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HS&DR Evidence Synthesis Centre Topic Report

Research evidence on different strengths-based approaches within adult social work: a systematic review

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Abstract

Background

A ‘strengths-based approach’ focusses on peoples’ goals and resources rather than their problems. Social care professionals and organisations are striving to practise in a strengths-based way and since the Care Act of 2014 it is an even stronger requirement. However, there are challenges in implementing strengths-based approaches into practise, and uncertainty remains about their effectiveness.

Objective

To summarise research evidence on the effectiveness and the implementation of different strengths-based approaches within adult social work in the UK.

Data sources

We searched seven databases: MEDLINE ALL, PsycINFO, Social Policy and Practice, HMIC, CINAHL, ASSIA and the Campbell Library. Supplementary web searches were conducted. No date or language limits were used.

Review methods

Eligible studies were about adults (≥18 years) being supported or assessed by social workers; or about initiatives involving adult social care teams. For the effectiveness question, outcomes could be directly related to people’s individual outcomes or outcomes at the level of families or communities. The Cochrane Effective Practice and Organisation of Care group’s Risk of Bias Tool was chosen to appraise the quality of effectiveness studies, and qualitative implementation studies were assessed using the Wallace criteria. Findings were tabulated and analysed using framework synthesis, based on the Consolidated Framework of Implementation Research (CFIR). Studies that were not synthesised were summarised descriptively.

Findings

Of 5,030 studies screened, none met our inclusion criteria for the effectiveness question. Fifteen qualitative or mixed methods studies met the criteria for the implementation question,

six of which were assessed as ‘good quality’. Seven examined Making Safeguarding Personal (MSP) and the remaining eight studies examined Local Area Coordination, Solution Focused Therapy, Family Group Conferencing, Asset-based Community Development, Strengths-based with Relationship-based Approach, Asset-based approaches, and Motivational Interviewing.

Seven studies on Making Safeguarding Personal (MSP), were synthesised into the following themes of implementation factors: 1) *MSP as an intervention*: seen as initially demanding but with long-term advantages; required significant practice change; needed tailoring to local settings. 2) *Culture and Settings*: required broad cultural changes; ‘outward facing’ and smaller/specialist councils tended to find this easier. 3) *Individual characteristics*: enhancing the knowledge, skills and confidence of stakeholders in MSP facilitated delivery; depended on practitioner skill in engaging people being supported; and people’s willingness to engage. 4) *Embedding and sustaining MSP*: depended on strong leadership and active engagement at all levels; required extensive planning and shaping of safeguarding practice that was user-focussed.

For the remaining eight studies of seven strengths-based approaches, we provide a summary of their findings.

Limitations

Our findings are mainly limited by the lack of available evidence in the UK. Higher quality studies may have revealed richer explanations of implementation.

Conclusions

There is a lack of good quality research evidence evaluating the effectiveness or implementation of strengths-based approaches. The synthesis revealed a wide range of factors that enabled or inhibited successful implementation of Making Safeguarding Personal. These factors may have wider relevance for the implementation of other strengths-based models of social work practice.

Future work

Higher quality evaluations of different strengths-based social work models are required.

Study registration: PROSPERO CRD42020166870

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Abbreviations

ABCD	Asset-Based Community Development
ADASS	Association of Directors of Adult Social Services
AI	Appreciative Inquiry
BASS	British Association of Social work and Social care
CFIR	Consolidated Framework for Implementation Research
EA	Ecological Approach
FGC	Family Group Conference
LAC	Local Area Coordination
MASH	Multi-Agency Safeguarding Hub
MI	Motivational Interviewing
MSP	Making Safeguarding Personal
NA	Narrative Approaches
PCA	Person-centred Approaches
RiPfA	Research in Practice for Adults (research/training charity)
RM	Recovery Model
RP	Restorative Practice
SAB	Safeguarding Adults Board
SBA	Strengths-Based Approach
SBAS	Strengths-Based Assessment
SBCM	Strengths-Based Case Management
SCIE	Social Care Institute for Excellence
SFT	Solution-Focused Therapy (or approach)
SSW	Systemic Social Work
SSWB	Signs of Safety and Wellbeing
TCM	Three Conversations Model

Glossary

Asset-Based Community Development (ABCD)

Community-driven identification and mobilisation of assets/skills/resources/capacities (individuals', universal and local community).

Appreciative Inquiry (AI)

An appreciative inquiry approach to professional practice, evaluation or organisational development aims to discover what energises people and what they most care about, to produce both shared knowledge and motivation for action. It uses a positive style of inquiry that builds from what works in a situation, rather than what the perceived problems are.

Deprivation of Liberty Safeguards

Administrative procedures (introduced to the UK in 2009, as amendments to the Mental Capacity Act 2005) to ensure the Mental Capacity Act's processes are observed in cases of adults who are, or may be, deprived of their liberty in care homes or hospitals. They seek to protect health and social care providers from prosecution under human rights legislation. Key elements include that the person must be provided with a representative and given the right to challenge the deprivation of liberty through the Court of Protection.

Ecological Approach (EA)

Emphasis on individuals, families, society and policies interacting together in a particular place or community – to identify strengths of the transactional and relational processes between each of these systems. Linked to ways of understanding social problems as complex systems.

Family Group Conference (FGC)

It is a family led approach, that brings together family (immediate/extended, friends and professional) to address concerns and identify solutions that would benefit the entire family.

Implementation

The constellation of processes intended to get an intervention into use within an organisation; the means by which an intervention is assimilated into an organization. Implementation is the processes and activities between a decision to adopt an intervention and the routine use of that intervention; the transition period during which targeted stakeholders become increasingly skilful, consistent, and committed in their use of an intervention.

Local Area Coordination (LAC)

Focuses on collaboration of various services (health, public health, emergency, housing, children, and family services) to offer one access point for the individuals. Building partnerships with the local community to strengthen outcomes.

Motivational Interviewing (MI)

Technique to support people regaining and keeping the motivation they require to be better at tackling/addressing/changing behaviours that may be holding them back from regaining skills.

Making Safeguarding Personal (MSP)

A personalised, outcomes-focused approach that enables safeguarding to be 'done with, not to, people'. The approach is based on principles of: co-production; enabling conversations about what matters to people and asking the right questions; focusing on desired and negotiated outcomes, and how people wish to achieve them. It started as a national programme (in England in 2009, and piloted in over 50 local authorities in 2013/14.

Mental Capacity Act 2005

The Mental Capacity Act 2005 is the law (in England and Wales, with subsequent amendments) that tells people what they can do to plan ahead in case they cannot make decisions for themselves, how they can ask someone else to make decisions for them and who can make decisions for them if they have not made such plans. The equivalent law in Scotland is The Adults with Incapacity (Scotland) Act 2000.

Narrative Approaches (NA)

Elucidates strengths of individuals and communities. Practitioners using this approach assume that hidden inside any 'problem' narrative is a story of strength and resilience. This will often require re-framing of the situation to highlight any unique instances of strengths into a story of resilience.

Person-centred Approaches (PCA)

Supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and wellbeing. It is coordinated and tailored to the needs of the individual. Ensuring that people are always treated with dignity, compassion and respect.

Solution-Focused Therapy (or approach; SFT)

Focused on identification of individual goals and the ways in which these goals can be achieved. Solution rather than problem focussed.

Recovery Model (RM)

(Related to mental health). Focuses on regaining a sense of purpose and control rather than being 'symptom free'. Future opportunity oriented.

Restorative Practice (RP)

Focuses on getting individuals to speak, acknowledging the harm and repairing relationships.

Strengths-based Assessment (SBA)

Rather than risk assessment this approach focuses on strength assessment (of both individuals and carers).

Strengths-based Approach (SBA) or Asset-based Approach

Identifies the individual's strengths – personal, community or social networks – and maximises those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving and maintaining their wellbeing.

Strengths-based Case Management (SBCM)

Combines a focus on individual's strengths with three other principles: promoting the use of informal supportive networks; offering assertive community involvement by case managers; and emphasising the relationship between the client and case manager. It is an approach that helps participants achieve specific desired outcomes.

Systemic Social Work (SSW)

A way of acting, thinking and viewing the world, which focuses on relationships and recognises that individuals are always embedded in their social context.

Relationship patterns both enable and limit processes of development and change. Meaning that problems in families are always part of larger processes. This implies that individuals cannot act entirely on their own, either for good or bad. Change in one part of a relational pattern, or system, can be expected to create adjustments throughout the family and immediate context.

Signs of Safety and Wellbeing

An evidenced-based method originally developed for child welfare. The Signs of Safety and Wellbeing Practice Framework is a strengths/asset-based, solution-focused approach with an emphasis on professional judgements about need and wellbeing. It offers an integrated practice framework, in which each case is mapped out with structured questioning and analysis toward forming a professional judgement.(Based on definition in: Strengths-based Working, Roundtable Report, Dept. of Health 2017)[1]

The Care Act 2014

The Care Act 2014 requires local authorities to consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' in considering 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve. (Based on definition in: SCIE: Care Act guidance on strengths-based approaches, 2015)[2]

Three Conversations Model (TCM)

A person-focussed approach to needs assessment and care planning. Focusing primarily on people's strengths and community assets. Supports frontline professionals to have three distinct and specific conversations. The first conversation is designed to explore people's needs and connect them to personal, family and community sources of support that may be available. The second, client-led, conversation seeks to assess levels of risk and any crisis contingencies that may be needed, and how to address these.' The third and final conversation focuses on long-term outcomes and planning, built around what a good life looks like to the user, and how best to mobilise the resources needed (including personal budgets), and the personal and community assets available.

Plain English summary

The problem

A ‘strengths-based approach’ to social work focusses on peoples’ goals rather than their problems, and builds on their existing skills, resources and relationships. While strengths-based approaches are being adopted by professionals and practised in communities, their application is variable.

Our aims and methods

We aimed to find and summarise research about whether strengths-based approaches work, or what factors may influence whether and how they are used. We identified seventeen different strengths-based approaches that are used within adult social work in the UK. We then searched for research that examined if these approaches were helpful in supporting people to achieve their goals or highlighted issues which affected how strengths-based approaches were used.

Main messages

We found no studies which looked at how effective strengths-based approaches were compared to traditional approaches to social work. Seven studies identified key issues related to how one UK based strengths-based approach, Making Safeguarding Personal (MSP), was put into practice. Its use depended on: how easy social workers thought using this approach was; to what extent their workplace environment and resources made it practical for them to use MSP; social workers’ personal beliefs and training; how the understanding of MSP was used within practice. We also found one or two studies on the following seven strengths-based approaches: Local Area Coordination, Solution Focussed Therapy, Asset-based Community Development, Relationships-based Approaches, Motivational Interviewing, and Family Group Conferencing. In general, issues which affected the use of MSP were similar to those found for the other approaches.

Conclusion

We did not find evidence on the effectiveness of strengths-based approaches. The successful application of MSP in particular (and other approaches more generally) was influenced by

some distinct features of strengths-based approaches, and how and within what contexts these approaches were being used to provide support.

Scientific summary

Background

Under the Care Act of 2014,[3] social workers and local authorities have to: 'consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' and consider 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve'. (Social Care Institute of Excellence, 2015 – cited with permission)[2]

Under this approach, assessing someone's support needs and capabilities should look at a person's life holistically, and consider their needs in the context of their skills, ambitions, and priorities. Social workers therefore should identify an individual's strengths – personal, community and social networks – and maximise those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving or maintaining their wellbeing. This approach to social work practice has come to be known as a *strengths-based approach*.

The application of strengths-based approaches have been advocated and adopted for a long time in social work with adults. While many social care professionals and care organisations have effectively adopted more person-centric and strengths-based approaches and have responded to calls to practice in a strengths-based way, they have also highlighted the challenges of doing this within organisational and resource constraints. Also, there are stronger and more specific legislative imperatives for social workers to work in a strengths-based way than apply to social care provision more widely.

The difficulty of incorporating the features of strengths-based approaches into a single integrated model, or an easily defined strengths-based intervention, contributes to the tension described above. While strengths-based approaches are about meeting a person's needs and goals, social workers must also adjust the principles of strengths-based working to achieve the best fit to their organisation's and community's circumstances.

Within this evolving context, the current systematic review was commissioned by National Institute of Heath Research on behalf of the Chief Social Worker for Adults in the Department of Health and Social Care, to identify and summarise the most rigorous and relevant evidence of the effectiveness of strengths-based approaches to social work practice, and other evidence

that might inform the effective implementation of strengths-based approaches. Two experienced social work professionals were closely involved in the project, as a co-researcher (GO) and as an expert adviser (SB).

Objectives:

The aim of this systematic review was to summarise and synthesise evidence on strengths-based approaches used in the area of adult social care in the UK. It aimed to answer the following two questions:

Research question one:

> What is the effectiveness of different strengths-based approaches used within adult social work within the UK?

Research question two:

> What factors enable or inhibit the implementation of different strengths-based approaches in adult social work within the UK?

Methods

We searched seven bibliographic databases to identify quantitative and qualitative research evidence from the UK about the effectiveness and implementation of strengths-based approaches in the area of adult social care: MEDLINE ALL, PsycINFO, Social Policy and Practice, HMIC, CINAHL, ASSIA and the Campbell Library. We also screened the reference lists of included studies and conducted searches of relevant websites and the Google Search engine. .

To assess effectiveness research we aimed to include all comparative evaluation study designs (e.g., randomised and non-randomised controlled trials). Effectiveness was defined as improvements in the lives and wellbeing of those adults, families or communities being supported by social workers. To assess factors influencing implementation of the strengths-based approaches, we sought qualitative evaluative studies that included a focus on the process of implementation of the strengths-based approaches. This enabled the potential inclusion of the perspectives of people being supported, carers, family members, social work professionals, policy makers and legal professionals.

Study selection, data extraction and critical appraisal were completed independently by two reviewers, with disagreements resolved by involvement of a third reviewer. Data were extracted, critically appraised and analysed using a framework synthesis approach for those strengths-based approaches where we found sufficient studies.

Framework synthesis was used to synthesise qualitative evidence relevant to research question two. Themes and subthemes within the initial framework were based on the main domains of the Consolidated Framework for Implementation Research (CFIR). The relevant data were initially extracted into the CFIR framework using the three studies that contributed the most relevant data. The themes underwent their final revision by referring to the extracted data within each theme.. The findings of studies where data were not synthesised were summarised descriptively.

Findings

Of 5,030 studies screened, none met our criteria for the effectiveness question. Fifteen qualitative or mixed methods studies met the inclusion criteria for the implementation question. Seven studies examined Making Safeguarding Personal (MSP) and the remaining eight studies examined Local Area Coordination, Solution Focused Therapy, Family Group Conferencing, Asset-based Community Development, Strengths-based with Relationship-based Approach, Asset-based approaches, and Motivational Interviewing.

The quality of the evidence included in this review was mixed; of the seven studies about MSP, two studies were graded at 'good quality' and five as 'poor quality'. Of the eight studies about the other strengths-based approaches, the ones about Asset-Based Community Development, Relationship-Based Approaches, Family Group Conferences, and one (of two_ studies) about Solution Focused Therapy were graded as 'good quality', with the others graded as poor. Framework synthesis was applied to the seven studies about MSP, with the findings from the other eight studies (seven approaches) summarised separately and descriptively.

Making Safeguarding Personal is a personalised approach that enables safeguarding to be 'done with, not to, people'. In this approach practitioners work towards objectives developed and agreed in collaboration with the people who need support. The approach is based on principles of: co-production; enabling conversations about what matters to people, and focusing on

desired outcomes. The seven included studies about MSP were conducted between 2015 and 2018, and included evidence provided by a range of study sites (from most local councils in England, to a single London Borough). Four themes emerged from the framework synthesis of the MSP implementation studies: the nature of MSP as an intervention; Culture and setting; Individual characteristics; and Embedding and sustaining MSP. All four themes are descriptive, inter-related and provide insight into factors which enable or inhibit the implementation of MSP.

The first theme, *Making Safeguarding Personal as an intervention*, highlighted that the successful implementation of MSP in different councils was associated with being able to adapt it to multiple settings, its simplicity (vs complexity), and whether it was seen as evidence-based and advantageous compared to traditional approaches of safeguarding. As a new intervention or approach, there were some negative views, including those about the additional investment in time and resources required to deliver MSP. However, the advantages and benefits of MSP for people in the longer term were believed by most respondents to outweigh these potential disadvantages. Implementation was also affected by the perceived strength and quality of evidence supporting the effectiveness of MSP. But rather than comprising formal research-based evidence, the underlying evidence tended to derive from local evaluation experience and more gradual learning.

The adaptability of the MSP approach was also found to be a critical determinant of successful implementation. Challenges included the need for many different people to engage with it (those seeking support, and professional and non-professional carers), and changes required to enable its use by partner agencies who work with local authorities (for example, acute hospitals, perhaps used to more traditional approaches to safeguarding). Findings suggested that more support was needed during implementation to identify which specific features of MSP might need to be adapted, and which features should be regarded as 'core' or essential in order to retain the anticipated benefits. The perceived complexity of introducing and sustaining MSP, relative to existing resources, existing professional capabilities, and competing priorities, also affected implementation success.

The second theme, *Culture and setting*, highlighted that both the broader setting, across different local authorities and partner organisations, government policies and legal

frameworks, and the 'internal setting' of the local authority, council and adult social work teams delivering MSP, had important impacts on the implementation process. The implementation of MSP required shifts in the culture of organisations and professionals, especially towards more person-centred and outcome-oriented approaches, following the 2014 Care Act. Culture change was enabled by, and required, leadership in adopting strengths-based approaches and the involvement in support processes of people being supported (e.g. family group conferences). Good inter-organisational collaboration and connectedness (e.g. between councils, with the NHS, with care homes) was also found to foster successful implementation of MSP ('cosmopolitanism').

Various structural characteristics, including size of the service or organisation, its staff capacity and access to services within the wider adult social care system affected the implementation of MSP, with most studies showing that smaller services and those with specialist safeguarding teams often finding it easier to implement. However, one study suggested smaller teams found it harder to implement MSP, because they suffered from lower staff morale due to high workloads. This may reduce their actual or perceived capacity or efficacy in implementing new models of care.

All seven studies about MSP discussed the impact of policies and regulations on the implementation of MSP. These might be external (national) policies or internal (local, council) policies and regulations. The Care Act of 2014 and Mental Capacity Act of 2005 were the national policies most often cited as driving change. However, some requirements of legislation, such as the need for training and specific knowledge (e.g. in relation to Deprivation of Liberty Safeguards), or tensions between the goals of autonomy/rights and protection, could make implementing MSP more challenging. Also local policies and procedures were sometimes not well-aligned with MSP approaches, and this could hinder implementation.

The third theme, *Individual characteristics*, included the influence of social workers'/social care professionals' and characteristics of people being supported. The implementation of MSP was affected by professional characteristics of care professionals such as: their confidence in their professional judgment and ability to execute MSP; creativity (especially in using limited available resources); enthusiasm, and resistance to change from using a traditional deficit-based approach to safeguarding. Implementation was also believed to be more successful when

providers had good knowledge about MSP, both its core principles and specific skills. Lastly, the successful implementation of MSP critically depended on the ability of providers to involve people meaningfully in decisions about their care and motivate them to attend meetings. However, there were particular challenges associated with involving those who lacked mental capacity or were vulnerable.

The last theme, *Embedding and sustaining Making Safeguarding Personal*, captured factors related to the embedding process and the factors related to embedding and sustaining MSP within the social care system – including the absorptive capacity for change within teams and organisations. Successful implementation processes were associated with effective planning, effective engagement with relevant stakeholders, and effective execution or delivery. A receptive implementation climate was dependent on the availability of sufficient resources (including training and skills), having committed and accountable leadership, and effective communication between people being supported and providers about shared goals. The resources required for the ongoing successful implementation of MSP, or similar approaches, include training and supervision of the staff, but also other specialised systems based on the need of the organisation(s), including technological systems, infrastructure, and physical space.

Strengths and limitations of the evidence found

There were no effectiveness studies that met our inclusion criteria (research question one). We only found enough (seven) studies reporting qualitative findings about implementation of the same strengths-based approaches in the UK. These studies examined Making Safeguarding Personal. We found one or pairs of studies about implementation for each of seven other approaches, and no studies in relation to nine of the named strengths-based approaches which were a focus of the review. While the assessed quality of included studies in the synthesis of studies about MSP was generally good, the overall quality of all studies included in this review was mixed, as six studies were graded at 'good quality' and nine as 'poor quality'. Our stakeholders suggest that some of the insights and experiences from implementation of MSP might be applicable to other strengths-based approaches in the UK. However, MSP is quite a specialised model of professional practice for certain situations, and is not as preventative as some other strengths-based approaches, so the applicability to other strengths-based approaches cannot be presumed.

In relation to the other strengths-based approaches that were discussed within the scope of this review (e.g., Motivational Interviewing, Solution Focused Therapy, Local Area Coordination, Asset-based Approaches and Family Group Conferencing), it was evident that the factors that influenced the implementation of MSP also often impacted the delivery of these other approaches within services. Studies that examined Solution Focussed Therapy and Motivational Interviewing emphasised the importance of professionals' characteristics and their attitude towards the adoption of these strengths-based approaches. This was related to professionals' ability to deliver care, which was closely aligned to their training and how well they were supervised. External collaborations with other agencies involved in providing care and support of leadership and stakeholders were identified as critical factors in implementing Asset-based Approaches, Local Area Coordination and Asset-Based Community Development. These findings suggest that some mechanisms of implementation of approaches under the umbrella 'strengths-based working' may be common.

Strengths and limitations of our methods

The review was rigorously conducted in line with guidelines for current best methods. However a more in-depth, inductive analysis of the included studies may have elicited richer explanations of the implementation of new ways of working; but this would also rely on having more conceptually rich and fully reported studies. Our findings are mainly limited by the lack of available evidence in the UK.

Conclusion

There are no comparative effectiveness studies to inform whether any of the 17 strengths-based approaches is associated with better outcomes for the people, families or communities being supported. We found 15 UK studies about implementation of eight different strengths-based approaches.

From synthesising evidence from seven studies about implementing Making Safeguarding Personal (MSP), we identified a range of factors that were associated with successful implementation of this strengths-based. Since similar implementation factors emerged across studies that examined other strengths-based approaches, these factors may help inform the wider implementation of many strengths-based approaches within social work in the UK.

There is a need for more and higher quality research evidence that has evaluated the effectiveness and/or implementation of strengths-based approaches to social work practice. In particular, future research about strengths-based approaches should aim to capture a range of notions of effectiveness, from multiple theoretical or professional perspectives, and at different levels (individual, family and community) and over different timescales. Given the person-centred nature of strengths-based working and the relationship-oriented goals, the evaluation approaches should also be participatory, with authentic engagement with the people and communities being supported.

Study registration

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1 Background

The Care Act 2014[3] requires local authorities – and thereby also social workers - to 'consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help' and consider 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve'. (Social Care Institute of Excellence, 2015 – cited with permission)[2] The person assessing someone's support needs should use 'an approach that looks at a person's life holistically, considering their needs in the context of their skills, ambitions, and priorities'.[2] Under this way of working social workers need to identify an individual's strengths – personal, community and social networks – and maximise those strengths to enable them to achieve their desired outcomes and maintain their wellbeing. This approach to social work practice has come to be known as a *strengths-based approach*.

