore her understanding of all the different areas of her care, Mary's conversation always appears cyclical in nature and returned on every occasion to her belief that she requires daily enemas (which has been stopped) […] her wish to return home despite [...] attempting to focus Mary on key concerns around risk to her physical and personal wellbeing [...] she has a Grade 4 Pressure Sore[...] concerns around her tissue viability and the need to be turned in bed every 2 hours [...] interference with her catheter[...] potential risk of infection [...] these factors were denied or ignored by Mary and discussion shifted to what her belief her care needs were. In addition, despite repeated warnings [...] around the risks of enemas [...] and [...] evidence[...] Mary was [...] passing stools with[out] [...] suppositories or laxatives, she insist that she requires enemas [...] following a comprehensive assessment of [...] capacity to make an informed decision around her future residency by weighing up and understanding the key information related to the decision, I have concluded that Mary lacks the capacity to make the required decision. (data extract MCA:Mary(1)**)**

In both the psychologist's letter and the social worker's capacity assessment the conclusion is that Mary's intensive focus on her personal care needs and the belief that she would be fine at home is evidence of her lack of capacity. The rationale for the decision making around this was the evident risk factors, with two being highlighted, skin damage and pressure area care. The basis for doubting capacity was one of insight, or in terms of mental capacity determination, the ability to balance or 'weigh' the risk (Mental Capacity Act, 2005:3(1b)). In this the ethnomethodological concept of indexicality (Garfinkel, 1967) is again evident. The context in which Mary's capacity is understood has changed based on the assessment of her lack of appreciation and understanding of the risk factors. Mary was concerned about her bowels, insisting that she needed enemas - but this view was not backed up by her care team. She was less concerned about her pressure areas, the issue that was most important to her health team. This revealed the differential power imbalances about what is acceptable risk (Horlick-Jones, 2005; Foot *et al*., 2014). This incongruence between Mary's view of what was important and her care needs was key to the decision that she did not have capacity. The capacity assessment ignores the string of formal testing undertaken by the psychologist (evidencing that Mary is within average ranges), in favour of the observational evidence that Mary does not appreciate the risks of having periods of time without care in place. The criteria for lack of capacity includes a requirement for a mental disorder to be causally linked to the ability to make the decision ([2020] EWCOP 29), a principle that forms part of both the Mental Health Act (1983) and the Mental Capacity Act (2005) (James *et al*., 2019).

Recent case law has cautioned against equating lack of insight with lack of capacity in certain circumstances ([2023] EWCOP 27). In other cases, a person can be deemed not to have capacity in relation to residence if they refuse to accept care assessed as being needed by professionals within this environment ([2021] EWCOP 50). In Mary's situation, it is not that she was unwilling to accept care - it was the level of care that Mary specified that she would require being insufficient to meet her needs. However, as discussed previously with reference to Joan, case law indicates an inability to describe care needs effectively should not necessarily be taken as evidence of lack of capacity ([2012] EWCOP 2136).

Over the course of the study the social worker's thinking evolved from a determination that Mary had capacity to Mary not having capacity. The social worker was initially confident that Mary had capacity, although less convinced that needs could be met at home. However, twelve months later in a follow-up conversation, the social worker confirmed that they no longer believed Mary had capacity regarding her decision to return home. The social worker's original assessment shifted over time, not through new evidence about Mary's cognitive functioning *per se*, but reflexively (Garfinkel, 1967) through the increased focus on the impact on Mary's health needs. Capacity was considered in the context of other expert professional's accounts, alongside the realisation that the care package likely to be needed to mitigate those risks was not going to be deliverable.

Mary's views were unwaveringly consistent; she wanted to go home. This was articulated in her capacity assessments, was evident in field observations, and documented in her Assessment. Other ethnographies have observed that social workers will actively advocate for people with capacity making unwise decisions (Burrows, 2022), however in this case I observed a more complex phenomenon; that the choices a person was making presented a risk that challenged the nature of the capacity a person had to make this, stretching the role of the MDT into a 'controlling and protecting function' (Taylor, 2006:1419). In Mary's situation it could be argued that she was displaying concretized emotion-belief complex (Halpern, 2012) in which her rational understanding and decision making was overridden by her belief. To Mary, management of her bowel movements was important. This led to a determination of lacking capacity as this was contrary to the privileged (Robinson *et al*., 2018) MDT view which was that pressure care was the most crucial factor.

Alternatively, it could be that Mary was so desperate to get home that the issue of pressure areas, which were poorly controlled even within the care home environment, were a less important than being in her own home, potentially an unwise rather than an incapacitated decision. Burgess (2020) highlights the challenges of determining capacity, noting that professionals sometimes use legal frameworks to enforce compliance (James *et al*., 2020). Other studies have suggested a strong association between the participant's view of danger and the assessment of a person's capacity (McDermott, 2010). This also resonates with studies considered in the literature review that suggest that capacity assessment across a range of contexts can be manipulated to justify interventions to prevent neglect (Aspinwall-Roberts *et al*., 2022), that external factors rather than functioning can impact on capacity (Keeling, 2017), and that there can be a focus on legal practices rather than the view of the person (Robb and McCarthy, 2023).

The capacity assessment reflected a split opinion amongst people that knew Mary about whether she did have capacity to make that decision. The social worker did not rush the capacity assessment and carefully recorded Mary's responses to questions when making this decision; ultimately the decision was that she lacked capacity in relation to this issue. Accepting this, it is the Best Interest decision that ultimately determined Mary's future. This was completed by the social worker and considered two options – going home and remaining in the care home.

Best Interests Decision

In the best interest document, the social worker clearly articulates 'Mary has stated consistently that she wishes to go home' (BID:Mary(1)), and this phrase is repeated several times in the document demonstrating the social worker recognised and acknowledged Mary's preferred view. The social worker completed a best interest balance sheet – which, although not a statutory part of the Mental Capacity Act, has been recognised in case law as best practice (Thompson Reuters Practical Law, 2025). The best interest template has a standardised rating system, and three areas are considered: physical, psychological, and social, with likelihood of advantage/disadvantage occurring on a scale of one to four, with four being the highest (BID:Mary(2))[6]. As with the assessment document (discussed in chapter four), this best interest assessment is also a 'preconstructed object' (Bourdieu and Waquant, 1992) setting out a standardised process for making and scoring the options - although unlike the assessment, the statements that form the balance sheet are not predefined. In Mary's best interest decisions two consultees are named: Mary and the specialist nurse. Two options were evaluated. The first was 'for Mary to return home with an enhanced package of care and other support services in place (such as District Nurses) and (out of hours doctors)'. Seven advantages were listed, six of which were scored. In summary,

---

[6] Balance sheet scoring best interest decision likelihood of advantage occurring (1-Definitely won't 2-Probably won't 3-Probably will 4-Definitely will). Likelihood of disadvantage occurring 1-Definitely won't 2-Probably won't 3-Probably will 4-Definitely will) standardised scoring taken from best interest decision making tool.

these were 'a familiar environment, specialised support, better access to family/friend support and care when she required', with an overall score of 27. Ten disadvantages were listed, all of which were scored. In summary, these were: 'not being able to get support when needed, requirement of specialist health intervention, need for enemas, cost of care maybe prohibitive, lack of understanding of risks/health needs, house may not be suitable, periods of time without support. Overall rating of 36' (information summarised from BID:Mary(3)).

The outcome of the balance sheet was that the disadvantages of going home were higher than the advantages, however there are no references to this being Mary’s preferred choice within the options. Despite this being noted in other parts of the document, Mary’s views were not actually taken account in the decision-making process; ethnomethodologically, her voice was downgraded. As Burgess posits 'it is easier to prove a person suffered broken bones than a broken heart' (James *et al.*, 2020:50-51), and there is significant written evidence both in Mary’s documentation and from field observation that her one wish was to return home, but this was excluded as a factor in balancing the decision.

Interestingly the potential prohibitive cost of care was considered as a disadvantage, which added weight to the disadvantage. Issues around lack of resources and social workers techniques for managing this in practice are discussed in chapter five. Case law has confirmed that best interest decisions are confined to available options (N v ACCG [2017] UKSC 22), therefore if the option of care at home is prohibitive based on costs, then this should not be an option to consider. The language is interesting as it says, 'may be' ((BID:Mary(3)) rather than it is prohibitive. This is important as the courts have overturned unanimous best interest decisions to keep a person in a care home against their will when a care package can be provided in the community, even when engagement with this support is not consistent ([2023] EWCOP 1). For Mary the issue was not engagement but whether the package was available.

Another disadvantage was whether Mary's house was suitable. However, in Mary's Care Act (2014) assessment the section on home reads:

> I own a property in [place] which is a bungalow. This is one of ten properties in a development for older people. I had input into the design of the property and the facilities within the home. (data extract record:SW1/Mary(6))

In this extract there is no reference to Mary's environment not being suitable, which would raise a question about why this was included on the balance sheet. The second option considered was 'For Mary to be placed in [Name] Care Home on a permanent basis in order to ensure her care needs are met' (BID:Mary(4)) Eight advantages were listed, all of which were rated. These can be summarised as:

> getting the medical treatment she requires, interventions in an emergency, the turning she requires to reduce risk of pressure sore, pain can be monitored, have access to support immediately, mental health support, receive visitors as and when she wishes to have them, environment geared to supporting her care needs. Overall rating 32. (summarised from BID:Mary(4))

Six disadvantages, all rated, were summarised as:

> May present with challenging behaviour and mental health needs, may say [she has] not had care when she has, most restrictive option, Mary has said she does not want to mix with others, Overall rating of 21. (summarised from BID:Mary(4))

The disadvantages included reference to the placement as 'the most restrictive option' (BID:Mary(4)), but the option of going home does not list a benefit of the least restrictive option. The disadvantages of the placement considered impact on mental health needs, which could be an impact of staying in the care home, but being supported, whereas a positive impact on Mary's mental health is not considered in the benefits in the options for going home. The advantage being that mental health can be supported within the care home environment, disregarding the concept that it is this environment that is the cause of the potential mental health need.

Considering the best interest decision through both a strengths-based and an ethnomethodological lens demonstrates interesting tensions. Mental health recovery is linked to regaining power and control (Tew, 2012), which for Mary will not happen if she remains in the care home. To ensure that a Best Interest decision can be considered, an assessment of need should be completed before the capacity assessment (Murrell and McCalla, 2016). In Mary's case the social worker had completed the assessment and was always concerned that the level of support available to Mary at home was not sufficient. The notion that identifying risk can be a method of social control (Fanning, 2016) is based on the acceptance that people will behave in a certain way if they were aware of the risks (Horlick-Jones and Prades, 2009).

Overall, the balance sheet rated the disadvantages for Mary of going home outweighed the advantages, and the advantages of remaining in the care home outweighed the disadvantages. Case law states that balance sheets should not be simply quantitative but also evaluative ([2016] EWCA Civ 759) - and should highlight the importance of view of the person within the decision-making process (Series, 2015). In considering Best Interests, the Courts reference specific considerations - essentially the choice a person would have made if they had capacity. Examples include refusals of medical treatment on religious grounds ([2015] EWCOP 60), previously expressed views, preferences, wishes, and the consistency of such ([2020] EWCOP 26; [2015] EWCOP 60) - including decisions not to continue life sustaining treatment ([2016] EWCOP 53). Each of these can be summarised by the balance of clinical treatment not outweighing the emphasis on the persons views as the 'core aspect of the 'objective best interests' test' (Essex Chambers, 2025(c) in reference to ([2013] UKSC 67).

One thing that was clear when considering this through the lens of strength-based approach in this scenario was that this Best Interest decision focused on management of health needs, pressure care, and bowel movements, which overruled Mary’s desired outcome. Taylor (2006) highlights that the provisions of Best Interest decision making are open to interpretation, which can lead to clinical interests outweighing the views of the person when these appear incompatible. This is particularly relevant as the specialist nurse consulted had specific views about Mary, leading to questions raised in studies about the role of the suitable person in best interests (Jepson *et al*., 2016). This privileging of hierarchies of knowledge (Robinson *et al*., 2018) resulted in a lack of weighting of Mary’s view against the overarching requirement to keep her safe, and the scoring attempts to quantify rather than consider the contextual factors (Kong *et al*., 2020), therefore functioning as justification for the MDT’s opinion of what was best for Mary rather than what was in her best interests.

In the fourteen or so months I shadowed the social worker, Mary was temporarily in one nursing home and was admitted to hospital and discharged to a second nursing home (after the first one gave notice). During this time Mary’s house was unoccupied. The reality of the situation for the social worker was that they did not believe the services were available to enable Mary to receive the level of support that she would require at home. The best interest decision was linear - home or care home. There was no suggestion of direct payments in the observed field work interactions with the social worker, or within the written records review. Mary's assessment of capacity was confined to understanding her care and support needs. There were no concerns about her cognitive abilities to manage finances and therefore direct payments could have provided an alternative option. Similarly, there was no discussion about a mixed package of care that incorporated periods of respite and recovery alongside going home.

One of the fundamental bases of a strengths-based approach is to enable the person's story to be heard (Rapp *et al*., 2006). However, MDT working is a bedrock of day-to-day work and a collaborative professional approach. Greene and Lee argue that effective MDT working is essential to promoting a strengths approach in a 'deficit environment' (2011:153) as it provides the opportunities and environment to manoeuvre and influence the discussions away from deficits towards possibilities and improvements. However, in the case of Mary the data suggested that the MDT influence had the opposite effect and fuelled by a lack of available local community support, it was agreed that Mary should remain in a care home for her best interests.

For Mary it was difficult to see the features of strengths-based working in action. The initial discussion witnessed in the field observations (and discussed in chapter four) showed that conversations were recorded in the assessment in a deficit manner, and a similar picture could be seen in the mental capacity assessment and best interest tool. If we compare the approach of the social worker to Mary to another of their interactions with John, the situation is quite different, highlighting that the MDT can be both a positive and a negative force within the construct of managing risky decisions.

John: capacity and risk taking:

John has been discussed in detail in other chapters, specifically in respect of the relationship his social worker had with him, and how they supported him with a variety of risks. An MDT strategy meeting in response to a particular a set of behaviours, namely phoning the ambulance service incessantly in the middle of the night, led to a detailed discussion around the rationale, the consequence, and the action that could be taken to reduce these behaviours. Across the multitude of professionals involved (ambulance service, psychologist, social worker, care providers) there was a consensus that John did have the capacity to understand his actions and was making unwise choices. In this context the discussions were focused on strategies for management and reduction of the risk rather than control of John.

Comparing the approach to John and Mary provides a stark contrast. In both cases the social worker actively engages with a multi-disciplinary team to navigate the complexities of risk and capacity. Examining these two scenarios through an ethnomethodological lens (Garfinkel, 1967), one could consider the sociological contexts of these two multi-disciplinary team scenarios in how the collective view shaped the narrative; Mary was already away from home and returning home presented a risk, whereas John was at risk, at home, and would not have consented to going into a care home given it is much harder to remove someone from their home than to prevent them from returning to it. In Mary's case the social worker was initially concerned about the practicalities of getting her home, particularly given a shortage of care capacity in the area. The influence of others within the space changed this narrative to a scenario in which she could not go home due to associated risks. It could be argued that the Best Interest decision was in the best interests of the health and social care team regarding what they could provide, rather than in the best interests of Mary. The common-sense knowledge (Garfinkel, 1967) about Mary was that she did not have capacity in line with the Mental Capacity Act (2005). It therefore followed that a decision needed to be made in her Best Interests. The resulting decision directly conflicted with what she wanted. If fundamentally the answer to the question about Mary's capacity was that she was able to self-determine, the management of the associated care plan would have been different.

Mary was already out of her home environment and had been for over two years. The challenge for the social worker was that the specific risks identified for Mary were physical health risks that fell within the remit of the health system to manage, specifically skin damage and continence management. This imbalance in role authority matters (Horlick-Jones, 2005; Strong in Horlick-Jones, 2009) as it highlights well-rehearsed power inequities between health professionals and Mary as a 'patient' (Ocloo *et al*., 2020; Odero *et al*., 2020; Joseph-Williams *et al*., 2014). The consequence was that these health elements could not be adequately balanced against risks to Mary's well-being, a Care Act (2014) requirement, privileging professional health over social care hierarchies.

In John's situation the MDT were unanimous in their opinion that John had capacity around his persistent calling of the ambulance service yet shied away from what could have been potentially draconian options to manage this; prosecution, refusal to send an ambulance, and other similar actions. The agreed approach was to provide behavioural change support, which, interestingly, the psychologist ascertained could only be provided effectively through a specialist residential facility (MDT:SW1/John(3)). Unsurprisingly, John refused this option. The social worker consistently reflected on the challenges with relation to supporting John which were multi-faceted and, as discussed in other chapters, not simply limited to his inclination to phone the ambulance service in the middle of night. Provision of services were not a solution, as a number had been trailed unsuccessfully. John needed something different. John's social worker consistently focused on John's strengths to overcome other challenges, highlighting the ongoing commitment to the relational approach.

John and Mary were both relatively young in adult social care terms; Mary was in her mid-sixties and John in his mid-fifties. Comparing the respective circumstances supports earlier work that suggests social workers are more likely to promote rights-based practice when a person is believed to have capacity (Lelkes *et al*., 2021; Symonds *et al*., 2018; Price *et al*., 2020; Lonbay, 2018; Cooper, 2018). However, returning to the chapter on risk, there were areas in which John was assessed as lacking capacity – namely his ability to prevent financial abuse. This assessment did not prevent the social worker advocating on his behalf that he did not want to move out of his flat to keep himself safe, recognising John's autonomy within the best interest decision, and again highlighting the strength of the relationship (Brun and Rapp, 2021) that existed between John and the social worker. Although Mary's social worker had a longevity of involvement, the relationship was not a relationship based one, but a functional one to resolve a care package.

Summary

This chapter has looked specifically at the social construction of capacity under the Mental Capacity Act (2005), and is application to work with Joan, Betty, Phyliss, Mary, and John. The first significant point to note is that capacity assessments are deeply embedded in social work practice, even when it is not formally recorded. It is a continuous consideration even if not recorded as such, as with Betty and Phyliss. While the Mental Capacity Act legislates assumed capacity, practically it can be argued that social workers don't assume capacity but consider it continuously as part of their day-to-day practice, sometimes unconsciously or informally, and at other times more formally and structurally. In the literature review I highlighted how strengths-based practice within the area of risk could be seen through SMCM relational social work more generally (Robb and McCarthy, 2023), and this can be seen for both Joan and John. Strengths-based practice and risk management were symbiotic with rights-based practice (McDonald, 2010), and this could be seen with Joan, Betty, and John. As demonstrated with Mary, this was less likely to occur when capacity was a concern (Lelkes *et al*., 2021). Other research observations were also apparent including a prioritisation of professional and technical element (McDonald, 2010) and assessments (Symonds *et al*., 2018). A lack of capacity was used to justify more restrictive options (Aspinwall-Roberts *et al*., 2022). There was less focus on the views of the person (Robb and McCarthy, 2023) and more focus on external factors rather than functioning (Keeling 2017). Conversely the opposite was also observable; Joan's social worker did intend to try to get her home, regardless of capacity and risk, if she was clear on that as the preferred option, and John' social worker advocated for John even in areas in which he was assessed as lacking capacity.

Research undertaken utilising mobile methods has provided insights on how social workers navigate and adjust their interactions with people to form a professional judgement of what is going on, rather than using a formulaic approach (Cefai, 2015; Ferguson, 2014; Ferguson, 2016). My data highlighted that miscommunication, social context, and conflicting narratives can mimic cognitive impairment, and decisions about capacity can be made and influenced in the moment by perceptions of professional hierarchies of knowledge (Robinson. *et al*, 2018). The data revealed that the professional constructions informed and shaped views of capacity and best interest. There is a fundamental question about the role of the social worker for adults in achieving the right balance between ensuring safety for people who are unable to protect themselves and enabling a person to maintain independence when they may no longer have the mental capacity to understand how to keep themselves safe. Strengths-based approaches would acknowledge the factors within, and surrounding, the person, alongside any memory or dementia considerations (Nelson-Becker *et al*., 2020). The question of how involved social workers should be is multi-faceted and has political and ideological undertones. Navigating between the Mental Capacity Act (2005) and the Care Act (2014) is particularly challenging (Pritchard-Jones, 2020).

The data reveals that the notion of capacity, the legal basis of this determination, and more importantly best interests' decision making, were continuous challenges for social workers. The strength of relationship between the social worker, the person supported, and the MDT were also significant factors in how autonomy was supported when capacity was in doubt.

Managing a delicate equilibrium is something that social workers are accomplishing on a day-to-day basis and, within this research, I could see examples of how external factors, such as the views of family and friends and other professionals can lead to a pseudo strengths-approach, over shadowing of the person's views and wishes in favour of keeping them safe.

7. Conclusions

This chapter summarises the findings of this study on strengths-based social work practice, explores its limitations, and identifies areas for future research. It discusses key conclusions and their relevance, outlines implications for practice, and ends with final reflections.

In chapter four I examined the realities of embedding strengths-based practice within the statuary framework of the Care Act (2014), particularly focusing on Care Act assessments (2014: s9). A considerable proportion of the ethnographic field observations between social workers and people with lived experience was related to assessment activity, and this finding emerged from reviewing the written records of field observations against the observed interactions. During the observations I noted the social workers' skills, sensitivity, and precision in ensuring that the discussions captured the information required to complete the assessment with a focus on strengths such as interests, relationships, and history. There was evidence of rights-based, ethical, and candid discussions balancing honesty and support and, at times, advocacy. There was effective use of existing relationships and assets to support conversations. In direct practice, social workers frequently embodied strengths-based principles such as hope-inducing interventions, the mobilisation of networks, and person-centred planning.

Although different social workers undertook the assessments there was a recognisable structure to these interactions. They were 'preconstructed' (Bourdieu and Waquant, 1992) for the purpose of achieving an outcome – to capture the data needed to complete the form. I was fortunate to have consent to access the completed forms, and it was here the ethnography entered another dimension. Analysis highlighted a marked difference between conversation practice and recording in that the written narrative did not reflect the spirit of the conversation. This assessment form, the second element of the preconstructed object (Bourdieu and Waquant, 1992), was structured in a way that undermined the concepts of strengths, despite written guidance to the contrary.

The role of language was of particular interest. Deficit-oriented phrases, often perpetuated through auto-population within electronic systems, reinforced labels such as 'cognitive decline' or 'risk of self-neglect' (data extract record:SW1/John(3)(4)), shaping not just how people were seen at that point in time, but also how they would be viewed in future interactions. The analysis found this replication of negative descriptors not only undermined strengths-based approaches but also created institutionalised deficit narratives across a person’s case history, raising interesting considerations for how IT solutions aimed to reduce bureaucracy could inadvertently magnify discriminatory uses of language.

Using the legal framework of the Care Act (2014) and associated case law, my data further showed that the design of the form promoted statutory non-compliance as eligibility was used as *de facto* prescription of need rather than needs being identified by the person being assessed and then eligibility being determined against the domains set out in The Care and Support (Eligibility Criteria) Regulations (2015).

The data also demonstrated that the wellbeing principle (Care Act, 2014:1) was inconsistently interpreted and not covered directly in any of the assessment conversations. Interpretations of the impact of need on wellbeing ranged from a mapping of need against a particular wellbeing element, a subjective feeling assigned to the person, or an interpretation of the needs as the wellbeing principle itself. This inconsistency reinforces the suggestion that application of wellbeing principles to need was about demonstrating eligibility, rather than empowerment of individual outcomes.

In summary the data showed that strengths-based approaches could be observed within direct interactions, but structural design of assessments results in a use of deficit language for recording. This is exacerbated by digital solutions that replicate this. Relational social work offered better opportunities to manage these tensions and embed strengths-based process, but even in these contexts the preconstructed (Bourdieu and Waquant, 1992) nature of the assessment limited the extent to which social workers could maintain a strengths-focus.

The second topic in chapter five arose from reviewing survey comments, which frequently highlighted risk issues. The survey surfaced challenges of enabling autonomy and positive risk taking against relational, systemic, and organisational barriers. The observational data revealed how these tensions were navigated and managed within day-to-day practice.

The chapter used a mixture of survey comments and observational data. The survey data indicated that practitioners understood ‘dignity of risk’ (Perske, 1972) and could link this knowledge with rights-based practice aligning risk taking with the strengths-based traits of capability and resilience (Saleebey, 2006). This comprehension was caveated with barriers to practicing in this way due to limited relational knowledge, structural challenges, and the influences of others within this space.

For each of the challenges identified in survey data, observations in practice showed how social workers navigated these, from acting as advocates for people making risky decisions, to highlighting structural pressures to prioritise safety over empowerment, and circumnavigating process and compliance to reduce risk. The data enabled insight into the complexity of balancing risk and strengths in practice, including examples of social networks that represent a source of resilience for people potentially also causing harm. The duality of balancing being 'at risk' and 'a risk' (Stanford, 2010) required skill and was navigated through collaboration with people and their wider networks of support. The data also demonstrated the pressure of prioritising safety over empowerment.

The data also showed how social workers used their skills to support safety within the context of limited availability of resources. This included intervening more actively with people for whom services were not available and using creativity and blurring of statutory boundaries to compensate for structural challenges with lack of available services, supporting a critique of the approach (Gray 2011; Withers and Pollock, 2020).

The role of partners in understanding and navigating risk taking was a significant factor in positive risk taking. Family and friend carers were recognised as being influenced through 'affect heuristics' (Slovic *et al*., 2013; Slovic 2010; Finucane *et al*., 2000), where emotions amplify perceived dangers. Social workers employed strategies to mediate these responses, including open communication, involving carers in decision-making, and reframing strengths to build confidence.

Care providers were another key influence. While regulation by the Care Quality Commission (CQC, 2025a) requires both autonomy and risk mitigation, survey data indicated this led to defensive practice. However, within observational data positive risk-taking was facilitated when social workers and providers had established, trust-based relationships. Joint discussions with people drawing on support, providers, and families allowed triangulation of perspectives, enabling proportionate strengths-based approaches to risk management.

Health colleagues were frequently perceived as more risk-averse in survey data, supporting previous analysis on the professional differences between health and social care systems.

However, in practice, the role and make-up of the MDT both enabled positive risk taking and reinforced more restrictive practice.

Multi-disciplinary team working often shaped the nature of managing risk. Within meetings social workers often functioned as advocates, but the absence of individuals themselves from these discussions limited authenticity in strengths-based practice. While advocates occasionally bridged this gap, the exclusion of people from risk deliberations contradicted the ethos of 'dignity of risk' (Perske, 1972).

Organisational and systemic factors also impacted on risk. Survey comments reflected previous literature that austerity (The King's Fund, 2025; Foster, 2025; Murphy *et al*., 2025; ADASS, 2025) and managerialism Matarese and Caswell, 2018; Gillingham and Humphreys, 2009; Harris, 1998; Harlow, 2003; Harlow *et al*., 2013; The social work taskforce, 2009) impacted on approach to risk. The newly emerging role of the Care Quality Commission in local authority assessment was also seen as a driver. Observational data showed that in these instances social workers adopted role distancing (Goffman, 1959) and used work arounds to improve outcomes for individuals - but as such were reinforcing social injustices.

Overall, the findings demonstrate that social workers understand and often practice positive risk-taking, despite the perceived and real constraints of dynamics with family and friend carers, provider defensiveness, health-sector hierarchies, and organisational pressures that privilege safety, compliance, and resource management over autonomy and empowerment.

Chapter six focused on the issue of mental capacity and strengths-based approaches. As highlighted in the literature review, previous studies indicated that social workers find it more challenging to promote strengths when there are concerns about capacity (Symonds *et al*., 2018; Price *et al*., 2020; Lonbay, 2018; Cooper, 2018), and in this chapter I explored how social workers actively integrated dynamic assessments of mental capacity (Mental Capacity Act, 2005) into their day-to-day practice. To explore this concept, I approached analysis through a series of case studies drawing on ethnomethodology (Garfinkel, 1967), alongside the statutory framework of the Mental Capacity Act and the Mental Capacity Act Code of Practice (2020), and case law to look at the way social workers engage with, and construct capacity assessments within practice. The data revealed how the social workers employed their tacit skills and knowledge operationally, balancing compliance, professional judgement, and social constructs when undertaking these assessments.

The data showed that social workers recognised the importance of supporting individuals to make decisions, using mental capacity as a positive tool to promote autonomy in the face of external challenges, to demonstrate reasoning, articulate preferences, and promote strengths. When it came to Best Interest decisions, however, the focus on autonomy was less prevalent and, in some cases, used as a tool to overrule autonomy. The key difference between best interest decisions that promoted independence and autonomy and those that did not was the impact of the multi-disciplinary team makeup and attitudes.

Analysis of the electronic recording of capacity assessments underscored the importance of process and application of this to decision-making. Attempts to weigh best interest options used scoring mechanisms that were professionally led, rather than focused on what was important to the person, undermined the sense of rights-based justice within the approach.

Overall, the findings showed that social workers could understand and enact strengths-based practice, but this was more evident when the relational element of social work was stronger. Recording systems mandated and reinforced deficit-based assessment, which was not necessarily statutorily compliant. Automatic pre-population tools in electronic case management systems magnified the impact of this.

Limitations of study and opportunities for future research

This study is, by design, small scale and qualitative. Involvement in this study was voluntary and, although extended to all adult social workers in the host authority, those that choose to take part reported that their motivations were an interest in strengths-based approaches and improving their own practice. This may not be a reflective position for all adult social workers in England.

As discussed in the methodology, the participant sample, although demographically representative of area in which it took place, is not demographically representative of the wider population of England. Similarly, Council structures, organisational arrangements, and culture will vary across single and two-tier authority structures, different political agendas, and geographical makeup of the area. There will also be differences in range of resources and other factors. Data collection took place between 2022 and 2023, which was at the start of the international recruitment drive for adult social care, and unmet care needs were particularly high across the county at this time and acutely experienced within the research site. Lack of access to care was a prevalent consideration for participants at this time.

Future research could explore further the links between strengths-based approaches and language used in recording systems, and how digital recording systems shape and influence practice, and considering discursive and disability rights perspectives to make recommendations.

Engaging directly with people with lived experience separately to social workers was an ambition for this study that did not come to fruition due to challenges within the study site.

In this study I have used what I observed, heard, and saw to understand how people who draw on social care interventions experienced these, but there are opportunities to build on this further to understand what happened before and after the intervention from the perspective of a person with lived experience.

The survey data was at times supported by the field observations and reviews of records; at other times there was a significant difference. This raises an interesting question about measurement. Although most studies and reports reviewed in the literature were qualitative in nature, those conducted in the UK relied predominantly on participant feedback rather than observational methods - a distinction noted in previous research for revealing specific challenges (Jerolmack and Khan, 2014). It would be helpful, when trying to understand practice, to be able to increase the number of practice ethnographies to enable insights into behaviours through actions.

Whilst there is a focus on the structural challenges of adult social care, and this is being considered through the current Casey review (Casey Commission, 2025), it would be useful for future research to focus on how to make these changes in a sustainable way.

Discussions and conclusions

It would be easy to write another piece on how social work practice is stifled by managerialism (Matarese and Caswell, 2018; Gillingham and Humphreys, 2009; Harris, 1998; Harlow, 2003; Harlow *et al*., 2013; The social work taskforce, 2009) and austerity (The King's Fund, 2025; Foster, 2025; Murphy *et al*., 2025; ADASS, 2025). As I said in my introduction, I accept these realities and reference them within this thesis as they are relevant. In the spirit of my constructionist ontology, I accept these as ordinary factors (Garfinkel, 1967) – indeed there are references in each of the chapters that highlight extensive waits and lack of care provision. Both Renee and Phyliss waited several weeks for their assessments; Joan was placed in a care home away from her friends and family; Betty, who specifically requested an out of area care home to be near her family, was placed in a care home near where she had been living – not near her family - and was still there over a year later; Mary was discharged to a care home from hospital and the social worker believed there was never realistically the care available to get her home; John was on the waiting list for care at night; and there was no immediately available reablement or care at home for the family that requested support for their father through the duty system. There was a significant backlog of unallocated work as highlighted though the new duty process. I clearly do not think that these are acceptable or positive attributes of social care, and my acknowledgement of these factors is not, in any sense, intended to downplay or belittle these realities for the individuals involved or the social workers working in this environment. However, in the spirit of a strengths-based approach it is through the context of these circumstances that I consider the practices I witnessed, despite these structural system deficits.

In my literature review I reject the notion that there is an insufficient evidence base for a strengths-based approach because it is not measurable in a traditionally positivist manner. I accept the contributions, with their potential limitations, which come from the various grey-literature reports and peer reviewed journal articles, and aim to go a step further to see what can be learned from getting close to practice. My research was inevitably curbed by the constraints of a professional doctorate; completions alongside full-time work, family commitments, and word constraints compared to a traditional doctorate. As such, my three findings' chapters are focused very deliberately on elements of practice that have not received as much attention in the English-centric literature.

The literature highlighted that in England there was a significant focus on implementation of strengths-based approach as being an early intervention with a focus on the community support elements. Studies also suggested that when it came to more intensive working the approach is less effective if applied at point of crisis (Caiels *et al*., 2024; Jessops *et al*., 2025). Capacity was a crucial factor (Price *et al*., 2020; Lonbay, 2018), and capacity assessments could be manipulated to justify both action and inaction (Aspinwall-Roberts *et al*., 2022). If capacity was a concern, then approaches were more risk adverse (Symonds *et al*., 2018; Price *et al*., 2020) and safeguarding less personalised (Price *et al*., 2020; Lonbay, 2018; Cooper, 2018; Lonbay and Barndon, 2017). It is this area of practice that my ethnography focuses on, and my analysis led me to four conclusions for discussion:

- Strengths-based practice was strong when there was a relationship-based approach.
- There is a need to bridge the divide between bureaucracy and practice to ensure statutory compliance and continuous focus on strengths.
- The importance of language in recording cannot be underestimated, and this needs significant consideration with the introduction of generative artificial intelligence.
- In line with other studies, the relationship between risk enablement, risk dignity, and strengths is impacted by a range of relationship and organisational factors. Social workers are good at supporting positive risk taking for people with capacity but, in line with other research, there is further work needed when capacity is a concern.

Relationship based social work

The concept of relationship based social work features across the three analytic areas as a critical, but under-acknowledged, element of how social work practice embodies strengths-based approaches and rights-based approaches. The model of application used within the literature review is strengths-model case management (Brun and Rapp, 2001). I chose not to adopt this nomenclature, recognising (as Rapp and Goscha (2004) did) that this is not strengths-based language. This is a helpful point of reference for broader relationship models that enable social workers to genuinely embrace strengths-based, risk enabling approaches for people despite statutory and organisational constraints, and external influences.

