Embedding strengths-based practice

Introduction

'Strengths-based practice' has been defined as:

...a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets.

(SCIE, 2015)

The *Care Act 2014* guidance refers explicitly to strengths-based approaches, by requiring 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.

(Department of Health and Social Care, 2018)

Strengths-based approaches also fit well with core social work values, such as promoting the rights to participation and self-determination. BASW's Code of Ethics states that:

Social workers should focus on the strengths of all individuals, groups and communities and thus promote their empowerment.

(BASW, 2014)

This publication complements Research in Practice for Adult's Strategic Briefing on *Developing strengths-based working* (Ford, 2019), which focuses on:

> The policy and legal context for strengths-based approaches and their development.
> Different models of strengths-based practice.
> Approaches to evaluating their success.

This briefing, which is aimed at frontline social care practitioners and their managers:

> Proposes and explains seven key principles of strengths-based approaches in social care, and the evidence base supporting them.
> Presents a series of practical tools to support strengths-based practice, focusing on communication skills.
> Considers some of the challenges to strengths-based practice as experienced by practitioners, with practical recommendations for practitioners, teams and managers on how they can embed the approach sustainably.

Research evidence for strengths-based practice

The evidence on 'strengths-based practice' is limited, not least because it is hard to define and distinguish it as a distinct 'intervention' whose effectiveness can be compared with other approaches. This challenge was highlighted by Tse et al (2016) in their critical review of the research regarding the use and effectiveness of strengths-based approaches in mental health service settings. Despite this challenge, their review identified emerging evidence that use of a strengths-based approach can improve outcomes for people with serious mental illness, including hospitalisation rates, employment, educational attainment and intrapersonal outcomes, such as self-efficacy and a sense of hope.

There is an extensive evidence base relating to each of the *components* of strengths-based practice, including:

> Qualitative research, which has asked people with lived experience what they value most.
> The theoretical underpinnings and efficacy of related models of practice (for example, narrative approaches, motivational interviewing, positive psychology, etc).

The following section provides examples of these different types of evidence, including references and links to further reading, under each of the strengths-based principles.

Key principles of strengths-based approaches in social care

In their book on supporting older people using strengths-based and attachment-informed approaches Blood and Guthrie (2018) propose the following seven principles:

1. Collaboration and self-determination

Bringing together personal and professional knowledge to find solutions:

> People are experts in their own lives; the social care workers' aim is to facilitate a person/family to identify and express what matters to them.
> Professionals bring general expertise – how the system works, what help and resources might be available, what has worked for other people.

Evidence:

A recurring theme from qualitative research is that people who use services want to maximise their freedom and independence (older people in Blood et al, 2016) and have a say in decisions that affect them (people with learning disabilities in Hoole and Morgan, 2011).

2. Relationships are what matters most

Relationship-based practice is core to a strengths-based approach. It recognises that:

> Relationships are central to wellbeing.
> As social care workers, our relationships with individuals and their families are the service (not a 'nice-to-have' or simply a means to completing processes or tasks) (O'Leary et al, 2013).
> Positive relationships within professional systems, including managerial and supervisory relationships, are key to maintaining workers' emotional resilience, and their ability to practice in a strengths-based way (Adamson et al, 2012).

Evidence:

Relationships are consistently identified as a key driver of quality of life by a wide range of adults using services, for example people living with dementia (Williamson, 2010). The Mental Health Foundation (2016) also identifies relationships as being the foundation of mental wellbeing at all stages of the life course. There is evidence that relationships are the main driver of positive change in professional relationships (Cooper, 2008).

3. Everyone has strengths and something to contribute

Alongside understanding people's problems, we should find out and build on:

> What the person does not need help to do, what keeps them strong and what they are good at.
> How they can be supported to make a contribution – this might be about volunteering or employment, or it might be about creating small opportunities for someone to provide emotional support to others, to show someone else how to do something or to take part in preparing a meal (rather than just having everything done for them).