While the Care Act 2014 has given formal, legal impetus to the implementation of strengths-based approaches, and subsequent reports from the Social Care Institute of Excellence and the Department of Health and Social Care have further encouraged the effective use of a strengths-based approach, [1, 4] the basic tenets of strengths-based working have been advocated and adopted by social workers for decades. Strengths-based approaches in social work with adults are widely accepted as a means of achieving positive outcomes by realising the inherent potential of people and communities. Indeed, the internationally accepted definition of the social work profession has at its core the concept of working with strengths, not as a possible model or approach in social work, but as a defining feature of social work practice itself:

> "Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. " International Federation of Social Work, 2014 [5]

In the UK, strengths-based working is also a defining feature of practice, being a standard that registered social workers must achieve in order to maintain their professional status:

> "Standard 1. Promote the rights, strengths and wellbeing of people, families and communities" Social Work England 2020[6]

In the UK social care system, the promotion of strengths-based approaches is also frequently conceptualised in terms of "*cultural change*" in the relevant professions with the desired culture being contrasted with *"… working from a Care Management-deficit-based-needs led, perspective"*. [7] Duffy's (2011) promotion of a shift away from a Professional Gift Model towards a Citizenship Model also contrasts strengths-based working with paternalistic systems and practice of an earlier time. [8]

Although a strengths-based approach seems an inherently good thing and has been embraced by many as a positive initiative that aligns with professional values and code of conduct for social workers, it is also a source of contention. Some experienced social workers see the perceived need to foster strengths-based approaches as an implicit suggestion of widespread deficiency of existing social work practice. For example, some frontline social workers have responded to calls to practice in a strengths-based way by pointing out that they have always sought to do so, but against limits set by organisational and resource constraints. [9, 10]

The difficulty of defining and incorporating the features of strengths-based approaches into a single integrated model, or an easily defined strengths-based intervention, may have slowed its adoption. It may also help explain why evidence of the effectiveness of strengths-based approaches remains elusive. Strengths-based working is an inherently variable practice; it operates at the level of each individual and their interaction with others in their immediate circle and wider community. It is perhaps best seen as an 'approach' implemented (at an individual or a community level) by combining various practices rather than a neatly defined or standardised 'intervention'. Social workers must adjust the principles of strengths-based working to achieve the best fit to the unique configurations of each adult or family's circumstances. Unless such adaptation adjustments are recorded and understood, this limits the usefulness of conventional outcome evaluations (which are typically based on establishing the effectiveness of standardised interventions which might be 'replicated').

The diversity of needs and practice in the field of adult social care contributes further to the problem described above. Differences in the nature and severity of needs and circumstances between individuals have a strong influence on how a social worker might try to engage them in strengths-based work. Inevitably, some situations hold greater potential for support and progress than others. This links to an important practice issue, i.e. that the current emphasis on

strengths-based working does not address sufficiently; that is, the circumstances of those with less capacity to respond to it. [11, 12]

Lastly, but perhaps most importantly, previous systematic reviews of the effectiveness of interventions or approaches for social work in adults have revealed very little good quality effectiveness research, and much of what does exist relates to social work in the USA. [13]

Evidence for improving implementation

Strengths-based approaches are strongly endorsed by legislation and other major policies, and the principles are widely supported by many social workers and align with the core values of social work, yet they are still unevenly adopted. There has therefore been a growing perceived need to understand better how the approaches could be implemented more widely and consistently. This aim, for example, was the main purpose of the jointly published Practice Framework and Practice Handbook on the strengths-based approach. [4]

> *"… many social workers and social care professionals we met fundamentally supported a strengths-based approach within adult social work and social care but often found it difficult to demonstrate, evidence and practice such an approach in practice"* (in the Foreword by Carmen Colomina and Tricia Pereira, p.23)

Similarly, an earlier workshop and report commissioned by the Department of Health and hosted by the Social Care Institute of Excellence[1] sought to identify "the practitioner skills and organisational models needed to implement and embed strengths-based solutions which meet local needs"(p.4). So, while the need to generate and identify evidence of effectiveness has not been abandoned - and it is acknowledged that something as conceptual and relational as strengths-based working presents evaluation challenges - the current need for evidence has shifted to how strengths-based approaches can be more effectively and widely implemented. [7]

1.1 Key definitions

There are a variety definitions of what a strengths-based approach to social work involves or seeks to achieve.

Recent authoritative sources from the UK define a strengths-based approach to social work as one which:

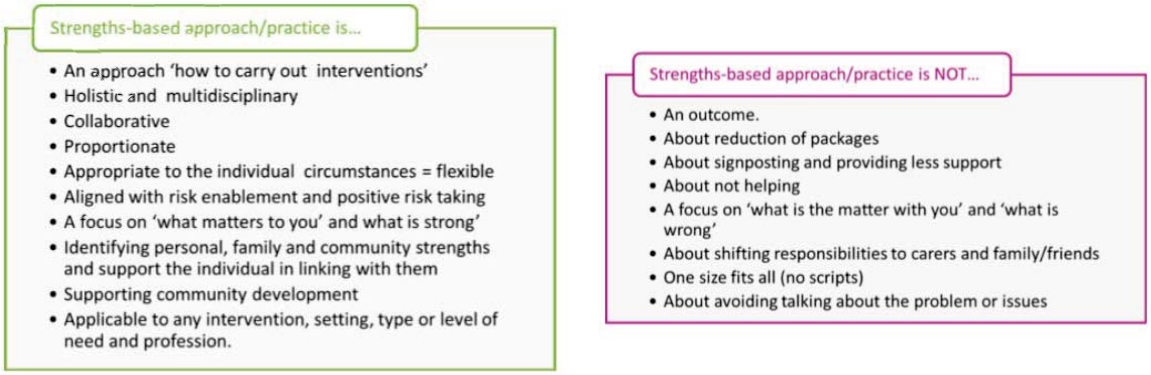
- Identifies the individual's strengths – personal, community or social networks – and maximises those strengths to enable them to achieve their desired outcomes, thereby meeting their needs and improving and maintaining their wellbeing. [2]
- Protects the individual's independence, resilience, ability to make choices and wellbeing.
- Concentrates on the inherent strengths of individuals, families, groups and organisations, deploying personal strengths to aid recovery and empowerment. [14]
- Explores, in a collaborative way the entire individual's abilities and their circumstances rather than making the deficit the focus of attention. This requires gathering a holistic picture of the individual's life; therefore it is important to engage and work with others (i.e. health professionals, providers, the individual's own network, etc.). [4]

The phrases 'strengths-based approach' and 'asset-based approach' are often used interchangeably. The term 'strength' refers to different elements that help or enable the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes in particular. These elements include:

- Their personal resources, abilities, skills, knowledge, potential, etc.
- Their social network and its resources, abilities, skills, etc.
- Community resources, also known as 'social capital' and/or 'universal resources.'[2]

To understand what a strengths-based approach is, it is also useful to highlight what a strengths-based approach is *not* – that is, the kinds of approaches to social work that it seeks to replace or avoid. Figure 1 below shows these according to a recent DHSC report.

Figure 1. Defining features of a strengths-based approach



Source: Baron et al (with DHSC) (2019) Strengths-based approach: Practice Framework and Practice Handbook. [4]

There are also different ways in which the effectiveness of strength-based approaches could be conceptualised and evaluated. The definition of effectiveness that this review uses derived from our understanding of the policy customer's remit to identify and summarise rigorous research evidence of effectiveness. This conventionally means comparative effectiveness which is captured by differences or changes in quantitative indicators (or 'outcomes') of intended improvements in the wellbeing, functioning or capabilities of those people seeking adult social care support or being assessed by social workers. Rigorous evaluations based on this concept of effectiveness would need to come from comparative studies, which include quantitative outcome data from groups of people exposed to or receiving strengths-based approaches, and data from those not exposed to the strengths-based approach(es) of interest. Where studies have been based on outcomes valued by and reported by the people getting support this would, we believe, be consistent with the person-centred principles of a strengths-based approach.

However, we acknowledge that in different domains of professional practice, and for those from different academic disciplines, the concept of effectiveness varies. In particular, in social work practice it is contentious whether the effectiveness of practice should ideally be captured through standard, quantitative measures, or can also be assessed through qualitative methods or the observations and experiences of professionals.[15] Furthermore, since most strengths-based approaches inherently aim to change *the way* people work and the *quality* of the relationships developed, there is a reasonable argument that these more intermediate and qualitative indicators of positive change could also be the focus of such a review of effectiveness.

1.2 Scoping the review topic

For the purposes of developing literature search terms, and better capturing the varied and nebulous nature of different approaches that are seen as fostering a strengths-based approach, we reviewed the following sources in order to produce a comprehensive list of those named strategies and approaches which are most frequently seen as closely aligned to strengths-based approaches to social work, or which aim to foster a strengths-based approach.

- IRISS Report on Strengths-based approaches for working with individuals. [14]
- Notes from phone call with Lyn Romeo (Chief Social Worker for Adults, DHSC; 9th September 2019).
- Table of Social Work Theory and Methods, annotated by Lyn Romeo to highlight those seen as closely aligned to a strengths-based approach).
- 'Bubble Diagram' (slide 2) in Roundtable presentation by Lyn Romeo (diagram source cited as: Dr A Howard, Newcastle University). [1]
- Joint DHSC-SCIE Webinar on Strengths-Based approaches to social work. [16]
- The DHSC's Strengths-based approach: Practice Framework and Practice Handbook. [4]
- Social Care Institute of Excellence: Roundtable Report. [1]

The final list of 17 named strengths-based approaches (those which are seen as either closely aligned to or as fostering a strengths-based approach within adult social work) that we used as a basis for this systematic review, is:

Asset-Based Community Development (ABCD)*

Appreciative Inquiry (AI)*

Ecological Approach (EA)

Family Group Conference (FGC)*

Local Area Coordination (LAC) *

Motivational Interviewing (MI)

Making Safeguarding Personal (MSP)

Narrative Approaches (NA)

Person-centred Approaches (PCA)

Recovery Model (RM)

Restorative Practice (RP)

Strengths-based Assessments (SBAS)*

Strengths-based Case Management (SBCM)

Solution-focused Therapy (SFT) / Solution Focused Approach

Systemic Social Work (SSW)

Signs of Safety and Wellbeing (SSW)

Three Conversations Model (TCM)*

It is worth noting that some of these are distinct organisational models of adult social care and service improvement across whole communities, while others are more specific approaches to social work practice (that is the knowledge, skills and behaviours used by individual care professionals). Relatedly, while some are delivered at an individual level (e.g. Motivational Interviewing or Solution-Focused Therapy) others can only be provided at the scale of whole groups or communities (e.g., Asset-Based Community Development).

1.3 Research Questions:

Research question one:

> What is the effectiveness of different strengths-based approaches used within adult social work within the UK?

Research question two:

> What factors enable or inhibit the implementation of different strengths-based approaches in adult social work within the UK?

For the purposes of this review, we aimed to answer research question one using rigorous quantitative evidence of comparative effectiveness; and research question two using high quality qualitative evidence of factors enabling or inhibiting implementation.

2 Methods

We conducted a systematic review of effectiveness evidence and evidence relevant to implementation. The methods used to identify and synthesise evidence followed the best practice approach recommended by the University of York's Centre for Reviews and Dissemination. The protocol for this systematic review was registered on the PROSPERO database (PROSPERO CRD42020166870). This report meets the PRISMA guidelines for reporting of systematic reviews.[17]

Two experienced social work professionals were closely involved in the project, as a co-researcher on the main evidence interpretation stages (co-author O'Rourke) and as an expert adviser (co-author Baron).

2.1 Search strategy

Identification of studies

We identified studies by searching an appropriate selection of bibliographic databases, screening the reference lists of all included studies and web searching using Google Search and topically relevant websites.

The bibliographic database search strategy was developed using MEDLINE (via Ovid) by an information specialist (SB) in consultation with the review team. Search terms were derived from the titles, abstracts and indexing terms (e.g. MeSH in MEDLINE) of relevant studies identified by background searches and supplemented with relevant synonyms. We also derived search terms from the list of strengths-based approaches supplied by social work and social care experts (see section 1.2). Careful attention was given to ensuring an appropriate balance of specificity (i.e. minimising the retrieval of irrelevant studies) and sensitivity (i.e. retrieval of all relevant studies) when constructing the search strategy. Pre-identified relevant studies were used to benchmark test the search strategy and to refine the balance of sensitivity and specificity.

The final search strategy consisted of two strands. The first strand used search terms for social work combined with generic search terms for SBA, e.g. "strengths approaches", "strengths based" and "strengths perspectives". The second strand used search terms for specific types of

SBA, e.g. “asset based community development”, “family group conference” and “solution focused”. Some of the terms in the second strand were combined with search terms for social work, and some were sufficiently limited to social work literature by definition to be searched by themselves.

The final search strategy was translated for use in an appropriate selection of bibliographic databases including:

ASSIA (via ProQuest)
Campbell Library (via the Campbell Collaboration website)
CINAHL (via EBSCO)
HMIC (via Ovid)
MEDLINE ALL (via Ovid)
PsycINFO (via Ovid)
Social Policy and Practice (via Ovid)

All bibliographic database searches were carried out in November 2019. No date or language limits were used. The search strategies and number of results retrieved for each bibliographic database are reported in sections A.1.1 and A.1.2, appendix 1. The search results were exported to Endnote X8 (Clarivate Analytics, Philadelphia, PA, USA) and de-duplicated using the automated de-duplication feature and manual checking.

To extend the rigour of the review, backward citation chasing was conducted to identify relevant literature. The reference lists of all included studies were identified via either Web of Science, or Scopus, depending on where each included study was indexed. The reference lists were exported to Endnote X8 and screened, and any potentially relevant studies were retrieved and taken forward to full-text screening. Three websites were also searched using keyword searches: the British Association of Social Workers and Social Care (https://www.basw.co.uk/), Social Care Institute for Excellence (https://www.scie.org.uk/) and the Association of Directors of Adult Social Services (https://www.adass.org.uk/). The search terms for each website are reported in section A.1.3, appendix 1.). Supplementary and Google Search search strategies used to find potentially relevant studies were same for research questions one and two.

Finally, we used Google Search to search for grey literature evaluation reports of SBAs conducted by UK local councils. Web searches related to LAC, MSP and SFT approaches were undertaken in February 2020, while web searches for remaining approaches were undertaken in April 2020. Searches were limited to the UK government domain suffix "gov.uk", which is the domain suffix used by UK local councils, using the "site: gov.uk" command in Google Search. Searches were also limited to PDF files using the "filetype: PDF" command, which improved the effectiveness of the search for retrieving evaluation reports (see sections A.1.4, appendix 1). The results were screened until saturation, i.e. until the results duplicated or were substantially similar (e.g. the same local council website) to the results that had been already screened. Given that web reports and sources do not provide title and abstracts, we followed the links on the Google search page to access full report to screen and assess whether the document was of relevance. While screening titles and abstracts for approaches that are adopted within integrated care models, e.g., "asset based approach", search terms such as "social work" and "strengths-based social work" were used to check if the studies were conducted within the context of adult social work. These searches were conducted for all SBAs which were prioritised for evidence synthesis and closely aligned or seen as fostering a strength-based approach within adult social work. A record for the relevant studies identified during the web search was maintained using Microsoft Word.

The search strategies and number of results retrieved and screened are reported in Appendix 1.

2.2 Inclusion and exclusion criteria

The following inclusion and exclusion criteria, based on the PICO categories (Population, phenomenon of Interest, Context, and Outcomes), were applied to the studies identified.

Population:

Inclusion of studies with any adult (≥18 years of age) or groups of adults being supported or assessed by social workers working in adult social care in the UK. Any social workers involved in providing adult social care.

Intervention

Inclusion of both effectiveness (research question one) and implementation (research question two) studies about any of the 17 subsidiary approaches to a SBA identified through background

scoping of key policy documents, and from input from policy customers at the DHSC (see list in appendix 2). There should also be some evidence that social workers (or adult social care teams) provide or are involved in providing the particular approach to support.

Comparator(s)

For research question one: Any area, service or teams of social workers who have *not adopted* the given subsidiary strengths-based approach - or *before they adopted* the given subsidiary approach. Or, studies which have compared two or more subsidiary approaches for fostering a SBA to social work.

For research question two: This criterion is not applicable.

Outcomes

For research question one: Any measures of outcome used in included studies, whether directly relating to people's outcomes or outcomes at the level of families or communities.

For both research questions (one and two): Any markers or indicators of the degree of adoption or adherence to a strengths-based approach or the particular subsidiary approach by social workers (or social care teams).

Study design

For research question one: Any of the following comparative study designs were included:

- Randomised controlled trial.
- (Non-randomised) controlled trial.
- Controlled before and after study.
- Interrupted time series study/repeated measures study.
- Uncontrolled before-and-after studies.

We excluded studies addressing research question one if these were:

Descriptive case series, cross-sectional, commentaries, opinion pieces, editorials or clinical audits.

For research question two: Studies were included if they collected qualitative data using any of the following study designs (first three bullet points) and data collection methods (last three bullet points):

- Case studies: based on qualitative or mixed qualitative-quantitative data, when the 'case(s)' examined or compared is at the level of the group (e.g. team, social care department) adopting a given approach.
- Mixed methods, if there is a qualitative (e.g. interviews, focus groups) element.
- Secondary qualitative data (evidence synthesis): if it is a systematic review looking at implementation of SBA in a number of settings/studies.
- Focus groups
- Interviews
- Training workshops

Exclude studies addressing research question two if these:

Do not have evaluative intent, define implementation as user's perception, do not focus on the process of implementation, do not have a clear qualitative component (in the case of mixed methods studies), or report case studies where the cases are individual people.

Geographical context

Studies from the UK only.

Date of publication

No date restriction.

2.3 Study selection processes

Searches were performed and all results were downloaded into Endnote (Endnote X8, Thomson Reuters, New York, USA) for removal of duplicate records. As an initial calibration exercise of inclusion judgments and refine inclusion criteria, the reviewers (AP, LA, CB, and RA)

conducted a pilot screening exercise on a sample of studies (n=100) from the bibliographic database searches. Decisions were discussed in a face-to-face meeting to ensure consistent application of inclusion criteria. Where necessary, inclusion and exclusion criteria were revised to reflect reviewer interpretation and judgement. To assess the consistency of decisions using the revised inclusion criteria, a second pilot screening exercise was conducted by the review team (n=100).

The revised eligibility criteria were then applied to the title and abstract of each identified citation independently assessed by two reviewers (AP, LA, CB, and RA). Disagreements were discussed in pairs and resolved. Unresolved disagreements were discussed at a group meeting to arrive at a consensus. There was only one search process, but the title-and-abstract screening and full-text screening was applied separately for the two research questions.

The full text of relevant studies taken forward from title and abstract screening was assessed independently for inclusion by two reviewers (LA and AP). Disagreements were settled by discussion with a third reviewer when necessary.

Endnote software was used to manage the references. Reasons for exclusion were recorded at full text screening and documented in a PRISMA flowchart.

2.4 Data extraction and quality assessment

A data extraction form was developed using Microsoft Excel, piloted by AP, LA, and CB and refined accordingly.

For both research questions one and two: We intended to extract the summary data for each study included after full text screening by one reviewer (AP, LA, or CB) to be checked by a second reviewer (AP, LA, or CB). Extracted data included first author, date of source, title of source, focus/aim of source, sample size, sample demographics, details of the evaluated subsidiary strengths-based approaches, data collection technique (e.g. RCT, survey, interviews, focus group), type of analysis performed, and findings or ideas relevant to research questions. For research question one, we intended to extract data like means and SD at post intervention whereas for research question two extracting both first (data by participants of the study) and second order data (author's recommendations and data interpretation) was the aim.

Extraction of data:

For research question one: We intended to use a standardised, piloted data extraction form in Microsoft Excel to collect data from each included paper. It was agreed that data extraction would be performed by one reviewer (LA, AP) and checked by a second (LA, AP), with disagreements being settled through discussion with a third (CB, RA). This excel sheet was designed to extract detailed information on the approach used within the study, population recruited, research methodology, comparators, and outcomes.

For research question two: Participant quotes and author interpretations (i.e. 'first order' and 'second order' construct data), from the results section of the included articles was extracted by one reviewer (LA, AP) into the Consolidated Framework for Implementation Research (CFIR; see synthesis section below),[18] and checked by a second reviewer (AP, LA).

Study quality assessment:

For research question one: We intended to use the Cochrane Effective Practice and Organisation of Care (EPOC) group's Risk of Bias Tool to appraise the quality of effectiveness studies. This tool is suitable for randomised and non-randomised evaluation study designs.[19, 20]

For research question two: The quality of qualitative studies or the qualitative element in mixed methods studies was appraised using the 'Wallace criteria'. This quality assessment tool, which is a mixture of 'essential' and 'desirable' criteria, is widely used for assessing the quality of qualitative research in a range of fields,[21, 22] including public health.[23, 24] It evaluates quality based on theoretical perspective, appropriateness of the study question, design and context of the study, sampling, quality of data collection and analysis, reflexivity, generalisability, appropriateness, and ethics. For each study, a 'yes' or 'no' was assigned to each criteria, depending on whether it had been met, or if there was insufficient information to assess, then 'can't tell' was indicated.

An overall assessment score was then derived for each study based on methods used in Husk and colleague's Cochrane review;[24] studies were graded as 'good' if all five 'essential' criteria were met, and 'poor' if not. These essential criteria were related to reporting clear information on the research question, study design and data collection, and whether the authors had

substantiated their research finding using their data. The quality assessment provides an important overview of the quality of the evidence contributing to the review and the confidence which can be placed in the synthesised findings. All quality assessments were undertaken by one reviewer and checked by a second (AP, LA), with disagreements settled by discussion with a third reviewer (CB, RA). NB. Although qualitative evidence was rated poor for purposes of this review, the research methods may have been appropriate for articles' intended purposes.

2.5 Methods of synthesis

For research question one: Meta-analysis of effectiveness data was not expected to be justifiable or feasible; this is because there would likely be insufficient homogeneity in the methods, analytical perspective, patient population and other characteristics of the included studies. Thus we intended that data were to be tabulated and discussed narratively for each separate strengths-based approach. Data tables for the effectiveness studies would have included details of the subsidiary approach, care/service setting and its implementation, sample characteristics of the included people population and the outcomes measured and compared. It was intended that narrative synthesis would be used to pool results across studies that evaluated the same model.

For research question two: A pragmatic decision was made to use a framework synthesis approach.[25] Framework synthesis has been recognised for its usefulness in making sense of qualitative evidence with reviews of health research and in improvement and implementation science. [25, 26] To ensure the validity and accessibility of the review findings, evidence was only synthesised for those strengths-based approaches that were evaluated by a minimum of three studies. For the approaches that were examined by less than three studies, the findings were tabulated and summarised descriptively.

Typically, the initial framework used within a framework synthesis would be selected from an existing theory or conceptual model relevant to the field or constructed from a thorough understanding of relevant background literature and related theory.[25, 26] For this review, we used the consolidated framework for implementation research (CFIR) to guide our exploration of research findings relevant to question two (see Appendix5.[18] The CFIR evaluates implementation of health care interventions, producing actionable findings that can help in improving implementation. It provides a framework of the complex and multi-level constructs

relevant to real-world implementation of interventions or service changes in care providing organisations.

The synthesis process used in this review was:

Piloting CFIR framework on three included studies

We initially extracted the first and second-order data we identified as being relevant to the research question within three of our included studies into the CFIR framework, which were selected based on the amount of data that discussed the implementation of MSP. This was undertaken by the review team together as a group (AP, LA and CB). We carefully adapted the framework to reflect the first and second-order data extracted from these initial three studies and operationalised the definitions used within it for this review. Where possible, we used the CFIR wording to maintain consistency of language and terminology, and to support generalisability of findings. In particular, the team discussed levels of evaluation at each of the five domains (intervention characteristics, outer setting, inner setting, characteristics of the individuals involved, and the process of implementation), as SBA involves individual, service and community level factors. We reviewed CFIR domains and themes in light of additional factors that emerged during data extraction of three of the included studies, and mapped these within the CFIR categories.

Applying the adapted framework to the remaining studies:

After the review team (AP, LA, and CB) had discussed constructs from the CFIR in the context of findings that were extracted, they adapted the framework to reflect the first and second-order data extracted from the initial three studies. This revised framework was then utilised to code data from the remaining four studies using a deductive approach. This process was undertaken by one reviewer (LA, AP), and checked by a second (LA, AP).