Chapter four discusses how relational social work enables more comprehensive strengths-based assessments, providing social workers with increased knowledge of individuals and allowing for improved documentation of outcomes through relational insights and contextual understanding. This approach offers an alternative to the limitations posed by standardised assessment tools, and facilitates creative practice within organisational boundaries.

In chapter five, relational social work demonstrated how practitioners balanced autonomy with risks, including safeguarding measures and balancing paternalistic interventions with coproduced risk enablement and proportionate responses. Risk was considered dynamically and involved the person, their family and friend carers, care providers and others, particularly health professionals. The relationship provided continuity and advocacy, allowing a mediation on balancing risk – however, even in these circumstances, there were still opportunities for people to be more involved in self-determination within multi-disciplinary discussion.

In chapter six the role of relational social work was less explicit but still significant. Capacity was supported as a general principle, and relationships were key to the promotion of strengths. The findings indicated that relational social work was not necessarily synonymous with longevity of involvement, but a subtler, nuanced relationship-building and rights-based approach. Long-term relationships focused exclusively on care outcomes rather than relational intervention did not demonstrate the characteristics of relational social work, even with ongoing involvement.

Bridging the divide between bureaucracy and practice

Social workers employed in a local authority adult services department in England statutorily operate under the duty of the Care Act (2014). The premise of strengths within the legislative context is consistently reinforced throughout the Care and Support Statutory Guidance (2025). The duties to assess, determine eligibility, and promote wellbeing are considered within an assessment tool. In practice, comparisons between conversations with people and the resulting recordings showed a significant difference between what was said and what was written, driven by the structure of the form template. This suggests social workers are struggling to balance strengths and compliance.

The Care Act (2014) assessment process is set out in sections 9 and 10, with section 9 specifically focused on the person with an appearance of need for care and support, and section 10 focused on carers needs (Care Act, 2014:s9 & s10). In this analysis the undertaking of an assessment conversation and the subsequent recording were treated as separate but interlinked preconstructed objects (Bourdieu and Waquant, 1992). These set the nature and tone for how interactions were constructed and recorded. Whilst intended to have a strengths-focus, the assessment was structured to privilege professional views over the view of the person, needs were pre-defined not co-produced, and there was no clear shared understanding of the wellbeing principle embedded in practice.

Furthermore, it emerged that the basis of the form did not capture the requirements of the Care Act (2014) itself, with a conflation of identification of need and eligibility determination. The Care Act (2014) clearly sets out definitions for the eligibility domains and elements of well-being, but the issue of need is less clearly defined - simply stating:

> Where it appears to a local authority that an adult may have needs for care and support, the authority must assess:
>
> (a)whether the adult does have needs for care and support, and
>
> (b)if the adult does, what those needs are. (Care Act, 2014: s9(1))

The issue of what a social care need is has been established in case law going back to the NHS and Community Care Act (Spencer-Lane, 2019) and has a variety of descriptors including Lord Lloyds interpretation: 'To need is not the same as to want. “Need” is the lack of what is essential for the ordinary business of living' (R. V Gloucestershire, 1997:598; [1997] UKHL 58). The Care and Support Statutory Guidance (2025) clearly indicates that it is the individual who identifies the need, and the local authority assesses the impact of this need. The concept of 'client as assessor' (Greene and Lee, 2011) is based on the premise that it is the person that knows best about their circumstances. The local authority should be supporting with this and retaining the decision making about which needs it will meet based on eligibility. Needs within the assessment document were predefined within the tool and based on the eligibility criteria domains (see figure six):

managing and maintaining nutrition;
maintaining personal hygiene;
managing toilet needs;
being appropriately clothed;
being able to make use of the adult’s home safely;
maintaining a habitable home environment;
developing and maintaining family or other personal relationships;
accessing and engaging in work, training, education or volunteering;
making use of necessary facilities or services in the local community including public transport, and recreational facilities or services
carrying out any caring responsibilities the adult has for a child.

Figure 6: A description of the eligibility domains (Care and Support (Eligibility Criteria) Regulations, 2015)

The Care and Support Statutory Guidance states that local authorities may use an 'assessment tool' (2025:6.43), however the guidance also makes clear that the identification of eligibility takes place after the assessment of needs, whereas this assessment tool treats eligibility as the needs hence eligibility is applied throughout. This is an original contribution and a significant finding that is unlikely to be particular to this study site. Examples of similar assessment processes can be seen on websites promoting use of AI technology supported assessment (Magic Notes, 2025) – this concept is discussed further in the discussion on language.

The eligibility criteria are deficit based, stating the adult must be 'unable to meet two or more outcomes' (The Care and Support (Eligibility Criteria) Regulations (2015:s2(b))) which reinforces the use of deficit-based language throughout the assessment documentation. Furthermore, the eligibility criteria consider impact on wellbeing which, as discussed, was interpreted differently by social workers and did not routinely seem to link back to outcomes described by the person.

Mental capacity assessments were less of a one-off process and more fluid. Social workers didn't necessarily assume capacity *per se* . They continuously embedded capacity considerations into day-to-day practice to ensure decision specificity and support to make decisions as needed demonstrating strengths-based working. This could be seen in ordinary observations of interactions (Garfinkel, 1967). Social workers discussed decisions in an informal and relaxed way, recognising the person's voice in decision making, and checking out understanding when there was confusion. This tacit application of mental capacity assessment witnessed in field observations were not recorded as formal capacity assessments but integrated within conversational activities.

In line with previous literature discussed in chapter two this study also highlighted that, at times, capacity assessments were used as vehicles to justify overriding unwise choices, with best interest decisions being used to validate restrictive decisions (Aspinwall-Roberts *et al*., 2022; Symonds *et al*., 2018; Price *et al*., 2020). In these cases, as with the assessment examples in chapter four, the forms constituted preconstructed objects (Bourdieu and Waquant, 1992) to justify actions and defensive practice and demonstrate compliance. This is discussed further under the risk and capacity discussion.

The importance of language in shaping identity

Language is important in shaping identity (Foremans, 2005) and power dynamics, and at times the language used in social work and social care can be dehumanising (Duffy, 2017; Gloriously Ordinary Lives; 2025). It is important that records are written in a way that reflects the person and they would be comfortable reading these (James & Mitchell, 2025; Saleebey 1992). The focus of deficit narratives within assessment and numerical balance sheets in best-interest decision recording reinforces these narratives, preferencing hierarchies of knowledge (Robinson *et al*., 2018) and reducing, and potentially at times eradicating, coproduction and strengths-based approaches.

Use of digital tools aimed at reducing bureaucracy through auto population further magnify this language. This is an important consideration, not just for current practice, but also for how we think about our interfaces with generative artificial intelligence (AI) in social care moving forwards. In January 2025, the UK government launched a plan for embracing AI (Department for Science, Innovation and Technology, 2025). Councils across the country are starting to explore the use of AI to support assessments and case recording. One AI provider claims to be working with sixty-five government bodies across the UK (Magic Notes, 2025), and AI is being trained on existing assessment templates (LGA, 2025). In the context of this study, which highlights that there is a systemic contradiction between policy intent and organisational implementation of Care Act (2014) assessments, there is a significant risk that the use of AI to support this function will exacerbate this situation. Potential areas for consideration are the lack of consistency in the implementation of wellbeing, the balance of the professional voice against the voice of the person, and the further replication of the deficit-based language embedding structural biases into people's records.

Whilst is recognised that there potentially are significant opportunities in this space for staff related to claimed time savings in administration (Department for Science, Innovation and Technology, 2025; LGA, 2025; Koutsounia, 2025), the implication for people being assessed is significant. This study highlighted that deficits in language are magnified through the automated functions within the system, and this is likely to become more, rather than less, pronounced as AI learns from and perpetuates existing deficit recording practices, further reinforcing power inequity and reducing strengths. Reports suggest that there are significant benefits to staff, but there are concerns about recording accuracy (Koutsounia, 2025) again enhancing the risk of deficit-based recording.

This discussion is not intended to reject or underplay the role that AI will inevitably have within social care (James and Whelan, 2021; Cearns and Knoxs, 2024). There are well known on-going challenges and concerns regarding use of AI in social work, particularly with reference to; safeguarding (Agbana, 2025;), ethics (Agbana, 2025; Reamer, 2023), data sharing (Reamer, 2023) and the inability to replace social workers tacit knowledge (Wassal *et al*., 2024; Cearns and Knox, 2024; Reamer, 2023). Equally there are significant opportunities to improve outcomes for individuals, including early warning signs and data sharing (Cearns and Knoxs, 2024; Nuwasiima *et al*., 2024). Opportunities to predict and monitor health and care, and identify and map community assets (NHS digital, 2025), offer significant potential (as would other AI supported opportunities) to map strengths and resilience to the delivery of care. There are significant risks of poor implementation (James and Whelan, 2021), and a clear need in social work to ensure competency through training (Ibrahim, 2025; Nuwasiima *et al*., 2024).

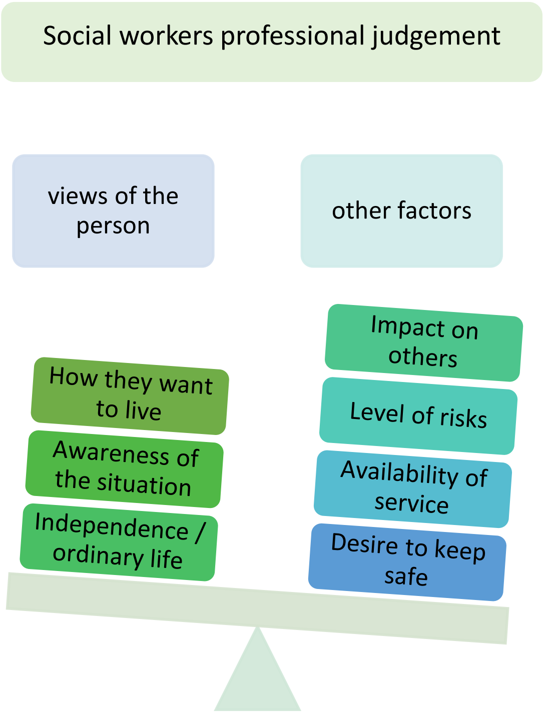
Strengths based approaches to risk including people where capacity is a concern

Social workers understood and embedded the principle of 'dignity of risk' (Perske, 1972) and its links with strengths-based practice. Field observations confirmed that even in the areas in which survey data suggests risk enablement was more challenged, the negotiation and relationship skills of social workers supported strengths-based outcomes for people. As discussed in the section on relational social work, these approaches enabled honest and candid discussions about managing risks. With family and friend carers, social workers reported and were observed to be working with the 'affect heuristics' (Slovic *et al*., 2013; Slovic, 2010; Finucane *et al*., 2000) to mitigate the impact of risk perception against likelihood and impact. Social workers built on existing relationships with health colleagues, and within an MDT setting the social worker often took an advocacy role as well as a partnership approach.

As with previous studies, a challenge within the space was upholding the voice of the person when capacity was a concern (Symonds *et al*., 2018; Price *et al*., 2020; Lonbay, 2018; Cooper, 2018), although interestingly in this study the nuances in this space were related only to the view of an unwise decision. These decisions were linked to the wider network of support from other partners in care, particularly the MDT. In situations in which capacity was a concern, but the person was unable to express a preference, the MDT was supportive of a least restrictive option that was assumed to be one the person would have made. In the situation when a person was making a choice the MDT felt was both incapacitated and unwise, the persons views were overridden. This suggests that there is further work to do in relation to ‘dignity of risk’ (Perske, 1972) when a person lacks capacity.

Despite all these constraints, social workers demonstrated creativity, reflexivity, and resilience to manage risk and seek solutions. These strategies reflected commitment to individualised support but exposed systemic injustices.

In summary, risk was seen as a delicate balance as in which the social workers professional judgement sought to balance and negotiate a range of factors, and the success and weight of each of these factors impacted on the outcome for individuals (see figure seven).



Impact of other partners in care and organisational / system factors can tip the balance.

Figure 7: A diagrammatic representation of the factors involved in balancing risk

Recommendations for practice

The four discussion areas lead naturally to two consolidated and interlinked recommendations for practice:

- **Recommendation one**: Implement relational based social work approaches to maximise strengths for people where there is a high perception of risk and for anyone for whom capacity may be a factor in this.

- **Recommendation two:** Restructure the way that tools used to support and record social work practices are embedded in practice to enable an amplification of strengths.

Recommendation one: Implement relational based social work to maximise strengths.

The idea of a named social worker or case manager is not a new one and has been particularly championed with learning disabilities services with a limited evidence base that suggests that this is a cost-effective option (SCIE and Innovation Unit, 2018). The issue is that capacity to meet demand in adult social care is a significant challenge. There are 671,000 people receiving statutorily funded adult social care in England, with over half a million new requests for care in the year 2024/2025 (DHSC, 2025), demonstrating the size and the scale of the challenge. In the field observations social workers practicing in this way were offsetting and managing with reduced levels of care.

There is a discussion about what one would expect of a social worker in this relational role. It is not simply about longevity or intensity of involvement – there were examples of practice that demonstrated these traits in short interventions. The key was the strengths-based approach, the time taken to understand the perspective of the person, and to have enough of a relationship to have honest and candid conversations that promote positive risk enablement.

The recommendation to build on relational based social work is specifically focused on applying this intervention when working with people who approach adult social care at the point of crisis.

Recommendation two: Restructure the way that tools used to support and record social work practices are embedded in practice to enable an amplification of strengths

This recommendation is particularly focused on the way that the assessment form is structured. As discussed, the current assessment does not follow the letter of the Care Act (2014) as needs and eligibility are treated as synonymous, and the application of eligibility throughout the assessment reinforces the need for deficit language. Examples of similar assessment process can be seen on websites promoting use of AI technology supported assessment (Magic Notes, 2025), suggesting that this approach is not particular to this local authority. Furthermore, there is an over reliance of the professional view of the assessor rather than a co-constructed narrative. The application of wellbeing is inconsistent across assessors and not defined by the individual. There is an opportunity to restructure assessment tools to prompt practitioners to identify and describe individual strengths, assets, and capabilities alongside needs and risks. Tools should guide reflection on how people have managed challenges, what supports they already draw upon, and how professional intervention can build on these. Eligibility should be applied only on completion of this.

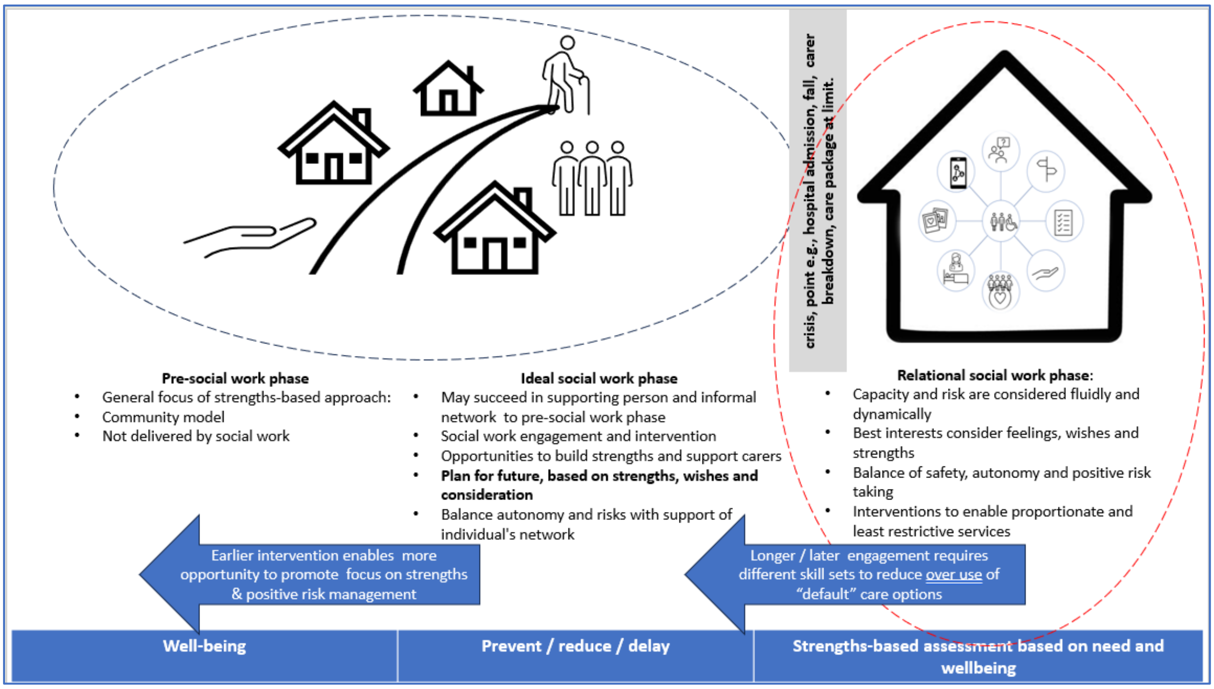
There is a growing movement focused on the language used in social care (Gloriously Ordinary Lives; 2025; Shannon,2025). Labels within assessments should be based on a full consideration of how and why they are determined, and consideration given to the impact that these have on people's sense of self and identity (Saleebey, 1992). There are opportunities to co-produce the language in assessments with people who have lived experience of social care. Social workers, and other assessors, should be supported through assessments to ensure that they can hear the voice of the person, or if appropriate, their advocate within assessments. Where auto population and potentially AI recording takes place, assessors should be alerted to check that the repeated information reflects the spirit of this.

Implications for practice: bringing together the recommendations

This study creates several areas of exploration and areas for future development of research. As discussed in the literature review there is an interest in using research to understand strengths-based approaches. The findings of this study add to the current evidence based and focus specifically on those elements which relate to the people who have in other research been identified as the most complex to promote strengths for.

The literature review at chapter two highlighted that the implementation of a strengths-based approach in England has concentrated on the promotion of community assets rather than a wider implementation of a strengths-based approach leading to developing consensus that it was more difficult to promote strengths when capacity or risk were a factor. This should not be the case as the concept is developed out of ways of working with people with complex mental health needs. In this study all the people with lived experience had a good range of community assets and support. Each was at a stage in their lives when something different and additional was needed. Observations demonstrate that this can still be strengths-based, but there are certain factors that impact on this: how people are assessed and described, how their voices are heard, what services are (or are not) available to support them, and ultimately, in the face of risk and potentially diminished capacity, how people can control and direct their own lives.

Previous studies have highlighted the challenge of applying strengths at these later stages in a person's care journey (Caiels *et al*., 2024; Jessops *et al*., 2025). This study adds to this knowledge   which suggests that this is the space in which there needs to be a practice focus. This study contributes to the gap of knowledge in this area. I used the term relational social work to describe an approach that is similar to, and potentially an extension of, the original strengths model case management (SMCM) of Rapp and Chamberlain (Weick *et al.*, 1989). SMCM is a way of working with people with significantly complex mental health needs and has demonstrated success in reducing requirement for over restrictive care environments (Fukui, 2012; Björkman *et al.*, 2002; Ibrahim *et al.*, 2014; Teague *et al.*, 2012) - albeit within the confines that the underlying needs did not necessarily stop being something that the person lived with (Tsoi, 2019; Björkman *et al.*, 2002; Fukui, 2012; Ibrahim *et al.*, 2014). This can be applied to the development of strengths-based practice in England; it would suggest that there is a need to consider the practice model across the whole of the social care pathway with a particular focus on relational social work support at this most complex end (see figure eight).



Pre-social work phase
- General focus of strengths-based approach:
- Community model
- Not delivered by social work

Ideal social work phase
- May succeed in supporting person and informal network to pre-social work phase
- Social work engagement and intervention
- Opportunities to build strengths and support carers
- **Plan for future, based on strengths, wishes and consideration**
- Balance autonomy and risks with support of individual's network

Relational social work phase:
- Capacity and risk are considered fluidly and dynamically
- Best interests consider feelings, wishes and strengths
- Balance of safety, autonomy and positive risk taking
- Interventions to enable proportionate and least restrictive services

Figure 8: A diagrammatic representation of where relational social work can have an impact on promoting strengths in complexity and risk.

In this model the pre-social work phase and the ideal social work phase can be seen in the popular implementation models described in chapter two; Local Area Coordination, Three Conversations, and Community Led Support. However, the relational social work phase places additional emphasis on working with people, who have either been through the first few phases and whose needs have changed or have been managing without adult social care involvement and reach a crisis. It does not mean that relational social work is not evident across all areas of adult social care, simply that is essential in this space. It is how social workers engage with people at this part of their life; it also applies to people like John and Mark who require a more ongoing interventionist approach rather than a single service solution. This model includes relationship based social work and improvements in recordings though strengths-based assessments. Demand for adult social care is high (DHSC, 2021) and acuity is on the rise, particularly since covid (Owens *et al*., 2023) - yet the cycle of responding to the most complex level of need with a quick-fire deficit assessment process and a prescription of intensive care (James *et al*., 2020) is not, and will never be truly, strengths-based.

This leads us on to the second recommendation and the need to consider strengths-based assessments. As discussed previously, the assessment template conflates the statutory duties of identifying need (2014:9(1) (4b)), determining eligibility (2014:13), promoting wellbeing (2014:1(2)) and assessing impact of needs on wellbeing (2014:9(4)). To address this, there is a need to restructure the assessment process so that individually defined needs are identified first, then the impact on wellbeing is considered, and finally eligibility applied (see figure nine).

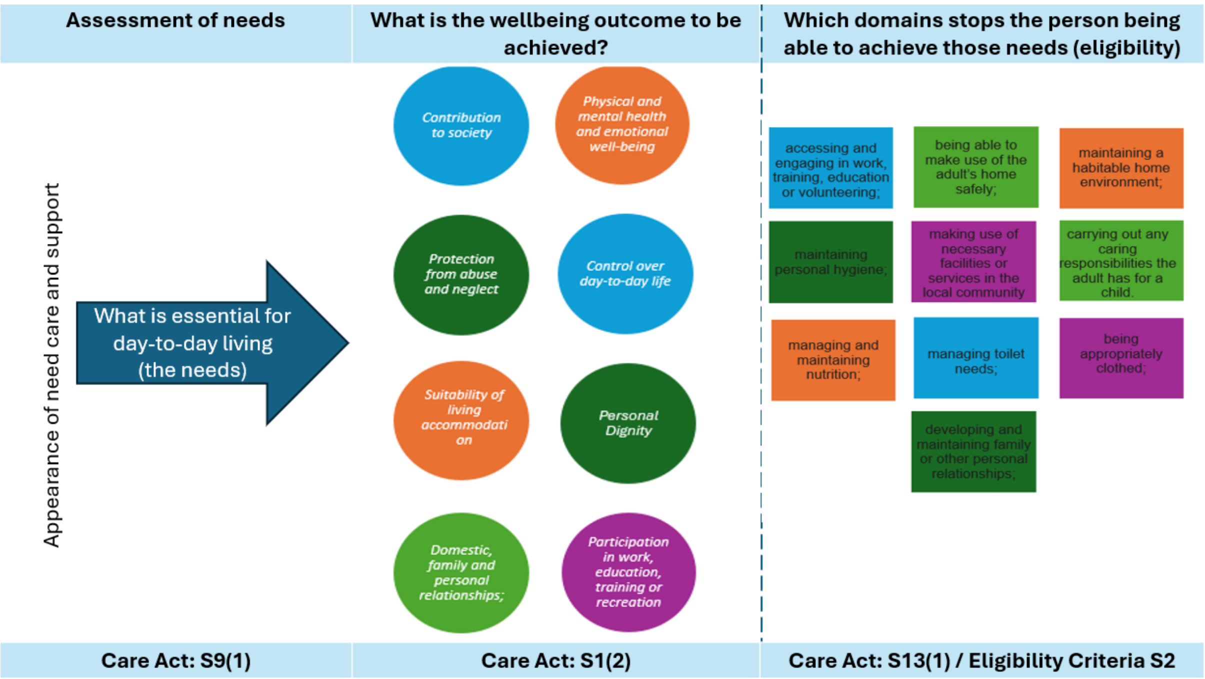


Figure 9: A diagrammatic example of the assessment approach to identifying needs, assessing wellbeing, and determining eligibility to improve identification of strengths.

Whilst there will always be a need to indicate a deficit due to the way that the legislation is worded – with a requirement that a person is 'unable to achieve two or more outcomes' (The Care and Support (Eligibility Criteria) Regulations (2015)), applying eligibility at the end would reduce the impact of the deficit language within the overall assessment documentation.

Routes to impact

The routes to impact from this research sit primarily at Local Authority practice level, with potential to inform wider national discussion through professional and policy networks. The findings highlight how the interpretation of eligibility, wellbeing, and assessment processes can shape day-to-day social work practice, often in ways that are more procedural than intended by Care Act guidance. As a result, one key route to impact is through influencing how assessment documentation, local policy guidance, and practice tools are designed and used within Local Authorities.

This could involve contributing to the review of assessment forms, ensuring that the language used prompts practitioners to explore wellbeing, strengths, and personal outcomes rather than focusing narrowly on eligibility thresholds. Practice briefings, team discussions, and training sessions could be used to share the findings with social workers and managers, encouraging reflection on how needs are framed in assessments and how this influences practice. Embedding these insights into supervision conversations and continuing professional development sessions would further support practitioners to adopt a more strengths-based, wellbeing-focused approach. This is something that I can directly impact in my professional work with local authorities through my consultancy work.

At a broader level, the research can inform Local Authority policy development by highlighting the gap between statutory guidance and how eligibility is operationalised in practice. Sharing the findings through internal reports, practitioner forums, and quality assurance processes offers an opportunity to influence how local procedures are interpreted and implemented.

Beyond the Local Authority, the research has relevance for national practice through dissemination at conferences, publication, and engagement with professional bodies in England such as the Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS) and social work networks. The findings speak directly to ongoing discussions about strengths-based practice, Care Act (2014) implementation, and assessment culture, and therefore provide an evidence base that can contribute to wider debates about how policy intentions translate into frontline practice. Through one of my consultancy businesses, I am currently authoring a national sector-led improvement tool for Partners in Care and Health, which is a partnership between the LGA and ADASS. This High Impact Change Model to support a strengths-based approach in adult social care will be launched in February 2026. It sets out ten high impact changes and provides practice based-action cards to support implementation. The model references and draws directly on my definition and findings as well as incorporating the other literature that I have reviewed in this thesis linking my research directly into national best practice guidance.

It is my intention to further use my research to impact practice through a national webinar, once published, to promote the findings accompanied by a training offer for local authorities and other social care professionals and organisations. I will also seek to publish further from this thesis in the future to support teaching within universities and maximise reach of the message.

Final comments

In the field of ethnography there is a consistent drive to get close to practice. In this study there was the ability to directly triangulate observed and documented practices, which enabled the discovery of insights that would have otherwise been unattainable, and this offers a novel perspective for consideration of future research.

In the literature review I noted the continuous focus on trying to measure the impact of the strengths-based approach, creating a narrative that there was work to do. However, the review showed that despite the variation and standardisation, there was breadth - if not necessarily depth - of evidence. There was a symmetry and consistency over time, geography, and epistemological approach. My research supports previous findings about the challenge of promoting strengths in the context of capacity, risk (Symonds *et al*., 2018; Price *et al*., 2020; Lonbay, 2018; Cooper, 2018) and crisis management (Caiels *et al*., 2024; Jessops *et al*., 2025). I add to this that these challenges are already being skilfully managed in a strengths-based way that can be built on. This suggests the right systematic support can enable strengths-based approaches to positive risk management, even when a person lacks capacity, which would improve a focus and strengths, support independence, and lead to less restrictive care provision. My research also uncovered improvements that could be made in assessment recordings that would improve both statutory compliance and provide opportunities to enhance strengths-based practice and strength-based language, offering thoughts and reflections on the emerging issue of utilising AI to support recordings of adult social care interventions.

Bibliography

ADASS. 2019. *ADASS budget survey 2019*. Available at: www.adass.org.uk/media/6434/adass-budget-survey-report-2018.pdf [Accessed: 13 March 2020].

Adult Social Care Committee. 2022. *Adult Social Care Committee A "gloriously ordinary life'': spotlight on adult social care Report of Session 2022-23 - published 8 December 2022 - HL Paper 99*. House of Lords. Available at: https://publications.parliament.uk/pa/ld5803/ldselect/ldadultsoc/99/9908.htm#_idTextAnchor125.

Agbana, T.M. [no date]. Ethical Considerations in Using Predictive AI for Risk Assessment in Child Protection Social Work.

AH, Re (Re Best Interests) [2023] EWCOP 1 (04 January 2023) URL: https://www.bailii.org/ew/cases/EWCOP/2023/1.html. [no date]. Available at: https://www.bailii.org/ew/cases/EWCOP/2023/1.html [Accessed: 8 August 2025].

Ahuja, L. *et al*. 2022. Implementation of the Making Safeguarding Personal Approach to Strengths-based Adult Social Care: Systematic Review of Qualitative Research Evidence. *British Journal of Social Work,* 52(8). doi: https://doi.org/10.1093/bjsw/bcac076.

Alfandari, R. *et al*. 2023. Making Sense of Risk: Social Work at the Boundary between Care and Control. *Health, Risk & Society* 25(1–2), pp. 75–92. Available at: https://doi.org/10.1080/13698575.2022.2147904.

Alvesson, M. and Sköldberg, K. 2000. On Reflexive Interpretation: The Play of Interpretive Levels. In: *Reflexive Methodology: New Vistas for Qualitative Research*. Third Edition.

APA. 2025. *What is the DSM?* Available at: https://www.psychiatry.org/patients-families/what-is-the-dsm [Accessed: 9 January 2025].

Aspinal, F. *et al*. 2019. Safeguarding and personal budgets: the experiences of adults at risk. *The Journal of Adult Protection* 21(3), pp. 157–168.

Aspinwall-Roberts, E., Fleming, V., Khatri, R. and Jones, P. 2022. 'They don't want them to have capacity': Multi-agency operationalisation of the Mental Capacity Act 2005 in England with adults who self-neglect. *Health Soc Care Community.* 30(6), pp. 4395–4404. doi: 10.1111/hsc.13839.

Averill, J. 2003. Keys to the puzzle: Recognizing strengths in a rural community. *Public Health Nursing* 20(6), pp. 449–455.

Bainbridge, L. and Lunt, N. 2021. Place, strengths and assets: A case study of how local area coordination is supporting individuals and families under conditions of austerity. *The British Journal of Social Work* 51(4), pp. 1354–1373.

Bark, H. 2024. Social work, personalisation, and the Care Act 2014: A Bourdieusian analysis. *The British Journal of Social Work*, p. bcae180. Available at: https://doi.org/10.1093/bjsw/bcae180 [Accessed: 16 February 2025].

Baron, S., Stanley, T., Colomina, C. and Pereira, T. 2019. Strengths-based approach: Practice framework and practice handbook. *Department of Health & Social Care*, p. 105.

BASW. 2021. The BASW Code of Ethics for Social Work. Available at: https://basw.co.uk/sites/default/files/2024-04/basw-code-of-ethics.pdf [Accessed: 27 May 2025].

Baye, Suzy. & Preston-Shoot, Michael. 2020. Adult Safeguarding. In: *The Care Act 2014: Wellbeing in Practice*. London: Sage, pp. 81–97.

Beck, U. 1992. *Risk society: Towards a new modernity*. sage.

Becker. 1971. Footnote added to the paper on page 10. Wax, M, 7 Wax, R (1971). Great Tradition, Little Tradition, and Formal Education. In, Wax, M. Diamond, S. Gearing F.O. (1971). In: *Anthropological Perspectives on Education. Basic Books, Inc. London.* London: Basic Books, Inc., pp. 3–18.

Björkman, T., Hansson, L. and Sandlund, M. 2002. Outcome of case management based on the strengths model compared to standard care. A randomised controlled trial. *Social Psychiatry and Psychiatric Epidemiology* 37(4), pp. 147–152.

Bolton, J. 2016. *Predicting and managing demand in social care Discussion paper*. Available at: https://ipc.brookes.ac.uk/wp-content/uploads/2024/07/Predicting_and_managing_demand_discussion_paper2016.pdf.

Bottery, S. and Jefferies, D. 2025. *Social care 360*. Available at: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/social-care-360.

Bourdieu, P. 1991. *Language and Symbolic Power.* Harvard University Press.

Bourdieu, P. and Wacquant, P. 1992. *An Invitation to Reflexive Sociology*. Polity Press.

Bown, H., Carrier, J., Hayden, C., Harflett, N., Mitchell, F., Clifford, C. and Girling, F. 2020. *CLS Evidence & Learning Briefings 2020 Paper 1: Programme findings and lessons about what makes Community Led Support work well for people and places across the UK*. National Development Team for Inclusion. Available at: https://www.ndti.org.uk/assets/files/CLS_Paper_1_Findings_MAY_2020_Fnl.pdf.

Bown, H., Carrier, J., Hayden, C. and Jennings, Y. 2017. What works in community led support. *First evaluation report. Findings and lessons from local approaches and solutions for transforming adult social care (and health) services in England, Wales and Scotland*. Available at: https://www.ndti.org.uk/uploads/files/What_Works_in_Community_Led_Support_First_Evaluation_Report_Dec_17.pdf.

Braun, V. and Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology* 3(2), pp. 77–101.

Braun, V. and Clarke, V. 2022. *Thematic Analysis A Practical Guid*. London: Sage.

Braye, S., Orr, D. and Preston-Shoot, M. 2017. Autonomy and Protection in Self-neglect Work: The Ethical Complexity of Decision-making. *Ethics and Social Welfare* 11(4), pp. 320–335. Available at: https://doi.org/10.1080/17496535.2017.1290814.

Breimo, J.P. 2016. Introduction to the special issue on Institutional Ethnography and Comparative Social Work. *Journal of Comparative Social Work* 11(1).

Briand, C. *et al*. 2022. Implementation of strengths model case management in seven mental health agencies in Canada: Direct-service practitioners' implementation experience. *Journal of Evaluation in Clinical Practice* 28(6), pp. 1127–1137.

Briggs, M. and Cooper, A. 2018. Making Safeguarding Personal: progress of English local authorities. *The Journal of Adult Protection* 20, pp. 00–00. Available at: https://api.semanticscholar.org/CorpusID:80509070.

Brongers, K.A., Cornelius, B., van Der Klink, J.J. and Brouwer, S. 2020. Development and evaluation of a strength-based method to promote employment of work-disability benefit recipients with multiple problems: a feasibility study. *BMC Public Health* 20(1), p. 71.