Qualitative research consistently shows how important it is to the quality of life and self-esteem of people who need support to be able to enjoy reciprocity in their relationships and to participate in activities they enjoy and are good at (Blood, 2013; Blood et al, 2016; O'Rourke, 2015).

SCIE recommend three areas to focus upon in order to discover what a person believes would represent a 'good life' (or at least a 'better life') for them and their families, within the context of *Care Act* assessments:

> Individual's strengths, hobbies, abilities, wishes.
> Individual's support network (friends, family, neighbours, professionals) and their strengths, abilities, knowledge.
> Needs, challenges, risks, (focusing on strengths does not mean ignoring risks but maximising and using strengths to overcome them).

(SCIE, 2015)

It's important for practitioners to remember they are also people with strengths. Identifying their own assets can help as they support others to do the same. It can also help practitioners to use and build on these strengths creatively in their practice – whether this is their skills in mediation, their love of sport, or the outdoors. Venkat Pulla asks the key question:

How can we find strengths in our clients if we cannot find strengths within ourselves?
(Pulla, 2013)

4. Stay curious about the individual

Strengths-based practitioners resist the tendency to find commonalities between people and make generalisations ('I know this type/how this story goes'). Instead, they stay curious about:

> What makes a person different?
> What makes them tick?
> What is the function of puzzling behaviour?
> What might this mean in practice for professionals, care and support providers, and family and friends?

Evidence:

There is significant literature on narrative approaches – which are based on the premise that we are defined by the stories we tell about ourselves, and those which others tell about us (Epston and White, 1990). Stokes (2008) tells the stories of people with dementia and how these can help us to understand and respond more effectively to puzzling behaviours.

5. Hope

Maintaining hope is an important aspect of strengths-based practice. It can be characterised as a belief in the capacity of humans to change over time, and a belief in the potential to repair fractured relationships. There is much support in literature for approaches based upon positive psychology (for example Seligman, 2002) which encourage individuals to identify the components of a life worth living.

Hope can also play an important role in sustaining emotional resilience in workers. Supporting workers to maintain their resilience is likely also to support effective practice, by promoting a focus on positive outcomes for others. Adamson et al (2012) write that: 'The construct of hope is important to social workers because it is an attribute that sustains belief in practitioners' abilities to achieve positive outcomes with clients and is closely aligned to the construct of self-efficacy'.

6. Positive risk-taking

Strengths-based social care promotes 'Positive risk-taking' or 'Risk enablement' - see further discussion of these concepts in the Research in Practice for Adults Practice Tool on *Enablement in dementia* (Blood, 2016) and in the Frontline Briefing on *Risk enablement* (McNamara and Morgan, 2016). This involves:

> Weighing up the risks of different options, including considering the risks of doing nothing, and the risks of going into residential care (not just the risks of going home from hospital).
> Considering possible emotional, social and psychological harms (or 'hidden harms' as Clarke et al, 2011, have called them) as well as potential physical harms.
> Looking at how available resources (in families and communities as well as in services) can be used to achieve the things that matter, while reducing risks.

7. Build resilience

This is about enabling people to build their own capacity to deal with challenges now and in the future, by:

> Avoiding the 'quick fix' and being aware that services can over-protect and de-skill people.
> Looking at which aspects of a person's life need to and can be strengthened – for example housing, finances, relationships.
> Helping people to make meaning of their experiences.

Practice Tool: Building relationships in a strengths-based way

This section considers ways in which social care professionals can use strengths-based approaches in practice, by focusing on use of language, questioning skills, and the ways in which we listen to a person's narrative. Our involvement with individuals and their families can range from one phone call to a sustained relationship over a period of years, and anywhere in between. Whatever the context for work with a person, these ideas may offer ways of anchoring a person to their strengths.

1. Using language to build strengths

One of the central themes of narrative approaches is that we are defined by the stories that we tell about ourselves, and that others tell about us (Epston and White, 1990). The language which professionals use to describe the individuals they work with has an influence on how those individuals are perceived, and on how they perceive themselves.