Final framework revisions:

One reviewer (LA) then revised the framework again, in discussion with a second (AP), using an inductive, iterative process in order to capture current or relevant ideas within the included studies that were not represented by the initial framework. At this stage, the framework was simplified by removing the categories that were not populated (e.g., removed ‘reflecting and evaluating’ sub-category from ‘the implementation process’ category) and names of certain

categories were reworded (e.g., 'other personal attributes' subcategory within the CFIR was changed to 'personal attributes of service providers'). The second reviewer (AP) then summarised findings by theme, using framework matrices. Two studies, (identified through later web searches/citation chasing), were added to the synthesis at a later stage [27, 28]. One reviewer (AP) re-familiarised herself with the existing framework, and extracted data from these two additional studies that fitted into the existing framework, recording any data that did not fit as 'other'. All new data was reviewed against the existing framework, considering where it added to, supported or challenged it. No further framework revisions were necessary. These data were then integrated into final emerging themes, which were written up in detail, supported by data from the included studies, and presented in a summary table (see Table 1). The potential links or relationships between existing themes and subthemes were then explored, as detailed in section 3.4.6. *NB. The synthesised findings were interpreted based on the insights of people with social work experience and adult social care leadership experience (co-authors O'Rourke and Baron).

3 Results

3.1 Study selection

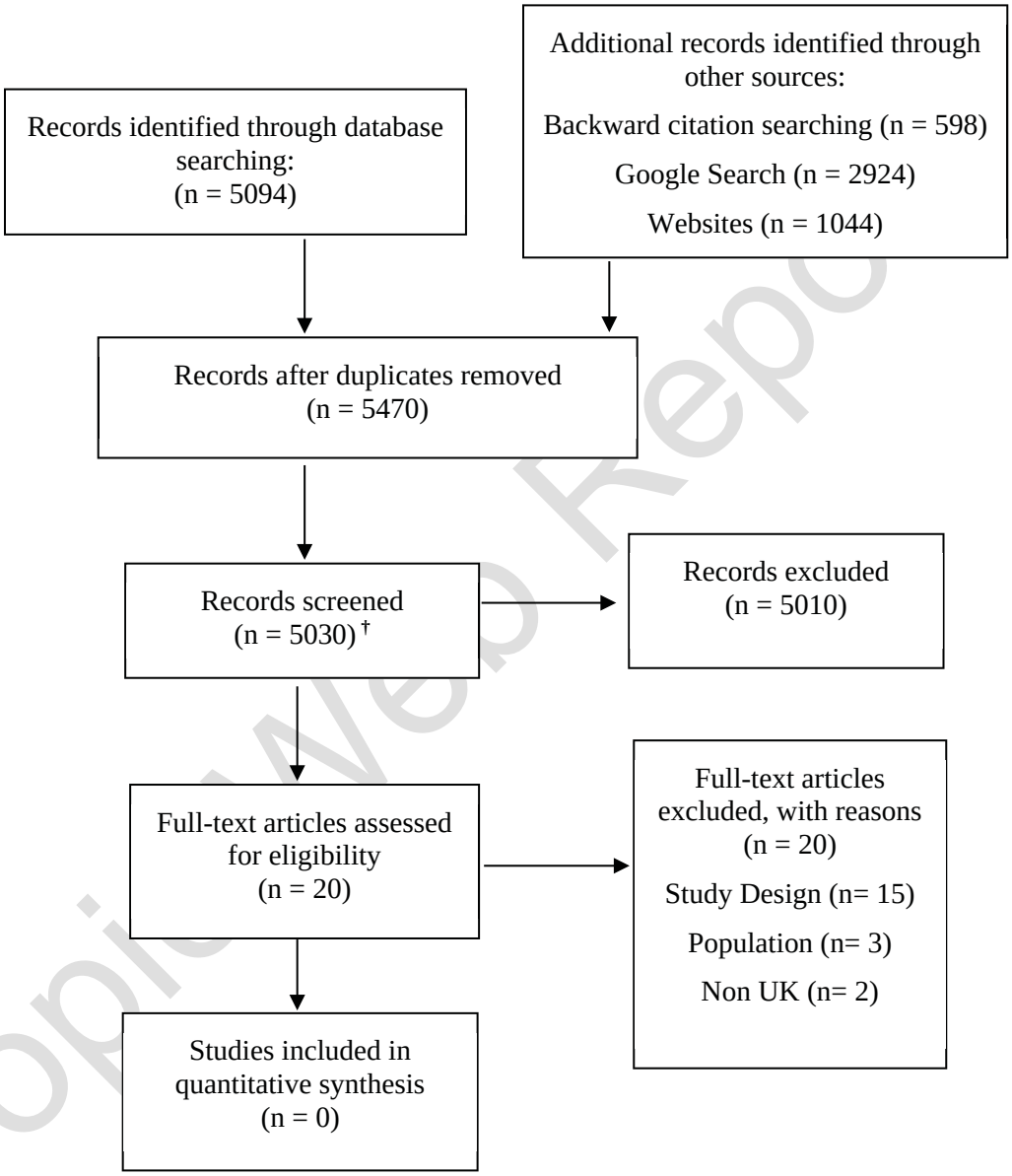
The two PRISMA diagrams summarise the study selection process for each of the questions (see Figure 2. PRISMA flowchart for research question one and Figure 3).

Bibliographic database and supplementary searches identified 5,094 and 3,522 records respectively. Following the removal of duplicates, there were a total of 5,470 unique records, of which 5,030 were screened against our inclusion and exclusion criteria to answer both review questions.

For research question one: The full-texts of 20 papers were sought and retrieved for further consideration. Following full-text screening, no papers were included (for details see Figure 2). Over three-quarters of papers (n = 15) were excluded due to their study design. Other reasons for exclusion included non-UK study (n = 3) and not examining our population of interest (n = 2). The citations of these excluded records are listed in Appendix 3. No papers were identified that met our inclusion criteria for question one.

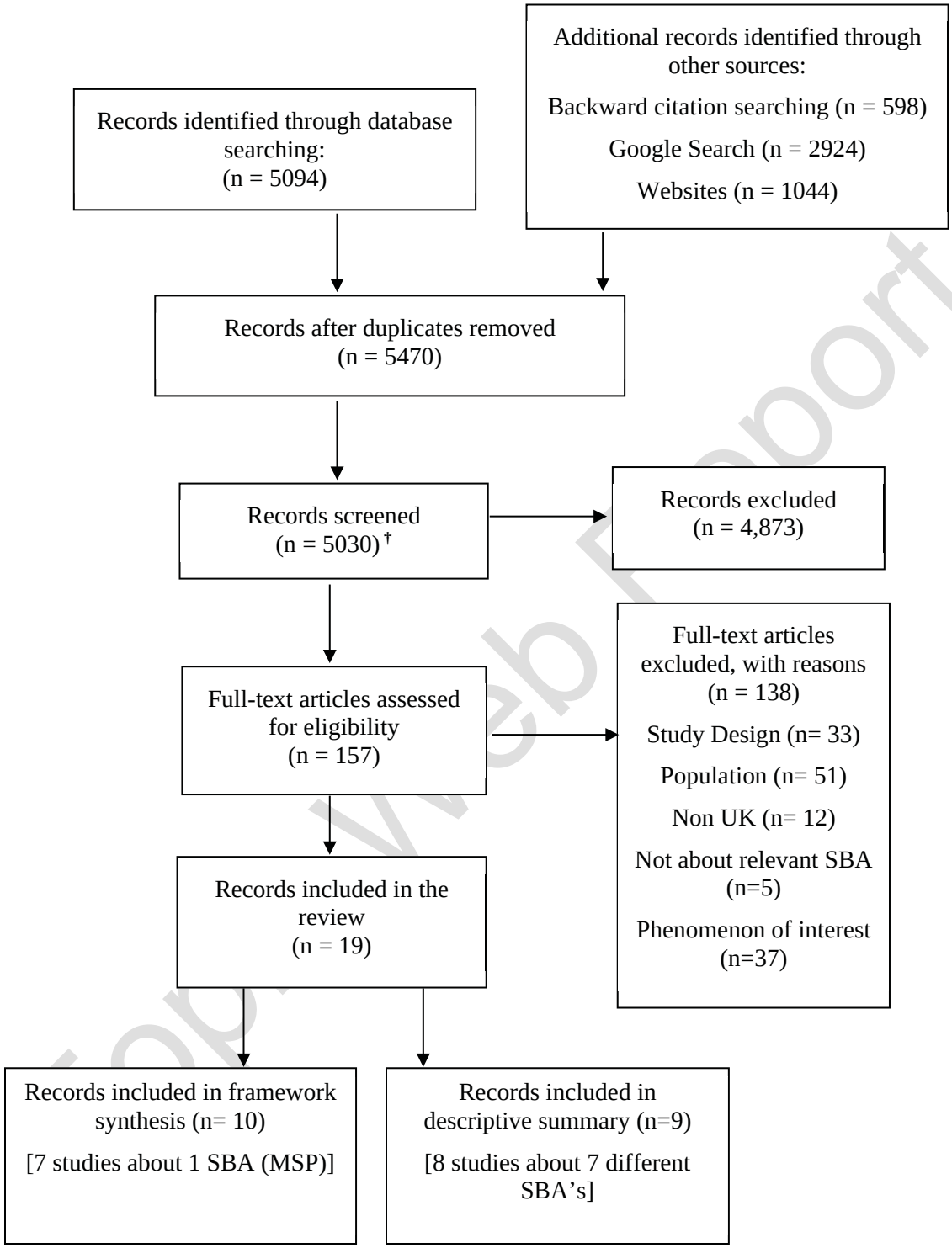
For research question two: The full-texts of 157 papers were sought for further consideration in relation to question 2. Of these, all full-texts were successfully retrieved. Following the full-text screening, 136 papers were excluded for the reasons specified in Figure 3. Most studies were excluded due to population (n=51), not reporting on our phenomenon of interest (n=34) & study design (n=31). Other reasons for exclusion included non-UK study (n=12) and not reporting on a relevant SBA targeted by this review (n=5). The citations of these records are listed in Appendix 4. Nineteen papers relating to 15 studies were identified that met our inclusion criteria.

Figure 2. PRISMA flowchart for research question one



† Fewer records were screened (n = 5,030) than the total number of unique records (n = 5,470) because Google Search results were screened to saturation (see Appendix 1).

Figure 3. PRISMA flowchart for research question two



† Fewer records were screened (n = 5030) than the total number of unique records (n = 5470) because Google Search results were screened to saturation (see Appendix 1).

3.2 Description of included studies for research question two

A total of 15 studies were identified and included for research question two examining eight different strengths-based approaches. Of the included studies, seven (10 papers) reported on the implementation of Making Safeguarding Personal (MSP), see Table 1. A framework synthesis was conducted on findings emerging from these (see Framework synthesis; section 3.5.[27-36] The remaining eight included studies (nine papers) examined seven different strengths-based approaches, see Table 4.[37-45] Due to the limited evidence found examining each of these (only one or two studies per approach), these studies were described, but their findings not synthesised (see Descriptive summary of studies on other strengths-based approaches; section 3.5, and Table 1).

Making Safeguarding Personal is a personalised, outcomes-focused approach that enables safeguarding to be carried out collaboratively and 'done with', rather than imposed on or 'done to' adults; with a focus on empowering them, as opposed to on only protecting them.[1] The approach is based on principles of: co-production; enabling conversations about what matters to people and asking the right questions; focusing on desired and negotiated outcomes, and how people wish to achieve them. It started as a national programme in England in 2009, and was piloted in over 50 local authorities in 2013/14. MSP should be co-ordinated by the most appropriate professional in each case, with other professionals and allies offering their contribution towards the goals that have been identified by the individual at risk as most important to them. In practice, MSP is most often led by social workers. Even when it is not, social workers are likely to make a significant contribution. This is because of the statutory responsibility placed on local authorities by the Care Act 2014, which requires them to lead their local multi-agency safeguarding adults system and make enquiries (or ask others to do so) when they think an adult is at risk. Local authorities discharge these responsibilities through social workers in specialist or generic adult social care teams.

The influence of social work practice on MSP (and vice versa) may be inferred from the current literature that highlights the role of a range of stakeholders, including the 'Principal Social Worker' in delivering MSP. There are competing perspectives on whether MSP is a philosophy encouraging the application of strengths based approaches, or is itself a strengths-based approach. Some studies conceptualise MSP as a framework for strengths based

practice at system level, in which specific techniques like motivational interviewing and family group conferencing, amongst other methods, may be used according to the particular circumstances, needs and preferences of the individual at risk. Others regard MSP as more independently associated with adult social work practice, such that it might be considered as a model for strengths based practice by social workers. These interpretations are not mutually exclusive, but the focus here tends to the latter, in line with the policy customer's request for an evaluation of the effectiveness and implementation of strengths-based approaches in adult social work.

The seven studies on implementation of MSP included data collected over a range of years (from 2015 to 2018) and included evidence provided by a range of study site sizes; from most local councils in England, to a single London Borough. The research aims of included studies varied. For several the main aim was to evaluate, explore or learn from, the implementation of MSP. Others primarily aimed to explore outcomes related to MSP, with a minor focus on evaluating the process of implementation itself. The people being supported by MSP were described as people identified as at risk of harm or abuse in all studies, with one study focussing on experiences supporting older adults, and younger adults with physical disabilities.[30] There was some overlap in methods and data between the seven studies, for example Hopkinson and colleagues (2015), reported on additional data collected from a local authority for which data on the same time period had already been collected by Lawson and colleagues (2014) and Cooper and colleagues (2015).[33-35] Qualitative data came from a combination of council staff, senior MSP leaders, MSP practitioners, and people at risk (and their families). Data was collected using various methods, often including focus groups or interviews, but also making use of data gathered from questionnaire or survey responses. In the majority of included studies, the analysis approach was not reported, however Hopkinson and colleagues (2015) applied principles of grounded theory to conduct a thematic analysis.[35] See Table 1 for a summary.

Table 1. Summary information of the seven synthesised studies about implementing Making Safeguarding Personal [1]

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Lawson, 2014[34]; Cooper, 2015[33]	Making Safeguarding Personal – to three different levels of implementation (2013-14)	People identified as at risk of harm or abuse	53 local councils in England; 47 provided impact statements, but only 43 had implemented MSP so their reports were analysed	Council practitioners, managers and service users (varied by council) (n = 41 practitioners who self-reported, + 2 from RiPfA and University of Birmingham)	Outline key findings from MSP programme, and support future implementation. 'Impact statements' made up of qualitative research data gathered through feedback questionnaires, focus groups of service users and staff (varied by council). Analysis approach not described.

[1] Making Safeguarding Personal is a social work practice approach delivered at an individual level

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Hopkinson, 2015[35]	Making Safeguarding Personal (2013-14)	Adults at risk	One local council in England (Sutton)	34 service users Council staff: 10 social workers 6 team managers and 6 administrators	Explore how effectively implementation had occurred, and identify ways to improve. Focus groups of service users (size ranging 2 to 15). Interviews with council staff. Analysis of focus groups applied the principles of grounded theory. Thematic analysis of interview data

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Butler, 2016[30]	Making Safeguarding Personal (pilot) (2014-15)	2 user groups: older adults with long-term needs for support; younger adults with physical disabilities	3 London boroughs of (Hammersmith and Fulham; Kensington and Chelsea; Westminster)	Members of adult social care teams (n = not reported)	A report to improve implementation experiences and outcomes for users and staff. Notes of weekly telephone conferencing with pilot sites; feedback and evaluation from workshops for staff; impact statements; telephone focus group notes; descriptions of specific team interventions; data collection at team level and from the main IT system. Analysis approach not described.

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Pike, 2015[36]	Making Safeguarding Personal (2015)	Adults at risk	Local councils (144 of 151 participating councils)	Six telephone focus groups with 16 MSP leads; five telephone interviews with senior leaders in adult safeguarding. [Also, survey responses from: 95 MSP leads; 63 staff responded to the survey from 15 councils – provided some qualitative data]	Explore the impact of MSP on experiences and outcomes for service users, and on the culture and practice of safeguarding. Explore factors that help or hinder implementation. Mixed methods, with focus groups and interviews being the qualitative data sources Analysis approach not described.

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Cooper 2016 & 2018[31, 32]; Briggs 2018[29]	Making Safeguarding Personal (2016)	People identified as at risk of harm or abuse	117 of 152 Local Authorities in England	Safeguarding leads from English Local Authorities (all but 2 responded i.e. n=115); Respondents were not necessarily working directly with service users, although they were responsible for quality assuring safeguarding practice.	Measure progress towards full implementation of MSP. Gather information to shape the safeguarding development programme. Telephone interviews (~1 hour) were conducted by a team of five people all with broad and deep experience of adult safeguarding, and followed the same topic schedule. Method of data analysis not reported (in any of the 3 reports).

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Lawson, 2018[28]	Making Safeguarding Personal	Adults at risk	It is based on work at two LGA/ADASS workshops (facilitated by Making Connections in April/May 2018 in England) on working with risk in the context of Making Safeguarding Personal.	Over 100 representatives from safeguarding adults boards (SBAs)	Provide support to Safeguarding Adult Boards and partner organisations in producing shared commitment to working with risk. Support implementation in front line practice. Data was collected through workshops. The analysis technique was not mentioned. However a thematic mind-map was attached in the document.

Study source lead author and year	Approach implemented and evaluated (Data years)	Type of people being supported	Location/setting	Sample type sample size	Research aims Data collection and analysis
Hertfordshire, 2017[27]	Making Safeguarding Personal (2014)	Adults at risk	40 local councils in England	Adults at risk, their carers, relatives and friends (n=382/976). Of 382 participants, 55% were females and 88% were white British.	Find out if practical to roll out pilot survey nationally. Survey aims not given. Data reported in the form of free text in response to a survey. Data analysis technique was not reported.

2

The remaining eight included studies (nine papers) examined the following different strengths-based approaches: Local Area Coordination (LAC) (two papers)[44, 45], Solution focused Therapy (SFBT)[37, 38], Asset-Based Community Development (ABCD)[39], Asset Based Approach [40], Motivational Interviewing (MI)[41], Strength-Based and Relationship-Based Approach[43] and Family Group Conferencing (FGC)[42]. Although these studies were within the scope of the review, due to lack of evidence from more than one study per approach, findings reported in these studies were not synthesised. However, we provide a descriptive summary of data emerging from these studies in section 3.5, and Table 4, contains a summary of the aims, sample characteristics, methods and emerging themes in relation to research question two, for these studies.

3.3 Study quality assessment

The quality of the 15 studies included in the review is shown in Table 2. Six were assessed as being of overall 'good' quality, [29, 31, 32, 35, 38, 40, 42, 43] with nine assessed as 'poor'. [27, 28, 30, 33, 34, 36, 37, 39, 41, 44, 45] Overall, studies scored well in several domains. All provided a clear research question and subsequently used appropriate study designs to answer them. However findings were not always substantiated by data,[27, 28, 30, 37, 44, 45] and it was not always possible to tell if they had been generalised to an appropriate degree.[27, 28] In terms of the reporting of methods, the context or setting was described well in 12 studies.[29-35, 38-46] While samples were usually appropriate, or their limitations acknowledged; for the description of data collection, six studies did not provide sufficient information to be able to reproduce the data collection setting.[27, 28, 30, 33, 34, 37, 39] There was insufficient evidence of rigorous data collection in six studies. [27, 28, 30, 36, 37, 39, 41] Nine studies were judged to have lacked evidence of rigorously conducted data analysis,[27, 28, 30, 36, 37, 39, 41] and six studies did not acknowledge their methodological limitations.[27, 28, 37-39, 44, 45] However, nine studies showed evidence of having addressed ethical issues and maintained confidentiality of data.[27, 28, 37, 39, 41, 44, 45]

Table 2. Quality assessment of included studies using Wallace criteria

Criteria (n, category)	1, E	2a, D	2b, D	3, E	4, D	5, E	6, E		7, E	8a, E	8b, D	9, D	10, D		
Approach, Study source (lead author & year)	Research question clear?	Is the perspective of author explicit?	Has this influenced design, methods or research findings?	Study design appropriate?	Context adequately described?	Sample drawn from adequate and appropriate population?	Data collection adequately described?	…and rigorously conducted to ensure confidence in the findings?	Evidence that analysis rigorously conducted?	Findings substantiated by the data?	Has consideration been given to limitations?	Do any claims to generalisability follow from the data?	Have ethical issues been addressed?	Overall quality assessment score	
MSP Briggs 2018; Cooper 2016 & 2018[29, 31, 32]	Yes	CT	CT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Good**	Can't tell
MSP Butler 2016[30]	Yes	CT	CT	Yes	Yes	Yes	No	CT	No	No	Yes	Yes	Yes	Poor*	Y
MSP Cooper 2015; Lawson 2014[33, 34]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	CT	CT	Yes	Yes	Yes	Yes	Poor*	Yes
MSP Hertfordshire SAB 2017[27]	No	No	CT	Yes	No	Yes	No	CT	No	CT	No	CT	CT	Poor*	

MSP Hopkinson 2015[35]	Yes	Yes	CT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Good**
MSP Lawson 2018[28]	Yes	No	CT	Yes	No	Yes	No	CT	No	CT	No	CT	CT	Poor*
MSP Pike 2015[46]	Yes	CT	CT	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Poor*
LAC Stalker 2007 & 2008[44, 45]	Yes	CT	CT	Yes	Yes	Yes	Yes	Yes	CT	CT	No	Yes	CT	Poor*
SFT Hogg 2004[37]	Yes	CT	CT	Yes	No	CT	No	CT	No	No	No	Yes	No	Poor*
SFT Smith 2011[38]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	CT	Yes	Yes	**Good**
ABCD Brown 2017[39]	Yes	CT	CT	Yes	Yes	Yes	No	CT	CT	Yes	No	Yes	CT	Poor*
ABCD McLean 2017[40]	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Good**
RBA Anka 2017[43]	Yes	CT	CT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Good**
MI Forrester 2008[41]	Yes	CT	CT	Yes	Yes	Yes	CT	Yes	CT	Yes	Yes	Yes	CT	Poor*
FGC Mason 2017[42]	Yes	CT	CT	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	**Good**

D=Desirable; E=Essential Wallace criteria; CT=Can't tell; SBA=Strength-based Approach; MSP=Making Safeguarding Personal; LAC=Local Area Coordination; SFT=Solution Focussed Therapy; ABCD=Asset-based Community Development; RBA=Relationship Based Approach; MI=Motivational Interviewing; SSW=Systemic Social Work; FGC=Family Group Conference

Green shading indicates a positive assessment; yellow shading indicates lack of information needed to assess; red shading indicates a negative assessment. Good=all essential criteria met; Poor=all essential criteria not met.* NB. Although rated as poor for the purposes of this review, these studies may have been of appropriate quality for their intended purposes.

3.4 Framework synthesis of studies describing the implementation of Making Safeguarding Personal

The four identified themes reflected all five major domains of the Consolidated Framework for Implementation Research (see appendix 5). These were: 1) MSP as an intervention, 2) Culture and Settings, 3) Individual characteristics, and 4) Embedding and sustaining MSP. Please note: the following data relates to the implementation of just one strengths-based approach (MSP), one that is practice-based, and usually delivered by social work teams.

All four themes are descriptive in nature, inter-related and provide insight into factors which enable or inhibit the implementation of MSP in adult social work within the UK, which is a personalised, outcomes-focused approach that enables safeguarding to be done with, not to, people.

For an overview of which studies contributed towards the development of each theme, please see Table 3 below. The four themes are discussed within each section below, and are supported by study data (quotations). Each quote is accompanied by a label to acknowledge the study author and year of publication, and whether it is a quotation from a study participant (first order data) or from the study author (second order data). The dominance of second order data in the following results sections reflects that many of the study authors did not present many quotations from their study participants, but instead summarised what the participants said in their own words. After discussing each of these themes independently, they have also been reviewed within the context of one another and mapped out using a diagram, please see Figure 4.