Brun, C. and Rapp, R.C. 2001. Strengths-based case management: Individuals' perspectives on strengths and the case manager relationship. *Social work* 46(3), pp. 278–288.

Bryant, L., Garnham, B., Tedmanson, D. and Diamandi, S. 2018. Tele-social work and mental health in rural and remote communities in Australia. *International Social Work* 61(1), pp. 143–155.

Bryman, A. 2016. *Social research methods*. Oxford university press.

Bueter, A. and Jukola, S. 2025. Multi-professional healthcare teams, medical dominance, and institutional epistemic injustice. *Medicine, Health Care and Philosophy* 28(2), pp. 219–232. Available at: https://doi.org/10.1007/s11019-025-10252-z.

Burrows, D. 2022. Social Work for 'Liquid Old Age': Some Insights from an Ethnographic Study of a Hospital Social Work Team. *Ethics and Social Welfare,* 16(3), pp. 258–273. doi: https://doi.org/10.1080/17496535.2021.1996619.

Butler, L. and Manthorpe, J. 2016. Putting people at the centre: facilitating Making Safeguarding Personal approaches in the context of the Care Act 2014. *The Journal of Adult Protection* 18, pp. 204–213. Available at: https://api.semanticscholar.org/CorpusID:78363526.

Caiels, J., Milne, A. and Beadle-Brown, J. 2021. Taking a strengths-based approach to social work and social care: A literature. *National Institute for Health Research*.

Caiels, J., Silarova, B., Milne, A.J. and Beadle-Brown, J. 2024. Strengths-based Approaches—Perspectives from Practitioners. *The British Journal of Social Work* 54(1), pp. 168–188. Available at: https://doi.org/10.1093/bjsw/bcad186 [Accessed: 7 December 2024].

Cardiff University. 2023. *Conducting and recording interviews or focus groups online -*. Available at: Conducting and recording interviews or focus groups online - Student intranet - Cardiff University.

Carrier, J. 2020. *CLS Evidence & Learning Briefings 2020 Paper 3: Understanding the nature of change in delivering Community Led Support*. NDTI. Available at: www.ndti.org.uk/assets/files/CLS_Paper_3_Messages_about_the_nature_of_change_May_2020.pdf.

Carroll, A. and McSherry, B. 2021. Risk management in the era of recovery and rights. *BJPsych Advances* 27(6), pp. 394–404. Available at: https://www.cambridge.org/core/product/F7D506B5730AD03F712CF11A8E32E401.

Casey Commission. 2025. *Casey Commission*. Available at: https://caseycommission.co.uk/?d102_cookies_enabled=essential [Accessed: 9 September 2025].

CCS. 2022. *Talking Cafes*. Available at: https://somersetagents.org/talking-cafes/?msclkid=29c9d832b97411eca1783ad4f1596021 [Accessed: 11 April 2022].

Cearns, J. and Knox, H. 2024. Safeguarding Data: The Data Consensus and the Public Good in Children's Social Services. *The Cambridge Journal of Anthropology* 42(1), pp. 23–41.

Cefaï, D. 2015. Outreach work in Paris: A moral ethnography of social work and nursing with homeless people. *Human Studies* 38(1), pp. 137–156.

Chavez, C. 2008. Conceptualizing from the inside: Advantages, complications, and demands on insider positionality. *The qualitative report* 13(3), pp. 474–494.

Chen, Y.-M., Chen, K.-M., Chang, C.-C., Chen, M.-C. and Yang, L.-Y. 2021. The individualized supervision strategy and effectiveness under the strength perspective: a pilot study for the case management model of the high-care elderly in communities. *BMC Health Services Research* 21(1), p. 546.

Chicoine, B., & Kirschner, K. L. 2022. Considering Dignity of Risk in the Care of People with Intellectual Disabilities: A Clinical Perspective. *Perspectives in biology and medicine,* 65(2), pp. 189–198. doi: https://doi-org.cardiff.idm.oclc.org/10.1353/pbm.2022.0014.

Clarke, J. and Newman, J. 2012. .The alchemy of austerity. *Critical social policy,* 32(3), pp. 299-319.

Cleland, J. and MacLeod, A. 2022. Disruption in the space–time continuum: Why digital ethnography matters. *Advances in Health Sciences Education* 27(3), pp. 877–892.

Cooper, A. *et al*. 2016. Making safeguarding personal temperature check 2016. *United Kingdom: Association of Directors of Adult Social Services*.

Cooper, A., Cocker, C. and Briggs, M. 2018. Making Safeguarding Personal and Social Work Practice with Older Adults: Findings from Local-Authority Survey Data in England. *The British Journal of Social Work*. Available at: https://api.semanticscholar.org/CorpusID:149744346.

Cootes, H., Heinsch, M. and Brosnan, C. 2022. 'Jack of all trades and master of none'? Exploring social work's epistemic contribution to team-based health care. *The British Journal of Social Work* 52(1), pp. 256–273.

Corrigan, P. and Deepa, R. 2012. On the self-stigma of mental illness: stages, disclosure, and strategies for change. *Canadian journal of psychiatry. Revue canadienne de psychiatrie* 57(8), pp. 464–469. doi: doi:10.1177/070674371205700804.

Cowger, C. Anderson, K. Snively, C. 2006. Assessing Strengths: The Policial Context of Individual, Family, and Community Empowerment. In: *The Strengths Perspective in Social Work Practice*. Forth. London: Pearson Education, Inc, pp. 93–115.

CQC. 2025a. Local authority assessment reports - Care Quality Commission 2025. Available at: Local authority https://www.cqc.org.uk/care-services/local-authority-assessment-reports.

CQC. 2025b. *Regulations for service providers and managers*. Available at: https://www.cqc.org.uk/guidance-regulation/providers/regulations-service-providers-and-managers.

Czaja, S.J. *et al*. 2009. Development of the risk appraisal measure: a brief screen to identify risk areas and guide interventions for dementia caregivers. *Journal of the American Geriatrics Society* 57(6), pp. 1064–1072.

Dash, P. 2024. *Independent report Review into the operational effectiveness of the Care Quality Commission: full report*. Available at: https://www.gov.uk/government/publications/review-into-the-operational-effectiveness-of-the-care-quality-commission-full-report/review-into-the-operational-effectiveness-of-the-care-quality-commission-full-report [Accessed: 5 May 2025].

De Montigny, G. 2018. Social workers' peculiar contribution to ethnographic research. *Qualitative Social Work* 17(3), pp. 452–468.

Delamont, S. 2016a. *Fieldwork in educational settings: Methods, pitfalls and perspectives*. Routledge.

Delamont, S. 2016b. Time to kill the witch? Reflections on power relationships when leaving the field. In: *Gender identity and research relationships*. Emerald Group Publishing Limited, pp. 3–20.

Delamont, S., Atkinson, P. and Pugsley, L. 2010. The concept smacks of magic: Fighting familiarity today. *Teaching and Teacher Education* 26(1), pp. 3–10.

Department for Science, Innovation and Technology. 2025. *Independent report AI Opportunities Action Plan*. Available at: https://www.gov.uk/government/publications/ai-opportunities-action-plan/ai-opportunities-action-plan#changes-lives [Accessed: 9 June 2025].

Derby City Council. 2021. *Local Area Co-ordination in Derby Evaluation report 2018 – 2021, Executive Summary*. Available at: https://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/healthandsocialcare/adultsocialcare/ylyc/local-area-coordination-report-summary-18-21.pdf.

Dewing, J., 2008. Process Consent and Research with Older Persons Living with Dementia. Research Ethics 4, 59–64. https://doi.org/10.1177/174701610800400205

DHSC. 2019. *Strengths-based approach: practice framework and practice handbook*. Available at: https://www.gov.uk/government/publications/strengths-based-social-work-practice-framework-and-handbook [Accessed: 8 August 2025].

DHSC. 2021. *Evidence review for adult social care reform: summary report*. Available at: https://www.gov.uk/government/publications/evidence-review-for-adult-social-care-reform/evidence-review-for-adult-social-care-reform-summary-report.

DHSC. 2025. *Adult social care in England, monthly statistics: July 2025*. Available at: https://www.gov.uk/government/statistics/adult-social-care-in-england-monthly-statistics-july-2025/adult-social-care-in-england-monthly-statistics-july-2025#:~:text=Number%20of%20people%20receiving%20local%20authority%20arranged%20or%20provided%20long,were%20receiving%20support%20in%20prison.

Drew, P. and Heritage, J. 1992. Talk at work. *Cambridge: Cambridge*.

Duffy, F. 2017. A social work perspective on how ageist language, discourses and understandings negatively frame older people and why taking a critical social work stance is essential. *British Journal of Social Work* 47(7), pp. 2068–2085.

Duggal, S., Miller, R. and Tanner, D. 2021. Implementing Asset-Based Integrated Care: A Tale of Two Localities. *International Journal of Integrated Care*. doi: 10.5334/ijic.5621.

Durose, C., Needham, C., Mangan, C. and Rees, J. 2017. Generating 'good enough' evidence for co-production. *Evidence & Policy* 13(1), pp. 135–151. Available at: https://bristoluniversitypressdigital.com/view/journals/evp/13/1/article-p135.xml.

Engel, R.J. and Schutt, R.K. 2016. *The practice of research in social work*. Sage Publications.

Erving Goffman and William B. Helmreich. 2007. The Moral Career of the Mental Patient. Available at: https://doi.org/10.4324/9781351327763-2.

Essex Chambers. 2025a. *Aintree University Hospitals NHS Foundation Trust (Respondent) V James (Appellant)*. Available at: https://www.39essex.com/information-hub/case/aintree-university-hospitals-nhs-foundation-trust-respondent-v-james-0 [Accessed: 30 August 2025].

Essex Chambers. 2025b. *Mental Capacity Case: LBX v K, L, M*. Available at: https://www.39essex.com/information-hub/case/lbx-v-k-l-m.

Essex Chambers. 2025c. *Re AH (Re Best Interests) Judge*. Available at: https://www.39essex.com/information-hub/case/re-ah-re-best-interests [Accessed: 30 August 2025].

Fanning, J. 2016. Continuities of risk in the era of the mental capacity act. *Medical law review* 24(3), pp. 415–433.

Fawcett, B., Johnson, M., Mould, F. and Ubhi, J. 2021. Birmingham taking the initiative: Changes and challenges in working differently with adults. *The British Journal of Social Work* 51(7), pp. 2554–2570.

Fawcett, B. and Pockett, R. 2015. Turning ideas into research: Theory, design and practice.

Ferguson, H. 2014. Researching social work practice close up: Using ethnographic and mobile methods to understand encounters between social workers, children and families. *The British Journal of Social Work* 46(1), pp. 153–168.

Ferguson, H. 2016. Observing social work practice using ethnographic and mobile research methods with social workers and service users. In, Hardwick, L Smith, R and Worsley,. In: *Innovations in Social Work Research*. London: Jessica Kingsley, pp. 140–154.

Finucane, M.L., Alhakami, A., Slovic, P. and Johnson, S.M. 2000. The affect heuristic in judgments of risks and benefits. *Journal of behavioral decision making* 13(1), pp. 1–17.

Floersch, J. 2000. Reading the case record: The oral and written narratives of social workers. *Social Service Review* 74(2), pp. 169–192.

Floersch, J., Longhofer, J. and Suskewicz, J. 2014. *The use of ethnography in social work research*. Sage Publications Sage UK: London, England. pp. 3–7.

Flückiger, C., Munder, T., Del Re, A.C. and Solomonov, N. 2023. Strength-based methods–a narrative review and comparative multilevel meta-analysis of positive interventions in clinical settings. *Psychotherapy Research* 33(7), pp. 856–872.

Foot, C. *et al*. 2014. People in control of their own health and care. *King's Fund*.

Foreman, P. 2005. Language and disability. *Journal of Intellectual and Developmental Disability* 30(1), pp. 57–59.

Foster, D. 2025. Adult social care funding in England. *House of Commons Library*. Available at: https://researchbriefings.files.parliament.uk/documents/CBP-7903/CBP-7903.pdf [Accessed: 15 May 2025].

Foster, D. and Harker, R. 2020. Adult social care funding (England). *House of Commons Library*.

Fricker, M. 2007. Testimonial Injustice. In: Fricker, M. ed. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press, p. 0. Available at: https://doi.org/10.1093/acprof:oso/9780198237907.003.0002 [Accessed: 30 August 2025].

Fukui, S., Davidson, L.J., Holter, M.C. and Rapp, C.A. 2010. Pathways to recovery (PTR): impact of peer-led group participation on mental health recovery outcomes. *Psychiatric Rehabilitation Journal* 34(1), p. 42.

Fukui, S., Goscha, R., Rapp, C.A., Mabry, A., Liddy, P. and Marty, D. 2012. Strengths model case management fidelity scores and client outcomes. *Psychiatric Services* 63(7), pp. 708–710.

Garfinkel, H. 2023. Studies in ethnomethodology. In: *Social Theory Re-Wired*. Routledge, pp. 58–66.

Garrett, P.M. 2010. Examining the 'conservative revolution': Neoliberalism and social work education. *Social Work Education* 29(4), pp. 340–355.

Gelkopf, M., Lapid, L., Werbeloff, N., Levine, S.. Z., Telem, A., Zisman-Ilani, Y. and Roe, D. 2016. A strengths-based case management service for people with serious mental illness in Israel: A randomized controlled trial. *Psychiatry research,* 241, pp. 182–189. doi: https://doi-org.cardiff.idm.oclc.org/10.1016/j.psychres.2016.04.10.

Geyer, S. 2012. Strengths-based groupwork with alcohol dependent older persons. *Groupwork*. Available at: https://api.semanticscholar.org/CorpusID:71266592.

Gillingham, P. and Humphreys, C. 2010. Child protection practitioners and decision-making tools: Observations and reflections from the front line. *British journal of social work* 40(8), pp. 2598–2616.

Gitterman, A. and Germain, C.B. 1976. Social Work Practice: A Life Model. *Social Service Review* 50(4), pp. 601–610. Available at: http://www.jstor.org.abc.cardiff.ac.uk/stable/30015414 [Accessed: 24 May 2025].

Goffman, E. 1959. *The presentation of self in everyday life.* Anchor Books. Available at: https://archive.org/details/presentationofs00goff.

Goffman, E.. 1961. *Asylums: Essays on the social situation of mental patients and other inmates.* Anchor Books.

Goffman, E. 1963. *Stigma: Notes on the management of spoiled identity.* London: Simon & Schuster.

Grant, J.G. and Cadell, S. 2009. Power, Pathological Worldviews, and the Strengths Perspective in Social Work. *Families in Society* 90(4), pp. 425–430. Available at: https://doi.org/10.1606/1044-3894.3921 [Accessed: 4 June 2025].

Gray, M. 2011. Back to basics: A critique of the strengths perspective in social work. *Families in society* 92(1), pp. 5–11.

Gray, M., Dean, M., Agllias, K., Howard, A. and Schubert, L. 2015. Perspectives on neoliberalism for human service professionals. *Social Service Review* 89(2), pp. 368–392.

Graybeal, C. 2001. Strengths-Based Social Work Assessment: Transforming the Dominant Paradigm. *Families in Society* 82(3), pp. 233–242. Available at: https://doi.org/10.1606/1044-3894.236 [Accessed: 4 June 2025].

Green, R., Gregory, R. and Mason, R. 2006. Professional distance and social work: Stretching the elastic? *Australian Social Work* 59(4), pp. 449–461.

Greene, G.J. and Lee, M.Y. 2011. *Solution-oriented social work practice: An integrative approach to working with client strengths*. Oxford University Press.

Greer, B. 1964. First Days in the Field. (1964). Basic Books, Inc. London. p322-344. In: *Sociologists at Work: Essays on the Craft of Social Research.* London: Basic Books, Inc., pp. 322–344.

Gu, Y. 2018. Narrative, life writing, and healing: The therapeutic functions of storytelling. *Neohelicon* 45(2), pp. 479–489.

Guba, E.G. and Lincoln, Y.S. 1994. Competing paradigms in qualitative research. *Handbook of qualitative research* 2(163–194), p. 105.

Haight, W., Kayama, M. and Korang-Okrah, R. 2014. Ethnography in social work practice and policy. *Qualitative Social Work* 13(1), pp. 127–143.

Hall, C., Slembrouck, S., & Sarangi, S. 2006. *Language Practices in Social Work_.* Routledge.

Hall, P. 2015. Social Work and the Transformation of Adult Services: Perpetuating a Distorted Vision? *The British Journal of Social Work* 45(8), pp. 2480–2481. Available at: https://doi.org/10.1093/bjsw/bcv107 [Accessed: 15 May 2025].

HALPERN, J. 2012. WHEN CONCRETIZED EMOTION-BELIEF COMPLEXES DERAIL DECISION-MAKING CAPACITY. *Bioethics* 26(2), pp. 108–116. Available at: https://doi.org/10.1111/j.1467-8519.2010.01817.x [Accessed: 3 August 2025].

Hammersley, M. 2018. What is ethnography? Can it survive? Should it? *Ethnography and education* 13(1), pp. 1–17.

Hammersley, M. and Atkinson, P. 2019. *Ethnography: Principles in practice*. Routledge.

Harlow, E. 2003. New managerialism, social service departments and social work practice today. *Practice* 15(2), pp. 29–44.

Harlow, E., Berg, E., Barry, J. and Chandler, J. 2013. Neoliberalism, managerialism and the reconfiguring of social work in Sweden and the United Kingdom. *Organization* 20(4), pp. 534–550.

Harris, J. 1998. Scientific management, bureau-professionalism, new managerialism: The labour process of state social work. *The British Journal of Social Work* 28(6), pp. 839–862.

Hassink, J., Elings, M., Zweekhorst, M., van den Nieuwenhuizen, N. and Smit, A. 2010. Care farms in the Netherlands: Attractive empowerment-oriented and strengths-based practices in the community. *Health & place* 16(3), pp. 423–430.

Hayashi, M., Raymond, G. and Sidnell, J. 2013. Conversational Repair and Human Understanding. Cambridge University Press.

Health Foundation. 2023. *Adult social care funding pressures: what might it cost to meet demand and improve access to care?* Available at: [online] The Health Foundation. Available at: https://www.health.org.uk/reports-and-analysis/analysis/adult-social-care-funding-pressures [Accessed: 15 May 2025].

Healy, J.C. and Dray, R. 2022. Missing links: safeguarding and disability hate crime responses. *he Journal of Adult Protection,* T24.

Heritage, J. & Maynard, D. W. (Eds.). 2006. *Communication in Medical Care: Interaction Between Primary Care Physicians and Patients.* Cambridge University Press.

Hertfordshire Safeguarding Adults Board. [no date]. *Making Safeguarding Personal survey: Results – January 2017 to October 2017*. Available at: Hertfordshire Safeguarding Adults Board. (2017) Making Safeguarding Personal Survey - Results Jan 2017 - October 2017, Hertfordshire, Hertfordshire Safeguarding Adults Board.

Holley, C.K. and Mast, B.T. 2009. The impact of anticipatory grief on caregiver burden in dementia caregivers. *The Gerontologist* 49(3), pp. 388–396.

Hopkinson, P.J., Killick, M., Batish, A. and Simmons, L. 2015. 'Why didn't we do this before?' the development of Making Safeguarding Personal in the London borough of Sutton. Professor Michael Preston-Shoot and Dr Adi Cooper Editor: Bridget Penhale ed. *The Journal of Adult Protection* 17(3), pp. 181–194. Available at: https://cardiff.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/why-didnt-we-do-this-before-development-making/docview/1686034976/se-2?accountid=9883.

Horlick-Jones, T. 2005. On 'risk work': Professional discourse, accountability, and everyday action. *Health, risk & society* 7(3), pp. 293–307.

Horlick-Jones, T. 2009. Finding a way between nihilism and romanticism: Some reflections on the practice and politics of the sociology of risk. *Health, Risk & Society* 11(2), pp. 91–98. Available at: https://doi.org/10.1080/13698570902786328.

Horlick-Jones, T. and Prades, A. 2009. On interpretative risk perception research: some reflections on its origins; its nature; and its possible applications in risk communication practice. *Health, risk & society* 11(5), pp. 409–430.

Houghton, C., Murphy, K., Brooker, D. and Casey, D. 2016. Healthcare staffs' experiences and perceptions of caring for people with dementia in the acute setting: Qualitative evidence synthesis. *International journal of nursing studies* 61, pp. 104–116. doi: 10.1016/j.ijnurstu.2016.06.001.

HRA. 2025. *Approvals and Amendments*. Available at: https://www.hra.nhs.uk/approvals-amendments/ [Accessed: 1 September 2025].

Huby, G., Stewart, J., Tierney, A. and Rogers, W. 2004. Planning older people's discharge from acute hospital care: linking risk management and patient participation in decision-making. *Health, Risk & Society* 6(2), pp. 115–132. Available at: https://doi.org/10.1080/1369857042000219797.

Hutchinson, A.J. 2019. Research evidence to inform strengths-based policy and practice: mapping the coping strategies of young women in Mozambique. *The British Journal of Social Work* 49(1), pp. 116–134.

Ibrahim, A.T.H. 2025. Reshaping Social Work in the AI Era: Implications for Tomorrow's Practice. *Global Perspectives on Social Work in Transition: Navigating Technological, Cultural, and Academic Challenges*, p. 109.

Ibrahim, N., Michail, M. and Callaghan, P. 2014. The strengths based approach as a service delivery model for severe mental illness: a meta-analysis of clinical trials. *BMC psychiatry* 14(1), p. 243.

IFSW. 2014. *The Global Definition of Social Work*. Available at: https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/ [Accessed: 25 September 2025].

James, A. and Whelan, A. 2022. 'Ethical 'artificial intelligence in the welfare state: Discourse and discrepancy in Australian social services. *Critical Social Policy* 42(1), pp. 22–42.

James, E., Mitchell, R. and Morgan, H. 2020. *Social work, cats and rocket science: Stories of making a difference in social work with adults*. Jessica Kingsley Publishers.

James, E., Mitchell, R. 2025. *Social work, cats and rocket science: Guide to rights-based practice. An A-Z from Advocacy to Zones of Influence*. Jessica Kingsley Publishers.

Jefferson, G. 1988a. On the Sequential Organization of Troubles-Talk in Ordinary Conversation*. *Social Problems* 35(4), pp. 418–441. Available at: https://doi.org/10.2307/800595 [Accessed: 3 July 2025].

Jensen, L.X., Bearman, M., Boud, D. and Konradsen, F. 2022. Digital ethnography in higher education teaching and learning—a methodological review. *Higher Education* 84(5), pp. 1143–1162.

Jepson, M., Laybourne, A., Williams, V., J., Cyhlarova, E., Williamson, T. and Robotham, D. 2016. Indirect Payments: when the Mental Capacity Act interacts with the personalisation agenda. *Health and Social Care in the Community* 25(5), pp. 623–630. doi: https://doi.org/10.1111/hsc.12236.

Jerolmack, C. and Khan, S. 2014. Talk Is Cheap: Ethnography and the Attitudinal Fallacy. *Sociological Methods & Research* 43(2), pp. 178–209. Available at: https://doi.org/10.1177/0049124114523396 [Accessed: 25 August 2025].

Jessop, B., Cook, J. and Thierry, H. 2025. *Bridging the Gaps In Evidencing Prevention: Key Findings from a Multi-site Study of Local Area Coordination.* National Institute for Health and Social Care Research.

Jones, S. 2004. Problematizing the familiar: Deaf students as researchers of Deaf people. *Qualitative Social Work* 3(1), pp. 27–38.

Joseph-Williams, N., Edwards, A. and Elwyn, G. 2014. Power imbalance prevents shared decision making. *Bmj* 348.

Keeling, A. 2017. *'organising objects': support for legal capacity in adult safeguarding and article 12 of the un convention on the rights of persons with disabilities*. Ph.D., England: University of Nottingham (United Kingdom). Available at: https://cardiff.idm.oclc.org/login?url=https://www.proquest.com/dissertations-theses/organising-objects-support-legal-capacity-adult/docview/2001156702/se-2?accountid=9883.

Kelly, G. 1955. *A theory of personality: The psychology of personal constructs*. WW Norton & Company.

Kemshall, H. 1998. Defensible decisions for risk: Or 'It's the doers wot get the blame'. *Prob. J.* 45, p. 67.

Kemshall, Hazel. 2002. *Risk, Social Policy and Welfare*. Buckinghamshire: Open University Press.

Kong, C., Coggan, J., Dunn, M. and Ruck Keene, A. 2020. Aide memoire for a balancing act? Critiquing the 'Balance Sheet' approach to best interest decision-making. *Medical Law Review* 28(4), pp. 753–780.

Koutsounia, A. 2025. *AI tool improves direct work in adult social care despite accuracy concerns, practitioners report*. Available at: https://www.communitycare.co.uk/2025/02/10/ai-tool-adult-social-care-accuracy-issues-practitioners-report/ [Accessed: 9 February 2025].

LAC. 2025. LOCAL AREA CORDINATION. Available at: https://www.communitycatalysts.co.uk/lacnetwork/the-network/areas/ [Accessed: 18 August 2025].

Lawson, J., Lewis, S. and Williams, C. 2014. Making safeguarding personal 2013/14: report of findings. *England: Local Government Association, Association of Directors of Adult Social Services*.

Leigh, J. 2015. Being brave, doing creative. *Innovations in Social Work Research: Using Methods Creatively*.

Leigh, J., Disney, T., Warwick, L., Ferguson, H., Beddoe, L. and Cooner, T.S. 2021. Revealing the hidden performances of social work practice: The ethnographic process of gaining access, getting into place and impression management. *Qualitative Social Work* 20(4), pp. 1078–1095.

Leigh, J., Morriss, L. and Morriss, M. 2020. Making visible an invisible trade: Exploring the everyday experiences of doing social work and being a social worker. *Qualitative Social Work* 19(2), pp. 267–283.

Lelkes, J., Bouch, A. and Holmstrom, C. 2021. Well-Being: From Concept to Practice? *Practice* 33(4), pp. 289–307.

LGA. 2025. *Kingston Council: Using AI in Adult Social Care administration*. Available at: https://www.local.gov.uk/case-studies/kingston-council-using-ai-adult-social-care-administration [Accessed: 9 February 2025].

Lipsky, M. 1983. *Street-Level Bureaucracy: The Dilemmas of the Individual in Public Service*. Russell Sage Foundation.

Lloyd, J., Patterson, T. and Muers, J. 2016. The positive aspects of caregiving in dementia: A critical review of the qualitative literature. *Dementia* 15(6), pp. 1534–1561.

Loewenstein, G.F., Weber, E.U., Hsee, C.K. and Welch, N. 2001. Risk as feelings. *Psychological bulletin* 127(2), p. 267.

Lonbay, S.P. 2015. *Bridges and barriers: Exploring the involvement of older people in adult safeguarding*. University of Northumbria at Newcastle (United Kingdom).

Lonbay, S.P. 2018. 'These are vulnerable people who don't have a voice': exploring constructions of vulnerability and ageing in the context of safeguarding older people. *British Journal of Social Work* 48(4), pp. 1033–1051.

Lonbay, S.P. and Brandon, T. 2017. Renegotiating power in adult safeguarding: the role of advocacy. *The Journal of Adult Protection* 19(2), pp. 78–91. Available at: https://doi.org/10.1108/JAP-09-2016-0023 [Accessed: 18 August 2025].

Longhofer, J., Floersch, J. and Hoy, J. 2012. *Qualitative methods for practice research*. Oxford University Press.

Lunt, N. and Bainbridge, L. 2019. Local Area Coordination: Summative evaluation.

Lunt, N., Bainbridge, L. and Rippon, S. 2021. Strengths, assets and place–The emergence of Local Area Coordination initiatives in England and Wales. *Journal of Social Work* 21(5), pp. 1041–1064.

Lymbery, M. 2014. Understanding personalisation: Implications for social work. *Journal of Social Work* 14(3), pp. 295–312.

Lymbery, M. 2017. Austerity, personalisation and older people: the prospects for creative social work practice in England. *European Journal of Social Work* 17(3), pp. 367–382.

Lynch, M. 1993. *Scientific Practice and Ordinary Action: Ethnomethodology and Social Studies of Science.* Cambridge University Press.

Magic Notes. 2025. *Transform social workers' productivity with AI*. Available at: https://magicnotes.ai/ [Accessed: 1st September 2025].

Mahesh, S., Bharatan, I. and Miller, R. 2024. Strengths-based practice in adult social care: Understanding implementation. *NIHR Open Research* 4. Available at: https://api.semanticscholar.org/CorpusID:269202553.

Mahon, S., O'Neill, L. and Boland, R. 2024. "Whose safeguarding is it anyway?" service user engagement in safeguarding processes. *The Journal of Adult Protection* 26(2), pp. 72–83. Available at: https://doi.org/10.1108/JAP-11-2023-0031 [Accessed: 28 June 2025].

Mannay, D. and Creaghan, J. 2016. Similarity and familiarity: reflections on indigenous ethnography with mothers, daughters and school teachers on the margins of contemporary Wales. In: *Gender identity and research relationships*. Emerald Group Publishing Limited, pp. 85–103.

Manthorpe, J. *et al*. 2009. Safeguarding and system change: Early perceptions of the implications for adult protection services of the English individual budgets pilots—a qualitative study. *British Journal of Social Work* 39(8), pp. 1465–1480.

Manthorpe, J., & Moriarty, J. 2010. Nothing Ventured, Nothing Gained: Risk Guidance for People with Dementia.

Manthorpe, J., Samsi, K. and Rapaport, J. 2013. "Capacity Is Key": Investigating New Legal Provisions in England and Wales for Adult Safeguarding. *Journal of Elder Abuse & Neglect* 25(4), pp. 355–373. Available at: https://doi.org/10.1080/08946566.2013.770313.

Manthorpe, J., Woolham, J., Steils, N., Stevens, M., Martineau, S., Owen, J. and Tinelli, M. 2022. Experiences of adult social work addressing self-neglect during the Covid-19 pandemic. *Journal of Social Work* 22(5), pp. 1227–1240. Available at: https://doi.org/10.1177/14680173221083446 [Accessed: 8 September 2025].

Marsh, Pauline & Kelly, Lisa. 2018. Dignity of risk in the community: a review of and reflections on the literature. *Health, Risk & Society* (20), pp. 1–15. doi: 10.1080/13698575.2018.1519115.

Marty, D., Rapp, C.A. and Carlson, L. 2001. The experts speak: the critical ingredients of strengths model case management. *Psychiatric Rehabilitation Journal* 24(3), p. 214.

Mason, J., Oatley, C., Harris, K. and Ryan, L. 2021. How and why does Local Area Coordination work for people in different contexts? *Methodological Innovations* 14(1), p. 2059799120985381.

Matarese, M.T. and Caswell, D. 2018. 'I'm gonna ask you about yourself, so I can put it on paper': Analysing Street-Level Bureaucracy through form-related talk in social work. *British Journal of Social Work* 48(3), pp. 714–733.

MCDERMOTT, S. 2010. Professional judgements of risk and capacity in situations of self-neglect among older people. *Ageing and Society* 30(6), pp. 1055–1072. Available at: https://www.cambridge.org/core/product/EFDC8B853CA0260D3874F2C541A567ED.

McDonald, A. 2010. The Impact of the 2005 Mental Capacity Act on Social Workers' Decision Making and Approaches to the Assessment of Risk. *The British Journal of Social Work* 40(4), pp. 1229–1246. Available at: https://doi.org/10.1093/bjsw/bcq021 [Accessed: 16 August 2025].

McGovern, J. 2015. Living better with dementia: Strengths-based social work practice and dementia care. *Social Work in Health Care* 54(5), pp. 408–421.

McMillen, J.C., Morris, L. and Sherraden, M. 2004. Ending social work's grudge match: Problems versus strengths. *Families in Society* 85(3), pp. 317–325.

Mikkonen, E., Laitinen, M. and Hill, C. 2017. Hierarchies of knowledge: Analyzing inequalities within the social work ethnographic research process as ethical notions in knowledge production. *Qualitative Social Work* 16(4), pp. 515–532.

Miller, R. *et al*. 2024. *Changing culture not just process: Community led support in action*. University of Birmingham. Available at: https://www.ndti.org.uk/assets/files/Culture-not-Process-NDTI-Evaluation-May-2024.pdf.

Miller, R. and Mahesh, S. 2025. *Strengths-Based Practice in Adult Social Work and Social Care*. Routledge Oxon.

Miller, R., Waterman, C., Jackson, C., Mahesh, S., Tingle, A., Mayrhofer, A. and Toma, M. 2025. Leading by example? Culture, change, and strength-based social work. *The British Journal of Social Work*, p. bcaf070. Available at: https://doi.org/10.1093/bjsw/bcaf070 [Accessed: 15 August 2025].

Mitchell, D. and Kumara, R. 2009. Risk, choice and rights: The dignity of risk in aged care. *Health Sociology Review, 18(3), 304–316* 18(3), pp. 304–316.

Morgan, Stephen. 2014. *Positive risk-taking: an idea whose time has come*. pp. 18–19. Available at: https://static1.1.sqspcdn.com/static/f/586382/9538512/1290507680737/OpenMind-PositiveRiskTaking.pdf [Accessed: 6 April 2025].

Morley, C. 2015. Critical reflexivity and social work practice. *International encyclopaedia of the social and behavioural sciences (Second edition)*, pp. 281–286.

Morriss, L. 2014. *Accomplishing social work identity in interprofessional mental health teams following the implementation of the Mental Health Act 2007*. University of Salford (United Kingdom).

Munro, E. 2011. *The Munro review of child protection: Final report, a child-centred system*. The Stationery Office.

Murphy, P., Dom, B.K., Eckersley, P., Lakoma, K. and Jones, M. 2025. Written evidence to the House of Commons Public Accounts Committee on Local Government Financial Sustainability.

Murray, J. *et al*. 2019. The impact of care farms on quality of life, depression and anxiety among different population groups: A systematic review. *Campbell Systematic Reviews* 15(4), p. e1061.

Murrell, A. and McCalla, L. 2016. Assessing decision-making capacity: the interpretation and implementation of the mental capacity act 2005 amongst social care professionals. *Practice* 28(1), pp. 21–36.

NDTI. 2025. *Community Led Support*. Available at: https://www.ndti.org.uk/programme/community-led-support/ [Accessed: 21 September 2025].

Nelson-Becker, Holly, Chapin, Rosemary and Fast, Becky. 2006. The Strengths Model with Older Adults Critical Practice Components. In: *The Strengths Perspective in Social Work Practice*. Fourth. London: Pearson Education, Inc, pp. 148–170.

NHS Digital. 2025. *AI in adult social care*. Available at: https://digital.nhs.uk/services/ai-knowledge-repository/case-studies/ai-in-adult-social-care [Accessed: 9 February 2025].