For example, when Vallelly and colleagues (2006) interviewed care staff in extra care housing schemes they described how tenants living with dementia would 'wander' and be at risk of getting lost. However, when Vallelly interviewed the tenants, they explained that they were walking with purpose – to exercise, to get out of their flats and to be with other people. The risks of getting disorientated may still be real, but 'enabling someone to go for a walk' (which is important to them) is a very different conversation from trying to 'stop someone from wandering' (which frames the walk as something negative – or at best pointless). After all, at what point in our lives do we stop 'walking' and start 'wandering'?

The importance of language is apparent in conversations about safeguarding. There is a big difference between labelling someone as 'vulnerable' or even 'at risk' and describing them as 'taking a risk'. 'Taking a risk' implies an active decision to do something which might have either a positive or a negative outcome; 'being at risk' suggests a permanent state of vulnerability in which someone needs to be protected. Finlayson (2015) suggests that we move away from the language of 'risk' in our conversations with people and their families, and find out instead about their 'worries'.

There are implicit value judgements in comments like 'still driving' (which suggests someone should probably have stopped by now) and 'fiercely independent' (which might imply that someone should stop being so stubborn and start accepting their limitations). This is also relevant when considering the language used to describe family members or carers - there is a big difference between describing a parent of a young adult with a learning disability as 'very demanding' as opposed to 'committed to protecting the human rights of his/her child'.

Different organisations promote different language to describe the adults and families they work with. Some examples we are familiar with include citizens, service users, adults, customers, patients and clients. Each of these terms characterises the relationship between the individual and the professional in a particular way, and raises issues of who holds the power, and who is active or passive in the relationship. This isn't to suggest that very real issues of power in social care relationships can be resolved by changing the language we use - however, language can either anchor people to their strengths, or the opposite.

? Questions for reflection

Thinking about a practice dilemma you are facing with a person or family you are working with:

> Can you identify the language you and other professionals use to describe them?
> Does this emphasise the things they can do and the resources they have (their strengths) or does it emphasise the things they can't do, or the resources they lack?
> How could you alter this language?
> Might doing so change the direction of the conversation or open up different options, approaches and ideas?

2. Using questions to embed strengths

We met with Social Services and my mother-in-law then answered the questions that were being asked: "Are you ok?" "Yes." "Can you do this?" "Yes." "Can you manage?" "Yes, no problems at all." And I'm sitting there thinking, 'No, she can't!' Because people from that era are that proud they don't want anyone to know that they can't do this and that.

Family member interviewed in Blood, Copeman and Pannell (2016)

Many of the questions asked by social care professionals typically steer people into 'problem-talk', which can emphasise people's difficulties and things which they lack. For example:

> So, what seems to be the problem?
> What has triggered this crisis?
> What are the main needs and concerns that have prompted you to get in touch?
> Which daily tasks do you need help with?
> How long have you been struggling to cope?

Whilst it's important that practitioners gain an understanding of the struggles and challenges which a person is facing, strengths-based practitioners strive to achieve a balance, by asking '...meaningful questions that will combat the relentless pursuit of pathology, and ones that will help discover hidden strengths that contain the seeds to construct solutions to otherwise unsolvable problems' (De Jong et al, 2012).

Saleeby (2005) has identified a number of different types of strengths-based questions:

Question type	Examples
Survival	> How have you managed to cope so far with the challenges you have faced?
Support	> Who supports you now – or has in the past? > What support do you give/have you given to them?
Exception	> When things were going well for you, what was different? > Which parts of you/your life would you like to recapture/relive?
Possibility	> What kinds of things do you like doing? > What kinds of things would you like to do more of? > What do you want out of life?
Esteem	> What is it about your life, yourself and your accomplishments that give you real pride? > When others say good things about you, what are they likely to say?
Perspective	> What sense do you make out of your recent experiences and struggles?
Change	> What are your ideas about how things might change? > What's worked in the past? > How can I help? Who else could help you?