1 **Table 3. Themes and sub-themes identified**

Theme	Papers contributing to subtheme	Subtheme	Description
1. MSP as an intervention	1,8,10	Relative advantage	Stakeholders' and staffs' perception of the advantages of implementing the new model of adult social care in comparison to previous 'usual' practice.
	2,4,8	Adaptability	A complex intervention, and staff need support to adapt and tailor it to local settings.
	2,4,10	Complexity	Perceived as complex to implement, with need for significant changes in practice, better legal literacy, and working partner organisations.
2. Culture and setting	2,3,5,6,9,10	Culture	Broad cultural shifts essential. Some successful adaptations reported, but work required must not be underestimated.
	1,2,3,6, 9,10	*Cosmopolitanism*	Councils that were outward facing and communicated well, tended to do better.

Theme	Papers contributing to subtheme	Subtheme	Description
	3,10	*Structural characteristics*	Smaller councils and those with specialist teams, found implementation easier.
	1,2,3,4,5,6,8, 9,10	*External and internal policies and incentives*	The 2014 Care Act is a main driver of change. However the need to understand the Mental Capacity Act can be a barrier to implementation.
3. Individual characteristics	2,3,4,10	Personal attributes of the service providers	Many staff embraced MSP with enthusiasm, which facilitated delivery. However, need to increase practitioner confidence, to overcome resistance to change.
	2,3,4,6,8,10	Knowledge and beliefs about the intervention	MSP 'brand' generally well known, however some danger it could be misunderstood. Need to educate stakeholders and partner organisations.
	2,3,4,6,7,8,10	Service user needs and resources	Effective implementation depended on service user willingness and capacity to actively engage in their own care, plus practitioners' ability to engage them. Particularly challenging when working with people who lacked capacity.

Theme	Papers contributing to subtheme	Subtheme	Description
4. Embedding and sustaining MSP	2,3,4,7,8,9,10	Embedding process	
	2,4,7	*Planning*	Organisations need to to more to meaningfully involve service users in planning and shaping safeguarding services.
	2,3,10	*Engaging*	Must engage all key stakeholders: including adult social care directors, leaders and frontline staff.
	3,8,9	*Executing*	Required a major shift from outcome to user-focussed practice. Affecting all processes and systems. Reports of variable execution, especially where ways of questioning service users had not been adapted.
	1,2,3,4,5,6,10	Factors related to embedding and sustaining MSP	

Theme	Papers contributing to subtheme	Subtheme	Description
	2,3,4,5,9,10	*Availability of resources*	Main resources included staff skills and confidence, suitable recording systems, and managerial support. Training seen as critical, and when lacking (often due to lack of money and time) this was a barrier. Effective recording systems were a determining factor in consistent application of MSP principles.
	1,2,3,6,9,10	*Leadership engagement*	Strong leadership engagement: from cabinet ministers, to directors of adult social services, and practitioners was important. Some reports of lack of confidence in management.
	2,4,9,10	*Use of goals and feedback*	Critical that social work teams discuss ways of achieving and managing goals set with service users. Better mechanisms for peer feedback and sharing best practice are needed to support this.

Key to papers (grouped by study): (1=Briggs 2018, 2=Cooper 2016, 3=Cooper 2018); (4=Butler 2016); (5=Cooper 2015, 6=Lawson 2014); (7=Herts SAB 2017); (8=Hopkinson 2015); (9=Lawson 2018); (10=Pike 2015).

3.4.1 Theme 1. Making Safeguarding Personal as an intervention

This theme describes the characteristics of MSP that can make the implementation of this approach successful. Three subthemes contribute towards this theme: i) Relative advantage, ii) Complexity, and iii) Adaptability. Data from five papers (four studies) contributed towards the evidence of this theme.[30-32, 35, 36]

3.4.1.1 Relative advantage

This subtheme focusses on stakeholders' and MSP staffs' perception of the relative advantages of implementing MSP in adult social work and social care in comparison to 'traditional' safeguarding practices. Three publications (four studies) discussed how MSP was perceived when compared to other approaches used within safeguarding services.[31, 32, 35, 36] Three publications (four studies) discussed how MSP was perceived when compared to other approaches used within safeguarding services.[31, 32, 35, 36] Cooper and colleagues (2016) highlighted that despite concerns over additional time commitment required, practitioners felt that MSP was an approach that, through up-front meaningful engagement with people, could lead to beneficial outcomes for a range of people involved, including people being supported, and carers, as well as front line staff.[33] The perception for many respondents was that the initial increase in investment of time and resource, led to a decrease in future referrals and reduced burden on other multidisciplinary services involved in the safeguarding process.[31, 36]

> "we have not found it to be any more time intensive because of the work we did on the systems first" **(Social work safeguarding lead; Cooper, 2016)**
>
> "…you know from the offset what you want to achieve, and at the end it doesn't seem to drift on indefinitely" **(Social care provider; Pike, 2015)**

This study also highlighted how MSP has helped transform social work practice to become more aligned to the agenda of personalisation, as proposed within the 2014 Care Act.[31] Respondent views implied that MSP led to services becoming more user-focused and collaborative in nature, which ensured individuals needing safeguarding felt more in control and heard by the services.

> "For the first time service users are in the driver's seat, they can say how fast they want to travel and when they want to put the brakes on" … **(Social work safeguarding lead; Cooper, 2016**)

However tensions were identified between the perceived advantage of people being at the centre of their care, and increased demands on practitioners.[36] Pike and colleagues (2015)

highlighted that MSP was time consuming, less effective in providing immediate relief, and led to an increased workload.[36] These perceived negative characteristics of MSP were however at times counterbalanced by advantages, including a possible reduction in future complaints and fewer strategy meetings.

> "It's more time-consuming… you're asking more questions, you're using advocates, [completing more] mental capacity assessments … although I think a lot practitioners are welcoming it, it's just that tension with your case load" **(Social care provider; Pike, 2015)**

These findings highlight that while MSP may place more demands on practitioners in the short-term, in long-term this approach may be more beneficial compared to traditional safeguarding approaches, due to enhanced planning that involves input in the model of care from people being supported. However when tensions emerge between best practice and case-load, this often indicates a need for better resourcing (in terms of staff time, training and supervision). This is discussed in section 3.4.4.1, availability of resources. If front line practitioners are appropriately resourced from the outset, MSP's preventative nature, ability to reduce pressure on services, and user-focus, has the potential to outweigh its short-comings.

3.4.1.2 Adaptability

This subtheme focuses on the extent to which MSP can be adapted, tailored and streamlined to meet the local needs of people being supported and organisations. Data from three papers (three studies) highlighted how adaptable MSP is within adult social care practice. [30, 31, 35]

Hopkinson and colleagues (2015) identified issues around adaptability of MSP in practice. These issues included the need to enable engagement with a range of stakeholders, respond to unexpected challenges, create a safe environment for people using the safeguarding services, and staff delivering services, especially when dealing with conflict.[35] Cooper and colleagues (2016) highlighted a critical issue related to the transferability of MSP approach to other organisations, with respondents noting that in some contexts staff were still using traditional systems to safeguard adults at risk, leading to compromised implementation of MSP.[31]

> "Having a multi-agency approach has not reached the front-line staff in services outside the council" … "Acute hospitals are tied into a more traditional approach and are focused on bed-blocking" **(Two social work safeguarding leads; Cooper, 2016)**

On further exploration, they found that it was the numerous and varied adaptations needed in practice, culture and staff training, when changing from a traditional approach to using MSP that led to problems around implementing MSP in partner organisations. While these findings

highlight problems related to implementing MSP across organisations, it is important to note that the evidence referred to in these studies does not talk about specific aspects of MSP that services find difficult to adapt and the factors that align with the challenges, which defines a scope for further investigation in this area.

3.4.1.3 Perceived complexity of the change/intervention

This subtheme captures how the perceived difficulty (complexity) of practicing MSP affects its implementation. This may be reflected by the changes that need to be made and sustained within the current safeguarding system, so that MSP is implemented effectively. Data from three studies (four papers) underlined the complexity of this approach. [30, 31, 36, 46]

Butler and colleagues (2016) identified various factors which led to the perception that MSP was a complex intervention to implement. [30] These aspects of complexity included issues around allocating staff time, current team capacity, and professionals' attitudes. This study highlighted other challenges such as:

> …having enough support to respond to problems in a timely manner rather than set timeframes; building team capacity to become more legally literate and increasing practitioners' confidence when making professional judgements. **(Author interpretation; Butler, 2016)**

This links to issues around resourcing, including training and supervision, discussed in section 3.4.4.1, and to the confidence and self-efficacy of staff, discussed in section 3.4.3.1. Pike and colleagues (2015) identified that the need for changes to happen through reflective practice also contributed to the perceived complexity of MSP, affecting its implementation.[36, 46] In addition, tensions between the principles of autonomy for individuals and their protection made implementing MSP challenging.

> Colleagues should bear in mind that MSP requires significant change to pre Care Act practice – even if it is perceived as 'what we do anyway'. Reflective practice is important to recognising where changes need to be made **(Author interpretation; Pike, 2015)**

Lastly, Cooper and colleagues (2016) highlighted their concerns about the organisations' capacity to make changes, training staff, improving team capacity and sustaining changes and improvements that were already made.[31] These factors not only contributed to the perceived complexity of the MSP approach, but also led to anxiety in the practitioners and negative reactions to the shifting safeguarding culture, as illustrated by the following comments:

> "Now they are very positive, 6 months ago - fairly, a year ago - not very" … "As social workers this is what we are all aiming to do but we do get stressed about risk and capacity" **(Two social work safeguarding leads; Cooper, 2016)**

In summary, there were various features of MSP, from adaptability, complexity and tensions to be reconciled, which sometimes required new skills and knowledge of social workers that influenced the implementation of this intervention. Some of the concerns about extra demands on resources, and particularly staff time, also resonate in other subthemes. Although there has been a shift in culture and social workers are accepting the advantages of using MSP to safeguard high risked individuals, in practice, stakeholders lack insight on why they are practicing MSP to safeguard individuals, which acts as a barrier in embedding this approach within the system.

3.4.2 Theme 2. Culture and Setting

Both the broader setting, across local authorities and partner organisations, government policies and legal frameworks and the 'internal setting' of the local authority, council and adult social care teams delivering MSP strongly influenced the implementation process of MSP. This theme, which highlights factors both within organisations and those functioning at a national level, is made up of four subthemes: i) Culture, ii) Cosmopolitanism, iii) Structural characteristics, and iv) Internal and external policies. Data from five studies (seven publications) contributed towards the evidence of this theme.[28-31, 33-36]

3.4.2.1 Culture

Within our chosen framework for understanding implementation culture refers to the norms, values and assumptions of an organisation or group (CFIR framework).[18] This subtheme captures how after the 2014 Care Act, there has been a shift in culture across and within organisations to be more person-centred and empowering and, towards making adult social care practice more strength-based. Four studies (six publications) discussed how successful implementation of MSP was based on the culture of the organisation, which also affected the setting-related factors.[28, 31-34, 36]

> Delivering MSP was about achieving culture change in organisations and across organisations **(Author interpretation; Cooper, 2015)**.

When asked, "what does MSP mean to you?", respondents to Cooper and colleagues (2016) typically highlighted that people needing services had been brought onto centre stage: [31]

> "A shift in culture from a process to the person being at the centre" **(Social work safeguarding lead; Cooper, 2016)**

Cooper and colleagues (2018) identified the critical need for culture change at a broader level, while acknowledging that a range of factors challenged this culture change process.[32] Attachment to safeguarding practices used before the Care Act (2014) was identified as one factor that resisted this. For example the authors reported that:

> Resistance to implementing MSP was said to be due to: an attachment to pre-Care Act 2014 ways of working, concerns about … time it takes to engage people in conversations about what they want from safeguarding…, risk-averse attitudes and reluctance to ask people for feedback **(Author interpretation; Cooper, 2018)**

Pike and colleagues (2015), and Lawson and colleagues (2014, 2018) also highlighted the role of an organisation's culture in implementation processes.[28, 34, 36] They indicated that participation of people being supported could be a key driver of culture change processes:

> "Part of MSP is about asking the person ...what they want as an outcome, even taking on board where shall we hold the strategy meeting… – it's taking on board what is best for them, how they can be fully involved in the whole process from the beginning till the end." **(MSP safeguarding lead; Pike, 2015)**

Another mechanism that was reported as important in achieving a culture shift was proactive leadership undertaken at all levels to empower staff to work in ways that are tolerant of risk, thus enabling people at risk to become actively involved in the safeguarding process. [28] Cultural shifts can be facilitated through the use of MSP champions, improved communication with partner organisations, and an improved understanding for all stakeholders of key outcomes in safeguarding.

> There needs to be a shared culture that supports risk enablement **(Author interpretation; Lawson, 2018)**

> "[MSP is a] huge cultural shift … [that] we mustn't be naïve about it" **(Senior leader in adult safeguarding services; Pike, 2015)**

> To effectively implement this approach across the board will require a culture change from the SAB [Safeguarding Adults Board], who can be overly concerned with data collection and analysis and not on outcomes for individuals. **(Author summary of comments from council representatives; Lawson, 2014)**

These findings indicate that both social workers at frontline and management at the senior levels may be equally responsible for successfully embedding MSP within an organisation, which is only possible if they accept the cultural shift from 'process led' to 'user focussed' social work.

3.4.2.2 Cosmopolitanism

This subtheme captures the degree to which an organisation's connectedness with other care and support organisations affects the implementation of MSP. Within the broader implementation literature, a strong internal and external collective network of organisations indicates social capital (i.e. a collective resource) that enables smooth implementation of an intervention. The overall importance of cosmopolitanism in implementation processes was highlighted in five studies (six publications).[28, 29, 31, 32, 34, 36]

Good inter-council collaborations, and linking in with multi-agency partners were identified as factors facilitating implementation of MSP within adult social care practice by three studies (four publications).[28, 31, 32, 34, 36] These studies highlighted that services that were inter-connected with other services and stakeholders within the adult social care domain had a stronger understanding of MSP as a safeguarding approach and were therefore more motivated to implement it.

> Some councils were outward-facing … working together with their neighbours, subsequently mutually benefitting from the shared learning. On the other hand there were a number of councils who could not find the time or motivation to work with others and were subsequently fairly isolated, struggling to get traction [for MSP] **(Author interpretation; Cooper, 2016)**

While collaboration with other social care services was identified as a key factor supporting implementation, Pike and colleagues (2015) also highlighted that partnership working between multi-disciplinary organisations involved in safeguarding individuals at risk (e.g., care homes, the NHS, community and acute services, the ambulance service, the police, and environmental health) also positively influenced the implementation process.[36] However, there were various challenges in achieving this, primarily due to differences in culture across organisations.

> The importance of involving all multi-agency partners in MSP was highlighted. ...support from Safeguarding Adults Boards was seen as a key success factor, but cultural differences between agencies around involving people in decisions could cause challenges. **(Author interpretation; Pike, 2015)**

Four studies highlighted key underlying factors associated with strong networking and communication between and within organisations.[28-31, 36] These studies indicated that individual relationships, involvement of MSP champions, and support from organisations such as Safeguarding Adults Boards promoted successful implementation.

> Opportunities for practitioners should be created so that they can share their experiences of MSP at local and regional levels. **(Author recommendation; Cooper, 2016)**

> One focus group participant [safeguarding lead] felt that 'personalities and relationships' had led to good multiagency working. **(Author interpretation; Pike, 2015)**

However, Cooper and colleagues (2018) also highlighted that there could be mixed responses of partnering organisations when asked to adopt MSP approach for safeguarding adults at risk.[31] A key reason highlighted by this study was reluctance to transform existing safeguarding practices, which may be due to service provider's attachment with traditional approaches of safeguarding that were used pre-Care Act 2014, as discussed in section 3.4.2.1, which discusses adaptability of MSP.

> Whilst champions were emerging from local authorities who were taking the MSP message out to practitioners in partner organisations, they were met with a mixed response... Respondents emphasised the need for all partners involved in safeguarding to adopt the MSP approach **(Author interpretation; Cooper, 2018)**

One study (two publications), highlighted the need for wider 'buy-in' to MSP to support implementation.[31, 32] This related to wider political and council based support for MSP as an approach that may be effective in safeguarding adults at risk. Supportive political leadership, was also noted as having a positive impact:

> "There has been strong support from councillors who have protected the services from some of the local authority cuts" **(Adult social care provider; Cooper, 2018)**

These findings indicate that strengthening collaborations within and between services and multiple agencies (e.g., NHS, community and acute services, the ambulance service, and the police) that actively work towards safeguarding individuals may facilitate implementation of MSP. Gaining wider political support may help in establishing new collaborations and strengthening older ones.

3.4.2.3 Structural characteristics

This subtheme captures how various structural characteristics, including size of the service or organisation, its staff capacity and access to services within broader adult social care system affects the implementation of MSP. Five studies (seven publications) identified structural characteristics as important factors influencing the implementation process.[29-34, 36]

In three studies the capacity of a team in terms of staffing, time available to implement, and caseloads, were key factors for successful implementation, with staff/resource shortages negatively affecting roll-out.[30, 32, 36] Two papers (two studies) reported that delivery of MSP was affected by the size and organisational structure of the teams involved and the approach to implementation, with smaller councils and those with specialist teams often finding it easier to implement MSP, while larger councils required more pre-planning.[32, 36]

> "We focused too long on the safeguarding team but it would have been better to have rolled MSP out to other teams sooner" … "MSP was seen as an 'add on' so has suffered because it was not mandatory in the process" **(Two safeguarding team leaders, Cooper, 2018)**

It is possible that the structural characteristics of smaller councils make it easier both for team members to communicate about changes internally, and to link more with other councils, thus facilitating shared learning (see section 3.4.2.2). However, Butler and colleagues (2016) highlighted that smaller teams found it difficult to implement MSP as it required staff to be highly committed, which was sometimes undermined due to low morale related to high workloads.

> ...operational senior managers raised concerns about the capacity of teams to engage in the pilot whilst juggling other high level commitments, such as meeting end-of-year deadlines, and pressures on staff morale **(Author interpretation; Butler, 2016)**

Two studies highlighted that adopting a 'single point of access' system could be an effective structural way of supporting delivery of approaches like MSP within organisations. [29, 31] This may be because single point of access could manage higher volumes of referrals by diverting them to the right service.

> Local organisations should improve ways of managing the increase in safeguarding alerts and referrals by considering integration of front doors either through MASH [multi agency safeguarding hub] or a jointly staffed Single Point of Access **(Author recommendation; Cooper, 2016)**

Lastly, pressures of high service demand were identified as a key factor affecting the pace of MSP implementation. Two studies (three publications) highlighted that high levels of demand for safeguarding in adult social care, which can be a stressful and emotionally draining experience for all stakeholders, created difficulties in implementation progress, as teams were working under pressure.[29, 31, 32] Pressure on teams was linked to a large-scale increase in Deprivation of Liberty Safeguards applications (see Glossary) resulting from a Supreme Court judgment in 2014, which widened the scope of people who could be subject to them.[29, 31, 32] These findings indicate that the structural characteristics such as team capacity and services' ability to manage user demand may facilitate implementation of MSP. In practice, managing the service delivery demands is a challenge due to high work load. However, adopting provisions like single-point access systems could help to address this.

3.4.2.4 National and local policies and incentives

This subtheme focuses on external (national) and internal (local, organisational) policies that either promote or inhibit the spread of interventions, including policy and regulations (e.g. governmental), external mandates, recommendations and guidelines, pay-for-performance, collaborative, and public or benchmark reporting. Every study about MSP included within the scope of this synthesis, except the 2017 Hertfordshire survey, discussed the impact of policies and regulations on the implementation of MSP. The Care Act of 2014[3] and Mental Capacity Act of 2005[47] were most often cited as driving change, alongside specific safeguarding policies and procedures, that if aligned to MSP approach, contributed to its effective implementation. Although the 2005 Mental Capacity Act applies only to England and Wales, the issues covered by this act are governed by the provision of section 51 of Adults with Incapacity (Scotland) Act.

The Care Act of 2014, which according to Cooper et al. enshrines MSP as a must do, and not an option[33] was reported to be a main driver of change by most studies.[29-31, 33, 36] However, Pike and colleagues (2015) noted that despite being a lever for change, training needs related to implementing the Care Act placed competing pressures on teams that were working to implement MSP.[36] A key concept emerging from the majority of included studies was that the MSP principle of involving the people being supported required teams to have more extensive knowledge, understanding and practice relating to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards than previous practice. [28, 32-36] This was critical because the

principle of placing individuals at the centre and considering them as the main decision makers, was at the core of MSP.

> "It has outed how very variable from good to extremely poor people's understanding of the Mental Capacity Act is, and the application of that in their practice" (**MSP safeguarding lead; Pike, 2015)**

This was linked to the challenges related to what were perceived to be higher risk approaches of actively involving people in decisions, and how senior staff supported managing such risks. This was especially the case for people who may lack capacity. [32, 35, 36] The complex nature of demands on staff when applying the Mental Capacity Act[47] in the context of MSP, partly explains why specialist training and supervision, and the 'availability of resources' for staff emerges as a key factor in embedding and sustaining this approach (as discussed in section 3.4.4.2) Also why individual characteristics, self-efficacy, and knowledge and beliefs of providers, can play a key role in implementation of this approach (see section 3.4.3.2).

> There are specific challenges in using MSP for social work with older adults …regarding mental capacity issues for service users, communication skills and the need to combat ageism in service delivery. Some respondents reported a lack of confidence by management in …involving service users in decisions about their lives **(Author interpretation; Cooper, 2018)**

> MSP, however, posed a number of challenges. Some adults at risk were alleged to have caused harm, requiring careful information sharing and approaches that supported their involvement whilst still focusing on the person harmed. … Social workers sometimes struggled with finding the best way to involve adults at risk **(Author interpretation; Hopkinson, 2015)**

Two studies (three publications) identified that existing local safeguarding policies and procedures were not always well aligned with MSP approaches, which inhibited the smooth implementation of this safeguarding approach in practice. [30, 33, 34] One explanation for this could be that the local authorities were applying the model of MSP differently based on their understanding of this approach and the resources available to them.

> Safeguarding policy and procedures need to be revised and changed to reflect MSP and remove potential barriers to person-centred safeguarding practice **(Author recommendations; Cooper, 2015)**

These findings suggest that both national safeguarding policies and those that define the

functioning of a local service need to be aligned with strength-based principles outlined by Care Act 2014. This may facilitate implementation of MSP across time and services. Standardisation of the ways the MSP approach is used in practice, with support structures in place to help adapt it to the local context, may be useful in formulating new policies and ensuring that existing ones are being implemented.

3.4.3 Theme 3. Individual characteristics

This theme includes three subthemes: i) the interaction between personal and professional attributes of the service providers, ii) provider's knowledge and beliefs about MSP and, iii) How practitioner's characteristics and beliefs influence the willingness of people being supported to attend safeguarding meetings and the take part in conversations. This theme explores how these factors interact, and influence the implementation of MSP.

3.4.3.1 Personal attributes of the service providers

This subtheme captures how service providers' attributes may impact the implementation of MSP, including their confidence in their professional judgment and ability to execute MSP, creativity, enthusiasm, resistance to change from using a traditional deficit-based approach to safeguarding to an approach that is more aligned to the core values of MSP and more broadly social work. Evidence from three studies (four publications) contributes to this subtheme. [30-32, 36]

Self-efficacy (confidence-related)

Two studies (three papers) highlighted the potential role of service providers' confidence in successful implementation of MSP. [30-32] Both studies suggested that practitioners' confidence was critical to delivering the MSP approach, implying a need for appropriate supervision and training.

> "As social workers, this is what we are all aiming to do but we do get stressed about risk and capacity" **(Adult social care social worker, Cooper, 2018)**
>
> "There is now an emphasis on asking in supervision 'how good are you at having difficult conversations?'" **(Social work safeguarding lead, Cooper, 2016)**
>
> Practitioners reported greater confidence in involving adults at risk in decisions about their safeguarding where this involved cross-cutting problems such as domestic abuse circumstances…However while some mentioned their increasing confidence in communicating the MSP approach to multi-agency partners most reported more work was

needed on this engagement **(Author interpretation; Butler, 2016)**

Butler and colleagues (2016) also highlighted that increasing staff confidence to communicate with multi-agency partners about MSP may impact its implementation. [30] These findings thus emphasise the role of self-efficacy in the implementation of MSP.