Nuwasiima, M., Ahonon, M.P. and Kadiri, C. 2024. The role of artificial intelligence (AI) and machine learning in social work practice. *World Journal of Advanced Research and Reviews* 24(1), pp. 80–97.

Ocloo, J., Goodrich, J., Tanaka, H., Birchall-Searle, J., Dawson, D. and Farr, M. 2020. The importance of power, context and agency in improving patient experience through a patient and family centred care approach. *Health Research Policy and Systems* 18(1), p. 10.

Odero, A., Pongy, M., Chauvel, L., Voz, B., Spitz, E., Pétré, B. and Baumann, M. 2020. Core values that influence the patient—healthcare professional power dynamic: steering interaction towards partnership. *International journal of environmental research and public health* 17(22), p. 8458.

O'Rourke, N., Kupferschmidt, A.L., Claxton, A., Smith, J.Z., Chappell, N. and Beattie, B.L. 2010. Psychological resilience predicts depressive symptoms among spouses of persons with Alzheimer disease over time. *Aging and Mental Health* 14(8), pp. 984–993.

Owens, J. *et al*. 2024. The Impact of COVID-19 on Social Care and Social Work in the UK: A Scoping Review. *The British Journal of Social Work* 54(3), pp. 885–904. Available at: https://doi.org/10.1093/bjsw/bcad237 [Accessed: 8 September 2025].

Parker, J. 2021. *Social work practice: Assessment, planning, intervention and review*. 6th edn. Learning Matters.

partners4change. 2025. *the three conversations*. Available at: https://partners4change.co.uk/the-three-conversations/ [Accessed: 21 September 2025].

Parton, N. 2008. Changes in the form of knowledge in social work: From the 'social 'to the 'informational'? *British journal of social work* 38(2), pp. 253–269.

Paulus, T.M., Jackson, K. and Davidson, J. 2017. *Digital tools for qualitative research: Disruptions and entanglements*. SAGE Publications Sage CA: Los Angeles, CA. pp. 751–756.

Payne, M. 2006. *What is professional social work?* Policy press.

Perrow, C. 2011. Normal accidents: Living with high risk technologies-Updated edition.

Perske, R. 1972. The dignity of risk and the mentally retarded. *Mental retardation (Washington)* 10(1), pp. 24–27.

Petrakis, M., Wilson, M. and Hamilton, B. 2013. Implementing the strengths model of case management: Group supervision fidelity outcomes. *Community Mental Health Journal* 49(3), pp. 331–337.

Phillips, M. 2025. *State of Rural Services 2025*. Available at: https://ruralengland.org/wp-content/uploads/2025/08/State-of-Rural-Services-2025-Full-Report-Final.pdf.

Pike, L. and Walsh, J. 2015. Making safeguarding personal 2014/15: evaluation report. *Local Government Association*.

Power, M.K. 2003. Auditing and the production of legitimacy. *Accounting, Organizations and Society* 28, pp. 379–394.

Price, A. *et al*. 2020. Research evidence on different strengths-based approaches within adult social work: A systematic review.

Pritchard-Jones, L. 2020. Unspoken and unthinkable: The older disabled body in judicial discourse. *International journal of law and psychiatry* 68, p. 101525.

Probst, B. 2015. The eye regards itself: Benefits and challenges of reflexivity in qualitative social work research. *Social work research* 39(1), pp. 37–48.

Prunty, J., Zhang, J., Toma, M., Miller, R., Forder, J. and Prunty, J.E. 2024. *Effect of strengths-based care: Community Led Support*. Center for Open Science.

Quick, E.K. 2008. *Doing what works in brief therapy: A strategic solution focused approach*. Academic Press.

Quinn, J., Cook, A. and Leeuwerik, T. 2023. Exploring the Experience of a Strengths-Based Approach within a Forensic Service. *Journal of Forensic Psychology Research and Practice* 23(2), pp. 136–153. Available at: https://doi.org/10.1080/24732850.2021.2016117.

Rapp, C. and Leiberman, A. 2020. Reflections. In: *Rooted in Strengths*. University of Kansas Libraries., pp. 15–23.

Rapp, C.A. and Chamberlain, R. 1984. Case Management Services for the Chronically Mentally Ill. *Social Work*, pp. 417–422.

Rapp, C.A. and Goscha, R.J. 2004. The principles of effective case management of mental health services. *Psychiatric rehabilitation journal* 27(4), p. 319.

Rapp, C.A. and Goscha, R.J. 2006. *The strengths model: Case management with people with psychiatric disabilities*. Oxford University Press, USA.

Rapp, C.A. and Goscha, R.J. 2011. *The strengths model: A recovery-oriented approach to mental health services*. OUP USA.

Rapp, C.A., Goscha, R.J. and Fukui, S. 2015. Enhanced consumer goal achievement through strengths-based group supervision. *Psychiatric Rehabilitation Journal* 38(3), p. 268.

Rapp, C.A., Saleebey, D. and Sullivan, W.P. 2006. The future of strengths-based social work. *Advances in social work: Special issue on the futures of social work* 6(1), pp. 79–90.

Rapport, F. 2010. Summative analysis: A qualitative method for social science and health research. *International Journal of Qualitative Methods* 9(3), pp. 270–290.

Ray, M. and Phillips, J. 2012. *Social work with older people*. University of Lincoln.

Reamer, F.G. 2023. Artificial intelligence in social work: Emerging ethical issues. *International Journal of Social Work Values and Ethics* 20(2), pp. 52–71.

Reeves, S., Kuper, A. and Hodges, B.D. 2008. Qualitative research methodologies: ethnography. *Bmj* 337.

Richardson, M. and Pitts, J. 2023. *Valuing Community Led Support (CLS) The economic case for strengths based, community led support January 2023*. National Development Team for Inclusion.

Available at: https://www.ndti.org.uk/assets/files/Valuing-Community-Led-Support-NDTi-Jan-2023-003.pdf.

Riemann, G. 2005. Ethnographies of practice—practising ethnography: resources for self-reflective social work. *Journal of Social Work Practice* 19(1), pp. 87–101.

Robb, M. and McCarthy, M. 2023. Managing risk: social workers' intervention strategies in cases of domestic abuse against people with learning disabilities. *Health, Risk & Society* 25(1–2), pp. 45–60.

Robinson, A., Rees, A. and Dehaghani, R. 2018. *Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews. [Project Report]*. Cardiff University. Available at: https://orca.cardiff.ac.uk/id/eprint/111010/1/Robinson%20Rees%20and%20Dehaghani%20%282018%29%20Thematic%20Review_english.pdf.

Robinson, L. 2016. A little bit of what I am about. Urban Photography for Social Work Research. In: *Innovations in Social Work Research*. London: Jessica Kingsley, pp. 295–313.

Roebuck, M., Aubry, T. and Manoni-Millar, S. 2022. A qualitative study of the working alliance in the strengths model of case management with people with severe mental illness. *Community mental health journal* 58(5), pp. 944–954.

Rogers, J. and Bright, L. 2019. Assessments of mental capacity: upholding the rights of the vulnerable or the misleading comfort of pseudo objectivity? *The Journal of Adult Protection* 21(2), pp. 74–84. Available at: https://cardiff.idm.oclc.org/login?url=https://www.proquest.com/scholarly-journals/assessments-mental-capacity-upholding-rights/docview/2210345467/se-2?accountid=9883.

Rose, D. 2003. Having a diagnosis is a qualification for the job. *British Medical Journal* (326), p. 1331. doi: 10.1136/BMJ.326.7402.1331.

Rosenhan, D.L. 1973. On being sane in insane places. *Science* 179(4070), pp. 250–258.

Rowlands, A. 2001. Ability or disability? Strengths-based practice in the area of traumatic brain injury. *Families in Society* 82(3), pp. 273–286.

Roy, A., Hughes, J., Froggett, L. and Christensen, J. 2015. Using mobile methods to explore the lives of marginalised young men in Manchester. *Innovations in social work research London: Jessica Kingsley Publishers*.

Sabat, S. R. 2001. *The Experience of Alzheimer's Disease: Life Through a Tangled Veil.* first. Blackwell.

Saleebey, D. 1996. The strengths perspective in social work practice: Extensions and cautions. *Social work* 41(3), pp. 296–305.

Saleebey, D. 2000. Power in the people: Strengths and hope. *Advances in social work* 1(2), pp. 127–136.

Saleebey, D. 2001. The diagnostic strengths manual? *Social work* 46(2), pp. 183–187.

Saleebey, D. 2004. Response to "Ending Social Work's Grudge Match". *Families in Society* 85(4), pp. 588–590.

Saleebey, D. 2006. *The Strengths Perspective in Social Work Practice*. 4th edn. London: Pearson Education, Inc.

Saleebey, D. 2008. The strengths perspective: Putting possibility and hope to work in our practice. *Comprehensive handbook of social work and social welfare: The profession of social work* 1, pp. 123–142.

Saleebey, D. 2013. Power in the people. In: *Social work*. Routledge, pp. 184–193.

Schegloff, E.A. 2007. *Sequence organization in interaction: A primer in conversation analysis I*. Cambridge university press.

SCIE. 2025. *Making Safeguarding Personal (MSP)*. Available at: https://www.scie.org.uk/safeguarding/adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal/ [Accessed: 9 January 2025].

SCIE. [no date]. *What are the six principles of safeguarding?* Available at: https://www.scie.org.uk/safeguarding/adults/introduction/six-principles/ [Accessed: 20 September 2025].

SCIE (2020a) Webinar 12th September 2019 [online]. 2019. Available at: https://www.youtube.com/watch?v=_OY9C5Jg9FE [Accessed: 11 May 2020].

SCIE and Innovation Unit. 2018. *Named Social Worker pilot: Programme evaluation – final report*. Available at: https://www.scie.org.uk/social-work/named-social-worker/final-report/.

Scourfield, P. 2021. Strengths-based approaches and the risk of individualising risk. *Critical and Radical Social Work.* (9(1)), pp. 97–111.

Series, L. 2015. Relationships, autonomy and legal capacity: Mental capacity and support paradigms. *Mental Capacities and Legal Responsibilities* 40, pp. 80–91. Available at: https://www.sciencedirect.com/science/article/pii/S0160252715000746.

Shannon, B., 2025. *Rewriting Social Care: Challenging and Changing Practice and Language for a Better, Brighter Future*. Jessica Kingsley Publishers.

Sharman, Z. 2014. Recruitment and retention of home support workers in rural communities. *Home Health Care Services Quarterly* 33(4), pp. 229–243.

Shaw, I. 2020. *Qualitative Research in Social Work*. pp. 243–254. Available at: dx.doi.org/10.4135/9781526421036.

Shaw, I. and Holland, S. 2014. Doing qualitative research in social work.

Shimei, N., Krumer-Nevo, M., Saar-Heiman, Y., Russo-Carmel, S., Mirmovitch, I., Zaitoun-Aricha, L. and Members, S.W.F.C.G. 2016. Critical social work: A performance ethnography. *Qualitative Inquiry* 22(8), pp. 615–623.

Silarova, B., Caiels, J., Milne, A.J. and Beadle-Brown, J. 2025. Reaching consensus on outcomes for evaluating strengths-based approaches in adult social care and social work: A Delphi study conducted in England. *Journal of Social Work* 25(4), pp. 470–499.

Sims, R., Michaleff, Z.A., Glasziou, P. and Thomas, R. 2021. Consequences of a Diagnostic Label: A Systematic Scoping Review and Thematic Framework. *Frontiers in public health* 9. doi: https://doi-org.cardiff.idm.oclc.org/10.3389/fpubh.2021.725877.

Slasberg, C. and Beresford, P. 2016. The eligibility question – the real source of depersonalisation? *Disability & Society* 31(7), pp. 969–973. Available at: https://doi.org/10.1080/09687599.2016.1215122.

Slovic, P. 2010. The psychology of risk. *Saúde e Sociedade* 19(4), pp. 731–747.

Slovic, P., Finucane, M.L., Peters, E. and MacGregor, D.G. 2013. Risk as analysis and risk as feelings: Some thoughts about affect, reason, risk and rationality. In: *The feeling of risk*. Routledge, pp. 21–36.

Smith, G. 2022. Fiction in Goffman. *The Sociological Review* 70(4), pp. 711–722. Available at: https://doi.org/10.1177/00380261221109029 [Accessed: 22 September 2024].

Smith, I.D. and Coombs, S.J. 2003. The Hawthorne Effect: is it a help or a hindrance in social science research? *Change (Sydney, NSW)* 6(1), pp. 97–111.

Spencer-Lane, T. 2019. *The Care Act Manual 3rd Edition*. 3rd edn. Sweet & Maxwell. Available at: https://uk.westlaw.com/Browse/Home/Books/CareAct?navId=9D4A3DDCC75494F7226017250F787E41.

Stanford, S. 2010. 'Speaking Back' to Fear: Responding to the Moral Dilemmas of Risk in Social Work Practice. *The British Journal of Social Work* 40(4), pp. 1065–1080. Available at: https://doi.org/10.1093/bjsw/bcp156 [Accessed: 23 June 2025].

Stanhope, V. 2012. The ties that bind: Using ethnographic methods to understand service engagement. *Qualitative Social Work* 11(4), pp. 412–430.

Steven, E.G. 2007. Perspective analysis: McKnight's careless society and the strengths-based approach to social work. *Social work* 52(3), pp. 275–277.

Stevens, M. *et al*. 2018. Implementing safeguarding and personalisation in social work: Findings from practice. *Journal of Social Work* 18(1), pp. 3–22. Available at: https://doi.org/10.1177/1468017316652001 [Accessed: 12 September 2025].

Stevens, M., Clark, M., Carlisle, J., Brimblecombe, N. and MacGill, M. 2024. Supporting Meaningful Implementation and Evaluation of Strengths-Based Approaches in Adult Social Care: A Theory of Change for The Three Conversations. *The British Journal of Social Work* 54(6), pp. 2583–2602. Available at: https://doi.org/10.1093/bjsw/bcae055 [Accessed: 19 August 2025].

Symonds, J., Williams, V., Miles, C., Steel, M. and Porter, S. 2018. The social care practitioner as assessor: 'people, relationships and professional judgement'. *The British Journal of Social Work* 48(7), pp. 1910–1928.

Tadd, W., Hillman, A., Calnan, M., Calnan, S., Read, S. and Bayer, A. 2012. From right place-wrong person, to right place-right person: dignified care for older people. *Journal of health services research & policy* 17(2_suppl), pp. 30–36.

Tarrant, A. 2024. The progressive potential of the Care Act 2014: wellbeing, autonomy and rights. *Journal of Social Welfare and Family Law* 46(3), pp. 472–475. Available at: https://doi.org/10.1080/09649069.2024.2381994.

Taylor, B.J. 2006. Risk Management Paradigms in Health and Social Services for Professional Decision Making on the Long-Term Care of Older People. *The British Journal of Social Work* 36(8), pp. 1411–1429. Available at: https://doi.org/10.1093/bjsw/bch406 [Accessed: 14 July 2025].

Taylor, C., & White, S. 2000. *Practising Reflexivity in Health and Welfare: Making Knowledge.* Open University Press.

Taylor, C. and White, S. 2001. Knowledge, truth and reflexivity: The problem of judgement in social work. *Journal of social work* 1(1), pp. 37–59.

Teague, G.B., Mueser, K.T. and Rapp, C.A. 2012. Advances in fidelity measurement for mental health services research: four measures. *Psychiatric Services* 63(8), pp. 765–771.

Teater, B. 2014. *An Introduction to Applying Social Work Theories and Methods. :* Maidenhead: Open University Press.

Tervo, H., Nikkonen, M. and Müller-Wille, L. 2005. At the Interface between Two Cultures—An Analysis of the Preparation for Fieldwork and Data Collection in Ethnographic Research. *Vård i Norden* 25(3), pp. 24–28.

Tew, J. 2011. *Social Approaches to Mental Distress.* Palgrave Macmillan.

Tew, J. 2013. Recovery capital: what enables a sustainable recovery from mental health difficulties? *European Journal of Social Work* 16(3), pp. 360–374. Available at: https://doi.org/10.1080/13691457.2012.687713.

Tew, J. *et al*. 2019. Implementing the Care Act 2014: Building social resources to prevent, reduce or delay needs for care and support in adult social care in England. *Department of Social Work and Social Care*.

The King's Fund. 2025. *Social care 360*.

The Social Work Taskforce,. 2009. *Facing up to the Task The interim report of the Social Work Task Force: July 2009*. Department of Health and Department for Children's Schools and Families. Available at: https://dera.ioe.ac.uk/id/eprint/10576/1/DCSF-00752-2009.pdf [Accessed: 14 May 2020].

Thiery, H. *et al*. 2023. Transforming adult social care systems? A systematic review of the costs and outcomes of local area coordination in England and Wales. *Social Sciences & Humanities Open* 8(1), p. 100714.

Thompsons Reuters Practical Law. 2025. *Mental capacity and best interests Legal framework*. Available at: https://uk.practicallaw.thomsonreuters.com/w-023-2001?transitionType=Default&contextData=(sc.Default)&OWSessionId=a3081a1701b3469998439e7167c042a5&skipAnonymous=true&firstPage=true [Accessed: 31 August 2025].

Thompsons Reuters Westlaw Books. 2017. *R. (on the application of JF) v Merton LBC | Books*. Available at: https://uk.westlaw.com/Document/I86D4A9C0627111E7B0E89F1739991DCB/View/FullText.html?originationContext=document&transitionType=DocumentItem&ppcid=14038e7301514aba874f40a5c6fee58f&contextData=(sc.CommentaryUKLink)&comp=books [Accessed: 16 February 2025].

Tirraoro, T. 2020. *Challenging opaque, illegal social care plans for disabled adults*. Available at: https://www.specialneedsjungle.com/challenging-opaque-illegal-social-care-plans-for-disabled-adults/#:~:text=Thefirstleveljudgefoundthatthes26CareActdutytospecifythepersonalbudgetfortheadultrequired%C2%A0atransparentfigure%C2%A0toidentifyhoweligibleneedscouldbemet.This [Accessed: 13 May 2022].

Toros, K. 2019a. Miracle question promotes open communication and positive interaction between clients and practitioners. *International Social Work* 62(2), pp. 483–486.

Toros, K. 2019b. Social work graduate students’ understanding of strength-eliciting questions in the context of social work assessment. *European Journal of Social Work* 22(3), pp. 412–422.

Tse, S. *et al*. 2016. Uses of strength-based interventions for people with serious mental illness: A critical review. *International Journal of Social Psychiatry* 62(3), pp. 281–291.

Tse, S. *et al*. 2021. Process research: Compare and contrast the recovery-orientated strengths model of case management and usual community mental health care. *BMC psychiatry* 21(1), p. 534.

Tsoi, E.W., Tse, S., Canda, E.R., Goscha, R.J. and Lo, I.W. 2022. The meaning of “strengths” for strengths-based mental health practice in Hong Kong Chinese culture: A qualitative exploratory study. *Psychiatric Rehabilitation Journal* 45(1), p. 71.

Tsoi, E.W., Tse, S., Yu, C.-H., Chan, S.-K., Wan, E., Wong, S. and Liu, L. 2019. A nonrandomized controlled trial of strengths model case management in Hong Kong. *Research on Social Work Practice* 29(5), pp. 540–554.

Ungar, M. 2004. A constructionist discourse on resilience: Multiple contexts, multiple realities among at-risk children and youth. *Youth & society* 35(3), pp. 341–365.

Van Maanen, J. 1991. Playing Back the Tape: Early Days in the Field. In: *Experiencing Fieldwork: An Inside View of Qualitative Research*. SAGE Publications, Inc., pp. 31–42.

Vance, C. 2017. Toward a radical model of social work in rural communities. *Journal of Progressive Human Services* 28(1), pp. 2–5.

Victor, C.R. *et al*. 2021. The prevalence and predictors of loneliness in caregivers of people with dementia: findings from the IDEAL programme. *Aging & mental health* 25(7), pp. 1232–1238.

Vincent, A. 2010. Local area coordination: an exploration of practice developments in Western Australia and Northern Ireland. *Practice: Social Work in Action* 22(4), pp. 203–216.

Wahab, S. 2005. Motivational interviewing and social work practice. *Journal of Social Work* 5(1), pp. 45–60.

Wassal, K., Ashurst, C., Hron, J. and Zilka, M. 2024. Reimagining AI in social work: Practitioner perspectives on incorporating technology in their practice. *arXiv preprint arXiv:2407.10244*.

Weick, A., Rapp, C., Sullivan, W.P. and Kisthardt, W. 1989. A strengths perspective for social work practice. *Social work* 34(4), pp. 350–354.

Westlake, D. 2015. Front row seats: why researchers need to get closer to practice and how we can do so. Jessica Kingsley.

Westoby, P., Lathouras, A. and Shevellar, L. 2019. Radicalising community development within social work through popular education—A participatory action research project. *The British Journal of Social Work* 49(8), pp. 2207–2225.

White, M., & Epston, D. 1990. *Narrative Means to Therapeutic Ends.* New York: Norton. Available at: https://archive.org/details/narrativemeansto00whitrich/page/n11/mode/2up?q=problem.

WHITE, S. 1997. Beyond Retroduction? — Hermeneutics, Reflexivity and Social Work Practice. *The British Journal of Social Work* 27(5), pp. 739–753. Available at: https://doi.org/10.1093/oxfordjournals.bjsw.a011263 [Accessed: 23 March 2025].

White, S., Hall, C., & Peckover, S. 2009. The Descriptive Tyranny of the Common Assessment Framework: Technologies of Categorization and Professional Practice in Child Welfare.

Whittington, C. 2016. The promised liberation of adult social work under England's 2014 Care Act: Genuine prospect or false prospectus? *British Journal of Social Work* 46(7), pp. 1942–1961.

Williams, V. and Symonds, J. 2022. Who knows what about you? Managing topic shifts during 'conversational 'social care assessments in England. *Qualitative Social Work* 21(6), pp. 1104–1122.

Wilson, T.D. and Gilbert, D.T. 2005. Affective Forecasting: Knowing What to Want. *Current Directions in Psychological Science* 14(3), pp. 131–134.

Withers, A. and Pollock, S. 2019. Social work with adults. In: *Social Work and Society*. Policy Press, pp. 85–98.

Wöllner, C., Ginsborg, J. and Williamon, A. 2016. Familiarity and reflexivity in the research process. In: *Music and Familiarity*. Routledge, pp. 175–195.

Wolniak, M. and Houston, S. 2023. A sociologist in the field of social work: Pierre Bourdieu's theory and its relevance for social work practice. *Critical and Radical Social Work* 11(2), pp. 183–198. Available at: https://bristoluniversitypressdigital.com/view/journals/crsw/11/2/article-p183.xml.

Xie, H. 2013. Strengths-based approach for mental health recovery. *Iranian journal of psychiatry and behavioral sciences* 7(2), p. 5.

Statute and Legislation

Care and Support Statutory Guidance. 2025. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

Human Rights Act. 1998. Available at: https://www.legislation.gov.uk/ukpga/1998/42/contents.

Mental Capacity Act. 2005. Available at: https://www.legislation.gov.uk/ukpga/2005/9/contents.

Mental Capacity Act Code of Practice. 2020. Available at: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed: 29 September 2025].

NHS and Community Care Act. 1990. Available at: https://www.legislation.gov.uk/ukpga/1990/19/contents [Accessed: 12 July 2024].

The Care Act. 2014. Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents.

The Care and Support (Eligibility Criteria) Regulations 2015. 2015. Available at: https://www.legislation.gov.uk/uksi/2015/313/contents/made.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 2014. 2936. Available at: https://www.legislation.gov.uk/uksi/2014/2936 [Accessed: 6 June 2025].

Cases

[2013] EWHC 3230 (Fam) [2013] IN THE HIGH COURT OF JUSTICE FAMILY DIVISION FD07P00104

[2013] UKSC 67 (United Kingdom Supreme Court)

[2015] EWCOP 60 [2015] COURT OF PROTECTION 12749739

[2016] EWCA Civ 759 [2016] THE COURT OF APPEAL (CIVIL DIVISION) ON APPEAL FROM THE HIGH COURT OF JUSTICE FAMILY DIVISION B4/2016/2671

[2016] EWCOP 53 [2016] THE COURT OF PROTECTION 12942115

[2019] EWCA Civ 1614 [2019] IN THE COURT OF APPEAL (CIVIL DIVISION) ON APPEAL FROM THE QUEEN'S BENCH DIVISION ADMINISTRATIVE COURT C1/2018/063

[2020] EWCOP 26 [2020] THE COURT OF PROTECTION 1360935T

[2020] EWCOP 29 (THE COURT OF PROTECTION)

[2021] EWCOP 50 [2021] THE COURT OF PROTECTION 13699739

[2023] EWCOP 1 [2023] COURT OF PROTECTION 13909989

[2023] EWCOP 27 [2023] COURT OF PROTECTION 13715813

AH, Re (Re Best Interests) [2023] EWCOP 1 (04 January 2023) URL: https://www.bailii.org/ew/cases/EWCOP/2023/1.html

Barry, R (on the Application of) v Gloucestershire CC & Anor (House of Lords)

CC v KK & STCC [2012] IN THE HIGH COURT OF JUSTICE THE COURT OF PROTECTION COP 12041541 IN THE

N v ACCG [2017] UKSC 22 (United Kingdom Supreme Court)

Appendices

Appendix one: Specific Literature Searches and results (2022 and 2025)

Year	Search Term	Platform	Initial Results	Accepted	Rejected	Duplicates
2022	Strengths-based AND Social Work NOT children	Google Scholar & Cardiff Library	224	14	206	4
2022	Asset-based AND Social Work NOT children (title only)	Google Scholar	139	12	126	1
2022	Local Area Coordination	Google Scholar	14	—	—	—
2022	Community-Led Support & any social work (title only)	Google Scholar	28	—	28	—
2025	Strengths-based approaches in adults (since 2022)	Elicit	Identified 14	4	10	1
2025	Making Safeguarding Personal in England + strengths-based approaches	Elicit	Elicit analysed 30 from 500	12	9	7
2025	Any field: strengths-based, AND social work NOT children and adults	Cardiff University Library / Google Scholar search	122			
2025	UK model websites (title review)	Direct review	Most already covered in 2022 or picked up in other literature searches			

Appendix two: overview of studies considered in the literature review

Information in the following table was generated from bibliography using Elicit software following full literature review and then edited

Author	Year	findings	Methodology	Study design
Ahuja et al.	2022	Key themes in implementing MSP include cultural change, staff training and support, and clear communication and collaboration between agencies. MSP can lead to improved outcomes such as increased autonomy and well-being, but challenges include resistance to change and difficulties in measuring outcomes.	The study is a systematic review of qualitative research evidence focusing on the implementation of the Making Safeguarding Personal Approach to strengths-based adult social care.	Systematic review of qualitative research evidence
Aspinal, et al.	2019	Three main themes: levels of information and awareness, safeguarding concerns and processes, and choice and control, highlighting the complex interactions between personalisation and safeguarding. Many participants experienced multiple forms of abuse or neglect concurrently or repeatedly, indicating significant safeguarding issues in personal budget management. Adults receiving personal budgets need ongoing information and advice to address poor quality care and safeguarding concerns, balancing individual choice with organisational and legal requirements.	Semi-structured / 12 participants who had recently been the focus of a safeguarding investigation. Participants were recruited from two English local authority areas. Data was analysed using thematic analysis. Informed consent was obtained from all participants. Interviews lasted between 30 and 90 minutes.	Qualitative study Semi-structured interviews Multi-site (two English local authority areas) Thematic analysis Small-scale Observational study
Aspinwall-Roberts, et al.	2022	The study identified three key themes: a lack of understanding of the MCA, reluctance to engage with MCA assessments, and a perception of manipulation of the MCA by other professionals. There is an urgent need to enhance the informed application of the MCA to prevent intrusive interventions resulting from professional misinterpretation. Professional groups may manipulate capacity assessments based on agency priorities, leading to distorted outcomes and potential harm for service users.	Qualitative study conducted in two local authorities in England from 2016 to 2017 Non-probability purposive sampling used to recruit 245 participants from 17 professional groups. Semi-structured interviews conducted in group, paired, and individual formats. Data analysed using thematic analysis with NVivo 10.	Qualitative study; non-probability purposive sampling; Semi-structured interviews; Thematic analysis; multi-site (two local authorities in England); Part of a wider action research study

Author	Year	findings	Methodology	Study design
Averill	2003	The study identified key healthcare issues in rural communities, including high prescription costs, limited access to primary and specialty care, and social isolation. Existing strengths within the community include elders' health knowledge, dedicated nurses, and a community action group working to improve services. Building on these strengths could transform the healthcare environment and improve inadequate healthcare for elderly rural community members.	An ethnographic study was conducted with multicultural elderly participants from a rural county in New Mexico to explore their definitions of health, health care perceptions, and health care needs.	Ethnographic study (observational study)
Bainbridge & Lunt	2021	LAC is operating as intended, being flexible and agile with less constraint from traditional service delivery methods. The program has positive impacts on individuals and families, including tackling isolation and loneliness, building a positive vision of the future, identifying non-service solutions, and ensuring individuals are heard. LAC is part of creating a more preventative and universal support system, helping individuals remain healthy and independent, countering loneliness, and building social capital.	Mixed-method evaluation approach Implementation plans, performance reports, case studies, minutes, policy papers Unstructured observation: LAC Leadership Group Meetings Qualitative interviews: 55 interviews with professional stakeholders and individuals supported by LAC. Face-to-face and telephone interviews Timeline interviews with residents Informed consent and digital recording of interviews Thematic analysis for data analysis	Mixed-method evaluation Qualitative interviews Documentary materials Unstructured observation Small-scale evaluation Non-experimental design Observational study

Author	Year	findings	Methodology	Study design
Björkman, et al.	2002	The strengths model of case management (SCM) resulted in a greater reduction in needs for care compared to standard care. There were no differences in clinical or social outcomes between SCM and standard care. SCM reduced the number of days spent in psychiatric inpatient services and improved client satisfaction with psychiatric services.	Randomised controlled trial (RCT) design. 77 clients with mental illness and serious impairment in social contacts, housing, or work situation Random allocation to strengths model of case management service (SCM) or standard care Outcome assessment: use of psychiatric services, symptom changes, psychosocial functioning, social network, needs for care, quality of life, client satisfaction Follow-up period: 36 months	Randomised controlled trial
Bown, et al.	2017	Community-led support can improve the well-being of people with dementia and their careers. Key factors for successful community-led support include strong community engagement, accessible and flexible services, and person-centred care. Involving people with dementia and their carers in service design and delivery is crucial for effective support.	Mixed-methods approach Systematic review of existing literature Semi-structured interviews for qualitative data Survey for quantitative data Thematic analysis Descriptive statistics	Mixed-methods study; Systematic review; Observational study (primary data collection through surveys and interviews)

Author	Year	findings	Methodology	Study design
Bown, et al.	2020	Community Led Support (CLS) is effective in improving outcomes for people and places across the UK.- Key factors for CLS success include community engagement, co-production, and building relationships and trust.- CLS addresses social isolation, improves mental health, and enhances community cohesion.	Review of evidence from the CLS programme- Mixed-methods approach (quantitative and qualitative)- Surveys, interviews, and focus groups- Case studies- Secondary data analysis from administrative records.	Systematic review or synthesis of existing data; multi-site
Briand, et al.	2022	The study highlights the importance of organisational support and training for successful implementation of the strengths model. Practitioners reported positive changes in their practice, such as increased focus on client strengths and empowerment. Challenges included resistance to change, lack of resources, and difficulties in integrating the model into existing practices.	Qualitative research design Semi-structured interviews with 35 direct-service practitioners Interviews conducted by phone or video conference. Thematic analysis for data analysis Use of NVivo software	Observational study, multi-site
Briggs, et al.	2018	MSP is being implemented across England, but local authorities are at different stages of development. There is a significant increase in social workers' enthusiasm for MSP, with 97% reacting positively. Implementation and culture change are affected by factors such as local authority systems, leadership support, service capacity, and skill development.	Guided interviews with SG lead from 115 English local authorities. Randomly selected sample Semi-structured interviews to explore various aspects of MSP implementation. Respondents used local data, social worker feedback, and service user questionnaires.	Observational study Cross-sectional design Stratified sampling Multi-site study Guided interviews Randomly selected sample

Author	Year	findings	Methodology	Study design
Brongers, et al.	2020	-The CARm method and training were found to be feasible for use by Labour Experts in supporting clients with multiple problems. Sufficient managerial support is crucial for successful implementation of the CARm method. The study suggests that the CARm method is worth testing for efficacy in a future trial.	Development of the CARm method based on the Strength model for work-disability beneficiaries. Training module for Labour Experts (LEs) to apply the CARm method. . Data collection: self-report questionnaires at baseline, during training, and after three months; semi-structured discussion meeting.	one-group, pre-post design; feasibility study; observational study
Brun & Rapp	2001	• Individuals participating in strengths-based case management had mixed reactions to the focus on strengths, including acceptance, holding onto strengths and deficits, and initial mistrust. • The relationship with the case manager was significant, with themes of acceptance, guilt when success was not achieved and not needing the relationship. • The study's findings have implications for improving social work practice in case management.	• Qualitative data collection methods were used to gather individuals' experiences in a substance abuse aftercare program.	• Qualitative observational study
Bryant, *et al.*	2018	• Rural and remote communities in Australia have complex mental health needs and inadequate services. • CTs offer a potential solution but have not been widely adopted in social work practice in these areas. • The paper provides suggestions for enhancing ICT engagement by social workers to improve mental health services in these communities.	• literature review of social work literature on ICT, drawing on research from tele-psychology and tele-education, to provide suggestions for enhancing ICT engagement in social work practice.	• Systematic review or literature review

Author	Year	findings	Methodology	Study design
Butler & Manthorpe	2016	The study emphasises the importance of person-centred approaches in safeguarding adults. Effective implementation of Making Safeguarding Personal requires a cultural shift within organisations, including staff training and support. Making Safeguarding Personal enhances the safeguarding process by focusing on individual needs and preferences.	-Mixed-methods approach combining qualitative and quantitative methods Interviews with practitioners and managers Focus groups with service users and carer. Survey of local authorities Analysis of policy documents and guidance	Mixed-methods study involving qualitative and quantitative data collection and analysis methods; data collection included interviews, focus groups, and a survey.
Caiels, *et al.*	2024	• Strengths-based approaches in adult social work in England led to positive outcomes such as improved well-being and satisfaction for service users and enhanced interactions between practitioners and service users. • The principles of strengths-based approaches align with high-quality social work, but there are challenges in capturing their impact and operationalising their benefits. • Challenges in implementing these approaches include structural and organisational barriers, such as incompatibility with existing systems and resource constraints.	• Two-stage project involving an online survey and semi-structured interviews. • Online survey completed by 32 respondents. • Semi-structured interviews with a sub-sample of 10 respondents. • Survey development informed by scoping review and advisory group consultation. • Framework analysis for qualitative data. • Use of NVivo for data management and IBM SPSS for descriptive statistics	• Observational study; qualitative research design; two-stage project; online survey; semi-structured interviews; self-reported data; not randomised; not controlled; not double-blind; not placebo-controlled; not meta-analysis; not systematic review; not retrospective; not multi-site; not stratified; not crossover design.
Author	Year	Findings	Methodology	Study design