Solution-focused brief therapy (SFBT) – also known as solution-focused therapy – was developed in America in the 1980s by Steve de Shazer and Insoo Kim Berg. It focuses on what people want to achieve rather than on the problems that made them seek help.

While acknowledging problems and past causes, its main focus is on an individual's strengths and future hopes – helping them to look forward and use their own strengths to achieve their goals. Effective questioning is key to SFBT.

A common approach using SFBT might involve asking a 'Miracle question', encouraging a person to imagine how their life might be if a miracle occurred and their problems were solved overnight. Saleeby's exception question is another possibility – 'When things are less bad, what is it that's working?'

The next step might be to use scaling questions to help people to evaluate what's working on a good, or less bad, day, which could be built upon to move one step closer to a good life.

More information about SFBT can be found at the website of the Institute of Solution Focused Therapy: **www.solutionfocused.net**

....

? Questions for reflection

> Which types of strengths-based questions do you ask?
> Are there other types which you don't ask, or only ask rarely?
> How might it make a difference to the people you work with if you were to ask more strengths-based questions?
> Are there times when it might be less appropriate to ask strengths-based questions?

3. Listening to a person's story through a strengths-based lens

The strengths perspective holds firm the idea that everyone who struggles learns something from their struggle, and develops capacities and traits that may ultimately turn out to be bountiful resources in moving towards a better life. It is to assert that everyone has dreams, visions and hopes even though they may currently be dashed on the shoals of disease, oppression, poverty, or muted by a run of rotten luck.

(Saleebey, 2000)

Much of the work of social care professionals involves asking people to share with us details of their lives, their relationships and their hopes for the future. The Research in Practice for Adults publication *Active listening* distinguishes different levels at which we may listen to a person:

www.outcomes.ripfa.org.uk/wp-content/uploads/2016/06/Active-listening-1.pdf

Strengths-based perspectives imply listening with a focus upon identifying the strengths and resources which a person has used to cope so far with the challenges they have faced (Baim and Morrison, 2011). This involves listening from an ethical position which recognises that people are more than the problems which they currently face. The aim is to work collaboratively to recognise existing strengths and build upon them.

The way in which listeners make sense of a person's story can either serve to emphasise problem areas, or to emphasise strengths and capabilities. If professionals work collaboratively with people, we can support them to frame their stories in ways which foreground the ways they have coped with and survived the challenges they have faced. A key idea is to move from the question "What is wrong with you?" to "What has happened to you" and perhaps even "How did you learn to cope?" In the field of mental health, these ideas are reflected in *Trauma Informed Approaches* (Sweeney at al, 2016) and the *Power Threat Meaning Framework* (Johnstone et al, 2018).

A further implication of this approach is that professionals consider a person's behaviour as influenced by their social environment, and frame it as an understandable response to adversity. For example, a mother may be referred to as 'manipulative' because she makes multiple phone calls to different professionals regarding the care of her adult son with a learning disability. However, considered through a strengths-based lens, fighting for her son's access to resources, and promoting his human rights, may represent her best attempt to care for her son and protect him. If we frame her as 'manipulative' or 'demanding' we are less likely to be able to work with her in a collaborative and respectful way. Affirming that she is prepared to take every possible step to advocate for her son may help to build trust with her, and to improve outcomes for her and her son.

Working in this way also requires the professional to consider a person's responses to professional involvement itself through a strengths-based lens. For example, an adult with a physical disability, who experienced abuse as a younger person in a residential school setting, may be afraid of working with a professional to assess their care needs, because of memories of abusive experiences, and fears that they may be put under pressure to live in a less independent way. These wholly understandable fears may result in the adult agreeing to appointments and then missing them, or expressing anger towards the professional, as a means of coping with strong emotions.