Creativity

One study reported that successful implementation of MSP sometimes relied on the creativity of staff, for example when resources essential to the practice MSP were lacking, or in response to the varied needs and wishes of people they were working with. [31] However, they confronted such situations by being creative and using the existing resources in the best way possible.

> "MSP enables people to be more creative and inventive" **(Social work safeguarding lead, Cooper, 2016)**

This implies that staff need to be working in a culture and setting (see section 3.4.2) that encourages inventive thinking, and moves away from a prescriptive approach. To be able to deliver personalised care while respecting the autonomy of adults at risk, staff will need support and flexibility from managers and safeguarding leads. It is important to note that staffs' ability to be creative in implementing MSP approach is likely to depend on: their understanding of the basic principles of MSP, how strongly they believe that this approach is relatively advantageous compared to traditional practices, and service providers' perceptions about the complexity of this approach.

Embracing MSP and being enthusiastic

Two studies highlighted that enthusiasm about the use of MSP, including embracing it as strengths-based and closely aligned to the core values of social work and social care, which positively influences the process of implementation.[31, 36] Social workers were said to be enthusiastic about implementing MSP because it enabled them to undertake direct work with all adults at risk (people being supported and their families), focusing on what was important to the person, which marked a shift away from the process-led culture of 'care management'.

> "[staff have] approached this with such enthusiasm and such pleasure in re-engaging with skills they didn't feel that they had, it's so palpable" … "I think it's helped to make them feel stronger in their role and why they're there" **(MSP safeguarding leads; Pike, 2015)**

The enthusiasm of MSP leads was said to be a main driver of change, and when staff were well supported, the MSP approach seemed to help staff enjoy their work more, building a sense of efficacy, and purpose, in line with core values of social work.

Resistance to change

One study identified individual's 'resistance to change' as a factor that inhibited implementation of MSP. [31] Cooper and colleagues (2016) identified that some social workers preferred using the existing practices within social work to provide care to adults at risk. This resistance to change was also said to be due to concerns around MSP, including the idea that the approach was not time-efficient and fear that using an MSP approach would take longer, discomfort in asking people for feedback, lack of understanding of MSP, and aversion to risk taking.

> "The staff culture of 'I know best ' still exists" … "Staff fear of legal challenge when we support the individual's allegations of neglect" **(Two social work safeguarding leads; Cooper, 2016)**

This resistance to change may also be attributed to personal attributes/beliefs of the service providers and their experiences of using MSP. Further, the extent to which frontline workers are supported by the management of organisation may determine their willingness to change their approach towards safeguarding high risk individuals. This sub-theme highlights the importance of culture and setting, (see section 3.4.2), as well as providing appropriate resources, such as training and supervision to embed and sustain MSP (see section 3.4.4). In order to overcome resistance to change, staff need a working environment which supports positive risk taking, training and supervision with time for reflection and peer feedback, and a system that will appropriately support and protect staff with a balanced enquiry if things go wrong.

3.4.3.2 Knowledge and beliefs about the intervention

This subtheme captures how practitioners' knowledge of MSP as a strengths-based approach and their beliefs about this intervention may facilitate or inhibit the implementation of MSP. While on a broader level, practitioners' knowledge depends on how well they understand core principles of MSP, on a more technical level, understanding and applying specific skills that distinguish MSP from other strengths-based approaches critically defines service providers' knowledge of this intervention. Data from four studies (six publications) contributes towards this subtheme.[30-32, 34-36]

Two studies discussed how MSP was understood by practitioners within adult social work. [31, 36] Pike and colleagues (2015) highlighted that this subsidiary approach was often reported as well understood by staff. [36] Moreover, this approach was seen to bring about a positive change in the adult safeguarding system, improving the existing services. However, this study also highlighted that staffs' understanding of this approach was based on their personal interpretation that in turn complicated the process of developing a shared understanding across key people in the organisation.

> "People think they understand them and apply their own interpretation, but nothing changes…" ".. The challenge locally is we've got sign up from key people with a role in the organisation related to safeguarding, but taking your point about it being 'everyone's responsibility' - we still struggle with that" **(Social care provider; Pike, 2015)**

Cooper and colleagues (2016) also highlighted similar findings, warning that the 'brand of MSP' could be misunderstood, which sometimes led to inappropriate care. [31]

> "The biggest problem is that staff thought they were doing MSP but have now recognised that they were not" … "What would help is a tool to enable us to get them to recognise and undertake MSP in other organisations." **(Two safeguarding leads; Cooper, 2016)**

Two publications (two studies) discussed the role of practitioners' beliefs about MSP in successful implementation of this approach.[30, 31] One of these highlighted positive beliefs related to MSP, including the fact that it helped staff feel closer to the person, who was put at the centre of care. Early engagement with the adult at risk was seen as enabling a more reflective and considered response to safeguarding enquires.

> "Meetings with service users are becoming more purposeful – with specific aim of seeking views and desired outcomes" **(Safeguarding manager; Butler, 2016)**

However, another study highlighted a negative belief among some local authorities and many partner organisations that an MSP approach was more time intensive. This ties in with Theme 1 and stakeholders perceptions of the relative advantage (or disadvantage) of MSP as an intervention. Study authors commented that to support implementation, evidence from research studies should be used to address these beliefs.

> "There is a belief that MSP takes longer - sometimes it does but in fact it is outweighed by far better quality outcomes and real prevention" **(Social work safeguarding lead; Cooper, 2016)**

Five studies highlighted how important it was for staff to fully understand MSP as a strength-based intervention, including the skills they need to implement this intervention consistently and appropriately.[30, 32, 34-36]

> "One thing MSP has really brought to the table is learning to have those difficult conversations with service users" **(Adult social care provider; Cooper, 2018)**

> "[There is a] need for greater emphasis on a skills-based approach to support staff in negotiating the wishes and desires of people who could sometimes be challenging in the decision making process" **(Author interpretation; Butler, 2016)**

Several study authors concluded that staff training in communication and engagement skills was essential to facilitate implementation. In particular, training around how to make information accessible, how to help people identify outcomes, making use of advocates, and knowing how to involve people who have been assessed as lacking mental capacity.[30, 31, 35] It is possible that providing some basic training in MSP across different organisations would help address some of the cultural challenges faced (see section 3.4.2) when limited communication between organisations is a barrier to implementation.

3.4.3.3 Needs and resources of people being supported

This subtheme, which was evident in five studies (seven publications), captures the impact of the perspectives and characteristics of people being supported on implementation.[27, 30-32, 34-36] It includes how people's willingness to attend MSP meetings, and MSP practitioner's ability to engage with them and their families, may affect the implementation process. It also covers challenges associated with actively and appropriately involving people being supported in decisions, especially when they lack capacity. Some respondents reflected that not all adults referred for safeguarding want to, or are able to, engage without an advocate.

> "My wife has dementia and I don't believe that she would be able to fully answer questions without me being present. I was not contacted during the concern." **(Relative of a person being supported; Hertfordshire SAB, 2017)**

> "Quite a few people have said 'you commissioned this service, you sort it out, I'm not coming in to a meeting!'…" **(MSP safeguarding lead; Pike, 2015)**

These comments illustrate the importance of finding ways to support carers to attend safeguarding meetings when appropriate, and finding ways of working with people who do not wish to attend. Two studies highlighted that practitioner's anxiety and difficulties with engaging people being supported, often when the conversation was sensitive in nature, made

implementation of MSP challenging.[30, 31] This anxiety could also potentially be the reason why practitioners perceive the implementation of MSP as complex (as discussed in section 3.4.1.3).

> Some practitioners were anxious about having difficult conversations and engaging with the adult at risk or their representative **(Author interpretation; Butler, 2016)**

Several study authors noted that MSP has raised challenges in how to actively involve people in their own care, especially when they lack mental capacity or are vulnerable; concluding that more work needs to be done by SABs to help engage people who are being supported in planning and shaping safeguarding services.[31, 36]

3.4.4 Theme 4. Embedding and sustaining Making Safeguarding Personal

This theme captured the implementation processes and the receptiveness to change, or 'implementation climate', in an organisation. Successful implementation processes were characterised by effective planning, effective engagement with relevant stakeholders, and execution or delivery. A receptive implementation climate was dependent on the availability of sufficient resources (including training and skills), having committed and accountable leadership, and effective communication between providers and people being supported - especially about shared goals. Data from all seven included studies contributed towards this theme.

3.4.4.1 Embedding process

This subtheme encompasses three core activities of the implementation of an intervention: planning, engaging, and executing.

Planning

The core principle of the planning stage is to design an action plan for the effective implementation of an intervention, which in this case, was MSP. While this stage is related to building local capacity at an individual and organisational level, the studies included in this review also emphasised the importance of engaging with the adults at risk and their families, and involving them in building a course of action during the planning stage. This focus is in line with the person-centred agenda of the Care Act, 2014, and the philosophy of the strengths-based approach that promotes autonomy and control of the person being supported. Four studies highlighted learning around the importance of, and challenges associated with,

achieving meaningful engagement between practitioners and people being supported during the planning stage. [27, 30, 31, 36]

> "The report presented to our first meeting had no starting point, no investigation of what took place or conclusions/actions. Content was shockingly minimal ... I would recommend a standard format to be used." **(Adult at risk; Hertfordshire SAB 2017)**

> All organisations and SABs need to do more to meaningfully engage service users in planning and shaping safeguarding services **(Author recommendation; Cooper, 2016)**

> "it was a negative experience for both staff members and the service user, because …they hadn't planned well enough… we realised we had to spend more time preparing people for what strategic meeting is about, … their role … within it, and how we can support them to have a positive outcome…" **(MSP Safeguarding lead; Pike, 2015)**

When it comes to planning for implementation of MSP, research suggests that, in additional to planning for organisational change, a fundamental shift of approach is needed to support services to involve people being supported at all levels of planning; both in shaping safeguarding services and planning the progress of individual cases. For a more general discussion on engagement, see the section on 'Engaging' below.

Engaging

This activity brings together the stakeholders who contribute towards implementation of the MSP approach, including: service providers (leaders and practitioners in adult social care), champions responsible for supporting, marketing and overcoming within-organisation resistance associated with implementing an intervention, and directors of adult social care. By definition, with MSP, this also involves people receiving care. For relevant quotes please also see those in the section on 'Planning' (above). Three studies (four papers) highlighted the importance of engaging all stakeholders (including clients) during the change to, and promotion of MSP.[31, 32, 35, 36] This process of engagement relied on support from the highest levels of leadership within adult social care.

> "I do see the value of MSP but want senior managers to support me" **(Safeguarding Adult Manager in MSP pilot site; Butler, 2016)**

> "We have given permission to practitioners to work in the way that works best for the person and to use their professional judgement" **(Safeguarding team leader; Cooper, 2018)**

The use of MSP 'champions' (designated leads) among the workforce seemed to help engagement, and taking the MSP message out to practitioners in partner organisations.

However some champions were met with a mixed response in these wider contexts. Cooper and colleagues (2016, 2018) provided evidence from two studies that, while the involvement of champions in the implementation process was seen as beneficial, some professional staff within partner organisations still did not realise the benefits of MSP.[31, 32]

> "The safeguarding team are fully on board but only about 50% of other professional staff are really engaged with MSP" **(Safeguarding team leader; Cooper, 2018)**

This quote highlights challenges faced by adult social care teams when trying to share MSP practice with partner organisations.

Executing:

This stage of the implementation process is about conducting the intervention with the individuals and their families who are seeking service. This theme is therefore about improving delivery of a new form of support by individual practitioners. Planning and engagement influence the execution stage of implementation. The following data captures a range of service changes that have been made, or recommended, for the effective execution of MSP, as well as challenges experienced by stakeholders.

Four studies (five papers) highlighted ways the execution of MSP could be supported, as well the associated challenges. [28, 32, 35, 36] Cooper and colleagues (2018) listed key changes that respondents reported as enabling successful execution of MSP including: making services more user-focussed; active engagement with, and involvement of, people being supported; incorporating flexible timescales; and use of reflective supervision. [32]

> "It has given us permission to deviate from … multiagency procedures in now inviting service users to strategy meetings … in addition to taking more time to meet with service users … at the start of the process … even if this means deviating from the prescribed timescales" **(Safeguarding manager in MSP pilot site; Butler, 2016)**

> "[As a result…] People are more involved in the process right from the start and they have developed an expectation that people will be asked from the beginning about what they want" **(Safeguarding team leader; Cooper, 2018)**

However Hopkinson and colleagues (2015), highlighted that in cases where people being supported did not want to engage with the negative thoughts and emotions that they experienced, this could make executing MSP in practice challenging. [35] Lawson and colleagues (2018) emphasised the need for workforce training and development, so that practitioners were

supported to deliver fundamental MSP principles, including engaging with people being supported and managing risk in a person-centred way.[28]

A view shared across several studies was that there was a lack of consistency about how MSP was being implemented, both within council services, and across partner organisations. Some respondents linked these issues to difficulties executing person-centred practice with user groups where the level of understanding limited people's engagement with defining outcomes. This is also discussed in relation to the needs and resources of people being supported, see section 3.4.3.3, and has implications around equity of provision of safeguarding services for those who may be most vulnerable. Other challenges related to failures to fully understand MSP principles; as discussed in section 3.4.3.2, (in relation to individual knowledge and beliefs), and section 3.4.2.3 (in relation to structural characteristics that pulled practice back towards less Person-centred Approaches).

> "The danger is slogans. People think they understand them and apply their own interpretation, but nothing changes…" … "The biggest barrier for us locally is our recording systems" **(MSP Safeguarding lead; Pike, 2015)**
>
> "The biggest problem is that staff thought they were doing MSP but have now recognised that they were not" **(Social work safeguarding lead; Cooper, 2016)**

For several study authors, and respondents, successful execution appeared to be linked to having the freedom to take a flexible and gradual stepped approach to implementation. This in turn allowed for accumulated learning, and provided the time needed to deal with any problems as they arose. [30, 31, 36]

> "Freeing up timescales and processes has been warmly welcomed" **(Social work safeguarding lead; Cooper, 2016)**
>
> "It does not have a straight line trajectory and progress is fluctuating" … "I think this very much going to have to be evolution not revolution" **(MSP Safeguarding lead; Pike, 2015)**
>
> Full implementation of MSP would require a measured response to changes … Advice on using a step by step approach to implementation via a service development initiative would help with the inevitable "teething" problems of implementation and provide an opportunity for consultation with the pilot staff (**Author interpretation; Butler, 2016)**

These findings suggest the importance of following a step-wise approach towards implementing MSP by: planning an action plan through meaningful engagement with people being supported and families, collaborating with all appropriate individuals who could

contribute towards smooth and successful implementation of the MSP approach (e.g., leaders, practitioners and champions) and executing the planning of action effectively. While a standardised approach of implementing MSP was suggested across studies, it is of note that in practice this may be difficult to attain as each local authority differs structurally and may have cliental with different needs.

3.4.4.2 Factors related to embedding and sustaining MSP within social work, and the social care system

The section captures factors that affect the implementation climate, defined as the 'absorptive capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of an intervention will be 'rewarded, supported, and expected within their organisation'. [18] A range of factors may affect implementation climate, including the availability of resources essential for implementation of the MSP approach, information or knowledge, infrastructure, training and supervision of MSP providers, and systems. Implementation climate is also influenced by leadership engagement, which is the extent to which team leaders and managers are committed and involved with MSP approach. This section encompasses three factors: i) available resources (e.g., IT systems, infrastructure, training, supervision and partnership working); ii) leadership engagement; iii) goals and feedback.

Availability of resources

Evidence under this subtheme indicates which tangible resources ensure organisations' commitment and ability to implement the MSP approach to safeguard adults at risk and their families. Resource availability underpins elements emerging from many of the themes discussed above; including the importance of sufficient resource in supporting cultural change (see section 3.4.2), and the importance of appropriate training to address gaps in practitioner knowledge (see section 3.4.3). Various resources are required for ongoing operations of an intervention and its successful implementation, including training and supervision of the staff, specialised systems based on the need of the organisations, including technological systems, infrastructure, and physical space. Six of the seven included studies identified the importance of availability of resources in implementing MSP, and made recommendations about what needs to change within the current MSP culture to make this intervention effective. [28-36] Evidence suggested that supervised training of the MSP staff was a critical factor that acted as both a facilitator and an inhibitor in the implementation of the MSP approach. Lack of money,

time and staff also influenced supervised training of the staff, leading to unsuccessful implementation of MSP.

> "I had some issues around my team's capacity to do the level of in depth conversation which is needed in MSP. We do have to balance demands from many sources" **(Safeguarding manager in MSP pilot site; Butler, 2016)**

> When training, supervision and peer support mechanisms were provided to support social workers to develop their skills and confidence in this area, it was successfully implemented **(Author interpretation; Cooper 2018)**

Some respondents and study authors suggested that the MSP staff could be trained better if they were provided a 'toolkit' that was based on their learning needs, highlighting guidelines of good practice.

> "Some staff 'get it' and really just need permission to get on with MSP. Others want more of a tool-kit and it would be helpful to prioritise up-to-date tools for councils to use" **(Social work safeguarding lead; Cooper, 2016)**

> Training and best practice sharing should also be made available to encourage the effective use of MSP Toolkit approaches… Staff learning needs around MSP should be identified using a learning needs analysis. (**Author interpretation; Pike, 2015**)

While various authors acknowledged that staff's skill development determined how successfully MSP was being implemented in the area of adult social care, Butler and colleagues (2016) highlighted an important issue about the difficulties in demonstrating how MSP skills should be practiced. [30]

> The biggest challenge to staff development was how to practically demonstrate effective use of a skills based, outcomes focused approach to supported decision during the safeguarding process. **(Author interpretation; Butler, 2016)**

In this study, the respondents reported that they valued several different methods of training and development, including close working relationships with the Professional Standards Adult Safeguarding Team, participating in reflective forum discussions, attending bespoke workshops, and sharing experiences of best practice across localities. [30]

Effective recording systems, including IT systems within an organisation, were identified as another important factor that determined the effective implementation of the MSP approach. Five publications (four studies) highlighted that the recording/information systems of the current services were not adequate, which led to ineffective implementation of MSP. [29-31, 34, 36]

> The information systems used to record information and capture data seem to be a determining factor in prompting social workers to apply MSP consistently in their practice, and this was reported as being a major barrier or enabler **(Author interpretation; Cooper, 2018)**

> A patchy picture of IT systems emerged: some councils have more success with the same system than others and some have either bought in or grown their own modifications. It is an area ripe for further investigation and development. **(Author interpretation; Cooper, 2016)**

To address this issue, one respondent recommended that a centralised recording system could help, although another felt that each council would need to adapt its own localised system.

> "…it would have been helpful if, given there's a small number of [IT system] providers if something could have been done centrally with providers, rather than having to individually negotiate a cost/ spec as I think that's slowing a lot of us up" **(MSP Safeguarding lead; Pike, 2015)**

In summary, the limited availability of suitable resources to support MSP implementation emerged as a strong theme in most studies. Key factors identified included: a lack of good information about safeguarding to give to people using services, limited staff awareness about advocacy, unsuitable IT and recording systems, staffing issues that made it difficult for all staff to attend training, and a lack of safeguarding policies and procedures that were appropriate for person-centred care.

Leadership engagement

This factor, which is closely aligned with section 3.4.4.1 that discusses engagement stage of embedding MSP, highlights the key role of leaders and managers in the successful implementation of MSP approach. Six publications (four studies) highlighted how crucial the involvement, commitment, accountability, and leadership of all senior stakeholders was in embedding MSP into adult social care. [28, 29, 31, 32, 34, 36] This factor was noted as having the potential to facilitate or inhibit the implementation process.

> "This is going to be a very hard nut to crack without more support from yourselves [Research into Practice for Adults (RIPFA)] and from ADASS [Directors of adult social services] etc." **(MSP Safeguarding lead; Pike, 2015)**

> "MSP has been owned and backed by senior management since the start - they see it as the right thing to do - it's seen as a golden thread and not as an add-on" …"There has been strong support from councillors who have protected the services from some of the Local Authority cuts" **(Two social work safeguarding leads; Cooper, 2016)**

Data from respondents in these studies implied that, in addition to within-organisation leadership and management, support at a national level was crucial; including for example, engagement from Directors of Adult Social Services (ADASS), Safeguarding Adults Board (SAB) members, Health and Well-being Board members, and cabinet members. Leaders also needed to work alongside practitioners, and people who have experienced safeguarding support during the process of implementation of MSP. [34]

Use of goals and feedback

This factor is related to the extent to which providers and people being supported are communicating with one another regarding the goals to be achieved during an MSP intervention, learning from feedback, and acting on this in a collaborative manner. Data from four studies contributed to the description of this subtheme. [28, 30, 31, 36]

Within the strengths-based professional culture and practice that MSP is embedded in, more attention is given to agreeing the wishes and desired outcomes with adults involved in the safeguarding process and having honest discussions about how outcomes can be realised. This enables staff to be more supportive of the adult at risk and less anxious about following person-centred processes. It also helps people being supported to guide service development, and to feel engaged and informed during the safeguarding process.

> "A key change was talking to the adult before the strategy meeting … now the adult is part of the strategy discussion even if they don't want to be part of the safeguarding process..." **(Safeguarding Adult Manager in MSP pilot site; Butler, 2016).**

> "We invited service users to recent Board away day and asked their views. This was very successful" **(Social work safeguarding lead; Cooper, 2016)**

However, some respondents implied that, despite reports of effective involvement, in some cases people being supported were still not routinely included in development of service goals or in feeding back on service experience, which was a missed opportunity.

> "Not aware of a service user rep on SAB; not aware of any engagement with service user groups" … "We need to look at how we get views from people and [hear] their voice" **(Two social work safeguarding leads; Cooper, 2016)**

From the service providers' perspective, it becomes critical that the set goals of safeguarding individuals at risk are discussed within social work teams, through sharing case studies. For efficient goal-fulfilment, all the staff members, including the leadership within and outside

organisations, may need to provide feedback on instances of MSP in practice to achieve these goals. This was highlighted as a critical aspect of implementation process by Lawson and colleagues (2018) and Cooper and colleagues (2016). [28, 31]

> Where Safeguarding Adult Review repositories are being developed at a regional (or national) level, these should be enhanced to include reflective opportunities from MSP practice and users' views **(Author interpretation; Cooper, 2016)**

In line with this, it may also be beneficial for the practitioners to discuss successful cases in terms of how they approached safeguarding using MSP principles. This peer feedback approach could improve implementation and increase the confidence of the team.