Caiels, et al.	2021	The literature review highlights the importance of focusing on individuals' strengths and capacities in social work and social care. A strengths-based approach can lead to improved outcomes such as increased empowerment, self-esteem, and social connections. Challenges to implementing this approach include the need for cultural and organisational change.	Search of relevant databases. Used a combination of keywords and phrases related to strengths-based approaches, social work, and social care. Applied inclusion criteria to select relevant studies. Employed a systematic approach to select studies based on relevance to the research question.	Systematic review or literature review (the exact type is not specified)
Carrier	2020	• Community Led Support (CLS) has been successful in delivering support with a focus on prevention and early intervention. • CLS has been effective in addressing social isolation and loneliness through community-led approaches. • CLS has built community capacity and promoted social connections.	• Review of existing literature and research • Systematic approach to identify key themes and patterns. • Sources include academic research, policy documents, and grey literature. • Insights from interviews with practitioners and stakeholders	• Not mentioned (the paper does not specify the study design)
Cefaï	2015	• The study reveals the complex and often contradictory nature of outreach work, where social workers and nurses must balance professional obligations with moral imperatives of care and compassion. • Building trust and rapport with clients is crucial but navigating professional and personal boundaries is challenging. • Outreach workers must negotiate tensions between caregiving and social control roles.	• Ethnographic study / Participant observation • Interviews with outreach workers and nurses • Focus groups with homeless individuals. • Data collection in various settings (streets, shelters, day centres)	• Observational study; Ethnographic study; multi-site study

Author	Year	findings	Methodology	Study design
Chen, *et al.*	2021	• The supervision model under the strength perspective empowered social workers by enhancing their professional confidence and autonomy, leading to improved service quality and client satisfaction. • The model allowed social workers to interpret challenges creatively, which was a key factor in its success. • The study emphasised the importance of creating a supportive environment that leverages the strengths and resources of social workers.	• case-by-case supervision service • Collection of supervision meeting records and related data for qualitative analysis • Interpretivism through in-depth interviews and narrative analysis • Regular consultations (every 3-4 weeks for 18 months) and group supervision meetings (every 3 months) • Open coding for data classification • Semi-structured interview guide for data collection	• Qualitative study • Observational study • Longitudinal design • Case consulting model • In-depth interviews and narrative analysis • Non-controlled • Non-randomised • Non-double-blind
Cooper, *et al.*	2016	• The Making Safeguarding Personal program aims to support person-centred and outcome-focused adult safeguarding practices. • The temperature checks identified areas where practice is strong but also highlighted areas needing improvement. • Continued support and development are necessary to ensure consistent person-centred and outcome-focused practices.	• survey of local authorities to assess the progress of the Making Safeguarding Personal (MSP) programme. • survey was conducted online and questions about implementation of MSP principles, policies, and practices. • Data analysis to identify trends and areas for improvement.	• Observational study (temperature check implies an assessment or evaluation)

Author	Year	findings	Methodology	Study design
Derby City Council	2021	• The Local Area Co-ordination program has had a positive impact on the lives of individuals and families in Derby. • Key findings include improved well-being, increased social connections, and enhanced community engagement. • The program supports vulnerable populations and promotes community resilience.	• Mixed-methods approach • Review of existing literature and policy documents • Interviews with key stakeholders and service users • Surveys for quantitative data collection • Administrative data analysis • Focus groups with service users and stakeholders	• Not mentioned (the paper does not provide specific details about the study design)
Duggal, *et al.*	2021	• The implementation of Local Area Coordination (LAC) showed marked differences between two sites in terms of process, impact, and collaboration with other agencies.- Successful implementation depends on maintaining a common vision, engaging with leaders, addressing anxieties, and working with community groups.- Despite challenges in measuring outcomes, both sites reported improvements in individuals' lives, highlighting the potential effectiveness of LAC when implemented correctly.	• Case study approach- Qualitative data collection through interviews with stakeholders, service users, and carers- Thematic analysis of data- Participation of Lived Experience Advisory Panel and local community champions- Ethical permission from Social Care Research Ethics Committee- Use of NVivo coding for data analysis	• Observational study- Case study approach- multi-site (two local authorities)- Qualitative data collection (interviews and focus groups)- Thematic analysis

Author	Year	Findings	Methodology	Study design
Fawcett, *et al.*	2021	• The Three Conversations approach led to a significant reduction in the proportion of longer-term services being taken up by new clients, from a baseline to 8.8%. • The approach resulted in a total saving of £4,926,780 in benefits over the evaluation period. • The evaluation showed a cultural transformation in social work practices, focusing on citizen-centred and relational care.	• Mixed-methods evaluation combining quantitative and qualitative data. • Baseline data collection for comparison. • Objectives set with expected outcomes and timeframes. • Adaptation of existing data collection systems. • Collaborative evaluation process between University and Adult Directorate.	• Longitudinal study; Mixed-methods evaluation; Observational study; Before-and-after study design
Ferguson	2014	• The study uses ethnographic and mobile methods to observe interactions between social workers, children, and families during home visits with child protection concerns. • These methods provide new insights into everyday social work practices and service users' experiences. • The study aims to understand dynamics like those leading to breakdowns in practice in child death cases.	• Mobile methods: walking and driving interviews with social worker. • Ethnographic methods: participant observation and audio-recordings of interactions between social workers, children, and parents	• Observational study using ethnographic and mobile methods involving participant observation and audio-recordings.
Ferguson	2016	• The study highlights the importance of understanding relational dynamics between social workers and service users. • Ethnographic and mobile research methods are valuable for capturing real-time nuances of social work practice. • The research provides insights into how social workers navigate complex situations and make decisions in practice.	• Ethnographic and mobile research methods were used to observe social work practice with social workers and service users.	• Observational study using ethnographic and mobile research methods

Author	Year	findings	Methodology	Study design
Flückiger, *et al.*	2023	• Positive interventions had a significant positive effect on mental health outcomes in clinical settings. • Tailoring interventions to individual strengths and needs enhances their effectiveness. • Strength-based methods are effective in improving mental health outcomes in clinical settings.	• literature search using multiple databases: lang Eng, clinical samples, reporting outcomes related to positive interventions. • multilevel meta-analysis to compare effects of interventions. • Analysed interventions such as gratitude journals, acts of kindness, and mindfulness-based interventions.	• narrative review, comparative multilevel meta-analysis
Foot, *et al.*	2014	• The report highlights the need for a fundamental shift in healthcare delivery to empower individuals to take control of their own health and care. • Current systems and services often fail to support individuals in taking control of their health and care due to barriers like lack of information and access. • A more person-centred approach is needed to empower individuals and communities to take control of their health and care.	• Review of existing literature • Analysis of data from national surveys and administrative data • Case studies of innovative care models	• Not mentioned (the paper is a report based on a review of existing literature and analysis of data, but specific study design characteristics are not detailed)

Author	Year	findings	Methodology	Study design
Fukui, *et al.*	2010	• The study found statistically significant improvements in self-esteem, self-efficacy, social support, spiritual well-being, and psychiatric symptoms among participants in the PTR peer-led group. • The findings suggest that PTR is a promising tool for facilitating recovery in a peer-led group format.	• Single-group pretest / -post-test research design • Participants: 47 / 12-week PTR peer-led group • Measures: Rosenberg Self-Esteem Scale, General Self-Efficacy Scale, Multidimensional Scale of Perceived Social Support, Spirituality Index of Well-Being, Modified Colorado Symptom Index. Statistical analysis: Paired Hotelling's T-square test	• Single-group pretest-post-test research design; non-controlled; non-randomised; non-double-blind; non-placebo-controlled; non-multi-site; non-retrospective; non-stratified; non-crossover; non-parallel;
Fukui, *et al.*	2012	• Higher fidelity scores in Strengths Model case management are associated with better client outcomes. • The study supports the use of the Strengths Model as a best practice in case management.	• Correlational design relationship fidelity scores and outcomes • Data collected from 12 mental health agencies • Fidelity scores calculated using the Strengths Model Fidelity Scale • Client outcomes measured using the Colorado Client Assessment Record (CCAR)	• Retrospective observational study • Retrospective design analysing existing records
Gelkopf, *et al.*	2016	• The intervention group showed a significant reduction in symptoms and improvement in quality of life compared to the control group. • The intervention group had a significant increase in social functioning and employment rates compared to the control group. • The study suggests that a strengths-based case management service is an effective approach for improving outcomes for people with serious mental illness.	• The study was a randomised controlled trial conducted in Israel, testing a strengths-based case management service for people with serious mental illness.	• Randomised controlled trial

Author	Year	findings	Methodology	Study design
Geyer	2012	• The strengths-based groupwork program improved the psychosocial functioning of alcohol-dependent older persons by increasing their repertoire of strengths and helping them achieve or move towards ego integrity. • The program is considered complementary to current treatment programs, offering an additional or alternative approach. • The program positively impacted self-image and encouraged engagement with religious and spiritual lives.	• Mixed methods. • Concurrent triangulation research design • Questionnaire with Likert scale. • Eight randomly selected respondents from 35. • Empowerment process with goal formulation and working agreements. • Evaluation phase with summary and reflection on skills and strengths.	• no control group • Non-double-blind • Non-placebo-controlled • Non-multi-site • Non-retrospective • Non-stratified • Non-crossover design Not an observational study, meta-analysis, or systematic review
Gillingham & Humphreys	2010	• The Structured Decision-Making tools were not used as intended by their designers in child protection practice. • The tools tended to undermine the development of expertise by child protection workers.	• Ethnographic research was used to explore how child protection practitioners used Structured Decision-Making tools in their daily practice.	• Observational study; Ethnographic research
Hassink, *et al.*	2010	• Care farms in the Netherlands are experienced as unique services due to characteristics like personal involvement, safe community, diverse activities, and green environment. • These characteristics lead to an informal context close to normal life, benefiting clients with mental health issues, youth care backgrounds, and frail elderly. • Care farms are considered innovative community-based services that improve clients' quality of life.	• The study used a qualitative approach, involving interviews with 41 clients, 33 care farmers, and 27 health professionals to identify characteristics of care farms relevant to different client groups.	• Observational study

Author	Year	Findings	Methodology	Study design
Healy & Dray	2022	- Prior to the Care Act (2014), safeguarding practices often failed to prioritise criminal justice interventions for disability hate crimes. - Improving multi-agency collaboration and raising awareness within safeguarding teams can enhance reporting and outcomes for adults at risk. - There is limited recognition of disability hate crimes within safeguarding practices, which hinders effective responses.	- Semi-structured interviews with key informants who work with disabled people and organisations. - Thematic analysis using NVivo software. - Data analysis followed the principles of "open coding" within a constructivist perspective. - Confidential and anonymised participation. - Ethical approval from Middlesex University's Ethics Sub-Committee.	- Observational study; Semi-structured interviews; Qualitative thematic analysis; Small sample size (15 participants); Limited to England; Not randomised, double-blind, controlled, or placebo-controlled; Not a meta-analysis or systematic review; Not multi-site; Not retrospective.
Hertfordshire Safeguarding Adults Board	-	- The survey showed improvements in reporting and addressing safeguarding concerns. - There was a notable increase in safeguarding referrals during the survey period. - Areas for improvement were identified in communication and support for vulnerable adults.	- The methodology involved conducting a "Making Safeguarding Personal survey" from January to October 2017 gathered information on the experiences of safeguarding. -	- Observational study (survey)

Author	Year	findings	Methodology	Study design
Hopkinson, *et al.*	2015	• In 81% of safeguarding cases, outcomes were achieved satisfactorily. • Focus groups identified the importance of freedom of movement, freedom of association, being listened to, and regular communication with a consistent person. • Practitioner interviews revealed themes of increased efficiency, effectiveness, empowerment, and transformation of relationships.	• Quantitative analysis of 47 safeguarding cases to assess desired outcomes and their achievement. • Qualitative analysis using focus groups to explore people experience. • Interviews with SW's, TM, and admin to gather their experiences with implementing MSP.	• Observational study; Mixed-methods approach; Non-controlled; Single-site; No randomisation; No blinding; No control groups; No baselines
Hutchinson	2019	• Many coping strategies used by young women in Mozambique in response to unintended pregnancy were relational, emphasising the importance of strengthening these naturally occurring strategies. • Strengths-based research is crucial for identifying and reinforcing existing strengths within communities, particularly for groups considered unable to cope. • Relational strategies are key to addressing structural inequalities and discrimination underlying unintended pregnancy.	• Semi-structured narrative interviews with 21 young mothers (16-19 years old) from urban and rural regions in Mozambique. • Data analysis using Nvivo 7 for thematic analysis. • Data translation from Portuguese to English by regional and language-familiar research assistants. • Coding of problems, responses, and outcomes to categorise coping strategies.	• Qualitative research; Observational study; multi-site study; Semi-structured narrative interviews; Thematic data analysis

Author	Year	Finding	Methodology	Study design
Ibrahim, *et al.*	2014	- No significant difference was found between the strengths-based approach and other service delivery models in level of functioning and quality of life. - A significant effect on symptoms favoured other service delivery models, indicating they may be more effective in symptom reduction. - Further evidence is required due to the low number of trials and moderate quality of evidence.	- Systematic review and meta-analysis of RCTs and quasi-experimental studies. - Methodological quality assessed using CONSORT 2010 and TREND. - Data extraction with EPOC checklist and meta-analysis with Review Manager software. - Included studies published in English, focusing on adults with psychotic disorders aged 18 to 65. - Random effect model used due to heterogeneity. - Missing data handled by contacting authors or narrative synthesis. - PRISMA flow diagram used to report search outcomes. - Narrative synthesis for studies with missing data - I-squared test for heterogeneity assessment	- Systematic review - Meta-analysis - Includes randomised controlled trials (RCTs) and quasi-experimental studies. - Participants: Adults aged 18 to 65 years, diagnosed with psychotic disorders, receiving care at community mental health settings - Studies published only in English - Adhered to fidelity of strengths-based approach
Jepson, *et al.*	2016	- The interaction between the Mental Capacity Act and the personalisation agenda can lead to challenges, particularly with indirect payments. - The use of indirect payments can create difficulties in ensuring individuals receive necessary care while respecting their autonomy and rights. There is a need for clearer guidance and support for individuals, families, and professionals involved in indirect payments.	- Qualitative study - In-depth interviews with people with dementia, carers, and social care professionals - Data analysis using thematic analysis.	- Systematic review

Author	Year	findings	Methodology	Study design
Jessop, *et al.*	2025	• The study found a significant reduction in social isolation among participants, with a notable increase in community participation and social connections.- Local Area Coordination (LAC) was effective in fostering community resilience and social cohesion, bridging gaps in evidencing prevention.- The multi-site study demonstrated that LAC can be effectively implemented across different local contexts, leading to positive outcomes in terms of social isolation and community engagement.	• Mixed-methods approach- Data collection: surveys, interviews, observational studies- multi-site study across 15 local areas- Data collection period: 12 months- Quantitative analysis: statistical software- Qualitative analysis: thematic analysis	• Multi-site study
Joseph-Williams, *et al.*	2014	• A systematic review highlighted deep-rooted attitudes in patients that need to be changed for shared decision making. • Many patients feel they cannot participate due to perceived inability or role expectations, not lack of desire. • Patients undervalue their understanding of medical information and feel inferior to clinicians, contributing to a power imbalance.	• The methodology involved a systematic review of 44 studies on patient perceptions and barriers to shared decision making, analysing existing literature to understand attitudinal barriers, and proposing new strategies for patient engagement. .	• Systematic review

Author	Year	findings	Methodology	Study design
Keeling	2017	• The denial of legal capacity affects a wider group than previously acknowledged, extending beyond those with mental impairments. • Social workers struggle with the legal framework's individualistic approach to mental capacity, which limits support from third parties. • Vulnerable adults are disempowered due to the link between vulnerability and lack of relational capacity, leading to them being treated as objects rather than agents.	• Ethnographic approach • Participant observation of an adult safeguarding team over a 17-week period • Interviews with 7 social workers	• Observational study; Ethnographic approach; Participant observation; Interviews
Lawson, *et al.*	2014	• The report highlights the importance of making safeguarding personal and ensuring that individuals are at the centre of safeguarding processes. • There is a need for greater emphasis on prevention and early intervention in safeguarding. • Better communication and collaboration between agencies and professionals involved in safeguarding are necessary.	• Survey of English LA Oct 2013 to Jan 2014. • Data collection focused on implementation of MSP. • identifying trends and patterns in MSP implementation across local authorities.	• Not mentioned (no information on study design is included in the provided text)
Lonbay	2015	• The study developed a theoretical model to understand the involvement of older people in adult safeguarding at both strategic and individual levels. • The model identifies factors that help and hinder involvement, including individual circumstances and environmental factors. • Establishing clear roles and responsibilities is crucial for effective involvement in adult safeguarding.	• Qualitative approach informed by critical realism • Data collection: interviews, observations, compiling policy documents. • Participants: social workers, SAB members, families & advocates • Data analysis: thematic analysis	• Qualitative, observational, multi-site, thematic analysis

Author	Year	findings	Methodology	Study design
Lonbay	2018	• The study identified several barriers to the involvement of older people in adult safeguarding. • Older people are considered inherently vulnerable, which reduces their opportunities for engagement in safeguarding processes. • Recommendations for practice and policy were made based on the findings.	• Qualitative approach with a critical realist research paradigm • In-depth, semi-structured interviews with stakeholders • Observations of strategic meetings • Analysis of policy and guidance documents • Thematic analysis for data analysis	• Qualitative approach; Observational study; Semi-structured interviews; Observations of meetings; Analysis of policy documents
Lonbay, & Brandon	2017	• The study reports benefits of advocacy in supporting older people during safeguarding processes. • Practical limitations and factors affecting advocacy support are considered. • Theoretical implications for power, empowerment, and advocacy are explored.	• Participants: Advocates and social workers with experience in safeguarding for older people in two NE England local authorities • Method: In-depth interviews. • Theoretical framework: Critical realist approach.	• Observational study • Qualitative research • In-depth interviews • Multi-site (two North East England local authorities)
Lunt & Bainbridge	2019	• The evaluation found that LAC has a positive impact on reducing social isolation and improving well-being. • LAC supports individuals in maintaining their independence and living in their own homes. • Areas for improvement include more effective communication and collaboration between agencies.	• Mixed-methods approach Data collection: surveys, interviews, focus groups. • Quantitative analysis: descriptive statistics • Qualitative analysis: thematic analysis • Evaluation framework informed by LAC principles and outcomes framework	• Observational study; Mixed-methods approach; Surveys, interviews, and case studies

Author	Year	findings	Methodology	Study design
Lunt, *et al.*	2021	• The emergence of Local Area Coordination (LAC) initiatives in England and Wales reflects a shift towards community-led, asset-based approaches to social care. • LAC initiatives focus on building community capacity and resilience by identifying and mobilising local assets and strengths. • The findings suggest that LAC initiatives can contribute to more personalised and responsive social care services by leveraging local assets and community networks.	• Mixed-methods approach combining qualitative and quantitative data. • Comprehensive review of existing literature • Semi-structured interviews with key stakeholders • Survey to gather quantitative data. • Case studies for in-depth insights •	• Systematic review; Qualitative analysis; Observational study
Mahesh, *et al.*	2024	• Local authorities are at different stages in their implementation journey of strengths-based practice (SBP). • The Care Act(2014) and support from key professional groups are major drivers for implementing SBP. • Successful implementation requires a whole system approach with collaboration across sectors and addressing staff confidence and skills gaps.	• Mixed methods research design • Data collection: scoping review, 36 interviews with practice leaders, two surveys (one for adult social care staff, one for external organisations) • Analysis guided by CFIR and NPT • Interviews analysed deductively, surveys analysed descriptively	• Mixed methods; Scoping review; Qualitative interviews; Quantitative surveys; multi-site study; Deductive analysis of interviews; Descriptive analysis of surveys

Author	Year	findings	Methodology	Study design
Mahon, *et al.*	2024	• Service users with intellectual disabilities demonstrated knowledge of safeguarding and wanted to be involved in planning. • Their plans showed little variation from those created by trained staff, indicating their capability in contributing to safeguarding planning. • The study identified key themes of understanding, restorative justice, consent, and emotional intelligence, highlighting the need for authentic leadership and cultural shift for implementation.	• Qualitative research was used to examine participants lived experiences and knowledge of safeguarding. • Focus groups. Thematic analysis was applied to identify common themes. • Two objectives: measuring participants' understanding of safeguarding and comparing participant-created plans with those by trained staff.	Qualitative research; Focus groups; Thematic analysis; Single-site study
Manthorpe & Moriarty	2010	• The paper emphasises the need for risk guidance for people with dementia to balance risk management with autonomy and well-being. • Effective risk guidance should be person-centred, flexible, and responsive to the changing needs and capacities of individuals with dementia.	• Literature review of existing literature and policy documents • Systematic approach to identify key themes and issues. • Authors' research and practice experience in dementia care	Systematic review
Manthorpe, *et al.*	2022	• There was an increase in referrals from community sources concerned about neighbours' welfare during the pandemic. • Some local authorities offered early help to older people at risk of self-neglect or hoarding, indicating a proactive approach. • Online inter-agency meetings were positively received but raised concerns about excluding older people.	• Interviews with 44 participants from 31 English LA's • Online interviews Nov-Dec 2020. • Analytic induction methods used to develop themes. • Semi-structured topic guide for interviews. • Audio-recorded and transcribed verbatim. • Data analysis involved initial coding and subsequent development of new themes and codes using NVIVO	Multi-site Observational study Non-randomised Qualitative research using analytic induction methods. Semi-structured interviews

Author	Year	findings	**Methodology**	Study design
Manthorpe, *et al.*	2013	• There was overwhelming support for the Mental Capacity Act 2005 as it enhances people's rights and provides a framework for assessing decision-making capacity. • Participants suggested improvements such as better publicity and more detailed guidance on new offenses. • The Act's effectiveness is influenced by its integration with other government policy goals.	• The study involved qualitative interviews with 15 Safeguarding Adults Coordinators in 2008 and follow-up interviews with 12 of them in 2010 to gather their views and experiences on the Mental Capacity Act 2005.	• Longitudinal observational study
Manthorpe, *et al.*	2009	• The introduction of individual budgets may lead to a shift from reactive to proactive approaches in adult protection services. • Participants expressed concerns about increased risk and vulnerability for service users with complex needs or who are isolated. • Adult protection services need to adapt and develop new strategies for safeguarding in the context of individual budgets.	• Qualitative study conducted in six pilot sites in England. with 120 individuals. • Semi-structured interviews with key stakeholders (local authority staff, service providers, users, and carers). • Data collection took place between June and September 2007.	• Qualitative study; observational study
Marty, *et al.*	2001	• The study assessed the level of agreement among experts on the critical ingredients of the strengths model of case management. • Experts rated the significance of 72 elements/behaviours and 8 distracter elements. • There was an extremely high agreement among experts on virtually all items.	• Experts rated the significance of 72 elements/behaviours and 8 distracter elements. • Five open-ended questions were used to gather opinions on agency structure, service delivery, etc	• Qualitative study involving expert ratings and open-ended questions; no randomisation, blinding, or control groups mentioned.

Author	Year	Findings	Methodology	Study design
Mason, *et al.*	2021	- The Local Area Coordinators' ability to facilitate a 'golden triangle' of listening, trust, and time were key factors that made Local Area Coordination work. - Local Area Coordination worked for different people in different ways, as demonstrated by contextual differences between subgroups.	- Realist evaluation methodology - Blend of realist approaches - Q-method - Realist interviews - Sample of 18 participants	- Realist evaluation; Qualitative study; Observational study; Q-method and realist interviews; Cross-sectional sample of 18 people
Matarese & Caswell	2018	- The study found that standardised formats in social work can either strictly adhere to questionnaires, limiting client voice, or deviate from them, allowing more client participation. - These formats can provide transparency but at the cost of client participation, or they can be more participatory but less transparent. - The authors are critical of the use of forms but cautiously optimistic about their implications for social work.	- The study involved analysing naturally occurring data from social work interactions (conversations) in a homeless shelter, using a discursive perspective to examine how forms are used in these interactions.	- Observational study; qualitative; discourse analysis
McDermott	2010	- Professional judgements of self-neglect focus on risk and capacity. - These perceptions influence when and how interventions occur. - The assumptions behind these judgements are analysed in relation to critical theory.	- 125 hours of observations at meetings and home assessments - Qualitative interviews: 18 in-depth interviews with professionals working with self-neglecting older people	- Observational study; Qualitative study

Author	Year	findings	Methodology	Study design
McDonald, *et al.*	2010	- Three distinct approaches to risk assessment emerged: legalistic, actuarial, and rights-based. - Rights-based approaches are considered necessary for supporting older individuals with dementia, despite legalistic and actuarial approaches dominating current practice. - The findings are relevant to changes in social work, including individual budgets and the National Dementia Strategy.	- The study is based on empirical research into the early impact of the 2005 Mental Capacity Act on social work practice, identifying three types of risk approaches. Specific methods are not detailed.	- Observational study (empirical research into the early impact of the Act)
Miller & Mahesh	2025	- -The study highlights the effectiveness of strengths-based practice in empowering service users and promoting autonomy. - Strengths-based practice leads to improved outcomes for service users, including increased confidence and self-esteem. - Challenges in implementing strengths-based practice include resistance from professionals and the need for cultural and organisational changes.	- - Qualitative research design - Semi-structured interviews with social workers and service users Thematic analysis for data analysis	- Systematic review
Miller, *et al.*	2025	- Leadership plays a central role in setting a clear vision and inspiring change in social work, but in practice, senior leaders remained central, and community influence was limited. - The need for culture change is recognised, but there is a lack of understanding on how to approach and sustain it within local contexts. - Improving distributed leadership and culture change practices, along with building stronger infrastructures for co-production and community development, is necessary for more effective transformation.	- The study used mixed qualitative methods over a twenty-four-month period, involving participants such as senior managers, social workers, operational managers, health professionals, and the voluntary and community sector, framed within the theory of change.	- Mixed qualitative methods; Longitudinal study over 24 months

Author	Year	findings	Methodology	Study design
Miller, *et al.*	2024	• Community-led support leads to significant cultural shifts, particularly in increased community engagement and empowerment. • Leadership commitment and community involvement are crucial for driving cultural change. • Community-led support enhances organisational capacity and improves service delivery.	• Case study approach • Mixed-methods approach (qualitative and quantitative) • Qualitative data collection: interviews with community members, focus groups with support workers. • Quantitative data collection: surveys of service users • analysis: thematic analysis / descriptive statistics	• Not mentioned (the paper's abstract and body are not provided, making it impossible to determine the study design)
Nelson-Becker *et al.*	2006	• The Strengths Model focuses on the strengths and resilience of older adults rather than their deficits or weaknesses. • The model emphasises maintaining independence, autonomy, and self-efficacy in later life by building on individual strengths. • The Strengths Model is grounded in a strengths-based perspective that empowers older adults to take control of their lives and make informed decisions about their care.	• Not mentioned (the paper is theoretical and does not include a methodology section)	• Not mentioned (no information on study design is included in the provided text)

Author	Year	findings	Methodology	Study design
Pike & Walsh	2015	• The evaluation found that Making Safeguarding Personal (MSP) has had a positive impact on the lives of adults at risk, with many reporting improved outcomes and increased confidence in their ability to stay safe. • The evaluation highlighted the importance of person-centred approaches in safeguarding, with adults at risk valuing the opportunity to take control of their own lives and make their own decisions. • The evaluation identified areas for improvement, including better communication and coordination between agencies and ensuring full involvement of adults at risk in the safeguarding process.	• Mixed-methods approach combining qualitative and quantitative data. • Survey of 152 local authorities with an 85% response rate • In-depth interviews with local authority staff, service users, and carers • Case studies in six local authorities • Analysis of existing data and documentation	• Observational study
Price, *et al.*	2020	• Strengths-based approaches in adult social work led to improved outcomes such as increased well-being and empowerment. • Co-production and collaboration between social workers and service users are crucial in strengths-based practice. • These approaches are effective in reducing social isolation and improving mental health outcomes.	• Employed a comprehensive search strategy across multiple databases (Scopus, Web of Science, PubMed). • Included studies were published in English, focused on adult social work, and evaluated a strengths-based approach. • Studies were screened based on title and abstract, followed by full-text screening. • Data extraction was conducted using a standardised form. • Quality assessment was conducted using the Effective Public Health Practice Project (EPHPP) quality assessment tool.	• systematic review to synthesise research evidence on strengths-based approaches in adult social work.

Author	Year	findings	Methodology	Study design
Prunty, *et al.*	2024	• The study found that strengths-based care, as part of Community Led Support, significantly improved the well-being and quality of life for individuals with complex needs. • Participants reported increased confidence and independence, with a notable reduction in social isolation. • The intervention led to a decrease in hospital admissions and emergency department visits, indicating a positive impact on healthcare utilisation.	• Mixed-methods approach combining qualitative and quantitative methods. • Quantitative data: Surveys and questionnaires at baseline and follow-up • Qualitative data: Semi-structured interviews and focus groups. • Data analysis: Thematic analysis for qualitative data, descriptive statistics for quantitative data	• Randomised controlled trial (RCT), double-blind, multi-site, longitudinal design
Quinn,*et al.*	2023	• The use of a strengths-based model within a forensic setting was perceived as providing relational security and hopefulness. • Most stakeholders had a positive experience of the service. • The Good Lives Model was found to be acceptable for formulating service users' needs and strengths in planning their transition to community living.	• Mixed-methods survey • Descriptive statistics • Thematic analysis	• Observational study; Mixed-methods survey; Descriptive statistics and thematic analysis
Rapp & Goscha	2006	• The paper discusses the purpose, principles, and research results of the strengths model in case management for people with psychiatric disabilities. • It provides conclusions or findings from research conducted on the strengths model. • The paper addresses common questions and objections related to the strengths model, including its effectiveness and challenges in managed care.	• Strengths Assessment: Amplifying the Well Part of the Individual • Personal Planning: Creating the Achievement Agenda • Resource Acquisition: Putting Community Back into Community Mental Health • Supportive Case Management Context: Creating the Conditions for Effectiveness	• Not mentioned (no specific study design characteristics are included in the provided text)

Author	Year	findings	Methodology	Study design
Rapp & Goscha	2004	• The paper identifies ten principles of effective case management associated with statistically significant positive outcomes for people with serious psychiatric disabilities. • The study is based on a review of 22 experimental or quasi-experimental studies. • The principles are discussed in the context of systems design for practical application.	• The study involved a systematic review of 22 studies using experimental or quasi-experimental designs.	• Systematic review
Rapp, & Chamberlain	1984	• The demonstration project successfully used social work students as case managers for the chronically mentally ill. • The exploratory design showed positive results for clients, students, and the system.	• Social work students were used as case managers for the chronically mentally ill. • An exploratory design was used to assess the effectiveness of this approach.	• Exploratory design; observational study
Richardson & Pitts	2023	• The paper presents the economic case for strengths-based, community-led support, highlighting its economic benefits. • The findings likely focus on the cost-effectiveness and value of this approach compared to other methods.	• Comprehensive review of existing literature (academic studies, policy documents, grey literature) • Data analysis using publicly available data sources Stakeholder engagement through interviews with key stakeholders.	• Not mentioned (no information on study design is included in the provided text)

Author	Year	findings	Methodology	Study design
Robb & McCarthy	2023	• The study finds that social workers' interventions in cases of domestic abuse against adults with learning disabilities often focus on individual responsibility for managing risk. • Four key strategies are identified: using professional relationships, promoting autonomous decision-making, using legal powers, and defensive practices. • The study critiques the individualisation of risk and suggests a need for a more nuanced understanding that includes structural factors.	• Empirical study with 15 social workers • 2-stage interview process • Semi-structured / vignettes and set questions. • Data collection: July 2015 - October 2016 • Constructionist approach • Thematic analysis with latent coding	• Empirical study • Qualitative research • Observational study • Non-randomised selection of participants • Thematic analysis • Constructionist • approach
Roebuck, *et al.*	2022	• Clients attributed personal life changes to their relationship with case managers, highlighting the positive impact of the working alliance. • The flexibility of case managers and their responsiveness to clients' preferences were valued aspects of the SMCM. • The working alliance is a key element of the SMCM, supporting its implementation for individuals with severe mental illness.	• Participants: Twenty people with severe mental illness • Method: Semi-structured, qualitative interviews • Data Analysis: Thematic analysis using first and second cycle coding	• Qualitative study using semi-structured interviews and thematic analysis
Rowlands	2001	• The Circles of Support intervention is a community-based approach that focuses on strengths rather than deficits. • The intervention aligns with strengths-based approaches, • The 3-year evaluation study supports the effectiveness of a strengths-based approach.	• The methodology involves a community-based intervention called Circles of Support, which was evaluated over a 3-year period.	• Observational study; 3-year evaluation study

Author	Year	findings	Methodology	Study design
Sharman	2014	• The rural context significantly influences employment decisions and opportunities for home support workers. • The reasons for becoming and staying in home support work roles are unique in rural communities. • Health human resource policies should be tailored to the characteristics, strengths, and challenges of rural communities to improve recruitment and retention.	• Qualitative study • Thirty-two participants recruited • Thematic analysis of interview data • Conducted in four island-based communities in British Columbia, Canada	• Qualitative study; thematic analysis of interview data
Silarova, *et al.*	2025-	• The paper highlights the challenges in evaluating strengths-based approaches due to limited evidence and the need for clear descriptions and numerical data.- A consensus approach identified twenty-six outcome measures across individuals, family and friend carers, community, and workforce impact.- The literature review found limited evidence for strengths-based approaches, with critics arguing for more robust evidence-based measures. • The expert panel agreed on 26 outcomes that are both relevant and feasible to measure for evaluating strengths-based approaches in adult social care and social work. • Eight outcomes were identified as relevant but not feasible to measure. • The study provides a set of outcomes for practitioners, researchers, and policymakers to consider in evaluations categorised into five levels of measurement: for individuals accessing social care, unpaid/family carers, community, workforce, and organisations.	• literature review of existing studies and grey literature on strengths-based approaches in adult social care, using systematic reviews and meta-analyses to evaluate effectiveness. Qualitative methods such as photography and mobile methods are used, along with mixed-methods surveys and thematic analysis. The study examines leadership and culture change in implementation and identifies seven themes related to strengths-based approaches. • The study used a Delphi consensus exercise with two rounds	• Study design: Systematic review
Author	Year	findings	Methodology	Study design