Working in a strengths-based way involves making sense of these responses as self-protective mechanisms, and respectfully negotiating a way of working with the person which emphasises their safety and independence. The importance of responding to the impact of traumatic events in a strengths-based way are highlighted in the Research in Practice for Adults Frontline Briefing

Person-centred approaches to adult mental health (Guthrie, 2018b):

www.ripfa.org.uk/resources/publications/ frontline-resources/personcentred-approaches- to-adult-mental-health-frontline-briefing-2018

4. Strengths-based communication approaches

Motivational Interviewing (Miller and Rollnick, 2002) is an example of a strengths-based approach, which focuses upon supporting individuals to recognise and build upon their motivation to make a positive change. One of its core elements is the affirmation. These are statements which focus on non-problem areas, in order to anchor the person to their strengths or values. Two common types are statements of appreciation for the person's values and qualities, and statements which recognise success in conditions of adversity. Affirmations are different from praise, because they place the focus upon the speaker, not the listener, and do not imply anything about the listener needing to give approval.

Affirmation of success in adversity

Ask yourself *"What am I hearing in this person's story which represents an achievement?"*

Example: "Over the last 10 years, you've been determined to care for your wife without any support from paid carers, despite some challenges."

Affirmation of values

Ask yourself *"What am I hearing in this person's story which tells me what is really important to them?"*

Example: "Your independence is so important to you that you are prepared to fight to remain in your own home, whatever the cost."

Appreciative Inquiry (AI)

Appreciative Inquiry is based on the '4D' model devised by Cooperrider and Srivastva (1987): *Discover, Dream, Design, Destiny*. As the term suggests, the focus of AI is very much on identifying what works (discovery), from this imagining the best of what could be (dreaming), developing these good practice examples and ideas (design) and ensuring there is a plan for implementing it more widely (destiny).

As an approach it involves learning from what works well rather than focusing on dissecting failures and learning from what went wrong, drawing upon the belief that what we focus upon becomes our reality (Hammond, 1998). Signs of Safety is an example of a practice model which draws upon Appreciative Inquiry.

For further reading on AI see the Research in Practice for Adults Practice Tool *Appreciative Inquiry in Safeguarding Adults* (2015):

www.ripfa.org.uk/resources/publications/ practice-tools-and-guides/appreciative-inquiry-in-safeguarding-adults-practice-tool-2015

Embedding strengths-based practice – the challenges

This section present some of the challenges and dilemmas that come up in the training room and in published critiques of strengths-based practice (for example Gray, 2011). Many of these stem from the current context of cuts and welfare reform and, as such, cannot be easily answered here. However, it attempts to draw from these broader debates some practical responses which individual practitioners, managers, teams and departments or organisations can take.

> **Following austerity, many communities and individuals have limited resources and are – more than ever – held back by structural inequalities. Is it enough just to change the way we communicate or do other interventions need to happen to re-build strengths?**

Hingley-Jones and Ruch (2016) have written about the tensions arising from relationship-based practice in an era of austerity. They encourage social workers to recognise the interplay between 'social suffering' (brought about by poverty and disadvantage) and personal circumstances and agency in their casework. They also argue that workers need to integrate outcome-focused and risk-averse bureaucracy with uncertain, emotionally intelligent practice if they are to work in this way in the current climate. This requires strong supervision.

Strengths-based practice is certainly harder when there are fewer community groups and facilities and resources, such as libraries or community centres, to link people with and where voluntary sector organisations have less flexibility to work outside of commissioned contracts.

Remember, however, that it is not just a question of thinking about alternative services (for example lunch clubs, befriending, peer support groups run by the voluntary sector), but also about *alternatives* to services. These might include local cafes or pubs, activities and groups linked to people's interests – arts, sports, etc. It's also not just about finding a place where people can receive support, but may also be about finding ways for them to make a contribution – perhaps as a volunteer themselves.