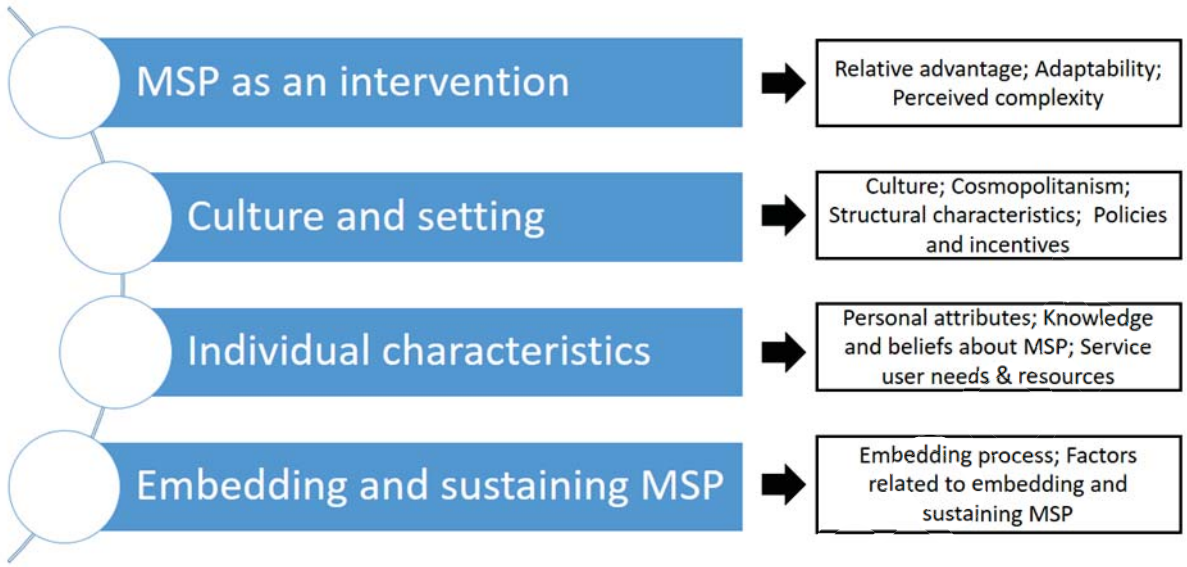
> Councils should capture and share successful case studies within their teams, to show how MSP can work well in their local context **(Author recommendation; Pike, 2015)**

These findings indicate that implementation of MSP can be improved by reforming the current social work climate to address issues around lack of appropriate resources to ensure; safeguarding information is available in a suitable format for people being supported; appropriate recording systems are available to staff; there is sufficient staff capacity to enable training and appropriate supervision; and that time for reflection is provided. Both leadership, within the organisation and the support of senior managers at national level, was identified as key factor that affected embedding MSP approach across councils. Lastly, these studies highlighted the importance of involving all stakeholders (including people being supported) in establishing goals when safeguarding individuals at risk, as well as the importance of supporting practitioners to make use of peer feedback and reflection on the process of goal achievement.

3.4.5 Summary of the four emergent themes:

The framework synthesis of experiences and evaluation evidence about Making Safeguarding Personal has produced a set of enabling and hindering implementation factors organised under four themes. These and the key sub-themes are shown in Figure 4 below. For a discussion of how concepts within one theme may be affected by those within other themes, please see section 3.4.6, 'Interactions across themes'.

Figure 4. The four implementation themes and their related sub-themes



Theme 1: Features of Making Safeguarding Personal as an intervention

The successful implementation of MSP in different councils was perceived to be associated with it being adaptable, not too complex, seen as evidence-based and perceived as offering advantages relative to traditional approaches to safeguarding. As a new intervention or approach, there were some negative views and additional investment in time and resources to deliver MSP. However, the advantages and benefits of MSP for people in the longer term were believed to outweigh these potential disadvantages (relative advantage subtheme). These advantages were experienced by people being supported, and carers, as well as frontline staff.

Implementation was also affected by the perceived strength and quality of evidence supporting the effectiveness of MSP (evidence strength and quality subtheme). But rather than comprising formal research-based evidence, the underlying evidence tended to derive from local evaluation experience and more gradual learning (for example, about the actual time required to deliver MSP, and the perceived benefits of a more person-centred approach).

The adaptability of the MSP approach was also found to be a critical determinant of successful implementation. This included the ability to change how different people engage with it (those seeking support, and professional and non-professional carers), and to enable its use by partner agencies who work with local authorities (for example, acute hospitals, perhaps used to more

traditional approaches to safeguarding). However, the studies did not identify which specific features of MSP might need to be adapted, or which features should be regarded as 'core' or essential in order to retain the anticipated benefits.

The perceived complexity of introducing and sustaining MSP, relative to existing resources, existing professional capabilities, and competing priorities, also affected implementation success. In part, this complexity arises due to MSP being about shifting professional culture and attitudes and behaviours, rather than introducing more discrete intervention components. For example, this requires the skills and time to enable changes through reflective practice.

Theme 2: Culture and setting

Both the broader setting - across different local authorities and partner organisations, government policies and legal frameworks - and the 'internal setting' of the local authority, council and adult social care teams delivering MSP had important impacts on the implementation process of MSP. The implementation of MSP was also supported by shifts in the culture of organisations and professionals, especially towards more person-centred and outcome-oriented approaches, following the 2014 Care Act. Culture change was in turn enabled by leadership in adopting strengths-based approaches and greater involvement of people being supported in support processes (e.g. family group conferences).

Good inter-organisational collaboration and connectedness (e.g. between councils, with the NHS, with care homes) was also believed to foster successful implementation of MSP ('cosmopolitanism'); partly because such collaborations spread a stronger understanding of what MSP comprises and achieves. Such connections could either be maintained between key individuals (e.g. 'MSP champions') or organisational structures (e.g. Safeguarding Adults Boards).

The studies also showed how various structural characteristics, including size of the service or organisation, its staff capacity and access to services within the wider adult social care system affects the implementation of MSP. For example, there was some evidence that 'single point of access' systems better supported approaches like MSP. While several studies found that smaller teams often found implementation easier, one study suggested smaller teams found it harder to implement MSP, possibly (the authors suggested) because they suffered from lower staff morale due to high workloads.

Every study about MSP included within the scope of this synthesis discussed the impact of policies and regulations on the implementation of MSP. These might be external (national) policies or internal (local, council) policies and regulations. The Care Act of 2014 and Mental Capacity Act of 2005 were the national policies most often cited as driving change. However, some requirements of legislation, such as the need for training and specific knowledge (e.g. in relation to Deprivation of Liberty Safeguards), or tensions between the goals of maintaining autonomy/rights and assuring protection, could make implementing MSP more challenging. Also local policies and procedures were sometimes not well-aligned with MSP approaches, and this could hinder implementation of MSP.

Theme 3: Individual characteristics

This theme captures the influence of the individual characteristics of care professionals' and people being supported. For care professionals, the implementation of MSP was affected by personal and professional characteristics linked to confidence in their professional judgment and ability to execute MSP, creativity (especially in using available resources), enthusiasm, and resistance to change from using a traditional deficit-based approach to safeguarding. Implementation was also believed to be more successful when care professionals had good knowledge about MSP, both its core principles and specific skills. Lastly, the successful implementation of MSP critically depends on engaging with those people being supported who have the mental capacity to be involved in decisions about their care and are sufficiently motivated to attend the meetings. Particular challenges were identified with involving people who lacked capacity, or were particularly vulnerable.

Theme 4: Embedding and sustaining Making Safeguarding Personal

This theme captured factors related to embedding and sustaining MSP within social care system – that is, the absorptive capacity for change within teams and organisations. Successful implementation processes were associated with effective planning, effective engagement with relevant stakeholders, and complete execution or delivery. A receptive implementation climate was dependent on the availability of sufficient resources (including training and skills), having committed and accountable leadership, and effective communication between people being supported and providers about shared goals. The resources required for the ongoing successful implementation of MSP or similar approaches include training and supervision of the staff, but also other specialised systems based on the need of the organisation(s), including technological/IT systems, infrastructure, and physical space.

3.4.6 Interactions across themes

While the factors discussed above have been categorised across different themes and subthemes, they were rarely seen as influencing the implementation process of MSP independently. All of the included studies provided evidence that a range of enabling and hindering factors, functioning at individual, organisational and national levels, interacted with each other; and determined the ease with which MSP could be embedded within the social care system. For example, the extent to which MSP is perceived as advantageous, adaptable and complex (as discussed in section 3.4.1 'MSP as an intervention') depends on personal attitudes of the service providers, their knowledge and beliefs and whether they feel that the needs of people being supported are being catered to by using MSP (as discussed in section 3.4.3 'Individual characteristics'). For the professionals to feel confident about using MSP as a safeguarding approach to achieve positive outcome, they need to be equipped with appropriate skills and resources during their supervised training. They could then plan and execute this approach more effectively and collaboratively with the multiple agencies often involved in providing social care (as discussed in section 3.4.4 'Embedding and sustaining MSP').

While these individual factors are key in facilitating the implementation process, MSP cannot be truly embedded and sustained if the existing social care system does not shift towards adapting a culture that is more person-centred, empowering, and strengths-based, as required by the Care Act 2014.

3.5 Descriptive summary of studies on other strengths-based approaches

Our searches also identified eight studies which reported analyses or qualitative information about the implementation of six other strengths-based approaches. These were qualitative studies or evaluations of:

- Local Area Coordination (LAC) in the UK [44, 45]
- Asset-Based Community Development (ABCD or community-led support)[39]
- Solution Focused Therapy (SFT) [38] [37]
- Family Group Conferencing (FGC) [42]

- Motivational Interviewing (MI) [41]
- Asset-Based Approaches [40]
- Strengths-Based and Relationship-Based Approach[43]

Following consultation with an expert stakeholder from the profession of social work and adult social care (co-author Baron) the approaches were grouped under two broader categories: i) Organisation change approaches, and ii) Practice approaches. While Organisation Change Approaches are implemented by local authorities as a mechanism to introduce different ways of working under the umbrella 'strengths-based approaches', Practice Approaches emphasise the use of specific skills, knowledge, underpinning theory and professional behaviours to create change.

Descriptive summaries of these eight studies are provided below, including the aim of the studies, site and source of data, methods used, quality of the evidence and study results. The findings presented in this section are related to the implementation process and also reflect major domains of the consolidated framework for implementation research (CFIR), [18] which was used to synthesis the studies examining MSP approach. The main focus of each included study and the main implementation themes identified by their authors are summarised in Table 4.

3.5.1 Organisational change approaches to strengths-based working

Two studies were identified using an 'organisational-model', which is implemented by local authorities as a mechanism to introduce different ways of working under the umbrella 'strengths-based approaches'. These two studies examined the implementation of Local Area Co-ordination [44, 45] and Asset-Based Community Development [39] and were published in 2007 and 2017. While the investigation of ABCD examined data collected across different geographical locations in the UK (Denbighshire, Derby, Doncaster, East Renfrewshire, Leeds & Shropshire), the study that examined the LAC approach collected data from Scotland (Edinburgh, Glasgow, Alloa). Our quality assessment judged that both these studies were of 'poor quality' (see Table 2).

3.5.1.1 Local Area Coordination

This approach emphasises establishing partnership working between various services (e.g., public health, emergency, housing, and family services) to offer one access point for

individuals and strengthen outcomes. Stalker and colleagues (2007, 2008) evaluated implementation of Local Area Coordination (LAC) in Scotland to explore (in broad terms): i) the outcomes of LAC work, ii) the lessons from its implementation of LAC, and iii) future scope of this strengths-based approach. [44, 45] This study used a mixed methods approach, including interviews with people being supported and providers (workers at frontline and managers) to generate qualitative understanding of LAC. The study was of 'poor quality' due to lack of clarity around the methods it used (see Table 2).

The findings highlighted that the implementation of LAC was determined by a range of structural or organisational factors. For example, pre-existing collaboration with other agencies and the size of area that LACs had to cover, impacted implementation process - those working in smaller communities sometimes had to turn away requests for support, which may be due to high case load that made it impossible for the service providers. Other barriers to implementation were practical rather than ideological, such as budgetary constraints and embedded bureaucratic structures. Individual factors affecting implementation related to views on the efficacy of LAC. In this study, line and operational managers had mixed views about the efficacy of Local Area Coordination, although generally welcoming it. Those who were enthusiastic, largely attributed this to the skills and experience of the workers they had recruited into the new posts. Where others were more sceptical, this was often due to the shortage of other resources within the local authority and the requirement that they managed this shortfall.

3.5.1.2 Asset-based community development (ABCD) approach

This strengths-based approach is community-driven and focuses on mobilising assets and resources at individual and local community level to provide care. Brown and colleagues (2017) shared the learning and examples of the impact identified from working with nine local authorities across England, Wales and Scotland that were working differently to improve the lives and support of local people using ABCD approach. [39] The qualitative data examined in this review was collated across four sites. The study was of 'poor quality' due to lack of clarity around the methods used by the authors (see Table 2).

This study also provided a detailed account of the issues and challenges faced in achieving care outcomes when utilising the ABCD approach. For example, resistance to change was associated with those areas/teams where the introduction of 'community-led services' felt imposed rather than invited (i.e., inviting expressions of interest to be innovation sites vs. imposed implementation). The issue of trust/mistrust of councils, between the council and its

partners, and between the community and various agencies emerged as a key factor that hindered the process of implementing the ABCD approach. Critical bottleneck and process issues were identified in establishing a redesigned, 'front doors' to the service. The study highlighted some confusion (especially in the early stages of community-led services implementation) about how services should promote where and with whom people should get in touch for support and advice.

Considered together, these findings about two organisation change approaches to strengths-based working suggest that both structural and individual practitioner factors play a critical role in embedding LAC and ABCD approaches within services. The perceptions of service providers (working at frontline and senior levels) and support from leadership are critical factors influencing the implementation of these approaches. But so also were adequate budgets and the existence and strength of pre-existing collaborative working. It is important to note that our searches had found other studies that examined LAC and ABCD approaches. However these studies were excluded as they did not clearly report to what extent social work teams were involved in delivering these approaches, whereas the two studies discussed above stated that social workers were clearly involved.

3.5.2 Social work practice approaches to strengths-based working

Six studies were identified of strengths-based approaches that emphasised the use of specific skills and professional behaviours to create change. [37, 38, 40-43] These studies examined a range of strengths-based approaches including Motivational Interviewing, Asset-Based Approaches, Solution Focussed Therapy, and Family Group Conferencing and were published between 2007 and 2017. These six studies examined initiatives in different locations in England (n=5) and Scotland (n=1). Our quality assessment process highlighted that while studies investigating Asset-based and Family Group Conferencing approaches were of 'good quality', [40, 42] one study that examined Motivational Interviewing approach was of 'poor quality.'[41] Of the two studies that investigated Solution-Focused Therapy, one study was graded as 'poor quality' [37] study and the other as 'good quality'. [38] (see Table 2) The study examining asset-based approach did not clearly highlight whether this approach was being applied at professional, organisational or both levels. However, we have categorised this approach as using practice model based on our current understanding and expert advice. It is also important to note that two studies evaluating Family Group Conference and Motivational Interviewing were related to social care

with children and families. These studies were included because they evaluated the data from parents of children who were seeking services.

3.5.2.1 Solution-Focused Therapy

Solution-Focused Therapy (or solution focused approaches; SFT) aim to identify individual goals and the ways in which these goals can be achieved. Two studies examined this strengths-based approach. [37, 38] Wheeler and Hogg (2004) discussed the 'mechanisms' of SFT. [37] Using data collected through in-depth interviews and focus groups, the researchers examined what makes solution-focused practice valuable, how do the practice tools work, what could help service providers learn solution-focused skills, and the role of senior management in embedding this approach and helping workers develop solution-focused skills. This study was graded as 'poor quality' due to missing information, including that the authors failed to provide details on the sample size recruited for the study and the location from where data was collected (see Table 2).

The study findings highlighted how this approach aimed to produce positive outcomes, adaptable, provided social workers with the skill set, and distinguished between what was working. There was evidence on how there were perceived advantages of using this approach (e.g., it could be used by different frontline professionals). Compatibility between solution-focused practice and key legislation and policy initiatives also facilitated its implementation. Lastly, this approach was seen as strengthening relationships within the family, which could be tailored to meet the needs of the people being supported and their entire family. It may be important to note that the findings of this study were not critically analysed clearly by the authors (as indicated in Table 2); specifically within the context of issues and challenges that social workers faced while delivering SFT. Further, it was unclear what factors hindered the implementation of this approach within the service.

Another study conducted by Smith and colleagues (2011) explored the impact of brief Solution-Focused Therapy (SFT) training for a group of community-based social workers. [38] The data were collected from a service in South East England (outside of London), using interviews with six social workers. These professionals worked with adults with intellectual disabilities and had attended a two-day training program nine months prior to data collection. This study was graded as 'good quality' overall but it was unclear whether the authors critically evaluated the methods and the results of this study (see Table 2). In this study, implementation of SFT was associated with social workers' views on the factors that impact the transfer of the skill set that

they were taught in the training. There seemed to be a lack of explicit knowledge about how this approach could be applied within particular contexts, which highlighted the importance of addressing such issues during training and supervision. The extent to which SFT skills could be appropriate in understanding their role as a social worker in the service, and the expectations about their work within the service also influenced the implementation of this approach. Changing care professionals' approaches for connecting with clients emerged as a key factor. This study also highlighted the time-consuming nature of this approach and ambiguity around its perceived applicability, which was a result of low confidence of the professionals in transferring solution-focused skills into practice, and this hindered the implementation of SFT approach.

3.5.2.2 Family Group Conferencing

Family Group Conferencing (FGC) is a strengths-based approach that brings together immediate and extended family, including friends, to address concerns of people being supported. Manson and colleagues (2017) examined a service in Leeds that practiced the FGC model to provide care to families affected by domestic violence. [42] This study focussed on evaluating: i) what FGC model was established and what difference it made to families; ii) what the features of an effective model were; iii) what the experiences and outcomes were for different family groups; iv) what services were commissioned and identified for commissioning in response to FGC, and why. This 'good quality' study (see Table 2) used a mixed methods approach, where FGC managers and coordinators were interviewed. The findings highlighted the role of these professionals' confidence in accessing practice supervision and developing professional relationships with families, and the need to recognise and respond to their anxieties in successful implementation of FGC approach. While factors playing at individual level (e.g., the perception of people being supported of positive features of FGC) emerged as important, organisational characteristics such as an organisation's culture of information sharing with other services, and wide engagement of stakeholders, were seen as central to the successful expansion of FGCs. Lastly, limited opportunities for FGC coordinators to come together across teams to share and reflect on practice was identified as a factor that hindered the implementation process. Although this study focussed on child social services and related outcomes, it evaluated data collected from whole families and professionals, which was one of the inclusion criteria of this review.

3.5.2.3 Motivational Interviewing

Motivational Interviewing (MI) is a skill-based technique that supports people to regain the positive motivation they require to be better at tackling behaviours that may be holding them back from recovering useful life skills. Forrester and colleagues (2008) evaluated the effectiveness of a two-day workshop in MI for social workers. [41] The focus of training was alcohol misuse but participants were encouraged to explore the use of MI with other issues. Although this study focussed on child services, it was included in the review as it provided insights into the mechanisms of this strengths-based approach and factors that facilitated or hindered MI skill development amongst child and adult social workers. This study evaluated quantitative and qualitative data collected from social workers across seven local authorities in London. The study was of 'poor quality' due to lack of clarity around the methods it used (see Table 2).

The findings highlighted how the training impacted social workers and key factors that facilitated or hindered them in developing their use of MI (e.g., the pressure to process cases rapidly and to obtain specific information was perceived to make the use of a client-centred approach difficult). An important factor that emerged about the implementation of FGC was the perceived usefulness of MI. For example, MI-related skills had helped reduce resistance and increase parental engagement. This, coupled with the findings indicating that this approach could be used to address a wide range of issues and its application, made clients feel that they were being heard, made this approach effective, and thereby increased the likeliness of its further implementation. While MI was associated with positive outcomes, its delivery by telephone was identified as less effective, indicating that how this approach is delivered may affect its implementation. Another barrier identified was about lack of strong support in skills development due to lack of supervision and training.

3.5.2.4 Asset-based Approach

This approach emphasises the utilisation of people's and communities' assets to provide care and support to high risk individuals. One study examined this strengths-based approach. [40] McLean and colleagues (2017) illustrated how asset-based principles were being applied within a range of services in Scotland, and explored the potential application of asset-based principles within such a setting. The services under evaluation supported young pregnant females, and adults suffering from learning disabilities, mental health issues, and addiction. This 'good quality' study (see Table 2) used a qualitative methodology to analyse data, including in-depth

interviews (collected from both people being supported and providers), case studies, end of year reports and meeting minutes.

The results of this study highlighted the role of power-sharing and the involvement of staff, people supported by services and community members in the design and development of the service. Leadership and partnerships at multiple levels were identified in influencing new ways of working and culture change within organisations that impacted the implementation of asset-based approach. At a more individual level, staff professionals' attitudes (e.g., flexible, sensitive and responsive) and their core skills affected the extent to which an asset-based approach could be easily implemented across the services. Also, the study did not clearly highlight whether this approach was being applied at professional, organisational or both levels. Although we categorised this approach as being primarily practice model (after consulting with an expert stakeholder from the profession of social work and adult social care), it may be that the approach evaluated here was more of a hybrid organisational and practice approach.

3.5.2.5 Strengths-based with Relationship-based Approach

This approach seeks to improve and maintain the wellbeing of people being supported by identifying the individual's strengths (at personal, community or social level), seeking to maximise those strengths, and work towards improving relationships within families to enable them to achieve their desired outcomes. One study examined what it called a strengths-based approach. [43] This study evaluated an intervention model of intensive meetings with people being supported, which was set up to provide early intervention and preventative services for adults falling outside of the national minimum eligibility threshold for care and support. The nature of these meetings between service providers and users was that were timed. This 'good quality' study (see Table 2) used a mixed methods design, where data were collected by interviewing people being supported, providers and other stakeholders. The findings highlighted that social workers felt that the strengths-based model being adopted offered greater autonomy to use core social work skills and aided people being supported, to prevent, reduce and delay the need for care and support. However, working in meetings that were timed was found to be a challenge that needed further thought, and perhaps could be managed by installing more effective IT systems within the organisation. Honest and transparent discussion with other colleagues within the organisation, and legal literacy emerged as important factors determining the implementation process. The participants (social workers) also reported that

by using this approach they were able to build 'a trusting relationship' that helped them talk to their clients more openly. This made people feel that the support being offered to them was genuine and for their personal benefit. Lastly, joint working and external collaborations were valued in providing a more holistic approach and embedding this approach with the service.

3.5.1.3 Common themes across the studies

There were some common themes that resonated across most of the studies. These themes included the role of leadership in culture change within organisations, individual characteristics of the service providers and their understanding of their role as a social worker, communication, and involvement of relevant stakeholders in embedding strengths-based approaches across local authorities.

While these factors affecting implementation were common, the extent to which each of these factors influenced change varied across approaches. For example, professionals' characteristics and their attitude towards the adoption of a strengths-based approach, and their ability to deliver care based on training and how well they were supervised emerged as stronger factors affecting implementation in studies that examined Solution Focused Therapy and Motivational Interviewing. One explanation for this may be that these approaches are more explicitly skills-based, and this requires professionals to be confident about their understanding of Solution Focused Therapy and Motivational Interviewing (both theoretically and practically). Likewise, the role of within-organisation and external collaborations, and involvement of higher level leadership and stakeholders were identified as key in studies examining the Asset-Based Approach, given that community assets are best utilised when services and external agencies are both working towards the common goal of person-centred care. Further, embedding Asset-Based Approaches becomes smoother if organisations' internal policies are closely aligned to national policies.

The implementation factors discussed above were similar to those that emerged across MSP studies that were synthesised using the CFIR framework. This may mean that there are some common factors informing the wider implementation of many strengths-based approaches in the UK, and which are relevant to both organisational change models and social work practice oriented strengths-based approaches.

Table 4. Study characteristics and themes of implementation factors identified for other SBAs

Local Area Co-ordination (Organisational change approach delivered at community level) **Stalker, 2008** Local Area Coordination: Strengthening support for people with learning disability in Scotland. [45] **Stalker, 2007** Evaluation of the Implementation of Local Area Coordination in Scotland [44] **Area** – Scotland (various locations)			
Aim or focus of paper (from paper)	**Sample**	**Data collection and analytic approach**	**Themes**
As part of its core funded programme for the Scottish Executive, the Social Work Research Centre at the University of Stirling was asked to conduct an evaluation of the implementation of Local Area Coordination (LAC) in Scotland. This 11 month study ran from October 2005 to August 2006.	Questionnaire: N= 44 local area co-ordinators (LAC's) from 24 different Local Authorities (LA's)	Questionnaires: were analysed using SPSS	Community capacity building Distinctive features of LAC View about LAC ethos Clarity of role, accountability and support The main barrier to implementation of LAC in the authorities that would have liked to implement it was predominantly financial Pressure to implement LAC The perceived need for LAC Leadership
Study aims were to: examine lessons from implementation of LAC across Scotland explore (in broad terms) outcomes of LAC work assess future scope for LAC	Semi-structured Interviews: n=35 LACs from 24 different LAs n=14 Managers from 13 randomly elected LAs with LACs n=7 Managers from 7 LAs without LACs Case Studies: N=4 carried out in 4 different LAs (selected to examine; Rural setting, Urban setting, Voluntary sector & across traditional service user boundaries) individuals and families, LACs, managers, and staff in other agencies.	Interviews: LAC's were interviewed for 60-90 minutes interviews were tape recorded and fully transcribed. Managers with LAC's were interviewed for approx. 60 mins. Managers without LAC's had a shorter interview schedule that was e-mailed or posted in advance & interviews were tape recorded using telephone audio recording equipment. Interviews lasted between 20 and 30 minutes. Case Studies involved a mixture of observation and interviewing. Topic guides were developed for local area co-ordinators, managers, service users, parents/families and community groups, along with consent forms and a framework for analysis.	