Stevens, *et al.*	2018	• The study identified five main themes related to safeguarding and personalisation: contexts and risk factors, views about risks associated with Direct Payments, approaches to minimising risk, balancing risk and choice, and weaving safeguarding and personalisation practice. • Social workers recognised similar risks associated with Direct Payments as previously identified, indicating a continuity in risk assessment. • The study emphasises the need for skilled professionals in managing the complex balance between autonomy and safeguarding, highlighting the importance of professional judgment.	• Statistical analysis of safeguarding referrals and personal budget uptake • Qualitative interviews with managers, social workers, and other professionals • Review of Safeguarding Adults Boards' Annual Reports • Analysis of national and local data • Semi-structured interviews with professionals in three English local authorities • Use of NVIVO software for data analysis with Framework analysis	• Multi-site study • Mixed-methods study (statistical analysis and qualitative interviews) • Observational study • Prospective study • Semi-structured interviews • Framework analysis for qualitative data
Stevens, *et al.*	2024	• The study developed a theory of change for The Three Conversations (3Cs) to understand its implementation and evaluation. • Potential benefits and pitfalls of implementing 3Cs were identified, along with barriers to its successful incorporation. • The theory of change has relevance beyond 3Cs, supporting the implementation and evaluation of other strengths-based practices.	• Collaborative work with three UK local authorities • Interviews with staff, carers, and people receiving services. • Workshops with staff, carers, and people receiving services Data collected by sites. • Wider consultation	• Multi-site observational study

Author	Year	findings	Methodology	Study design
Teague *et al.*	2012	• Fidelity measures in mental health services research must assess critical processes beyond structural features. • The four described fidelity measures have demonstrated satisfactory psychometric properties and are related to outcomes. • These measures are used for training, quality improvement, and certification, but further development is needed to address potential omissions and align with implementation science.	• The study describes the development and use of four fidelity measures: CTPAS, SM-FS, IMR-FS, and TMACT. • Each measure assesses fidelity in different treatment contexts, from dyads to teams. • The measures focus on critical elements of each intervention, including structural features and process components. • They are used for training, quality improvement, and certification. • The measures have different complexities and domains assessed, as detailed in the tables.	• Not mentioned (the paper reviews fidelity measures and does not conduct a new empirical study with a specific design)
Tew	2013	• Recovery capital is a comprehensive framework for understanding recovery from mental health difficulties, influenced by social, cultural, and economic factors. • The four key components of recovery capital are social capital, cultural capital, economic capital, and personal capital. • Recovery capital is a critical factor in enabling sustainable recovery from mental health difficulties.	• Qualitative study involving in-depth interviews with 30 participants. • Interviews were audio-recorded and transcribed. • Thematic analysis was used to identify patterns and themes in the data.	• Qualitative study; observational study; in-depth interviews; thematic analysis

Author	Year	findings	Methodology	Study design
Toros	2019(a)	• Social work graduate students have a limited understanding of strength-eliciting questions, which are crucial for identifying client strengths and resilience. The study highlights the need for more comprehensive training and education on strength-eliciting questions in social work programs. • Students' understanding of strength-eliciting questions is influenced by their prior experiences and field placements.	• Qualitative research design • Semi-structured interviews with 15 social work graduate students • Audio-recording and verbatim transcription of interviews • Thematic analysis for data analysis	• Qualitative research design; observational study; single-site study; semi-structured interviews
Toros	2019(b)	• The "miracle question" technique promotes open communication and positive interaction between clients and practitioners by focusing on solutions rather than problems. • It empowers both clients and practitioners by emphasising strengths and resources, leading to improved communication and relationships. • The technique encourages self-reflection among practitioners, helping them to adapt their approaches for better client outcomes and promoting a shift away from traditional deficit-focused practices.	• The methodology involves collecting and sharing the experiences of Estonian practitioners with the solution-focused approach, specifically the "miracle question" technique. It includes a seminar discussion, a training assignment where practitioners applied the technique in practice, and qualitative observation of their reactions before and after application.	• Observational study

Author	Year	findings	Methodology	Study design
Tse, *et al.*	2021	• The SMCM group showed improvements in functional recovery areas such as employment and family relationships, and service users gained a better understanding of their strengths and weaknesses. • The results support the use of the SMCM in mental health services for Chinese clients, with some need for refinements. • A good relationship between service users and case workers was vital for the success of the interventions.	• Qualitative design using individual interviews with service users and case workers. • Participants recruited from integrated community centres for mental wellness in Hong Kong. • Purposeful sampling used to select 24 service users and 14 case workers. • Inductive approach for data analysis.	• Qualitative design; Controlled (SMCM group vs. control group); non-randomised; non-double-blind; non-placebo-controlled; Observational study; Purposeful sampling; multi-site (three non-governmental organisations in different districts of Hong Kong)
Tse, *et al.*	2016	• Strength-based interventions can promote recovery and improve mental health outcomes for people with serious mental illness. • These interventions can enhance personal recovery, improve mental health outcomes, and promote social inclusion. • There is a need for more rigorous research to establish the effectiveness of strength-based interventions.	• Conducted a comprehensive literature search using multiple databases (PubMed, PsycINFO, Scopus). • Used inclusion and exclusion criteria to select studies focusing on strength-based interventions for people with serious mental illness. • Search strategy involved using keywords related to strength-based interventions and serious mental illness. • Included studies published in English from 2000 to 2015. • Evaluated studies for methodological quality using a standardised tool.	• Systematic review

Author	Year	findings	Methodology	Study design
Tsoi, *et al.*	2022	• The concept of "strengths" in Hong Kong Chinese culture encompasses a broader range of attributes than in Western contexts, emphasising social harmony and cultural values. • Participants highlighted the importance of family relationships and cultural values such as filial piety and respect for authority. • The concept of "strengths" is closely tied to the idea of "balance" and "harmony" in personal and social relationships.	• Qualitative exploratory study • In-depth interviews with mental health practitioners and service users • Thematic analysis for data analysis	• Qualitative exploratory study
Tsoi, *et al.*	2019	• The Strengths Model case management was effective in improving the quality of life and reducing symptoms of mental health problems. • The intervention was associated with significant improvements in social functioning and employment outcomes. • The findings suggest that the Strengths Model is a promising approach for mental health service delivery in Hong Kong.	• Nonrandomised controlled trial design • Participants assigned based on willingness to participate in the SMCM program. • Intervention group received SMCM program; control group received usual care. • Data collected at baseline and 6-month follow-up using standardised assessment tools	• Nonrandomised controlled trial
Vincent	2010	• The Local Area Coordination model, developed in Western Australia, combines case management and community social work roles for people with disabilities. • The model has been introduced in Northern Ireland, but its full implementation is challenged by the context of statutory social work. • Changes in social policy, such as the adoption of neo-liberal principles, have impacted the model's implementation in both Australia and the UK.	• The paper involves a qualitative exploration of the Local Area Coordination model's implementation in Northern Ireland, focusing on policy analysis and historical context rather than primary data collection.	• Observational study

Author	Year	findings	Methodology	Study design
Westoby, *et al.*	2019	• The project involved a participatory action research approach with thirty-three practitioners, motivated by global political events in 2017. • New initiatives were implemented, including the formation of a Popular Education Network, through cycles of research and action learning. • Popular education is identified as a crucial element in enabling the radicalisation of community development within social work, linking practice with progressive social movements.	• Participatory action research approach • Pre- and post-questionnaires • Observation • Focus groups. • Interviews Action learning: popular education knowledge exchange day, community of practice day, prototyping new projects	• Participatory action research; observational study; repeated measures design; before-and-after design; qualitative methods (observation, focus groups, interviews)
Wöllner, *et al.*	2016	• Familiarity with the research context and participants can lead to more nuanced and detailed data collection. • Reflexivity is essential for acknowledging and managing researcher biases, ensuring a more objective research outcome. Considering both familiarity and reflexivity in research design is crucial for ensuring validity and reliability.	• - Case study approach - Qualitative analysis of researchers' own experiences - Reflexive approach examining researchers' roles and biases	• Case study; Qualitative analysis; Observational study; Thematic analysis
Xie	2013	• The paper introduces the strengths-based approach in the psychiatric arena, focusing on individuals' strengths and resources rather than deficits. • This approach is relevant to mental health nursing and contributes to mental health recovery.	• Not mentioned (the paper does not describe specific methods or empirical research)	• Not mentioned (the paper does not specify a study design)

Appendix three: Research Protocol (redacted)

Research Protocol: A study into the application of strengths-based approaches in an adult social work in England – relevant sections in relation to methodology only

STUDY PROTOCOL

A study into the application of strengths-based approaches in an adult social work in England

The aim of the research is to examine the extent to which strength-based approaches are understood and embedded in adult social work practice and how these approaches can make a positive contribution to successful outcomes for people with care and support needs. This study is being completed as a doctoral thesis for the purposes of a professional doctorate in social work through Cardiff University. This thesis will be between 30,000 and 50,000 words and has a final submission date no later than September 2025.

[redacted] Council have been identified as a host authority for the purpose of this research, however there is no funding or reciprocal arrangement in place other than the Council permitting access and the researcher sharing the high-level findings and a copy of the completed thesis. The researcher was formally employed on an interim basis by [redacted] [redacted] and remains on an honorary contract with [redacted] until the completion of data collection.

Data will be collected through participant observations, interviews and discussions with social workers and people who have lived experience of adult social care interventions (people with lived experience).

Data will be collected over a period of 8-10 weeks part-time and will involve up to fifteen social workers up to twenty people with lived experience. Subject to research approval processes I hope to undertake this research from summer 2022. The governance process for commencement of data collection can be seen in the table at figure one.

Once a “favourable decision” from the research governance authority (REC) is in place participants will be recruited. Observations will be scheduled based on diary commitments of participants and the researcher to maximise the options for data collection.

RATIONALE

A strengths-based approach to social work focuses on what an individual wants to achieve rather than their deficits, assuming that a person with care and support needs should be empowered to ascertain and determine their own outcomes (Saleeby, 1996). The key to this empowerment is the individuals own ability to exercise self-determination (Ray & Phillips, 2012) and can be misconstrued as something that is bestowed rather than exercised.

This approach fits with a social work profession that is first and foremost value based (British Association of Social Workers, 2014) and is set out legislatively for adult social care in England through the Care Act (2014) statutory guidance (Department of Health, 2021). Despite the focus on this work most published studies of the strengths-based approach have been undertaken outside of the UK (for example, Averill, 2003; Bryant *et al*, 2018; Sharman, 2014; Vance 2017). A systematic review of over 5,000 UK studies identified just fifteen studies that examined the implementation of strengths-based models and did not identify any studies that measured the effectiveness of the strengths-based approach. (Price *et al*, 2020).

The aim is therefore to look at how social workers practice strengths-based approaches to add to this body of work.

THEORETICAL FRAMEWORK

The plan for this study is to use ethnography to examine the implementation of strengths-based practice by considering the approach from the perspective of social workers and people who are in receipt of adult social work interventions (people with lived experience). The rationale for this approach is to enable a focus on social constructs and environmental factors to create ‘context-dependent knowledge’ (Floersch *et al*. 2014:4). Ethnography has been identified as having significant benefits for exploring and understanding what is happening in relation to practice (Breimo, 2016) and there is a significant synergy between social work reflective practice and ethnography (Montigny, 2018; Floersch *et al*. 2014; Riemann, 2005; Tervo, *et al*., 2005; Sheimei, *et al*., 2016).

There is no standard method for ethnography and methodological descriptions can be as vague as a need to ‘be there’ (Engel & Schutt, 2017:263). Even narrowing the focus to consider ethnography in the field of social work there are significant variations in design in implementation that reflect the diverse nature of the field of work. Institutional ethnographies examine the structural elements of social work focusing on the interactions amongst and between social workers and other professionals in office or workplace settings. These studies look at what the social worker does within their day-to-day practice to highlight structural and organisational factors such as; the institutionalisation of hospital environments (Burrows 2020; Tadd, *et al*., 2012) and the impact of managerialism on social work tasks (Matarese & Caswell, 2018; Gillingham and Humphreys, 2009).

Social work ethnographies that focus more closely on the interaction between the social worker and the person they are working with rather than the organisational context in which the work takes place have been termed practice ethnographies (Ferguson, 2016). These studies tend to utilise more mobile methods such as walking tours with people to understand their experiences of marginalisation (Roy, 2016), travelling around with social workers as they undertake home visits (Ferguson, 2016) and accompanying outreach support teams as they engaged with homeless people on the streets of Paris (Cefai, 2015).

Both types of ethnographic approach offer useful contributions to the field. Other ways of exploring interactions such as performance ethnography (Sheimei, *et al*, 2016) and photography (Robinson, 2016; Leigh, 2016) have been used to highlight and explore themes that may otherwise have gone unnoticed and provide useful insights for both approaches.

RESEARCH QUESTION/AIM(S)

The research will focus on several lines of enquiry:

How do social workers define and understand strengths-based approaches in relation their practice?

How are these interpretations observable in day-to-day practice what are the factors that influence these?

How do people with care and support needs describe their experience of social work intervention?

Objectives

The objectives of this study are to explore how a group of adult social workers understand strengths-based approaches, how and where this understanding is demonstrated within their practice and what influences these and triangulate these discussions and observations with the experience of people who are in receipt of social work interventions and the records that are kept on social work interventions.

Outcome

The outcome of the study will be to further the knowledge and understanding of implementation of strengths-based approach at a practice level.

STUDY DESIGN AND METHODS OF DATA COLLECTION AND DATA ANALYSIS

This study will focus on practice ethnography, that is looking at the social worker and expert-by-experience interactions take place. The key to successful ethnography is the ability to adapt and be flexible (Hammersley & Atkinson 2007). However, to provide clarity around the data collection it is proposed to utilise the following methods:

Participant observations

Social workers will be observed in day-to-day aspects of practice and interaction. The social worker will continue to undertake activities of work as usual and agree to be shadowed through as many aspects of case work as possible. This may include accompanying social workers on face-to-face visits or assessments, joining relevant team meetings, phone calls or observing other discussions with managers and or colleagues including the case discussion elements of supervision. Unlike institutional ethnographies (Longhofer *et al.*, 2013) this will be targeted participant observation in practice settings. Observations will provide opportunities to explore what the social worker does, the way that the social worker approaches interactions with the people they work with how they describe these interactions and the stance they take when talking about cases and talking to people with whom they are working. The observations will allow an understanding of how the social work (and indeed the researcher's) involvement in an individual's life has an impact (reflexivity). This will be followed up with discussions (through semi-structured interviews) which will generate knowledge on the impact that this may have through reflection. In this way the data generated will be co-produced between the participant and the researcher (Bryman, 2016).

Reviewing of records

The similarities of social work practice and ethnography can be seen in the ways that social workers record data particularly for assessments (White, 1997). Use of records can offer significant benefit to contextualising ethnographic studies (Bryman, 2016) as the practitioner generates the data on which assessments are conducted (Morley, 2015). The aim of records is to present a factual and literal approach (Taylor & White, 2000). Specifically, use of records as tools for analysing multiple, differing accounts over periods of time is a key element of demonstrating professional judgements (Taylor & White, 2001) and therefore should be useful in exploring strengths-based practices.

Subject to receiving consent from the person whose record I am viewing I will use information contained on the adult social care electronic case management system liquid logic (referred to internally as IAS) to look a document such as individual assessments, contacts and relevant case recordings. From an information governance perspective, the Councils require the following steps are in place in regard to accessing adult social care records:

The researcher confirms she is aware that she cannot access records relevant to her research without proper authorisation from [redacted] information governance team and;

provides details of the records she requires access to in advance to allow the information governance team to put the required controls in place

provides copies of any consent forms she has completed to ensure access is granted to the correct records, for legitimate purposes and that individuals are informed about the nature of the research and how their data will be used

confirms how long access to records is required for is informed that her access to IAS will be monitored throughout the entire period that research is being undertaken

From a social work participant point of view access to these records will be crucial as this will provide additional context on how discussion with people with care and support needs, other professionals and relevant individuals shape the outcome and how this reflects what is observed in practice. For the people with lived experience the focus will be how much synergy there is between the information on the system and the reality of their experienced interventions.

Interviews

In advance of any observations taking place there will be a request to social workers to complete one formal baseline survey. The purpose of this survey is to understand how the social worker views their own practice in relation to the strengths-based approach. The survey will be based on the department of health strengths-based framework (Baron & Stanley, 2019). This can be completed by the social worker and returned or can be done as a conversation depending on the participant's preference. This will be the only standardised element of the ethnography. The format of the remaining participant observations will be based on negotiation with the participant.

Semi-structured interviews will be used with people with lived experience alongside participant observations to develop a narrative around the individual's experience of social work practice. The purpose of these interviews is to look at themes around the impact of practice on people in receipt of social work interventions. The structure of these interviews is being co-produced with representatives from a local carers' advocacy organisation. The purpose of the interviews will be to explore the outcomes that they want to achieve as part of the adult social care involvement, whether these were being met and their experience of the social work involvement. These interviews will be conducted with ten to twelve people who are identified at point of referral to adult social care service with an interview taking place following initial agreement to being involved and a follow up interview taking place ten weeks later, or earlier if appropriate, to review the outcome of this involvement. Additionally, people with lived experience who are identified and included in the study because their allocated social worker is a participant will have an interview focused specifically on their experiences of the social work intervention. Each interview is expected to last between 30 and 90 minutes. These may take place by phone, video conferencing or face-to-face with appropriate PPE in place based on individual circumstances and any relevant Covid-19 restrictions and with appropriate risk assessments in place. It is hoped that this will generate a further ten to fifteen semi structured interviews for analysis.

Semi-structured interviews will also be used with social worker participants to generate discussions and opportunities for reflection on areas of practice. These questions will be based on the national framework for strengths-based approach (Baron & Stanley, 2019) and co-produced with social work colleagues from the Councils. The purpose of the interviews will be to provide space for reflection on the observation, to explore any themes that may have been observed and to enable the participants to provide feedback that may be relevant in relation to impact of the researcher on the observation. These interviews may take place as part of each observation or only where the participant, or the researcher feels further clarity may be required. Interviews are expected to last approximately 30 minutes however they may take place within an observation rather than as a separated intervention.

All Interviews will be piloted prior to data collection commencing.

A summary of the interventions and time requirements for participants can be seen in the table at appendix 2.

Recording of data

In advance of data collection starting the research has received a "favourable decision" from the REC. Research will be based on the British Association of Social Workers code of ethics which incorporates the principles of human rights, social justice, professional integrity (British Association of Social Workers, 2014).

It is proposed that data are recorded through a mixture of note taking and where appropriate recordings of video conferencing and phone calls. Both Microsoft Teams and Zoom have transcription software that has been authorised as meeting the security requirements of Cardiff University (Cardiff, University, 2021). Confirmation will be sought prior to using these medium that the appropriate settings are in place to ensure access to the transcripts can be restricted to the researcher and not accessed by other participants. If this cannot be confirmed recording and transcription functions will not be used. Recordings will be subject to agreement by all participants. These data will be securely saved on the Cardiff University Research Data store and will only be retained for the purposes of analysis and evidence of data collection.

This study will use a qualitative approach to data collection. Data will be interpreted using six stages of thematic analysis.

Getting to know the data through reading it multiple times, transcribing, noting down ideas.

Assigning initial codes to strengths-based features of the data and identifying extracts of text that fit within these. This will be done systematically across all of the data collected.

Identifying potential themes by organising the codes and collating relevant data into topics to give an overall picture of the data.

Reviewing the themes and verifying that these work against the codes

Explaining the themes, giving these a name and analysing these to tell the story

Producing the final analysis based on the data reviewed, what this says about strength-based practice, how this links to the research questions and other studies and theories on strengths-based approaches.

(Adapted from Braun & Clarke, 2006).

Analysis will be discussed as part of the university supervision process with supervisors to ensure a level of check and challenge in relation to the themes identified.

Nvivo (March 2020 release) will be used to help to transcribe and code the data. Data that is collected through video conferencing though Teams and Zoom may also be transcribed directly as this has been approved by Cardiff University as; GDPR and university IT compliant and suitable for high confidential information (Cardiff University, 2021).

STUDY SETTING

The study will be based in [redacted] with the agreement of the statutory Director of Adult Services (DASS) from both Councils and with support from the adult services' senior leadership team of the Councils. The study will be conducted through a mix of virtual arrangements and face-to-face contacts as appropriate.

All adult social workers will be offered the opportunity to be involved, with a view to identifying up to fifteen social workers who wish to participate. Initially all social workers will be contacted using the global email system to request volunteers to take part in the study and for these volunteers to be shadowed in their day-today work for a mutually agreed period of time.

Volunteer social workers will be asked to identify people from their caseloads who may wish to be involved as people with lived experience and make introductions to the researcher. people with lived experience with permission of individuals on a case-by-case basis case records will be reviewed for individuals involved in the study. To meet the Council's information governance requirements the list of potential case records for review and evidence of consent obtained from individuals (or their families if appropriate) will be submitted to the Council before records are viewed as detailed in section 5.

SAMPLE AND RECRUITMENT

Eligibility Criteria

Eligibility criteria are adult social workers and people in receipt of adult social work interventions and / or carers (people with lived experience) within the Councils areas of responsibilities.

Inclusion criteria

Participants may be included if they are:

Social workers who work for the Councils Adults services department

Adults who may have care and support needs who:

Are over the age of 18 at the start of the research

Have the capacity to give informed consent to involvement in the research

Live within the boundaries of either of the Councils

Live in their own home or a care home

Are currently known to a social worker or are awaiting / have requested social work input

(For the avoidance of doubt people who may have care and support needs is a broad term and includes older people, people with learning and or physical disabilities, people experiencing mental health difficulties, people with sensory impairments, people with a dementia or memory loss, people under the influence of drugs and / or alcohol, people with delirium or confusion, people who have had a stroke, people with an acquired brain injury, young adults transitioning from children's services and other conditions. It is recognised that the individual level of need will vary amongst people with lived experience)

Friend and Family carers / unpaid advocates of people with care and support needs who live within the boundaries of either of the Councils.

Potential participants for whom there is an impairing condition under the Mental Capacity Act 2005, for whom there may be concerns about their ability to give informed consent to participation may still be included if:

The advice of a personal consultee (e.g., family, friend or LPA) or nominated consultee (for the purposes of this research the social worker) is that the participant would be unlikely to object to being included and that it would not cause psychological harm or distress to be involved. The consultee will be asked to provide this advice following an opportunity to review the consultee information leaflet (see section 11 appendices) and talk to other people that know the person if this is appropriate.

Exclusion criteria

Participants will be excluded if:

Work is exclusively undertaken in [redacted] (as these areas overlap with the researcher's former interim role with [redacted]).

The participant withdraws consent or objects to participating during the period of the study

At the time of recruitment, the participant becomes acutely unwell or is diagnosed with a serious condition.

During the study the participant becomes acutely unwell or is diagnosed with a serious condition. In these circumstances the participant will be withdrawn from the study unless they specifically request to remain involved and they have the capacity to make this decision (in line with the capacity assessment set out in section 8 of this protocol)

At the time of recruitment, the participants are experiencing a crisis that would make it inappropriate or harmful to be involved in this study (noting that many people in receipt of social work involvement are experiencing significant difficulties in their lives)

During the study the participant experiences a new or exacerbated crisis. In these circumstances the participant will be withdrawn from the study unless they specifically request to remain involved and they have the capacity to make this decision (in line with the capacity assessment set out in section 8 of this protocol)

Potential participants, for whom there is an impairing condition under the Mental Capacity Act 2005 and for whom the researcher has concerns about their ability to give informed consent to participate and has recorded this (see section 11 appendices) will be excluded if;

Following advice of a personal consultee (e.g., family, friend or LPA) or nominated consultee (for the purposes of this research the social worker) it is determined that the participant would be likely to object to being included or that involvement may cause psychological harm or distress

The consultee has advised that he or she does not consider it is in the persons best interests to take part

The consultee has advised that there is no objection to the participant being included but the participant expresses objection to the researcher’s presence

Sampling

The scope of the project requests up *to fifteen social workers. There will also be a request for around twenty* *people with lived experience. This may include active participants with whom interviews take place, and participants who simply consent to be observed as part of the social work intervention but have no further interaction with the researcher.*

Size of sample

The number of participants has been informed by consideration of other similar research and the constraints of this being a doctoral study. Ferguson's (2014) mobile methods ethnography with social workers involved twenty-four social workers and eighty-seven practice encounters with data collection taking the equivalent of working three months full-time. Morriss' (2014) doctoral research with social workers, although based on interviews rather than a full ethnography, involved seventeen interviews and there is of course precedent for ethnography to be based on single case studies (as described by Shaw, 2020).

Sa***mpling technique***

All adult social workers working in the Council's will be offered the opportunity to be involved, with a view to identifying up to fifteen social workers who wish to participate. Initially all social workers will be contacted using the global email system to request volunteers to take part in the study and for these volunteers to be shadowed in their day-today work for a mutually agreed period of time.

Volunteer social workers will be asked to identify people from their caseloads who may wish to be involved as people with lived experience and make introductions to the researcher.

Additionally, the study will recruit people with lived experience directly. This will be done through a screening question at the adults' single point of access, the place where citizens request adult social care involvement, to identify people who may willing to discuss their experiences with a researcher (no more than ten to twelve people)

Recruitment

There are two set of proposed participants for this study

Cohort one will be adult social workers who work for an adult social care department (the social workers). Cohort two will be people who are currently or have recently been in receipt of adult social work interventions from the same adult social care department either as a person with potential care and support needs or a family or friend carer (the people with lived experience).

Social Workers

The primary method for recruiting social workers is to seek volunteers who want to take part in the study. Social workers will be recruited through a direct email via the Council distribution list and a flyer (figure three). A letter detailing the study, information leaflet and consent checklist will be provided to social workers who express an interest following informal discussions (see section 11 appendices) As a secondary method, social workers may be identified due to their involvement with an expert-by-experience primary participant. These social workers will be approached directly the researcher initially by email. As with the primary method social workers will be provided with information about the study and a consent checklist. All participants will be given a minimum of twenty-four hours to consider if they wish to take part in the study.

Figure three

Calling adult social workers....lets develop the strengths-based approach together!

Are you passionate about strengths based social work?

- **Would you like to take part in a research project looking at how practice impacts on the people you support?**
- **Are you willing to honestly share your practice? your experiences? Your perspectives and your suggestions for future practice (all anonymously)**

- I am undertaking a professional doctorate in social work at Cardiff University, and I am looking for up to 15 adult social workers to take part in my thesis research project. Participants will need to be willing to be observed in their day-to-day work, have reflective discussions about their practice and undertake a questionnaire and interview on their strengths-based approach.
- To express an interest or have a further discussion about getting involved please either give me a ring on

Social work participants will be advised that I will also be making contact with people with lived experience who are people in receipt of adult social care services and or family friend carers. All engagement will be confidential, and all data anonymised and will be used for the purposes of the professional doctorate thesis.

People with lived experience There are two areas of exploration with people with lived experience. The first is to understand the adult social care journey from the perspective of the person experiencing this. by exploring the relationship between the social worker and the expert-by-experience and this may be just a snapshot of the person's adult social care journey to understand the role of the social worker's practice within this context (route two). Participants will be recruited differently for each route.

T discussion with the social work participants, we will identify existing people with lived experience from their caseloads. Ideally requests will go out to everyone, however there may be some people for whom this is not appropriate, and I will be reliant on the social workers to advise on the appropriateness of engaging directly with the expert-by-experience. For individuals with capacity to consent I will the make contact and request permission to observe the social workers interactions with them. For individuals who lack capacity to consent, and for whom there is no appropriate personal consultee (e.g. carer or family representative), the social worker will be asked to act as a nominated consultee. The decision will be made on the basis of a best interest decision which will be recorded and in consultation with appropriate family or friend representatives (see section 11 appendices). Advice will be sought a minimum of 24 hours in advance to ensure there is sufficient time for the participant to change their mind.

Participants will be offered the opportunity to be actively involved in the research and given the opportunity to meet with me separately to their social worker and discuss their experiences alternatively they can choose to be observed as part of the social work observation,

If consent is withdrawn at any stage, or a consultee changes there advice, the data process will cease. Data collected to date will be retained unless explicated requested not to.

Sample identification

Sampling techniques will follow the process set out in 7.2.2

Consent

All participants will be provided with participant information leaflets and consent forms. These forms have been individually designed to be appropriate for the cohort of people (see section 11 appendices)*:*

Participant information sheet social worker

Consent form social work participant

Participant information sheet person with lived experience

Consent form person with lived experience

Participant Information sheet personal consultee

Participant Information sheet nominated consultee

Consultee Declaration for

Participant information sheet general (for other people who may be part of the observation

Participant Consent form general

ETHICAL AND REGULATORY CONSIDERATIONS

Ethical considerations

This research will take place in a local authority in which I am currently employed as an interim consultant. A number of steps are being taken to provide a separation between the research and day-to-day employment:

I am self-funding the professional doctorate

Data collection will be undertaken in my own time

Participant observation will not take place within my day-to-day work areas

Participants will be provided with information on the research.

A Data Sharing Agreement will be put in place between Cardiff University and [redacted] Council to formalise any data transfer arrangements between the two organisations.

Potential harm to participants

This research involves observations and discussions regarding highly personal elements of individuals' lives. There is a risk for the expert-by-experience that this will be considered intrusive and cause embarrassment. If this is the case observations or interviews will be paused. All participants will be given the opportunity to rearrange or withdraw if they become uncomfortable. If the participant withdraws all data will be destroyed and this will be explained clearly to all participants both verbally and as part of the written information.

For the social work participants, it is expected that there is a reasonable level of transparency with relation to observation of practice. Social workers are observed routinely as students, and this extends into the first year of post qualifying practice. Social workers also frequently practice in collaboration in multi-disciplinary settings, undertake reflective practice and undertake interventions in the presence of families and carers. As involvement in this study will be anonymous and all outcomes confidential there will be no direct link between an individual social worker and his or her practice which should provide confidence that they will be not negative consequences. Therefore, it is not expected that observations of practice with participating social workers will cause any harm in itself.

Social work involves a level of day-to-day risk which can cause stress. Whilst the study will not generate these situations they may form part of the observations, interviews, or written records. As with the expert-by-experience social workers will have the choice to request that any elements of the observation are excluded from the study, to rearrange or to withdraw from the study, in which case all data would be destroyed.

Confidentiality of participants

All data will be anonymised, and participants provided with pseudonyms. Any quotes or references will not be identifiable to the individual that has made them. There will be no management feedback

Any observed issues that raise ethical or safeguarding concerns will be reported through the appropriate local channels, data collection paused, and ethics process reviewed. It is recognised that there is a need to ensure cultural sensitivity particularly around working with individuals with care and support needs (Haight, *et al* 2013) and this is a key element of social work ethics on human rights (British Association of Social Workers, 2014).

Mental Capacity Act considerations

To ensure the confidentially of adults with care and support needs and their carers, who may lack capacity to give informed consent to participate in the study and may be vulnerable, all data will be anonymised so that participants cannot be identified. The research will follow the guidance for research set out in sections 30-24 the Mental Capacity Act (2005). In practical terms this means that if any of the participants (most likely but not exclusively people with lived experience participants) are likely to lack the capacity to understand the research this must be considered in relation to whether the research is likely to cause any harm, discussions must be had with carers and or other interested parties regarding their involvement and the research stopped if the person objects. This is most likely to apply to people who may become indirect participants, for example, people who may be in a meeting that is being observed.

People with lived experience will be people who require involvement of adult social care, either as a person with potential care and support needs or as a family or friend carer. There is therefore a high probability that at least some participants will meet the threshold for consideration of capacity under section 2 of the Mental Capacity Act due to “an impairment of, or a disturbance in the functioning of the mind or brain” (Mental Capacity Act, 2005:2(1)). This means that there is a potential for vulnerability, but it should not be assumed that people with lived experience are vulnerable or that these participants lack capacity to understand the process should in itself preclude involvement.

Impairing conditions may include impairments due to dementia, mental health issues, learning disabilities, brain injuries, intoxication, or any other condition causing confusion, drowsiness or loss of consciousness (e.g. concussion, stroke, heart attack, epileptic fit, serious accident, delirium (HRA, 2022).

This research looks at social work practice and in particular how the social worker supports a person's strengths rather than their deficits. Whilst there is no individual benefit for a person with an impairment condition as participant in this research the benefit is at a population level in understanding how social workers practice with people who have this range of impairments.

Assessment of Capacity

The determination of capacity will be based on the potential participants understanding of the relevant information about the research. The researcher will assume that a participant has capacity unless there is reason to suspect this may not be the case.

The assessment of capacity will be undertaken by the researcher and follow the 2 point test;

Part one: (the diagnostic test): does the individual have a condition such as a disability, dementia, mental health issues etc which is either causing or contributing to, or may cause or contribute to, a disturbance of the mind or brain?

Part two: (the functional test) does the individual understand the required decision(s)?

That they are taking part in a university research project looking at social workers practice

That they will be observed when they are with their social worker (if they have one)

That they will be asked some questions about their experience

That the researcher would like to look at their social care record

That anonymised details about their lives will be recorded and may be published as part of this thesis.

To assess whether the person understands the decision the researcher will give consideration to whether the individual is able to understand the information, retain the information for long enough to make a decision, balance the risks (which in this instance are related to their privacy and confidentiality) and communicate the decision.

Capacity decisions will be recorded (see section 11 appendices) and if a person is considered not to have capacity a consultee will be identified.

Why include people who lack capacity?

This research is looking at the application of strengths-based approaches in adult social work. For the purposes of this research the “impairing condition” is the care and support need and the “treatment” is the social work intervention (Department of Health 2021b:206). The research will support the development of knowledge of social work practice (treatment) that will provide knowledge about practice with other people with care and support needs (the impairing condition) (Department of Health 2021b:207).

This approach by its very nature focuses on individuals’ capabilities and assets rather than deficits. This is arguably both more complex and more important for people who are unable to effectively articulate their own strengths as they are reliant on others around them to enable them to live their most independent lives. Social workers routinely work with people for whom there are queries about capacity and therefore it is essential that there is a focus on how the strengths of these people are promoted in social work practice and the outcomes that are achieved. The Mental Capacity Act Code of Conduct (Department of Health, 2021b) provides guidance on balancing the benefits and burdens of inclusion of people who lack the capacity to consent to take part in research. For this research the risks presented to a participant who is unable to consent for themselves include that the individual may become emotional when describing their experiences, they may find understanding, or retaining the interview questions challenging and that some anonymised details about their lives may enter the public domain. These will be managed through;

adjustment of the format of the interviews to become less formal and more observational and discussion based and involvement of family and friend carers or social workers within the process.

The benefits are the potential knowledge that can be generated that is directly relevant to people who will benefit most from having their strengths rather than their deficits promoted and ensuring that this group are not further marginalised from having their voices heard.

In relation to the three research questions:

A high proportion of people who receive adult social work support will have capacity issues. Focusing only on people who have capacity may impact on the ability to understand the first research question "How do social workers define and understand strengths-based approaches in relation their practice?" Whilst it may be possible to adjust the ethnography get social workers to describe interactions with people rather than undertaking observations to answer this question there are concerns about whether this would be a balanced and realistic view of day-to-day practice. Additionally, it is often the case that people surrounding an adult who lacks capacity are primarily concerned with keeping the person safe a position which can conflict with a strengths-based approach. If people who lack capacity are excluded from the research it will not be possible to explore how this balance of strengths and risk are defined and understood by social workers.

The second research question is "How are these interpretations observable in day-to-day practice what are the factors that influence these? This question cannot be explored without including a representative sample of the range of people supported so it is essential that people who may lack capacity are included within the study.

The third research question is "How do people with care and support needs describe their experience of social work intervention?". It is entirely possible that someone lacks the capacity to understand the research process but is still able to articulate their view in relation to their experience of social work practice. Therefore, exclusion of people who may lack capacity would impact on the exploration of this research question.

Data collection is expected to take place over an eight-to-ten-week period, on a part time basis with flexibility based on participants' availability.

Assessment and management of risk

There is a chance that research will identify safeguarding issues, these could be identified through interviews observations or through discussions.

Exclusion to confidentiality on the grounds of safeguarding is set out explicitly within the participant information leaflets (appendices 4a,4b & 4c) In the event that a potential current or historical safeguarding issue is identified then this will be reported in line with the with [redacted] safeguarding adult policy [redacted]. If the information set out presents a risk to children, this will be reported through the children's safeguarding hub. [redacted]

(NB both of the Councils have adopted the [redacted] Policies following local government reorganisation and these will be updated in due course. This protocol will follow the updated links for both parts of this policy for each of the Council's individually)

If a potential safeguarding is identified data collection with the effected participant(s) will immediately be paused. Data collection will only recommence after a risk assessment regarding the appropriateness of continuing has been agreed with the academic supervisors. This risk assessment will take into account professional advice from the police, or relevant safeguarding teams and the views of the participants involved (if appropriate).

Research Ethics Committee (REC) and other Regulatory review & reports

Before collection of data commences this study will have received a "favourable decision" from the *Research Ethics Committee (REC).*

Any substantial amendments to the research that require a review by REC will not take place until after this review has taken place and mechanisms are in place.

All correspondence with the REC will be retained

An annual progress review will be submitted with 30 days of the anniversary of the favourable decision until September 2025 or completion of the research if sooner.

If the study is ended prematurely then the REC will be notified

The REC will receive a final copy of the thesis and any publications / extracts to the REC

Regulatory Review & Compliance

The study has been reviewed and is supported by Cardiff University (the Sponsor) research governance processes and a letter of support has been issued.

Amendments

Minor amendments to this protocol will be made by the chief investigator in line with the academic supervisors. Significant amendments will be referred to the REC for review. The researcher will follow the guidance on the categorisation of amendments for studies on the HRA website. ***http://www.hra.nhs.uk/resources/after-you-apply/amendments/***

P***eer review***

This protocol has been discussed and reviewed in conjunction with the academic supervisors and all stages of development. It has also undergone a review as part of the university progress reporting framework and changes made following feedback from this process.

Participant & Public Involvement

The data collection approach is being co-produced in several ways:

people with lived experience interviews

I have received feedback from a local carers advocacy organisation to co-produce an appropriate semi-structured questionnaire for the expert by experience. I provided a draft and requested feedback on the following areas:

How the proposed questions / areas of discussion may be received by people with lived experience and whether there are any changes needed to these?

Whether there are topics or questions that will be useful to include from the perspective of the expert-by-experience?

The format of the questions / interviews and how these can be made accessible to a broad range of people?

Following discussions, I amended the interviews. Prior to starting data collection, I will test the interview out with a lay person to see how this flows and make any final changes.

social work baseline survey

I used the national framework for strengths-based practice (Baron & Stanley, 2019) to develop a short baseline questionnaire. This was also reviewed by the carers organisation and changed based on this feedback. I have identified social work colleagues with a solid understanding of strength-based working to work through this survey prior to implementation.

The research has been discussed in detail with the Adults services management team for the Councils. There will be further discussion of this as the research protocol is developed and changes made to the data collection methods in consultation with this group.

This protocol has been reviewed by the academic supervisors at all stages of development and submitted for review as part of the University annual progress review process

Protocol compliance

This is single researcher study and as such the chief investigator will monitor all aspects of compliance, any conjunction with the academic supervisors. Any major changes will be considered under the amendment process at 8.2.

Data protection and patient confidentiality

All data will be managed in line with data protection requirements and accordance with the researcher's data management plan, which will be revised as the data collection process is developed.   Personally identifiable data will be minimised and used by the researcher solely for the purposes of contacting participants and providing a reference for pseudonyms to ensure data is coded correctly.

Data collection and confidentiality

This research will collect data through observations and interviews. Data will be anonymised so all participants and the host local authority will be allocated a pseudonym.

Observations by video conferencing

Observations are undertaken using video conferencing this will either be by Teams or Zooms. These may be recorded and then transcribed using the video conferencing facilities. Confirmation will be sought prior to using these medium that the appropriate settings are in place to ensure access to the transcripts can be restricted to the researcher and not accessed by other participants. If this cannot be confirmed recording and transcription functions will not be used. Any recordings or transcripts will be quality checked by the researcher and the transcripts saved securely. Any nonverbal notes will be made on the transcripts and then the recordings deleted to ensure anonymity of participants.

Research notes

Research notes including records of any face-to-face observations or discussions will be typed using Word format, any handwritten notes will be destroyed.

Scanned documents

Any printed documentation collected will be redacted to ensure anonymity of participants, this will then be scanned and saved, and the original document destroyed.

Transcribing and coding

In addition to the transcription facilities in Zoom and Teams NVivo (March 2020 release) transcription software will be used to support data coding and transcription of anonymised data.

Saving and storing data

All data will be saved on the Cardiff University Research Data store, which has a capacity of 1TByte. This system has been designed to have no single point of failure. Copies of any changes to the data are kept for the preceding 20 days in case of data loss or corruption

File formats will be mainstream use e.g., Word, Excel, Adobe Reader PDF.

A summary of the data protection safeguards in place are summarised in the table at figure below:

Fair Processing	All data will be used for the purposes of this research study as set out in this research protocol
Used for specified purposes	All data will be used for the purposes of the study only
Minimum necessary	Personal data of participants will only be used for the purposes of making contact during the research period and for feeding back the research outcomes. if a participant withdraws from the research this data collected to date will be used.
Accuracy	Care will be taken with recording and transcribing of data to ensure accuracy
Kept for minimum time	Records will be kept for five years to allow transparency with relation to the research. personally identifiable data (for the purposes of contacting participants) will be kept until after the final feedback on the thesis has been provided.
In accordance with data subjects' rights	Participants will be provided with information on how their data will be stored and used, their right to have access to their own data and their rights to request that their data is destroyed or not used. These rights are set out in the participant information leaflet
Security and confidentiality procedure	All participants will be provided with pseudonyms and data anonymised
Not disclosed out of the EU	Data will not be disclosed outside of the EU

Indemnity

The Sponsor (Cardiff University) will have adequate public liability insurance in place to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management, conduct and design of the research. There are no special arrangements for the payment of compensation in the event of harm to research participants where no legal liability arises (‘no-fault’ cover).

Access to the final study dataset

The chief investigator and the academic supervisors will be the only people who will have access to the final dataset. In the case of the academic supervisors this will be for the purposes of auditing and assurance only.

DISSEMINIATION POLICY

Dissemination policy

This study is undertaken as a thesis for a professional doctorate in social work with a final submission date of September 2025. Once completed this will be available on the Cardiff Online Repository (ORCA). All data is owned by the Chief Investigator.

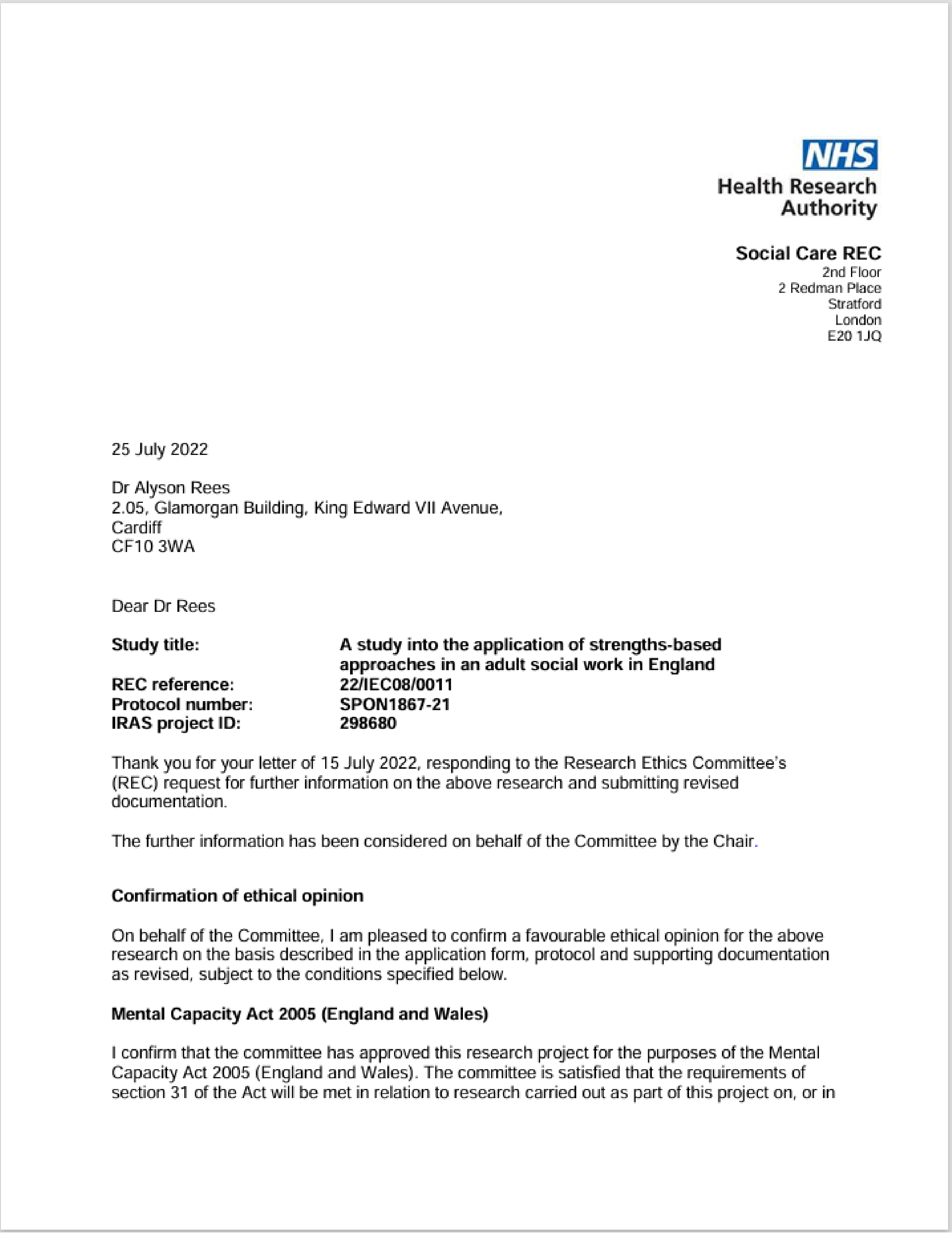
Initial findings will be provided to the participants and the Councils within six months of data collection completion.

The study protocol will be available for review on request however it will be redacted to remove the details that reference the Councils as this may lead to identification of participants.

Authorship eligibility guidelines and any intended use of professional writers

Authorship will remain with the Chief Investigator

Appendix four: Letter Confirming favourable opinion



NHS
Health Research
Authority

Social Care REC
2nd Floor
2 Redman Place
Stratford
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E20 1JQ

25 July 2022

Dr Alyson Rees
2.05, Glamorgan Building, King Edward VII Avenue,
Cardiff
CF10 3WA

Dear Dr Rees

Study title:	**A study into the application of strengths-based approaches in an adult social work in England**
REC reference:	**22/IEC08/0011**
Protocol number:	**SPON1867-21**
IRAS project ID:	**298680**

Thank you for your letter of 15 July 2022, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

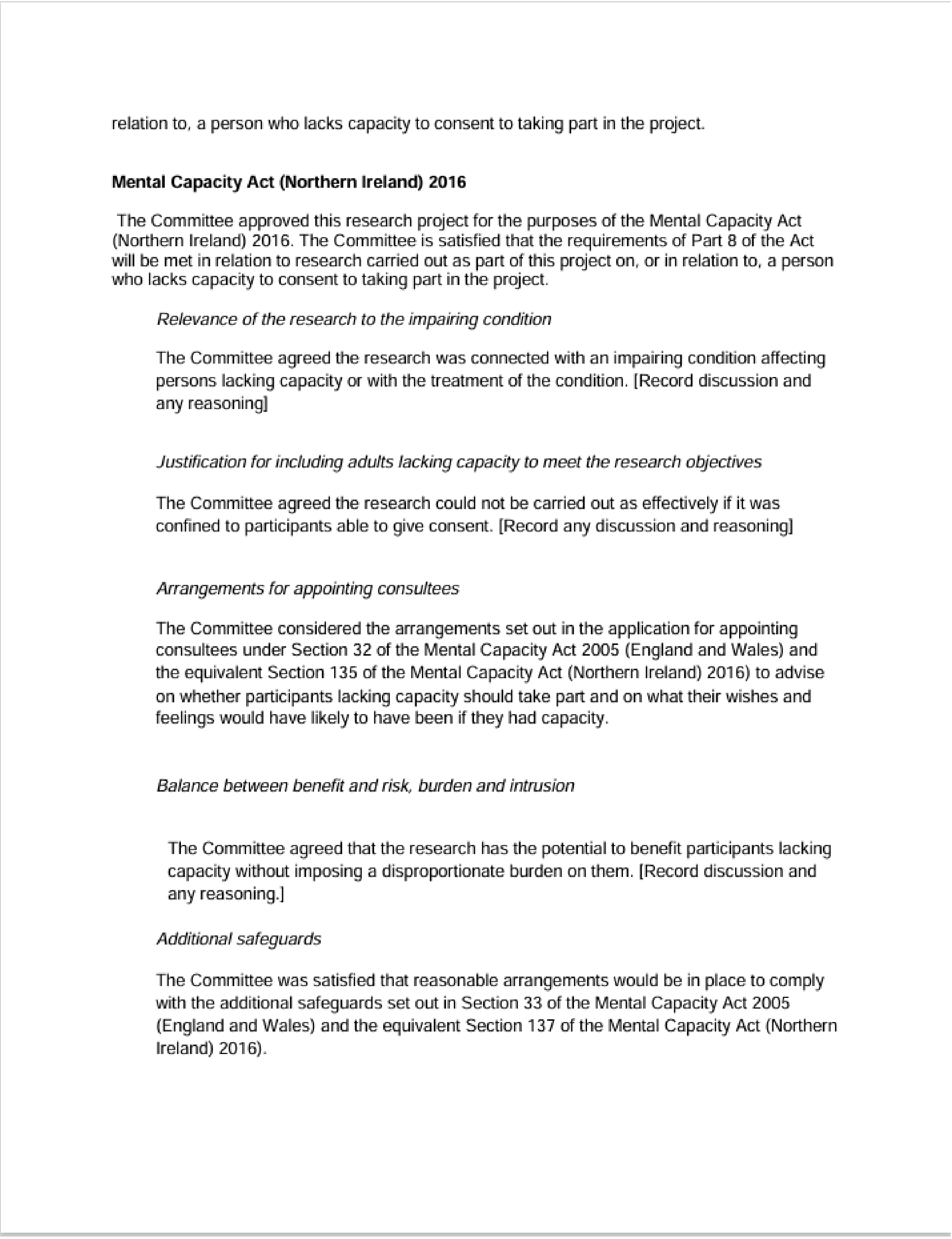
The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005 (England and Wales)

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005 (England and Wales). The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in



relation to, a person who lacks capacity to consent to taking part in the project.

Mental Capacity Act (Northern Ireland) 2016

The Committee approved this research project for the purposes of the Mental Capacity Act (Northern Ireland) 2016. The Committee is satisfied that the requirements of Part 8 of the Act will be met in relation to research carried out as part of this project on, or in relation to, a person who lacks capacity to consent to taking part in the project.

Relevance of the research to the impairing condition

The Committee agreed the research was connected with an impairing condition affecting persons lacking capacity or with the treatment of the condition. [Record discussion and any reasoning]

Justification for including adults lacking capacity to meet the research objectives

The Committee agreed the research could not be carried out as effectively if it was confined to participants able to give consent. [Record any discussion and reasoning]

Arrangements for appointing consultees

The Committee considered the arrangements set out in the application for appointing consultees under Section 32 of the Mental Capacity Act 2005 (England and Wales) and the equivalent Section 135 of the Mental Capacity Act (Northern Ireland) 2016) to advise on whether participants lacking capacity should take part and on what their wishes and feelings would have likely to have been if they had capacity.

Balance between benefit and risk, burden and intrusion

The Committee agreed that the research has the potential to benefit participants lacking capacity without imposing a disproportionate burden on them. [Record discussion and any reasoning.]

Additional safeguards

The Committee was satisfied that reasonable arrangements would be in place to comply with the additional safeguards set out in Section 33 of the Mental Capacity Act 2005 (England and Wales) and the equivalent Section 137 of the Mental Capacity Act (Northern Ireland) 2016).

Information for consultees

The Committee was satisfied that the information to be provided to consultees about the proposed research was adequate to enable consultees to give informed advice about the participation of persons lacking capacity.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Recommendation:	
1	Please Amend Participant Information Sheet Page 4 by replacing 'Health Research Agency' by 'Health Research Authority'.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

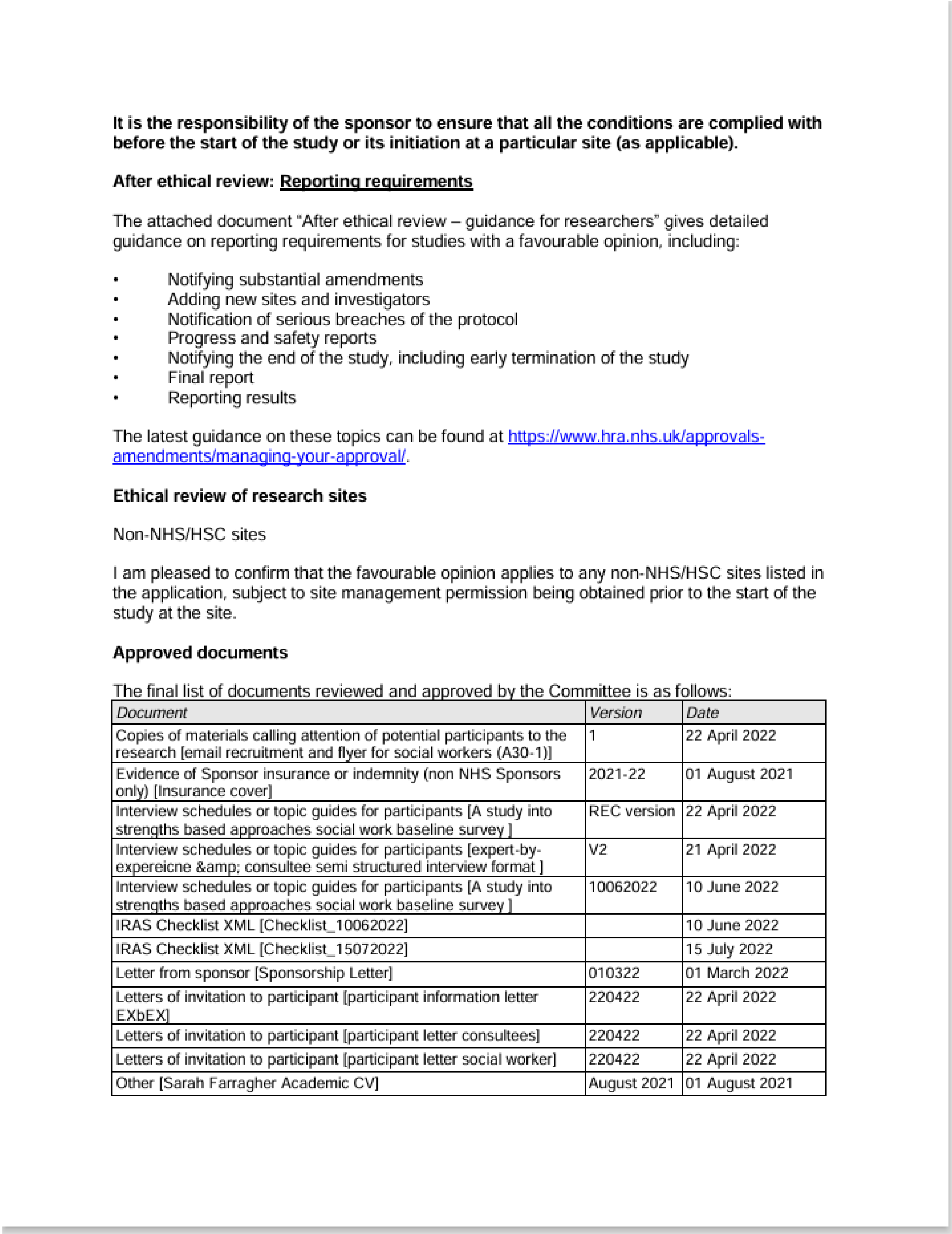
Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/



It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

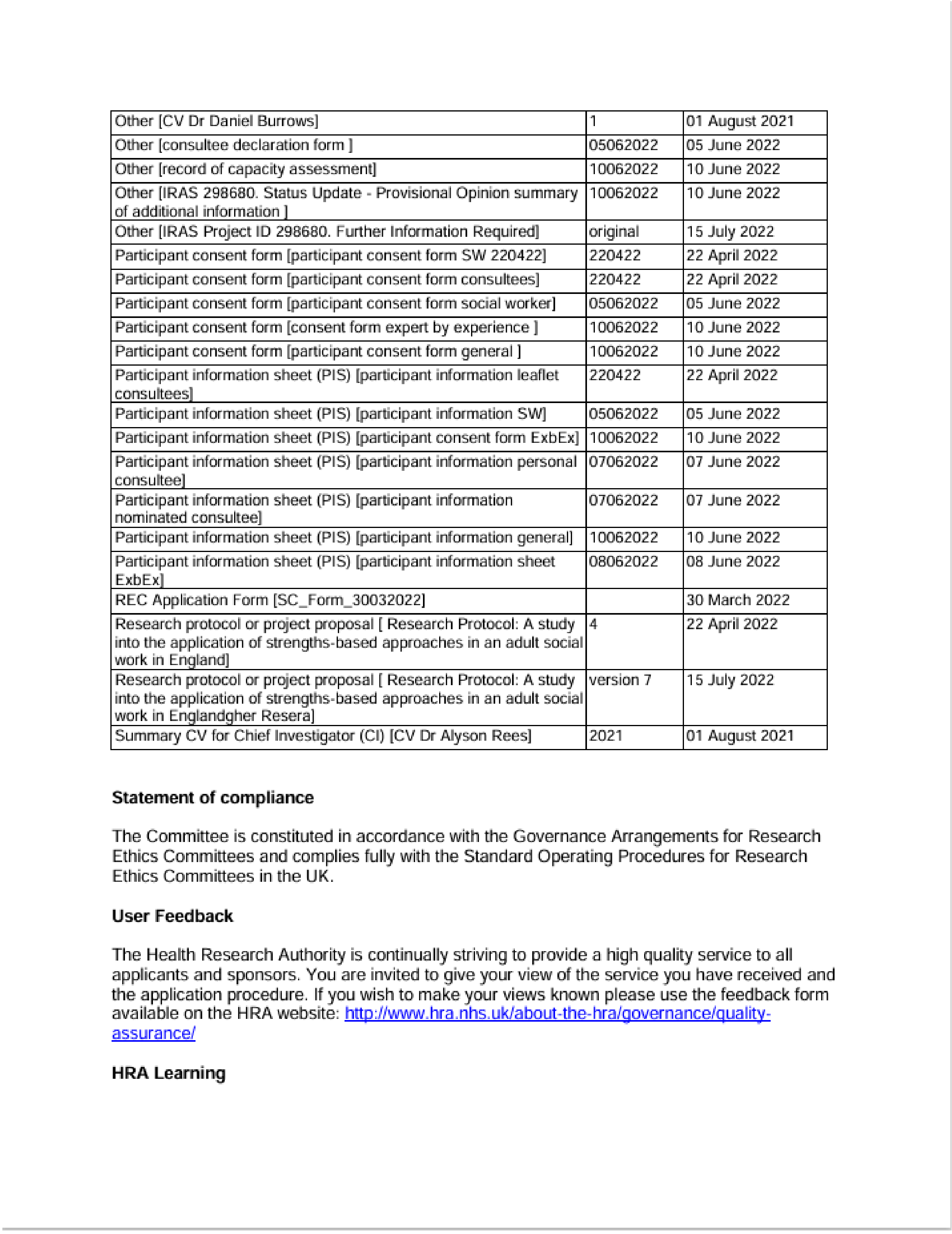
Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [email recruitment and flyer for social workers (A30-1)]	1	22 April 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance cover]	2021-22	01 August 2021
Interview schedules or topic guides for participants [A study into strengths based approaches social work baseline survey]	REC version	22 April 2022
Interview schedules or topic guides for participants [expert-by-expereicne & consultee semi structured interview format]	V2	21 April 2022
Interview schedules or topic guides for participants [A study into strengths based approaches social work baseline survey]	10062022	10 June 2022
IRAS Checklist XML [Checklist_10062022]		10 June 2022
IRAS Checklist XML [Checklist_15072022]		15 July 2022
Letter from sponsor [Sponsorship Letter]	010322	01 March 2022
Letters of invitation to participant [participant information letter EXbEX]	220422	22 April 2022
Letters of invitation to participant [participant letter consultees]	220422	22 April 2022
Letters of invitation to participant [participant letter social worker]	220422	22 April 2022
Other [Sarah Farragher Academic CV]	August 2021	01 August 2021



Other [CV Dr Daniel Burrows]	1	01 August 2021
Other [consultee declaration form]	05062022	05 June 2022
Other [record of capacity assessment]	10062022	10 June 2022
Other [IRAS 298680. Status Update - Provisional Opinion summary of additional information]	10062022	10 June 2022
Other [IRAS Project ID 298680. Further Information Required]	original	15 July 2022
Participant consent form [participant consent form SW 220422]	220422	22 April 2022
Participant consent form [participant consent form consultees]	220422	22 April 2022
Participant consent form [participant consent form social worker]	05062022	05 June 2022
Participant consent form [consent form expert by experience]	10062022	10 June 2022
Participant consent form [participant consent form general]	10062022	10 June 2022
Participant information sheet (PIS) [participant information leaflet consultees]	220422	22 April 2022
Participant information sheet (PIS) [participant information SW]	05062022	05 June 2022
Participant information sheet (PIS) [participant consent form ExbEx]	10062022	10 June 2022
Participant information sheet (PIS) [participant information personal consultee]	07062022	07 June 2022
Participant information sheet (PIS) [participant information nominated consultee]	07062022	07 June 2022
Participant information sheet (PIS) [participant information general]	10062022	10 June 2022
Participant information sheet (PIS) [participant information sheet ExbEx]	08062022	08 June 2022
REC Application Form [SC_Form_30032022]		30 March 2022
Research protocol or project proposal [Research Protocol: A study into the application of strengths-based approaches in an adult social work in England]	4	22 April 2022
Research protocol or project proposal [Research Protocol: A study into the application of strengths-based approaches in an adult social work in Englandgher Resera]	version 7	15 July 2022
Summary CV for Chief Investigator (CI) [CV Dr Alyson Rees]	2021	01 August 2021

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 298680   Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

[redacted]

pp

[redacted]

Chair

Email: socialcare.rec@hra.nhs.uk

Enclosures:	"After ethical review – guidance for researchers" *[SL-AR2]* After ethical review guidance for sponsors and investigators – Non CTIMP Standard Conditions of Approval]
Copy to:	[redacted] *Confidentiality Advise Team*

Appendix five: Participant information sheet example general

A study into the application of strengths-based approaches in an adult social work in England.

Invitation and brief summary

Thank you for expressing an interest in participating in my study looking at strengths-based approaches and the impact that these have on outcomes for people with care and support needs. This sheet sets out the information that you need to know about this study and your role within this.

About the researcher

My name is Sarah Farragher, and I am undertaking this research for a social work professional doctorate thesis at Cardiff University. You may already know me through the work that I do for XXX however I would like to reassure you that this work is being undertaken completely separately, in my own time and is in no way affiliated with XXX.   To ensure this separation can be maintained I will not be collecting any data from social work activities taking place within

About the research

A strengths-based approach is enacted through a consideration of a person in terms of their abilities, assets, and capabilities (i.e., their strengths) rather than focusing on the deficits and dependencies that are observable the presentation of needs.   The focus on my study is to look at strengths-based practice and will look at three questions:

- How do social workers define and understand strengths-based approaches in relation their practice?

- How are these interpretations observable in day-to-day practice what are the factors that influence these?
- How do people with care and support needs describe their experience of social work intervention?

I am hoping to include up to fifteen social workers and around twenty people with lived experience within this study. I hope to use this study to make recommendations for application of strengths-based practice.

This is an ethnographic study, that means that I will collect data through a mix of observations, discussions, interviews and reviewing information on IAS.

I will be undertaking all of the research myself and I will only discuss this with my University supervisors Dr Alyson Rees Reesa1@cardiff.ac.uk and Dr Dan Burrows BurrowsDR1@cardiff.ac.uk. The only exception to this is in relation to issues of safeguarding for adults or children where there is a statutory duty to report.

If this is the case the concern will be reported in line with the with XX safeguarding adult policy XX.

If the information set out presents a risk to children, this will be reported through the children's safeguarding hub. XX

How have patients and the public been involved in this study?

I will be recruiting participants who have lived experience, some of these may be people that you are working with. These participants will be afforded the same level of confidentiality and therefore unfortunately I will not be able to provide feedback on any discussions I have directly with these individuals with you.

As part of the development of this study, I have produced a short baseline survey on strengths-based approaches for social work participants and a questionnaire for people with lived experience. I have sought feedback on these documents from a local carers organisation.

What would taking part involve?

As a general participant you are agreeing to be observed in your interactions with either a social work participant or a person with lived experience participant. The focus of this research is on social work practice and these observations will only relate to the research questions and not directly to you.

What are the possible benefits of taking part?

There are no specific benefits to you and you will not be paid for taking part.

What are the possible disadvantages and risks of taking part?

I do not envisage any risks for you however recognise that this may appear intrusive and there may be some issues which are uncomfortable. If at any stage, you would like me to cease or rearrange observations please let me know.

Do I have to be involved?

There is no obligation to take part in this study. If you do decide you wish to take part, I will ask you to complete the attached consent form. You may however choose to withdraw this consent at any time. If you choose to withdraw from the study, I may still use data already collected unless you specifically ask for this to be destroyed.

Who is organising and funding this study?

I am undertaking this study as part of a professional doctorate in social work. I am self-funding this research and I am the only researcher involved. This study has been reviewed by Cardiff University research governance team and the Health Research Authority, which is the body responsible for regulating all research in health and social care in the UK. For this has been signed off by, Assistant Director and Deputy DAS and corporately by the County Council.

What will happen to the results of this study?

The data collected will be used in a thesis study which is due to be submitted September 2025. Following completion this thesis will be available on-line through Cardiff University however I will aim to provide you with a copy of my interim findings no more than six months after completion of data collection.

How will we use information about you?

All information collected will be confidential, with the exception of anything that would constitute a duty to report under safeguarding for adults or children. As a participant you will be allocated a pseudonym and you will not be identified within the study. Similarly, I will assign pseudonyms to any colleagues, people with care and support needs or others that you mention within the study. I will also be assigning a pseudonym to the County Council and your place of work if applicable.

I will retain your name, work email and agreed telephone number (either your work phone number or personal phone number based on your preference) for the duration of the study to enable me to contact you, but this information will not be available to anyone else.

Once I have finished the study, I will keep some of the data so we can check the results. Records will be kept on a secure university server for five years to allow transparency with relation to the research. I will write my report in a way that no-one can work out that you took part in the study.

My academic supervisors and I will be the only people who will have access to the final dataset. In the case of the supervisors this will be for the purposes of auditing and assurance only.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but I will keep information about you that I already have.
- I need to manage your records in specific ways for the research to be reliable.
- This means that I won't be able to let you see or change the data I hold about you.

Where can you find out more about how your information is used?

You can find out more about how I will use your information

- at www.hra.nhs.uk/information-about-patients/
- Data protection notices for research participants - Public information - Cardiff University
- by contacting me: farraghersa@cardiff.ac,uk

Further information and contact details

If you would like any further information about this study then you may contact me through my Council email address XX or if you prefer you can contact me at farraghersa@cardiff.ac.uk or by phone on 07531541208.

If you would like to talk to my university supervisors you can contact them by email.

Dr Alyson Rees Reesa1@cardiff.ac.uk

or

Dr Dan Burrows BurrowsDR1@cardiff.ac.uk

Consent:

If you are prepared to take part in this study, please can you completed the enclosed consent declaration and return to me by email to farraghersa@cardiff.ac.uk

Appendix six: Consent form example Person with lived experience

A study into the application of strengths-based approaches in an adult social work in England

Invitation and brief summary

As someone who has had recent contact with Adult Social Care, I would like to hear your story as a person with lived experience and particularly how your social worker supported you / the person you care for with what you wanted to achieve.