Community Led Support - Asset Based Community Approaches (ABCD; Organisational change approach delivered at community level)

Brown, 2017. Findings and lessons from local approaches and solutions for transforming adult social care (and health) services in England, Wales and Scotland - First evaluation report [39]

Area – Denbighshire, Derby, Doncaster, East Renfrewshire, Leeds & Shropshire

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
Report sharing the findings, learning and examples of the impact identified from working with 9 authorities across England, Wales and Scotland who are working differently to improve the lives and support of local people.	Waiting times: (to first contact, between first contact/first conversation, second conversation, support in place). Sites n=4 provided data on waiting times – for innovation sites, roll out sites, whole authority.	Review of local quantitative data collected, collated and analysed by 4 sites.	What is Community Led Support? What is Community Led Support achieving? Understanding impact of CLS Understanding the process of change
Essentially an evaluation report on the authorities' progress towards the outcomes and longer-term aims of community led support over an 18 month period.	Waiting lists: Sites n=4 provided data on waiting lists (mostly relating to innovation areas).	Review of local quantitative data collected, collated and analysed by these 4 sites.	
	'Footfall' through community hubs, appointments/drop-ins: Sites n=6 provided data on attendance/non-attendance.	Review of quantitative data collected, collated and analysed by these sites.	
	Numbers using different kinds of Support – by role/profession, community/ service solutions: Sites n=2 provided data on different kinds of support.	These sites participated in the Cost-benefit analysis (see below).	
	Financial performance – resources allocated/spent on different kinds of support Sites n=4 provided financial analysis of varying detail/coverage.	Review of financial information provided by 2 sites. Cost benefit analysis for the other 2 sites (who also provided information on support, above) using the New Economy Manchester methodology.	

	Feedback from 196 people participating in interviews, focus groups and observations during fieldwork visits: 73 change stories (including case studies) from 6 sites. *Other*: Sites n=4.	Thematic analysis of 52 stories from 4 sites. 4 sites provided data on customer and staff satisfaction surveys.	

Solution-Focused Therapy (Social Work Practice Approach delivered at individual level)

Smith, 2011 A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team [38]

Area – South East England (outside of London)

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
Explores the impact of brief Solution-Focused Therapy (SFBT) training for a group of community-based social workers.	Social workers n=6 working with adults with intellectual disabilities took part in the study. All had attended a 2 day workshop in SFBT, 9 months previously.	A *qualitative interview*-based design was used, with the researcher adopting an ethnographic stance to obtain a rich, detailed and focused account of events. The interviews were transcribed and subjected to thematic analysis.	Transferring techniques is hard without practice and support. How can the transfer and further development of skills in the specific techniques be done effectively Does it fit with my role?

Solution Focused Therapy (Social Work Practice Approach delivered at individual level)

Hogg & Wheeler, 2004 Miracles R Them: Solution-focused Practice in a Social Services Duty Team [37]

Area – England (UK)

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
1. What did the workers value about Solution-focused Practice? 2. How were the practice tools working? 3. What helped workers to develop skills in Solution-focused Practice? 4. What the manager did that helped? 5. What could managers in general do to help workers develop skills in Solution-focused practice?	Social work services team members, team manager, senior manager, team clerk. Details on sample size were not provided	Two-hour focus group with the social worker team were conducted to examine Questions 1 and 2. For questions 3, 4 and 5, the second author carried out a interviews with people coming from different perspectives: members of the team, the team clerk, the manager's manager and the manager herself.	Social work practice issues Working in partnership with service users/carers Interface between policy and practice

Family Group Conferencing (Social Work Practice Approach delivered at individual/family level)

Manson, 2017 Leeds Family Valued Evaluation report July 2017 [42]

Area – Leeds, England (UK)

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
To evaluate: 1.What is the Family Group Conference (FGC) model established at scale and what difference does it make to families? 2.What are the features of an effective model? 3. What are the experiences of, and outcomes for, different family groups, (example, those affected by domestic violence)? 4.What services are or can be commissioned in response to FGC, and why?	81 participants - surveys of 76; a telephone survey of 36 parents/carers and, analysis of administrative data.	Used a mixed methods approach. The qualitative strand of the evaluation combined: interviews and focus groups with FGC managers and coordinators.	Characteristics of FGC workforce Experience of FGC FGC prototype Role of Information sharing (with other services) Expansion of FGC (barriers and facilitators) Introduction of FGCs to families is of central importance A multi-agency approach

Motivational Interviewing (Social Work Practice Approach delivered at individual level)

Forrester, 2008. Child Risk and Parental Resistance: Can Motivational Interviewing Improve the Practice of Child and Family Social Workers in Working with Parental Alcohol Misuse? [41]

Area – Seven London Local Authorities

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
This study examined the effectiveness of a two-day workshop in Motivational Interviewing (MI) for social workers in changing self-reported practice over a three-month period, the levels of skills achieved, and factors associated with acquired skills, including the impact of post workshop supervision. The training was focussed on using MI with alcohol misuse amongst other issues.	Social Workers (n=40)	A multi-method pre and post design was used. The data were collected utilising both quantitative and qualitative methods and employing an embedded randomized controlled trial of the impact of supervision.	How did the training impact on the practice of workers? What helped or hindered them in developing their use of MI? In what situations did they find MI useful? What challenges were there in using MI?

Assets-Based Approach (Social Work Practice Approach delivered at individual/community level)

McLean, 2017. Asset-based approaches in service settings: striking a balance. [40]

Area – Edinburgh, Glasgow, Alloa

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
This study examined how asset-based principles are being applied within a range of services that impact on health and wellbeing. It further explored the potential application of asset-based principles within such a setting.	Key *service documents*: end of year reports, briefing papers, evaluation reports; published literature, minutes of Board and team meetings, plans and frameworks, performance management reports, funding proposals, and service-related information (example: leaflets, presentations, and website information).	The research fieldwork took place from February 2014 to March 2015. *1. documentary analysis* of key service related information. *2. semi-structured interviews* with strategic and operational staff and people supported by the service	Shifting the balance Leadership and influence Building relationships & partnerships Creating the conditions People and skills
Five research objectives were to: • examines, within and across case study examples, the characteristics, features, benefits and impacts, and limitations/challenges, of applying asset-based principles in a range of service settings • investigate the potential application of asset-based working within health and social care service settings, and the implications of this • highlight the workforce development implications of introducing and embedding asset-based principles • synthesise the learning to identify common features and themes, discontinuities, and transferable learning	Eighty-six *interviews* were conducted across the nine case studies: (61 with staff and 25 with people supported by the services).	*Data analysis* involved a case-by-case and a cross-case analysis of the data. A case study analysis framework was constructed. Analysis was carried out within cases initially and, subsequently, a thematic cross-case analysis was conducted	

• highlight policy implications and make recommendations for the future development of asset-based approaches in Scotland.			

Strengths-based & Relationship-based Approach (Social Work Practice Approach delivered at individual level)

Anka, 2017. Social work intervention with adults who self-neglect in England: responding to the Care Act 2014 [43]

Area – South East England.

Aim or focus of paper (from paper)	Sample	Data collection and analytic approach	Themes
This study examined a timed intervention model of practice comprising of up to 24 weeks of intensive meetings with adult service users who hoarded, which was set up by one local authority in England, to prevent and delay the need for care and support.	*Interviews:* Service users (n=13), Social workers (n=3), Social work managers (n=2) Stakeholders from external services and agencies (n=6). *"Satisfaction with life" self-report questionnaires (*completed at pre- and post-intervention stages): Service users (n=20)	It was a mixed-methods study, which included a costing analysis of staff time and an analysis of goals of service users.	The approaches used by the team The differences made to the service users

4 Discussion

4.1 Summary of the findings

We found no UK-based studies which met the inclusion criteria for assessing the effectiveness of any of the 17 named strengths-based approaches that were the focus of this systematic review.

We found 15 qualitative and mixed methods studies that provided evidence about the implementation of eight strengths-based approaches. There were seven studies (10 publications) providing insights into the implementation of Making Safeguarding Personal. We found two studies that examined Solution Focused Therapy and single studies about each of the following strengths-based approaches: Local Area Coordination, Asset- Based Community Development (community-led support), Strengths-based with Relationship-based Approach, Asset-Based Approaches, Family Group Conferencing and Motivational Interviewing. These studies were discussed within the context of the aims of the studies, methods, quality of the evidence and factors that related to the implementation.

Only seven of the 15 included studies, which examined Making Safeguarding Personal, were sufficiently similar in focus to warrant formal synthesis. Framework synthesis was used to synthesise the identified evidence. For this review, we adapted the consolidated framework for advancing implementation science (CFIR) [18] in the following ways to reflect findings of included studies: *culture* and *settings* were merged to form one theme; *inner and outer settings* were merged (as, within our studies, differences between these two overlapping constructs were not usually clearly defined); *individual characteristics* was extended to include people being supported (as MSP involves people being supported in delivery); and several sub-themes (that were not reflected in the data) were removed. These changes ensured the CFIR model reflected the data contained within the included primary studies. The key features and findings of the other eight studies about seven strengths-based approaches were summarised descriptively and within a table (see Table 4).

We found no UK-based studies that met our inclusion criteria which provided either effectiveness or implementation evidence in relation to the following 11 named strengths-based approaches that we had sought research evidence about: Appreciative Inquiry, Ecological Approach, Narrative Approaches, Person-centred Approaches, Recovery Model, Restorative Practice, Strengths-based Assessments, Strengths-based Case Management, Systemic Social

Work, Signs of Safety and Wellbeing, or Three Conversations Model. However, we appreciate there is some similarity and overlap between these labels and for some of the approaches for which we did find single studies (e.g. Asset-Based Approaches and Asset-Based Community Development).

The framework synthesis of qualitative evidence from seven studies about MSP showed the implementation of MSP in different councils was more likely to be successful when it was viewed or experienced as being adaptable, not too complex, seen as evidence-based and perceived as offering advantages relative to traditional approaches to adult safeguarding. The characteristics of the broader setting - across different local authorities and partner organisations, government policies and legal frameworks and the 'internal setting' (of the local authority, council and adult social care teams delivering MSP) had important impacts on the implementation process of MSP. The Care Act of 2014 was reported as a main driver of change, however sometimes current, more local safeguarding policies and procedures made it difficult to implement principles of person-centred care.

Participants in most of the included studies noted that delivering MSP demanded more extensive understanding and implementation of the Mental Capacity Act. This was linked to the fact that greater involvement of people in making decisions about their own care raised difficulties for teams, especially when those people might lack capacity.

Good inter-organisational collaboration and connectedness (e.g. between councils, with the NHS, with care homes) was also found to foster successful implementation of MSP. Various structural characteristics affected the implementation of MSP, including the size of the service or organisation, its staff capacity and access to services within the wider adult social care system,. The implementation of MSP was also affected by provider (e.g. social worker) personal and professional characteristics which linked to confidence in their ability to execute MSP, creativity (especially in using available resources), enthusiasm, and low resistance to changing from using a traditional deficit-based approach to safeguarding. The need to have a good theoretical and practical understanding of MSP, in relation to the specific skills needed, distinguishes MSP from less strengths-based safeguarding techniques, and was identified as critical. High levels of practitioner skills and training in working with the full range of people who needed support, especially those who either did not want to, or did not have the capacity to, engage actively in the safeguarding process, were reported as important, with limited skills potentially affecting equity of access to person-centred care for some of the most vulnerable

people. Lastly, successful implementation processes were associated with effective planning, effective engagement with, and personal characteristics of relevant stakeholders, and being conducted within organisations that had the absorptive capacity for change.

The factors discussed above in relation to MSP also emerged across studies that examined other strengths-based approaches. For instance, studies that examined SFBT and MI emphasised the importance of professionals' characteristics and their attitude towards the adoption of these strengths-based approaches. [37, 38, 41] This was related to professionals' ability to deliver care, which was closely aligned to their training and how well they were supervised. The studies that investigated FGC and strengths-based and relationship-based approaches highlighted the importance of effective communication within the team and family unit for the proper implementation of these approaches within services. [42, 43] External collaborations with other agencies involved in providing care and support of leadership and stakeholders were identified as critical factors in implementing asset-based approach, LAC and ABCD. [39, 44, 45]

While these findings suggest that the factors associated with the implementation of various strengths-based approaches may be similar, further rigorous evaluation of these factors in a wider range of service contexts may show in what circumstances particular enablers of barriers to implementation are more important. Further, it is critical to incorporate social workers' and other care professionals' perspectives in future studies when examining organisational approaches like LAC and ABCD, particularly as these differ from other strengths-based approaches in terms of their broader scale of delivery, distinctive features, process of change and their intended impact on the people being supported.

4.2 Comparison with recent advice on implementing strengths-based practice

The Strengths-based approach Practice Framework, the DHSC report published in early 2019, outlines ten 'key necessary enablers' at the organisational level for the successful implementation of a strengths-based approach.[4] Many of these ten enablers map closely to our 12 implementation sub-themes, that were identified from studies about the implementation of Making Safeguarding Personal (see Table 5). Nevertheless there are some differences in language and emphasis; for example, the key enablers in the practice framework place a stronger emphasis on the role of strong leadership, and staff training and development as key drivers of organisational culture change. There is also a greater emphasis on the processes of implementation at an organisational level needing to be consistent with the principles of strengths-based working; such as the promotion of collaborative and co-productive working,

the need to trust the workforce, the benefits of focusing on strengths (rather than what's wrong), and the need for shared commitment and accountability. More generally, their key enablers focus more on the processes of embedding strengths-based approaches from an organisational leadership and whole systems perspective, rather than highlighting pre-existing (and typically less modifiable) conditions or structural constraints; although, among 'other organisational issues' they highlight staff turnover, and the importance of having good professional supervision for social workers. Overall, there is good consistency and complementarity between the recommendations of this report and the findings of our evidence synthesis.

In 2019, Research in Practice for Adults also produced two briefings about developing and embedding strengths-based practice.[48, 49] Both short reports contained sections on the challenges of embedding such changes in adult social care working practices in (UK) local authorities. The strategic briefing used expert testimony and some key evidence overviews (such as Pattoni, 2012[14]) and highlighted selected attitudinal and structural barriers to implementation. The frontline briefing, drew on a mixture of reports and insights from running training courses in strengths-based practice.[49]

Both the briefings highlighted the impact of constrained public funding (or 'austerity') on local authorities, and the impact of this on services and the availability of community resources (e.g. libraries, community centres). They also noted that the success of strengths-based working is challenging when there are low levels of resources and assets available to families and communities – essentially, when poverty constrains people's ability to participate in a co-production approach to social care,[48] or when voluntary sector organisations have less flexibility to work outside commissioned contracts.[49] These conditions underline the importance of social care staff having an accurate and shared understanding of the services actually available, but also good knowledge of the alternatives to services – including that strengths-based solutions for some may arise from contributing to services themselves, for example by volunteering.[49]

The briefing on embedding strengths-based practice also emphasised the ongoing tensions between the principles of strengths-based practice, and national legislation whereby eligibility for much adult social care support is still largely determined by level of assessed need and financial circumstances. So social care staff feel they have to reconcile building trusting relationships and identifying strengths, while simultaneously having to identify deficits and express high needs to enable funding or service eligibility.[49]

While highlighting these structural and other barriers to embedding strengths-based practice, the frontline briefing also mentions more conceptual barriers – such as ambiguity and scepticism about the terminology of strengths-based practice (e.g. the proliferation of language such co-production and co-design) and difficulty grasping that strengths-based working is "not simply a matter of different methods or administrative processes" but instead represents "a cultural shift, a whole systems change to the way social care is envisaged and co-produced with individuals, families, groups and communities".[48] In short, one of the barriers to implementing strengths-based working is that it is a holistic set of ideas, beliefs and related skills and behaviours, rather than a discrete bundle of components and processes; and this represents a considerable change in mindset from the systems and procedures of case management. This seems related to the intervention complexity aspect identified in our evidence synthesis. They therefore emphasise the need for training, regular supervision and support, including to build personal resilience and confidence in exercising professional judgement. Lastly, they also note the lack of research evaluating the effectiveness of strengths-based working as a barrier to implementation.

Table 5. Comparison of our identified implementation factors to barriers and enablers highlighted in three recent reports

Synthesis sub-theme	Short description (in relation to Making Safeguarding Personal)	Baron/DHSC 2019[4] *Practice Framework on a Strengths-based approach* (Numbers related to numbered points in the report)	RiPfA 2019[48, 49] Briefings on: *Developing strengths-based working* and *Embedding strengths-based working*
Features of the initiative:			
Relative advantage	Stakeholders' and staffs' perception of the relative advantages of MSP compared with 'traditional' social work practice	Advantages for professional satisfaction and judgement; not just advantages for those supported (2) Measure outcomes and quality (9)	
Adaptability	Extent to which MSP can be adapted, tailored and streamlined to meet the local needs of people being supported and organisations	Support personalisation and control (5)	Forms and processes which capture more balanced picture of people
Perceived complexity	How the perceived difficulty (complexity) of practicing MSP affects its implementation	Could be linked to and countered (to some extent) by improved learning and development (7)	Ambiguity and scepticism about the language of strengths-based practice, and so difficulty grasping that strengths-based working is far more than different methods or administrative processes
Culture and setting:			

Synthesis sub-theme	Short description (in relation to Making Safeguarding Personal)	Baron/DHSC 2019[4] *Practice Framework on a Strengths-based approach* (Numbers related to numbered points in the report)	RiPfA 2019[48, 49] Briefings on: *Developing strengths-based working* and *Embedding strengths-based working*
Culture	Whether there has been a shift in culture across and within organisations to be more person-centred and empowering and, towards making adult social care practice more strengths-based	Strong Leadership: especially to shape culture within the organisation (1) Staff Learning and Development (7) to enable behaviour changes, and develop strengths of the workforce (8)	Challenging if the way in which services are commissioned and managed is: risk averse, seeks quick fixes, or values outputs over outcomes.
Cosmopolitanism	Degree to which an organisation's connectedness with other care and support organisations affects the implementation of MSP	Linked to Shared commitment and accountability (2): consistent vision across departments.	
Structural characteristics	How various structural characteristics, including size of the service or organisation, its staff capacity and access to services within broader adult social care system affects the implementation of MSP	Staff turnover mentioned	Constrained public funding, and the impact of this on social care services, community resources (e.g. libraries, community centres) and the resources of disadvantage families.
Policies and incentives	External (national) and internal (local, organisational) policies that either promote or inhibit the spread of interventions, including policy and regulations (e.g. governmental), external mandates, recommendations and guidelines, pay-for-performance, collaborative, and public or benchmark reporting	Ensure staff have the right information, tools, processes etc. to support working in the new way (6) – proportionate and flexible to need (not one-size fits all.	Performance management which focuses on outcomes and quality (not just outputs). Ongoing tension and deficit focus, as eligibility for adult social care support is still largely determined by level of assessed need and financial circumstances

Synthesis sub-theme	Short description (in relation to Making Safeguarding Personal)	Baron/DHSC 2019[4] *Practice Framework on a Strengths-based approach* (Numbers related to numbered points in the report)	RiPfA 2019[48, 49] Briefings on: *Developing strengths-based working* and *Embedding strengths-based working*
Individual characteristics:			
Personal attributes	How service providers' attributes impact the implementation of MSP; including their confidence in their professional judgment and ability to execute MSP, creativity, enthusiasm, resistance to change from using a traditional/existing approaches.	Trust in the workforce (4); especially to apply professional judgement and adapt interventions. Staff Learning and Development (7)	Create and protect opportunities for reflective practice. Training and high quality supervision.
Knowledge and beliefs about the SBA	How practitioners' knowledge of MSP as a strengths-based approach and their beliefs about this intervention may facilitate or inhibit the implementation of MSP	Ensure staff have the right information, tools, processes etc. to support working in the new way (6)	Create and protect opportunities for reflective practice
Needs and resources of people being supported	The impact of the perspectives and characteristics of people being supported on implementation; including: ability to engage or attend meetings, or mental capacity to be involved in decision making	Support personalisation: choice and control (5)	There may be significant relational issues in families, which hinder them from assuming greater responsibility for improving their situation; Older people may resist asking for support, for fear of 'being a burden'
Embedding and sustaining the SBA:			

Synthesis sub-theme	Short description (in relation to Making Safeguarding Personal)	Baron/DHSC 2019[4] *Practice Framework on a Strengths-based approach* (Numbers related to numbered points in the report)	RiPfA 2019[48, 49] Briefings on: *Developing strengths-based working* and *Embedding strengths-based working*
Embedding process	Three core activities or stages of the implementation of an intervention: planning, engaging, and executing	Continuous improvement (10)	Opportunities to exchange ideas, knowledge of local resources, and solutions across teams. A whole-organisational framework to communicate the approach (to all stakeholders and the public). Need for high quality strengths-based supervision Training and support for strengths-based communication skills.
Factors associated with embedding and sustaining the SBA	Factors that affect the 'implementation climate'; defined as the absorptive capacity for change, shared receptivity of involved individuals to an intervention, and the extent to which use of an intervention will be rewarded, supported, and expected within their organisation	Links to Strong Leadership (1) Promote working in a co-productive and collaborative way (6)	Needs to be a willingness to delegate financial decision-making to frontline teams and their managers (rather than micro-managing care plans). Performance management which focuses on outcomes and quality (not just outputs)

4.3 Limitations and strengths

Limitations of the evidence

The main weakness of the evidence found was that there were no includable studies to help answer research question one, on the effectiveness of strengths-based approaches, and relatively few studies to help answer research question two, about their implementation. Although various studies addressing implementation of strengths-based approaches in adult social care were identified, these were often excluded as it was unclear to what extent the intervention was delivered or co-ordinated by social workers, and this review was intended to inform social work practice. This especially applied when full-text studies examining Local Area Coordination, Asset-Based Community Development and Family Group Conferencing were screened for inclusion.

Of the full-text studies screened for inclusion, three were excluded in relation to research question one and 51 excluded in relation to research question two, due to the study population not meeting our inclusion criteria, and a significant proportion of these would have been because there was no indication that social workers were involved in care delivery or implementation. All studies excluded at full-text in relation to each review question are listed in Appendix 3 and Appendix 4.

Of the 17 strengths-based approaches that were prioritised in this review, we found the most evidence on Making Safeguarding Personal (MSP). While the synthesised findings highlighted a range of factors that influence the implementation of MSP, which helps us better understand the process of change, these findings may not be applicable to other less highly standardised and specified approaches to strengths-based working. This may be because safeguarding is a legislative requirement which makes the process of providing care to individuals at a high risk a priority. It is clear that there is a lack of research or high quality evaluation on other strengths-based approaches. In both cases, this presents as an opportunity to direct future research examining other approaches within the umbrella definition ‘strengths-based working’, and for this research to have a joint focus on effectiveness and implementation since they are so closely interrelated.

Two of the studies included in this review examined the implementation of strengths-based approaches (Family Group Conferencing and Motivational Interviewing) in child social work settings. Given that the evaluation of these two approaches was prioritised by the policy

customer of this review, it was decided that studies that collected data from parents of children or social workers who provided services to the family would be included. While these studies provided valuable and complementary information, we acknowledge that these two studies are different in this key respect and therefore potentially less applicable to adult social work.