This leaflet sets out the information that you need to know about this study and your role within this.

About the researcher

My Name is Sarah Farragher, and I am a doctoral student at Cardiff University

I am doing a piece of research looking at strengths-based practice in social work

You may know me as I work in XX helping people to XXX but this study is completely separate and has nothing to do with my job.

About the research

Strengths based practice means that the social worker focuses how a person can achieve their most independent life rather than on what they are not able to do.

The focus of my study is to look at strengths-based practice and will look at three questions:

- How do social workers define and understand strengths-based approaches in relation their practice?
- How are these interpretations observable in day-to-day practice what are the factors that influence these?
- How do people with care and support needs describe their experience of social work intervention?

I am hoping to include up to fifteen social workers and around twenty people with lived experience within this study. I hope to use this study to make recommendations for application of strengths-based practice.

This is an ethnographic study, that means that I will collect data through a mix of observations, discussions, interviews and reviewing written and electronic information.

I will be undertaking all of the research myself and I will only discuss this with my University supervisors Dr Alyson Rees Reesa1@cardiff.ac.uk and Dr Dan Burrows BurrowsDR1@cardiff.ac.uk. The only exception is when I legally have to report something for example a potential current or historical safeguarding concern for children or adults.

If this is the case the concern will be reported in line with the with XX safeguarding adult policy XX

If the information set out presents a risk to children, this will be reported through the children's safeguarding hub. XX

How have patients and the public been involved in this study?

As part of the development of this study, I have produced a short baseline survey on strengths-based approaches for social work participants and a questionnaire for people with lived experience. I have sought feedback on these documents from a local carer's organisation.

What would taking part involve?

Taking part in the research will mean taking part in an initial discussion (or 'interview') with me. You can choose if we do this face-face, by phone, or by video conferencing.

I may then contact you again a few months later for another discussion. Each discussion will last about 30-90 minutes and you can ask to stop for a break any time you want to. With your permission, I will record any conversations we have.

I will be spending some time talking to social workers and watching them work. I will listen to the conversations that they have and look at the written notes and assessments they record.

I will also be talking to social workers about what they understand about strengths-based working.

I would also like to look at the information held on the adult social care database about you and talk to your social worker. I will only look at this information if you tell me, it's ok to do so.

I will also be research activities with your / the person you care for social worker including

- Joining relevant team meetings
- Listening to phone calls
- Observing other discussions with managers and our colleagues.

What are the possible benefits of taking part?

There are no direct benefits to you for taking part in the study and you won't be paid for taking part. Taking part in the research will not disadvantage you in any way but will take up some of their time.

What are the possible disadvantages and risks of taking part?

I do not envisage any risks for you however I recognise that there may be some issues which are uncomfortable. If this is the case you may ask to rearrange or stop taking part at any stage.

You should also be aware that anonymised data about you will be used for the purposes of this study.

Do I have to be involved?

Choosing to take part in the study is completely up to you and you don't have to take part if you don't want to. If you decide you don't want to take part at any stage this is fine. You do not need to give me a reason. Unless you ask me not to, I will use any data that I have already collected.

Who is organising and funding this study?

I am undertaking this study as part of a professional doctorate in social work. I am self-funding this research and I am the only researcher involved. This study has been reviewed by Cardiff University research governance team and the Health Research Authority, which is the body responsible for regulating all research in health and social care in the UK. For XX this has been signed off by XX, Assistant Director and Deputy DAS and corporately by the XX Council.

What will happen to the results of this study?

I will use the data I collect as part of my university thesis. This is a big piece of work and not likely to be finished until September 2025. I am hoping to be able to feedback to all of the people who take part within 6 months of completing data collection.

How will we use information about you?

All information collected will be confidential, with the exception of anything that would constitute a duty to report under safeguarding for adults or children.

I will keep all of your details confidential and if I need to refer to anything you have said I will use a pseudonym, which is made up name rather than your name.

I need to make sure that the research is reliable, this does mean I won't be able to let you see or change the data we hold on to you.

I will retain your name and agreed telephone number for the duration of the study to enable me to contact you, but this information will not be available to anyone else.

Once I have finished the study, I will keep some of the data so I can check the results. Records will be kept on a secure university server for five years to allow transparency with relation to the research. I will write my report in a way that no-one can work out that your friend / relative took part in the study.

My academic supervisors and I will be the only people who will have access to the final dataset. In the case of the supervisors this will be for the purposes of auditing and assurance only.

What are your choices about how your information is used?

You can stop being part of the study at any time without giving a reason. I will keep information that I already have already collected for the purposes of the study unless I am specifically asked not to this.

I need to manage records in specific ways for the research to be reliable. This means that I won't be able to let you see or change the data we hold about them.

Where can you find out more about how your information is used?

You can find out more about how I will use your information

- by speaking to me or my supervisors.
- by viewing the Cardiff University Data Protection Policy: https://www.cardiff.ac.uk/public-information/policies-and-procedures/data-protection
- by sending an email to inforequest@cardiff.ac.uk
- by writing to the Cardiff University Data Protection Officer, Compliance and Risk, University Secretary's Office, Cardiff University, McKenzie House, 30-36 Newport Road, Cardiff CF24 0DE
- www.hra.nhs.uk/information-about-patients/

Further information and contact details

If you would like any further information about this study then you may contact me through my XX Council email address XX or if you prefer you can contact me at farraghersa@cardiff.ac.uk or by phone on 07531541208.

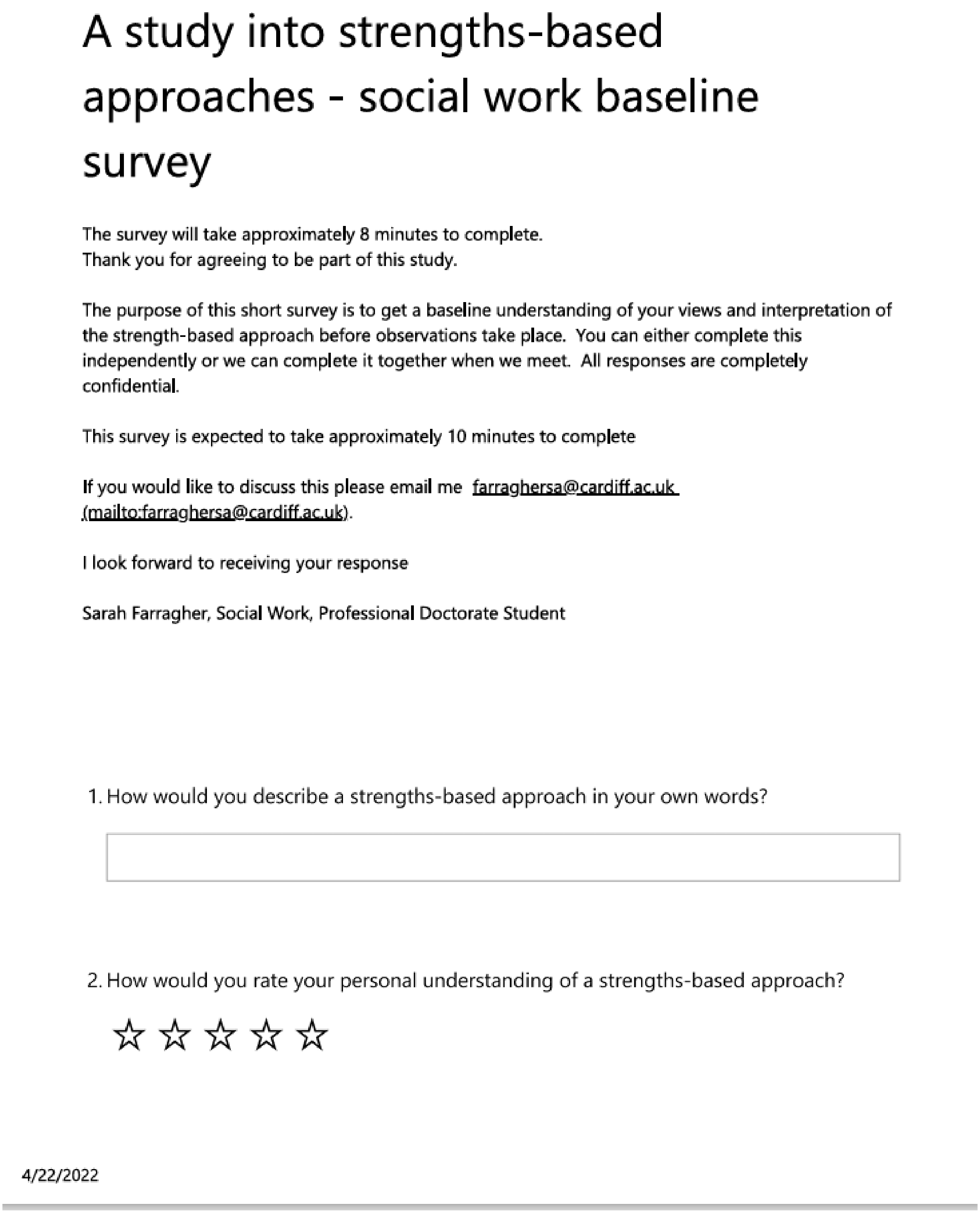
If you would like to talk to my university supervisors, you can contact them by email.

Dr Alyson Rees Reesa1@cardiff.ac.uk
or
Dr Dan Burrows BurrowsDR1@cardiff.ac.uk

Consent:

If you are prepared to take part in this study, please can you complete the enclosed consent declaration and return to me by email to farraghersa@cardiff.ac.uk

Appendix seven: strengths-based survey



A study into strengths-based approaches - social work baseline survey

The survey will take approximately 8 minutes to complete.
Thank you for agreeing to be part of this study.

The purpose of this short survey is to get a baseline understanding of your views and interpretation of the strength-based approach before observations take place. You can either complete this independently or we can complete it together when we meet. All responses are completely confidential.

This survey is expected to take approximately 10 minutes to complete

If you would like to discuss this please email me farraghersa@cardiff.ac.uk (mailto:farraghersa@cardiff.ac.uk).

I look forward to receiving your response

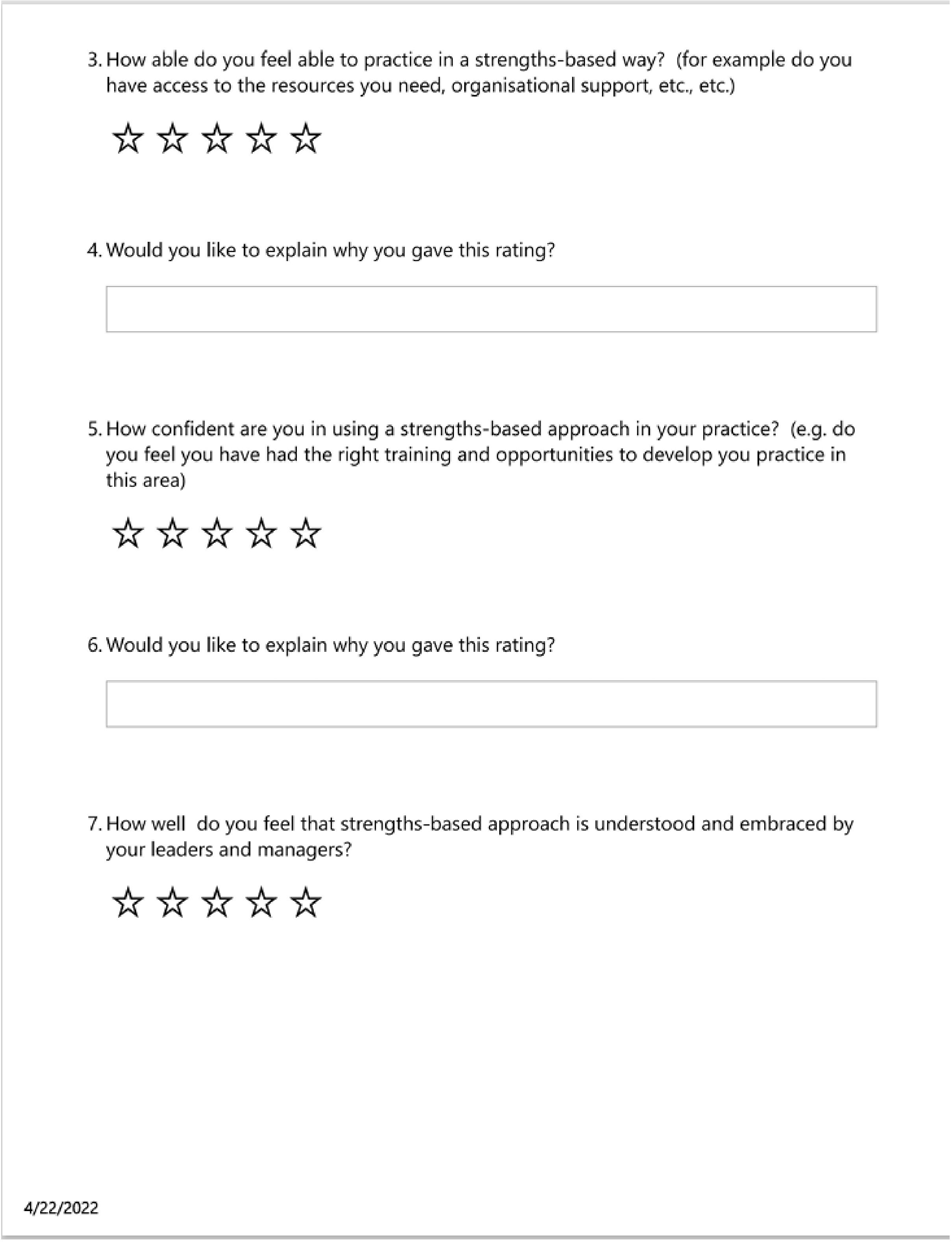
Sarah Farragher, Social Work, Professional Doctorate Student

1. How would you describe a strengths-based approach in your own words?

2. How would you rate your personal understanding of a strengths-based approach?

☆ ☆ ☆ ☆ ☆

4/22/2022



3. How able do you feel able to practice in a strengths-based way? (for example do you have access to the resources you need, organisational support, etc., etc.)

☆ ☆ ☆ ☆ ☆

4. Would you like to explain why you gave this rating?

5. How confident are you in using a strengths-based approach in your practice? (e.g. do you feel you have had the right training and opportunities to develop you practice in this area)

☆ ☆ ☆ ☆ ☆

6. Would you like to explain why you gave this rating?

7. How well do you feel that strengths-based approach is understood and embraced by your leaders and managers?

☆ ☆ ☆ ☆ ☆

4/22/2022

8. Would you like to explain why you gave this rating?

9. To what extent do you feel you are trusted to exercise your own professional judgement when working with people?

☆ ☆ ☆ ☆ ☆

10. Would you like to explain why you gave this rating?

11. To what extent do you feel able to promote positive risk taking?

☆ ☆ ☆ ☆ ☆

12. Would you like to explain why you gave this rating?

4/22/2022

8. Would you like to explain why you gave this rating?

9. To what extent do you feel you are trusted to exercise your own professional judgement when working with people?

☆ ☆ ☆ ☆ ☆

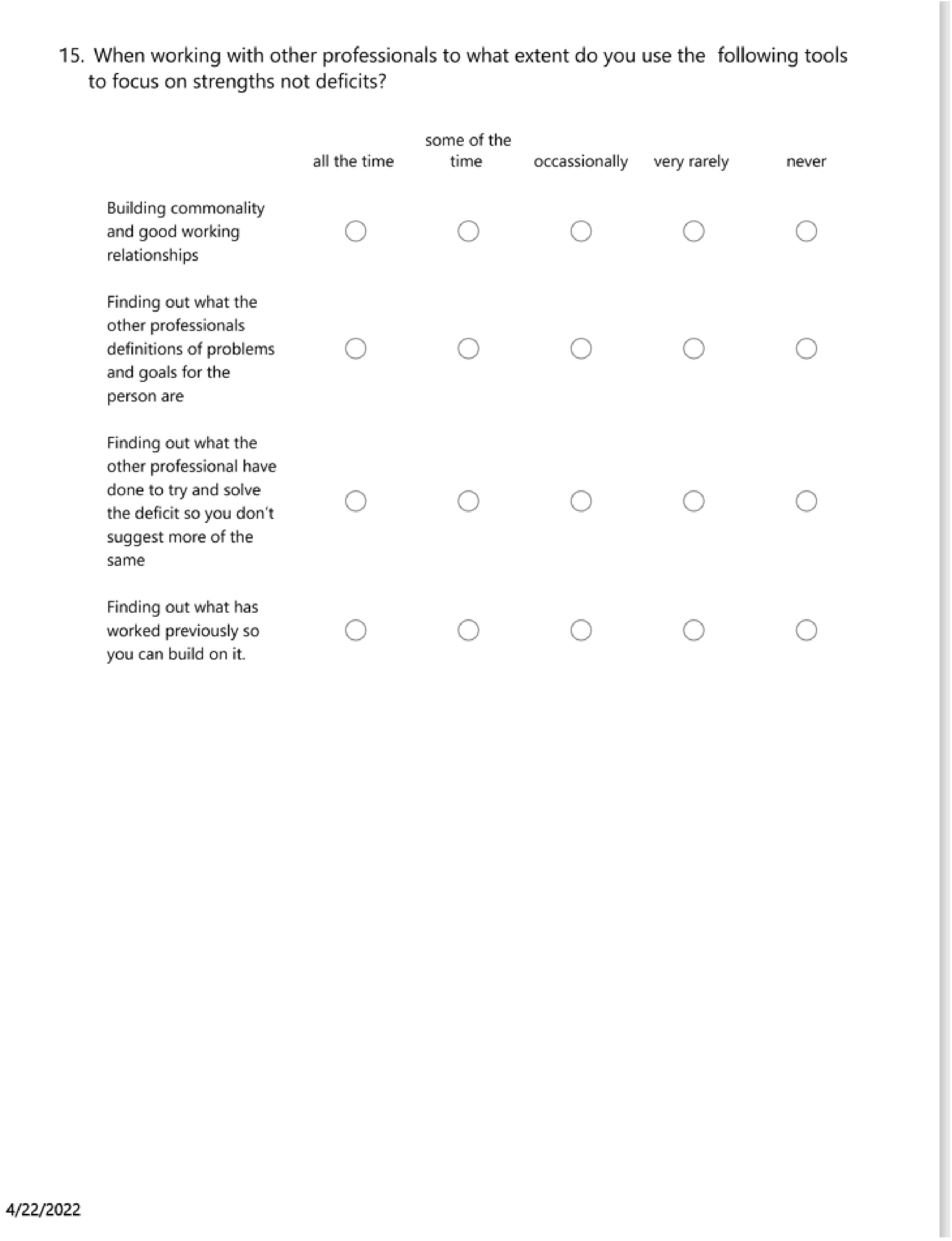
10. Would you like to explain why you gave this rating?

11. To what extent do you feel able to promote positive risk taking?

☆ ☆ ☆ ☆ ☆

12. Would you like to explain why you gave this rating?

4/22/2022



15. When working with other professionals to what extent do you use the following tools to focus on strengths not deficits?

	all the time	some of the time	occassionally	very rarely	never
Building commonality and good working relationships	○	○	○	○	○
Finding out what the other professionals definitions of problems and goals for the person are	○	○	○	○	○
Finding out what the other professional have done to try and solve the deficit so you don't suggest more of the same	○	○	○	○	○
Finding out what has worked previously so you can build on it.	○	○	○	○	○

4/22/2022

17. When working with people who have family and or friend carers how important do you think each of the statements below is?

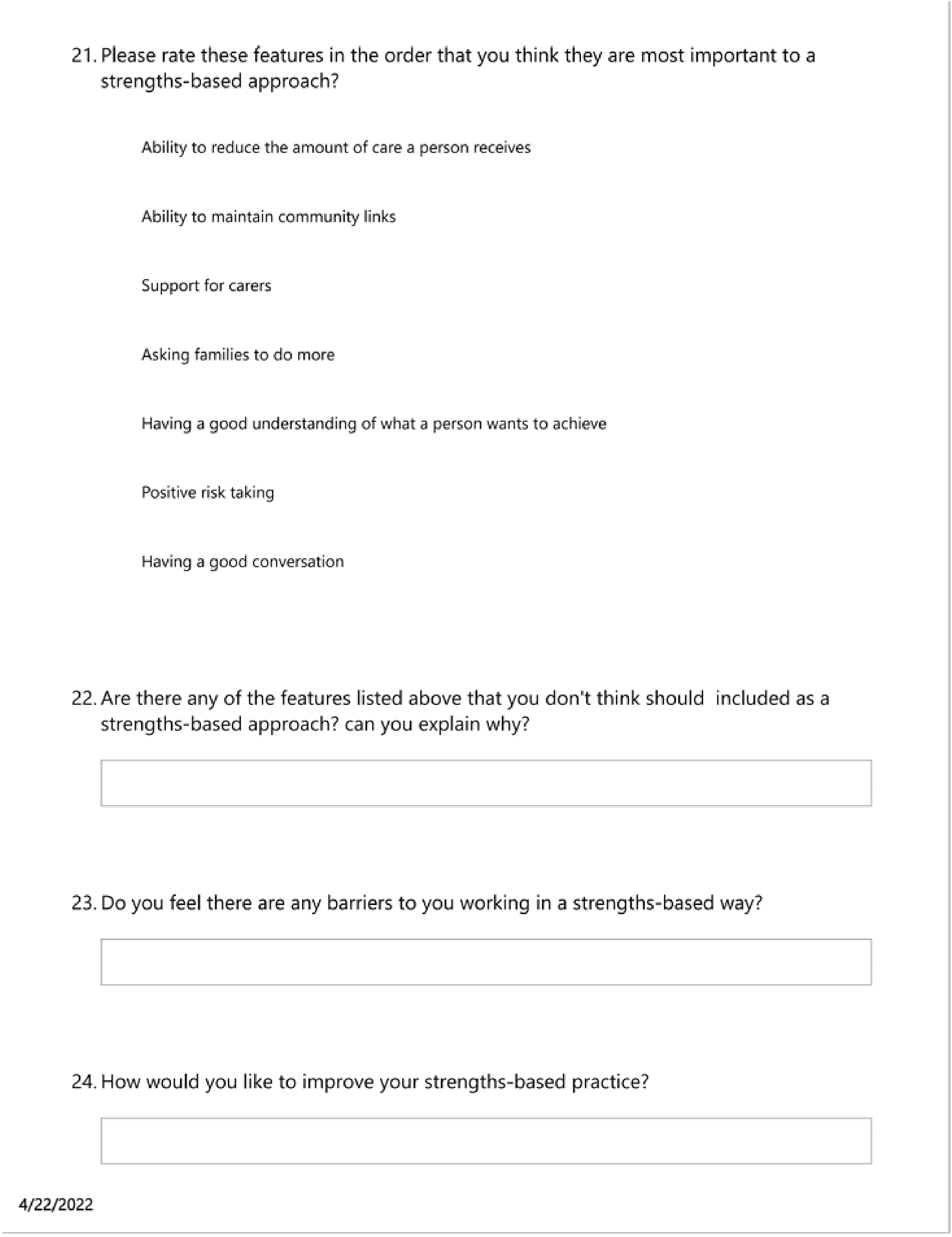
	essential	very important	moderately important	not really important	not relevant to the approach
It is important to get a good understanding of the relationship between the person and their carer	○	○	○	○	○
It is important to understand if the family or friend identifies as a carer	○	○	○	○	○
It is important to understand how much care is being provided and how much of a burden it is	○	○	○	○	○
It is important to understand if the family or friend wants to provide support	○	○	○	○	○
It is important to understand if the person is happy with their family or friend providing support	○	○	○	○	○
It is important that the family or friend is offered opportunities to take breaks and access carers support	○	○	○	○	○

18. When you are working with a person who has a family or friend informal carer and there is a difference between what the person wants and the carers view, how do you ensure you promote peoples strengths?

19. What would you do if the family or friend carer does not want to provide care? How might a strengths-based approach help support a solution?

20. To what extent do you use the following tools to develop an equal and collaborative relationship with the person you are working with?

	always	mostly	sometimes	hardly ever	never
Assume that the person wants to collaborate even if it seems like they may not want to.	○	○	○	○	○
Use language that focuses on what the individual wants to achieve or has achieved	○	○	○	○	○
Taking a position of not being an expert	○	○	○	○	○
Using curiosity to explore the persons understanding of the world	○	○	○	○	○



21. Please rate these features in the order that you think they are most important to a strengths-based approach?

    Ability to reduce the amount of care a person receives

    Ability to maintain community links

    Support for carers

    Asking families to do more

    Having a good understanding of what a person wants to achieve

    Positive risk taking

    Having a good conversation

22. Are there any of the features listed above that you don't think should included as a strengths-based approach? can you explain why?

23. Do you feel there are any barriers to you working in a strengths-based way?

24. How would you like to improve your strengths-based practice?

4/22/2022

Appendix eight: summary of data extracts

Data Extract Reference in order of appearance	Chapter	Page	Type of data	SW participant	Lived Experience participant
field notes: SW3/June(1)	Four	62	field notes	SW 3	anonymous (June)
reflection SW4(1)	Four	63	reflective discussion	SW 4	Phyliss
reflection SW1(1)	Four	64	reflective discussion	SW 1	Mary
survey comment 28	Four	64	survey	N/A	N/A
survey comment 210	Four	64	survey	N/A	N/A
survey comment 86	Four	65	survey	N/A	N/A
CAF1(1))	Four	66	summarised Care Act (2014) form structure	N/A	N/A
CAF1(2)))	Four	68	summarised Care Act (2014) form structure	N/A	N/A
field notes: SW1/Mary (1)	Four	68	Field Notes	SW 1	Mary
record: SW1/Mary (1)	Four	68	Extract from completed Care Act (2014) assessment	SW 1	Mary
record:SW4/Phyliss(1)	Four	68	Extract from completed Care Act (2014) assessment	SW 4	Phyliss
CAF1(3))	Four	69	summarised Care Act (2014) form structure	N/A	N/A
field notes: SW1/Mary (2)	Four	71	Field notes	SW 1	Mary
record:SW1/Mary(2)	Four	71	Extract from completed Care Act (2014) assessment	SW 1	Mary
record:SW1/Mary(3)	Four	71	Extract from completed Care Act (2014) assessment	SW 1	Mary
record:SW1/Mary(4)	Four	71	Extract from completed Care Act(2014) assessment	SW 1	Mary
transcript: SW5/Renee (1)	Four	73	field work transcript	SW 5	Renee
transcript: SW5/Renee (2)	Four	73	field work transcript	SW 5	Renee
record:SW5/Renee(1)	Four	74	Extract from completed Care Act (2014) assessment	SW 5	Renee

record:SW5/Renee(2)	Four	74	Extract from completed Care Act(2014) assessment	SW 5	Renee
record:SW5/Renee(3)	Four	75	Extract from completed Care Act (2014) assessment	SW 5	Renee

Data Extract Reference in order of appearance	Chapter	Page	Type of data	SW participant	Lived Experience participant
record:SW2/Peter(1)	Four	76	Extract from completed Care Act (2014) assessment	SW 2	Peter
record:SW2/Peter(2)	Four	77	Extract from completed Care Act (2014) assessment	SW 2	Peter
MDT:SW2/Peter(1)	Four	77	MDT transcript/minutes	SW 2	Peter
Case:SW2/Peter(1)	Four	77	Case Notes	SW 2	Peter
record:SW1/John(1)	Four	78	Extract from completed Care Act (2014) assessment	SW 1	John
record:SW1/John(2)	Four	78	Extract from completed Care Act (2014) assessment	SW 1	John
record:SW1/John(3)	Four	78	Extract from completed Care Act (2014) assessment	SW 1	John
record:SW1/John(4)	Four	79	Extract from completed Care Act (2014) assessment	SW 1	John
transcript: SW1/John(1)	Four	80	field work transcript	SW 1	John
reflection: SW1 (2)	Four	81	reflective discussion	SW 1	John
record:SW2/Mark(1)	Four	82	Extract from completed Care Act (2014) assessment	SW 2	Mark
record:SW4(1)/Phyliss(2)	Four	83	Extract from completed Care Act (2014) assessment	SW 4	Phyliss
transcript: SW4/Phyliss (1)	Four	83	field work transcript	SW 4	Phyliss
record:SW4/Phyliss(3)	Four	84	Extract from completed Care Act (2014) assessment	SW 4	Phyliss
record:SW2/Betty(1)	Four	84	Extract from completed Care Act (2014) assessment	SW 2	Betty

record:SW1/Mary(5)	Four	85	Extract from completed Care Act (2014) assessment	SW 1	Mary
record:SW5/Renee(5)	Four	85	Extract from completed Care Act (2014) assessment	SW 5	Renee
record:SW5/Renee(6)	Four	85	Extract from completed Care Act (2014) assessment	SW 5	Renee
record:SW5/Renee(7)	Four	85	Extract from completed Care Act (2014) assessment	SW 5	Renee
reflection:SW4 (2)	Four	88	reflective discussion	SW 4	Phyliss
field notes: SW1/Mary (3)	Four	88	Field Notes	SW 1	Mary

Data Extract Reference in order of appearance	Chapter	Page	Type of data	SW participant	Lived Experience participant
survey comment 114	Five	95	survey	N/A	N/A
survey comment 120	Five	95	survey	N/A	N/A
survey comment 125	Five	96	survey	N/A	N/A
transcript: SW1/John(2)	Five	96	field work transcript	SW 1	John
reflection: SW1(3)	Five	97	reflective discussion	SW 1	John
MDT:SW1/John(1)	Five	97	MDT transcript/minutes	SW 1	John
survey comment 118	Five	98	survey	N/A	N/A
survey comment 124	Five	98	survey	N/A	N/A
survey comment 113	Five	99	survey	N/A	N/A
survey comment 208	Five	99	survey	N/A	N/A
survey comment 116	Five	99	survey	N/A	N/A
transcript:SW5/Renee (3)	Five	100	field work transcript	SW 5	Renee
transcript:SW5/Renee (4)	Five	100	field work transcript	SW 5	Renee
survey comment 146	Five	100	survey	N/A	N/A
survey comment 135	Five	100	survey	N/A	N/A
survey comment 161	Five	100	survey	N/A	N/A
survey comment 158	Five	101	survey	N/A	N/A
transcript:SW3/Joan(1)	Five	101	field work transcript	SW 3	Joan
reflection: SW3(2)	Five	101	reflective discussion	SW 3	Joan
record:SW2/Peter(2)	Five	102	Extract from completed Care Act (2014) assessment	SW 2	Peter
survey comment 84	Five	103	survey	N/A	N/A
survey comment 113	Five	103	survey	N/A	N/A
survey comment 192	Five	103	survey	N/A	N/A
survey comment 220	Five	103	survey	N/A	N/A

reflection:SW4(3)	Five	104	reflective discussion	SW 4	Phyliss
transcript:SW1/John(3)	Five	105	field work transcript	SW 1	John
survey comment 113	Five	105	survey	N/A	N/A
survey comment 132	Five	105	survey	N/A	N/A
survey comment 215	Five	105	survey	N/A	N/A
survey comment 122	Five	105	survey	N/A	N/A
MDT:SW3(1)	Five	106	MDT transcript/minutes	SW 3	anonymous
MDT:SW3(2)	Five	106	MDT transcript/minutes	SW 3	anonymous
MDT:SW1/John(2)	Five	106	MDT transcript/minutes	SW 1	John
Data Extract Reference in order of appearance	Chapter	Page	Type of data	SW participant	Lived Experience participant
MDT:SW2/Peter(2)	Five	106	MDT transcript/minutes	SW 2	Peter
MDT:SW2/Peter(3)	Five	106	MDT transcript/minutes	SW 2	Peter
MDT:SW1/Mary(1)	Five	106	MDT transcript/minutes	SW 1	Mary
survey comment 25	Five	107	survey	N/A	N/A
survey comment 34	Five	107	survey	N/A	N/A
survey comment 37	Five	107	survey	N/A	N/A
survey comment 32	Five	107	survey	N/A	N/A
survey comment 48	Five	107	survey	N/A	N/A
transcript:SW3/annon(1)	Five	108	field work transcript	SW 3	anonymous
transcript:SW3/annon(2)	Five	108	field work transcript	SW 3	anonymous
reflection:SW3(3)	Five	109	reflective discussion	SW 3	anonymous
survey comment 42	Five	111	survey	N/A	N/A
survey comment 48	Five	111	survey	N/A	N/A
survey comment 41	Five	111	survey	N/A	N/A
survey comment 128	Five	111	survey	N/A	N/A
survey comment 31	Five	111	survey	N/A	N/A
survey comment 35	Five	111	survey	N/A	N/A
survey comment 117	Five	111	survey	N/A	N/A
survey comment 70	Five	111	survey	N/A	N/A
survey comment 119	Five	111	survey	N/A	N/A
reflection:SW3(4)	Five	112	reflective discussion	SW 3	anonymous

reflection:SW3(5)	Five	113	reflective discussion	SW 3	anonymous
transcript:SW3/Joan(2)	Six	119	field work transcript	SW 3	Joan
transcript:SW3/Joan(3)	Six	120	field work transcript	SW 3	Joan
transcript:SW3/Joan(4)	Six	121	field work transcript	SW 3	Joan
transcript:SW3/Joan(5)	Six	121	field work transcript	SW 3	Joan
transcript:SW3/Joan(6)	Six	122	field work transcript	SW 3	Joan
transcript:SW3/Joan(7)	Six	124	field work transcript	SW 3	Joan
transcript:SW3/Joan(8)	Six	126	field work transcript	SW 3	Joan
field notes: SW2/Betty(2)	Six	128	Field Notes	SW 2	Betty
field notes: SW2/Betty(3)	Six	129	Field Notes	SW 2	Betty
transcript:SW4/Phyliss(2)	Six	131	field work transcript	SW 4	Phyliss
MDT:SW1/Mary(3)	Six	133	mdt transcript/minutes	SW 1	Mary
Data Extract Reference in order of appearance	Chapter	Page	Type of data	SW participant	Lived Experience participant
LET:Mary(1)	Six	134	professional letter		Mary
MCA:Mary(1)	Six	134	Mental Capacity Assessment	SW 1	Mary
BID:Mary(1)	Six	138	Best Interest Decision	SW 1	Mary
BID:Mary(2)	Six	138	Best Interest Decision	SW 1	Mary
BID:Mary(3)	Six	139	Best Interest Decision	SW 1	Mary
record:SW1/Mary(6)	Six	140	Extract from completed Care Act (2014) assessment	SW 1	Mary
BID:Mary(4)	Six	140	Best Interest Decision	SW 1	Mary
MDT:SW1/John(3)	Six	146	MDT transcript/minutes	SW 1	John