In our results section the findings were often substantiated using second order data (i.e. study author's interpretations) rather than quotations from the social workers or people interviewed as part of the study. This reflects the fact that many of the study authors did not present many quotations from their study participants, but instead summarised what participants had said in their own words. Since interpretation of the same qualitative data may vary across authors, we acknowledge this as a key limitation of the evidence synthesised. Lastly, many of the studies were not sufficiently well described to judge whether the strengths-based approach under investigation was primarily an organisational model or a change in professional practice being applied at community or individual/familial level respectively. The lack of distinction between organisational models and practice models however may be a more general limitation because this research area is still underdeveloped.

Limitations of our review methods

The first weakness is the relatively small involvement of people being supported by adult social care in the review. Greater involvement would have balanced the primarily professional and managerial perspective of most of the studies, and potentially focussed our evidence synthesis on those aspects of implementation that are more valued by people being supported. The small level of involvement was related to a lack of resource available to the team, plus challenges recruiting people at short notice from potentially vulnerable groups. However, we are very grateful to the small group of people with lived experience of using adult social care services who have commented on the plain English summary of this report.

Expert stakeholders from the profession of social work and adult social care were involved at different stages of the review process, from protocol development to drafting the final report. The team prioritised making sense of the diverse and variable quality of included studies, which helped the team getting to a point of knowing how much research would need to be included and synthesised.

Other potential weaknesses of the review methods we used include:

- Limiting the review to studies only from the UK. It is possible that for some of the strengths-based approaches, studies from other high income countries (e.g. USA or New Zealand) might have yielded more evidence of potential relevance to adult social care in the UK. Since most of these were excluded at the title and abstract screening stage, it is not possible to say how many of these may have ultimately met all our other inclusion criteria.
- Our search strategies for identifying grey literature or web-based reporting of evaluations of strengths-based approaches were mainly based on searching local government or statutory agency websites. We therefore may have missed published evaluations of strengths-based approaches for supporting adults that were led or evaluated by third sector organisations.
- Characterising a 'Strengths-based Approach' indirectly, by choosing to focus on a range of named approaches or practices that are commonly seen as fostering or aligned with a strengths-based approach. The limited list of 17 approaches we used (see section 1.1), and based our searches on, was developed and corroborated by adult social care experts and policy makers. However this list may not be complete, and some of these approaches may be less inherently or less holistically 'strengths-based' than others. For example, we did not search for evidence in relation to Neighbourhood Networks/Neighbourhood Networking, Circles of Support, or community/council change processes based around co-production or co-design – which some would also regard as examples of strengths-based approaches.
- Limiting our review of evidence relating to research question one to studies that generated quantitative comparative outcome data may mean we missed potentially insightful qualitative evidence on stakeholder or user perceptions of effectiveness. We acknowledge that in different domains of professional practice, and for those from different academic disciplines, the concept of effectiveness and whether it should ideally be captured through standard, quantitative measures, or can also be assessed through qualitative methods, varies and may be contentious. Also, since most strengths-based approaches aim to change *the way* people work and the *quality* of the relationships developed, there is a reasonable argument that these more intermediate and qualitative indicators of positive change could also be the focus of such a review of effectiveness. However, the definition of research question one was developed in

consultation with the policy customer for this work, and met established criteria for rigorous quantitative evidence of comparative effectiveness.

Relatedly, for research question two we excluded studies that only defined implementation as user's perception (e.g. the acceptability of different strengths based approaches), focussing instead on professional and organisational provider views and accounts of implementation. Therefore our conclusions about improving implementation are restricted to those factors that are ostensibly within the control of professionals and local organisations.

- Our application of the framework synthesis approach within the context of a systematic review. While we could infer links across various themes and subthemes using this data analysis approach, it is possible that by adopting a relatively more descriptive and less interpretative approach we may have missed additional nuances, links or all key insights that could have emerged from interviews with social care staff and people being supported. Employing another method of evidence synthesis, such as realist review, might have allowed for the inclusion of a broader range of evidence. However as the review was conducted in the context of social work practice, it was important to identify and summarise evidence from that context as a priority (and at the outset, we did not know how much there would be).

Two of the studies included in this review examined the implementation of strengths-based approaches (Family Group Conferencing and Motivational Interviewing) in the child social work sector. Given that the evaluation of these two approaches were prioritised by the policy customers, it was decided that studies that collected data from parents of children seeking services (who come within adult population) or social workers who provided services to the family would be included. While these studies provide valuable information, we acknowledge that it may as also be a limitation. Strengths of the review

This systematic review has been conducted on a subject of defined need and policy importance, following exploratory scoping searches, using current best practice approaches for the conduct and reporting of systematic reviews, and according to a prospectively registered protocol. We sought detailed advice and comments on our review protocol from experienced social workers working in policy (Department of Health and Social Care) and social care researchers with experience in these topics (See our acknowledgements section).

The qualitative evidence synthesis of the MSP studies was carried out in two stages. The second data analysis phase provided an opportunity to be more careful in the selection of illustrative quotations, including relying more on study participant quotations rather than author interpretations. Further, the fact that we were able to integrate the findings of two additional studies, which were identified later in the research process, within the existing framework validated our understanding on strengths-based approaches, confirming the synthesis process.

The team conducting the review included an information specialist (SB) who has particular expertise in the design and conduct of web searches. This is especially important given that the kinds of research and evaluation the review sought would not often be published in well-indexed and peer-reviewed journals. We utilised extensive use of web searches for this review, which was clearly an effective strategy to identify relevant studies across various government websites and on Google that did not appear in bibliographic database search. This makes the current review a good case study on the importance of conducting web searches for certain research topics.

In the latter half of our review, we were also fortunate to have the closer involvement in the project of a researcher who is also a former social worker and an experienced former manager of adult social care services in two different Local Authorities (G O'Rourke) and a professor of social work who has been closely involved in Department of Health and Social Care initiatives to understand and promote the application of strengths-based approaches (S Baron).

5 Conclusions

There are no comparative effectiveness studies that would reliably inform whether any of these approaches were associated with better outcomes for the people, families or communities being supported, compared with previous or alternative approaches in UK social care settings. However, we found 15 UK studies about eight different strengths-based approaches which contained qualitative evaluations or analyses about the implementation of these approaches.

From synthesising evidence from seven of these studies, which were all relatively recent (post-2013) studies about implementing Making Safeguarding Personal (MSP), we were able to identify a range of specific factors perceived as associated with successful implementation of this strengths-based organisational approach in local authorities or adult social care teams. These factors related to: the features and nature of MSP itself (such as adaptability and simplicity); the internal organisational culture and setting of local authorities and social care teams, and the broader context of policy, laws and relations with other local organisations; the individual characteristics of social workers and social care leaders driving implementation, and the individual characteristics of those being supported; and, factors related to the implementation process - such as effective planning and authentic engagement with relevant stakeholders - and having an 'implementation climate' that is receptive to change within teams and organisations. Some of these factors may have wider relevance for the implementation of other strengths-based models of social work practice.

Overall, there is a lack of good quality research evidence that has evaluated the effectiveness or implementation of strengths-based approaches to social work practice. Therefore the findings of this review need to be used with a certain degree of caution for informing policy and practice.

We make the following recommendation for future research and evaluation:

- Studies examining the effectiveness of various strengths-based approaches within individual and across multiple services need to be based on a more complex systems-informed view of how these approaches may produce better outcomes compared to traditional, discrete 'intervention-based' approaches to providing social care for adults. These studies may still employ comparative controlled study designs to assess outcomes, but should capture them from multiple perspectives and at different levels (individual, family and community)

and over different timescales. Such studies should also endeavour to capture the resource use and cost of working in strengths-based way – especially the initial and ongoing staff time required. Perhaps most importantly, given the person-centred nature of strengths-based working and the relationship-oriented goals, the evaluation approaches should be participatory, with authentic engagement with the people and communities being supported.

- In relation to the implementation of strengths-based approaches used within adult social work, future research needs to address various limitations of the existing studies, including better reporting of how data were collected and analysed, details of data collection setting, and whether ethical issues were addressed. In particular, reporting should better capture the content and fidelity of the initiatives; that is, which components were delivered fully and which were adapted or omitted, perhaps in order to be more feasible and acceptable in different circumstances.
- It is also critical for future studies to address the methodological limitations which would help in estimating how generalisable the findings are. Such studies should ideally be based around the programme theory of how the new model of care or practice is believed to improve outcomes for different types of people; otherwise efforts to tailor initiatives will not be based on reliable knowledge of which aspects of programmes are 'core' (or essential) and which are more peripheral (more optional, adaptable). For more practice-based approaches this will be challenging, because strengths-based working cannot be reduced to discrete 'mechanical' components being present or not present – rather it is a holistic way of working, building relationships and having conversations that embodies certain theories, knowledge, behaviours and skills.
- Given that the understanding and application of strengths-based approaches in the area of adult social work is evolving and there has been a recent surge in interest and activity in these approaches, it may be useful to conduct evidence synthesis periodically, and using a range of evidence synthesis methods, including realist synthesis. However methods used will only be as productive as the quantity, richness and quality of the primary research data available for a given synthesis approach.

- We also suggest that future systematic reviews might include evidence from outside UK, to understand the effectiveness and implementation of strengths-based approached more broadly and in relation to different social and organisational contexts of social work practice.

This review mainly highlights the paucity of high quality empirical research conducted about this important and widely advocated approach to social work practice. Nevertheless, based on qualitative evidence about a specific strengths-based approach we have identified key factors which facilitate or inhibit implementation of strengths-based approaches, and that could help in creating the conditions required to embed strengths-based working in organisations, social care teams and the practice of individual social workers.

6 Acknowledgements

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Contribution of the authors

Latika Ahuja contributed to revising and finalising the review protocol, led on the additional searching (web based searches), screening searches for study inclusion, data extraction and quality assessment, contributed to the design and conducted qualitative evidence synthesis, drafted many key sections and summaries of the final report, PPI liaison, and project managed the review in the last four months. Managed reference library.

Anna Price contributed to revising and finalising the review protocol, led on the additional searching (citation chasing), screening searches for study inclusion, data extraction and quality assessment, oversaw the design and delivery and conducted qualitative evidence synthesis, project managed the review in the first four months, wrote several key sections and summaries in the final report.

Charlotte Bramwell contributed to revising and finalising the review protocol, screening searches for study inclusion, led on the additional searching, assisted in the development of data extraction and quality assessment, drafted many key sections of the final report, assisted PPI liaison, reviewed the synthesis and assisted the project management throughout the project. Managed reference library.

Simon Briscoe was involved in direction/conception, designing and conducting database searches and designed the supplementary web searches. Facilitated and advised on screening and lead contributed to write-up of search strategy in methods section.

Liz Shaw contributed towards development of protocol and planning searches. Advised on screening, data extraction, critical appraisal, and synthesis. Critically reviewed and edited sections of the report.

Michael Nunns involved in conception and planning searches. Advised on screening, data extraction, and critical appraisal. Critically reviewed and edited sections of the report.

Gareth O'Rourke shared his experience of being a manager of adult social care in two different Local Authorities, carefully reviewed the synthesis and drafted sections the introduction of the report.

Samantha Baron shared her experience of being an adult social worker and academic expertise, reviewed the synthesis, critically read and edited all sections of the report.

Rob Anderson oversaw the direction and completion of the review, drafted the review protocol, planned the searches, advised on all stages of conducting the review, drafted sections of the introduction and discussion, and critically read and edited all sections of the report. Guarantor of the report.

Data-sharing statement: Requests for access to data should be addressed to the corresponding author.

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Appendix 1. **Searches for studies**

A.1.1 Bibliographic databases

Database: ASSIA

Host: ProQuest

Data Parameters: n/a

Date Searched: 19/11/2019

Searcher: SB

Total hits: 850

Strategy:

Search 1

1. ti,ab("social work*")
2. ti,ab("social service*")
3. MAINSUBJECT.EXACT.EXPLODE("Social work")
4. MAINSUBJECT.EXACT.EXPLODE("Social services")
5. 1 or 2 or 3 or 4
6. ti,ab(strength* near/0 (approach* or assessment* or based or perspective* or theor*))
7. ti,ab(asset* near/1 (approach* or based))
8. 6 or 7
9. 5 and 8

Hits: 264

Search 2

1. ti,ab(("social work*" or "social service*") near/2 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary))
2. ti,ab("asset based community development" or "three conversations" or "3 conversations" or "signs of safety" or "making safeguarding personal" or "restorative practice")
3. (("social work*" or "social service*") near/9 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*" or "recovery model*"))

4. ti,ab(("social work*" or "social service*") near/4 (ABCD or systemic or ecological or narrative* or "family support"))
5. ti,ab(social and (appreciative near/0 (enquiry or inquiry)))
6. 1 or 2 or 3 or 4 or 5

Hits: 586

Database: Campbell Systematic Reviews
Host: Campbell Collaboration
URL: https://www.campbellcollaboration.org/better-evidence.html
Data Parameters: n/a
Date Searched: 19/11/2019
Searcher: SB
Hits: 4
Strategy: **Full-text/keyword field:** "social work*" OR "social service*"

Database: CINAHL
Host: EBSCO
Data Parameters: n/a
Date Searched: 19/11/2019
Searcher: SB
Hits: 663
Strategy:

1. TI "social work*" OR AB "social work*"
2. TI "social service*" OR AB "social service*"
3. (MH "Social Work+")
4. (MH "Social Work Service")
5. S1 OR S2 OR S3 OR S4
6. TI ((strength* n0 (approach* or assessment* or based or perspective* or theor*))) OR AB ((strength* n0 (approach* or assessment* or based or perspective* or theor*)))
7. TI ((asset* n1 (approach* or based))) OR AB ((asset* n1 (approach* or based)))
8. S6 OR S7
9. S5 AND S8

10. TI ((("social work*" or "social service*") n2 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary))) OR AB ((("social work*" or "social service*") n2 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary)))
11. TI (("asset based community development" or "three conversations" or "3 conversations" or "signs of safety" or "making safeguarding personal" or "restorative practice")) OR AB (("asset based community development" or "three conversations" or "3 conversations" or "signs of safety" or "making safeguarding personal" or "restorative practice"))
12. TI (("social work*" or "social service*") n9 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*" or "recovery model*")) OR AB (("social work*" or "social service*") n9 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*" or "recovery model*"))
13. TI (("social work*" or "social service*") n4 (ABCD or systemic or ecological or narrative* or "family support")) OR AB (("social work*" or "social service*") n4 (ABCD or systemic or ecological or narrative* or "family support"))
14. TI (social and (appreciative n0 (enquiry or inquiry))) OR AB (social and (appreciative n0 (enquiry or inquiry)))
15. S10 OR S11 OR S12 OR S13 OR S14
16. S9 OR S15

Database: HMIC
Host: Ovid
Data Parameters: 1979 to September 2019
Date Searched: 19/11/2019
Searcher: SB
Hits: 195
Strategy:

1. "social work*".tw.
2. "social service*".tw.
3. 1 or 2
4. (strength* adj1 (approach* or assessment* or based or perspective* or theor*)).tw.
5. 3 and 4

6. (("social work*" or "social service*") adj3 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary)).tw.
7. (ABCD or "three conversations" or "3 conversations" or "local area coordination" or "local area co-ordination" or "signs of safety" or "making safeguarding personal" or "recovery model*" or "restorative practice").tw.
8. (appreciative adj1 (enquiry or inquiry)).tw.
9. (("social work*" or "social service*") adj10 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*")).tw.
10. (("social work*" or "social service*") adj5 (systemic or ecological or narrative* or "family support")).tw
11. (asset* adj2 (approach* or based)).tw.
12. or/6-11
13. 5 or 12

Database: MEDLINE ALL
Host: Ovid
Data Parameters: 1946 to November 15, 2019
Date Searched: 19/11/2019
Searcher: SB
Hits: 384
Strategy:

1. "social work*".tw.
2. "social service*".tw.
3. exp social work/
4. or/1-3
5. (strength* adj1 (approach* or assessment* or based or perspective* or theor*)).tw.
6. (asset* adj2 (approach* or based)).tw.
7. 5 or 6
8. 4 and 7
9. (("social work*" or "social service*") adj3 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary)).tw.
10. ("asset based community development" or "three conversations" or "3 conversations" or "signs of safety" or "making safeguarding personal" or "restorative practice").tw.

11. (("social work*" or "social service*") adj10 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*" or "recovery model*")).tw.
12. (("social work*" or "social service*") adj5 (ABCD or systemic or ecological or narrative* or "family support")).tw.
13. (social and (appreciative adj1 (enquiry or inquiry))).tw.
14. or/9-13
15. 8 or 14

Database: PsycINFO
Host: Ovid
Data Parameters: 1806 to November Week 1 2019
Date Searched: 19/11/2019
Searcher: SB
Hits: 1691
Strategy:

1. "social work*".tw.
2. "social service*".tw.
3. exp social services/
4. exp social casework/
5. or/1-4
6. (strength* adj1 (approach* or assessment* or based or perspective* or theor*)).tw.
7. (asset* adj2 (approach* or based)).tw.
8. 6 or 7
9. 5 and 8
10. (("social work*" or "social service*") adj3 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary)).tw.
11. ("three conversations" or "3 conversations" or "local area coordination" or "local area co-ordination" or "signs of safety" or "making safeguarding personal" or "restorative practice").tw.
12. (("social work*" or "social service*") adj10 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*" or "recovery model*")).tw.

13. (("social work*" or "social service*") adj5 (ABCD or systemic or ecological or narrative* or "family support")).tw.
14. (social and (appreciative adj1 (enquiry or inquiry))).tw.
15. or/10-14
16. 9 or 15

Database: Social Policy and Practice
Host: Ovid
Data Parameters: 201907
Date Searched: 19/11/2019
Searcher: SB
Hits: 1307
Strategy:

1. "social work*".tw,de.
2. "social service*".tw,de.
3. 1 or 2
4. (strength* adj1 (approach* or assessment* or based or perspective* or theor*)).tw,de.
5. 3 and 4
6. (("social work*" or "social service*") adj3 (collaborative* or holistic* or "multi disciplinary" or multidisciplinary)).tw.
7. (ABCD or "three conversations" or "3 conversations" or "local area coordination" or "local area co-ordination" or "signs of safety" or "making safeguarding personal" or "recovery model*" or "restorative practice").tw,de.
8. (appreciative adj1 (enquiry or inquiry)).tw,de.
9. (("social work*" or "social service*") adj10 ("motivational interview*" or "solution focus*" or "personal agency" or "person centred" or "family group conference*")).tw.
10. (("social work*" or "social service*") adj5 (systemic or ecological or narrative* or "family support")).tw
11. (asset* adj2 (approach* or based)).tw,de.
12. or/6-11
13. 5 or 12

A1.2 Bibliographic database search results

Table 6. Bibliographic database search results

Database	Hits
ASSIA	850
Campbell Systematic Reviews	4
CINAHL	663
HMIC	195
MEDLINE ALL	384
PsycINFO	1691
Social Policy and Practice	1307
Total hits	**5094**
Duplicate hits	**1782**
Unique records	**3312**

A.1.3 Web searches

Websites

Website: Directors of Adult Social Services (ADASS)
URL: https://www.adass.org.uk/
Date Searched: 28/1/2020
Searcher: LA
Hits: 194
Strategy: "strengths based"

Website: British Association of Social Workers
URL: https://www.basw.co.uk/
Date Searched: 28/1/2020

Searcher: CB

Hits: 27

Strategy: "strengths based"

Website: Social Care Institute for Excellence (SCIE)

URL: https://www.scie.org.uk/

Date Searched: 28/1/2020

Searcher: CB

Hits: 823

Strategy: strengths based

A.1.4 Google search strategies and results

We searched used Google Search to search for specific types of strengths-based approaches included in our analysis. The Google Search settings menu was used to display 100 results per page. CB searched for studies on MSP, LAC and SFT whereas LA searched for studies examining the remaining strengths-based approaches.

Table 7. Google search strategies and results

			Results	
Search Engine	**Search strategy**	**Limits**	**Total**	**Screened**[†]
Google Search www.google.co.uk	"making safeguarding personal"	filetype:pdf site:gov.uk	274	first 150
	"local area coordination"	filetype:pdf site:gov.uk	260	first 100
	"solution focused" "social work"	filetype:pdf site:gov.uk	267	first 100
	"asset-based community development"	filetype:pdf site:gov.uk	254	first 100

“appreciative inquiry”	filetype:pdf site:gov.uk	232	first 100
“ecological approach”	filetype:pdf site:gov.uk	71	all
“family group conferencing”	filetype:pdf site:gov.uk	267	first 100
“motivational interviewing”	filetype:pdf site:gov.uk	253	first 100
“narrative approaches”	filetype:pdf site:gov.uk	20	all
“person-centred approaches”	filetype:pdf site:gov.uk	243	first 100
“recovery model”	filetype:pdf site:gov.uk	263	first 100
“strengths-based assessments”	filetype:pdf site:gov.uk	269	first 100
“strengths-based case management”	filetype:pdf site:gov.uk	0	n/a
“systemic social work”	filetype:pdf site:gov.uk	90	all

“signs of safety and wellbeing”	filetype:pdf site:gov.uk	24	all
“three conversations model”	filetype:pdf site:gov.uk	72	all

† Results were screened to saturation, i.e. until the results duplicated or were substantially similar (e.g. the same local council website) to the results that had been already screened.

A.1.5 Backward citation chasing from included studies

Citation index: Web of Science (Core Collection); Scopus.
Date searched: January 2020
Searcher: CB (in phase 1 of the project) and AP (in phase 2 of the project)
Search strategy: CB and AP searched for included studies in Web of Science. If a study was indexed in Web of Science, CB exported the citations to Endnote. If a study was not indexed in Web of Science, CB searched for it in Scopus.

Appendix 2. **List of strengths-based approaches of interest**

Asset-Based Community Development

Appreciative Inquiry

Ecological Approach

Family Group Conference

Local Area Coordination

Making Safeguarding Personal

Motivational Interviewing

Narrative Approaches

Person-centred Approaches

Restorative Practice

Recovery Mode

Solution-focused Therapy (SFT) / Solution Focused Approach

Signs of Safety and Wellbeing

Strengths-based case Management

Strengths-based Assessments

Systemic Social Work

Three Conversation Model

Appendix 3. **Full text papers excluded for research question one**

1) Anka A, Sorensen P, Brandon M, Bailey S. Social work intervention with adults who self-neglect in England: responding to the Care Act 2014. The Journal of Adult Protection. 2017;19(2):67-77.
2) Barnsdale L, Walker M. Examining the use and impact of family group conferencing. Edinburgh: Scottish Executive; 2007. https://www.iirp.edu/images/pdf/2007_FGC_Scotland_Research.pdf
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Appendix 4. **Full text papers excluded for research question two**

1) Associations of Directors of Adult Social Services. Making Safeguarding Personal Outcomes Framework. Final Report. Directors of Adult Social Services, Local Government Association, Institute of Public Care, Research in Practice for Adults; 2018. https://www.local.gov.uk/sites/default/files/documents/msp-outcomes-framework-final-report-may-2018.pdf
2) Ambition For Aging. Asset based approaches and inequalities: briefing. Greater Manchester: Ambition For Aging; 2018. https://www.ambitionforageing.org.uk/assetsandinequalities
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Appendix 5. **Consolidated Framework for Implementation Research**

Five Domains of Consolidated Framework of Implementation Research				
Intervention characteristics	**Outer setting**	**Inner setting**	**Characteristics of individuals**	**Process**
Intervention sources	Patient needs and resources	Structural characteristics	Knowledge and beliefs about the intervention	Planning
Evidence strength and quality	Cosmopolitanism	Networks and communications	Self-efficacy	Engaging
Relative advantages	Peer pressure	Culture	Individual stage of change	Executing
Adaptability	External policies and incentives	Implementation climate	Individual identification with the organisation	Reflecting and evaluating
Trialability			Other personal attitudes	
Complexity				
Design quality and packaging				
Cost				