Understanding the resources that exist in the area where you work and for different communities (including communities of interest – for example based around sport or music - as well as geographical or cultural communities) is a key starting point. Opportunities to exchange ideas and solutions across teams can help to share knowledge about specific resources and stimulate thinking 'outside of the box'. Approaches such as Circles of Support and Family Group Conferencing which bring friends and family together to help the person build a 'real world' network of support and social activities can also help here. Local authority investment in community development posts or projects (for example using Asset Based Community Development or Local Area Coordination) can provide infrastructure support in this area for strengths-based social care.

To find out more about **Circles of Support**, you could read Macadam and Savitch's (2015) accessible article on using this model with people with dementia, or the easy-read guide produced by the Foundation for People with Learning Disabilities (2015):

www.ndti.org.uk/uploads/files/Journal_of_ Dementia_Care_Article.pdf

www.mentalhealth.org.uk/sites/default/files/ a-guide-to-circles-of-support.pdf

To find out more about **Family Group Conferencing**, read Tim Fisher's blog for Research in Practice for Adults – **www.ripfa.org.uk/blog/ family-group-conference-in-social-work.** This contains links to further resources, including videos which Camden Adult Social Care have made about their work in this area.

For example you can watch the excellent film *Alice – a Picture Portrait: family group conference in a Camden neighbourhood* at: **https://t.co/eqjVpMcgHk**

See the accompanying Strategic Briefing on *Developing strengths-based working* (Ford, 2019) and Jeanette Sutton's (2018) Leaders' Briefing on *Asset-based work with communities* - **www.ripfa.org.uk/resources/publications/ leaders-briefings/assetbased-work-with- communities-leaders-briefing-2018** - for information about other models, such as Asset-Based Community Development and Local Area Coordination, which local authorities might commission in order to build stronger relationships in communities.

> **How can people trust we're not trying to trick them, when the Department of Work & Pensions increasingly needs them to present as bleak a picture of their problems as possible?**

> **I'm being encouraged to work with individuals in a strengths-based way, but I have to make needs sound very high to get decisions from funding panels?**

Further guidance and support on embedding strengths-based practice can be found in the Department of Health and Social Care resource *Strengths-based social work: Practice framework and handbook* (Department of Health and Social Care, 2019):

www.gov.uk/government/publications/ strengths-based-social-work-practice- framework-and-handbook

Despite the rhetoric of strengths-based practice within the *Care Act 2014*, eligibility for adult social care support is still largely determined by level of need (and by financial circumstances). This is also true of disability benefits and Continuing Health Care funding, where there is an even greater focus on people's deficits. Practitioners can face a difficult balancing act where they are trying to build strengths-based relationships with families, yet need to justify their assessments internally with a clear narrative around deficits and urgency. Slasberg and Beresford sum up this dilemma:

It is relatively straightforward to work in strengths-based ways with people who do not yet require public resources. The practitioner can focus on the person, their views of their needs and the strengths and assets around them without having to also deliver the eligibility process. The situation changes if the person does require public resources on a continuing basis – the eligibility-based process becomes dominant.

(Slasberg and Beresford, 2017)

If strengths-based practice is to be embedded in local authority social care departments, **there needs to be a willingness to delegate financial decision-making (at least to certain monetary limits) to frontline teams and their managers**, and to trust in their skills, judgement and in care plans which have been co-produced with people who use services. Joe Godden of the British Association of Social Workers has highlighted the existence of:

...effective delegated decision making at the level of the social worker and team manager – decision-making by people who know and understand the situation best, leading to better outcomes for service users and more money for services.

(Carter, 2018)

Statutory guidance for the *Care Act* (S.10.85) states that local authorities should refrain from using approval panels which amend or micro-manage care plans, especially for financial reasons.

Practice example

As part of implementing the strengths-based 'Three Conversations' model, Cambridgeshire's Integrated Learning Disability Team has delegated budget-making decisions to team members. Workers can put place in a budget of up to £2000 without needing approval, where they are having a 'Conversation 2' (i.e. about what can be done to make a person safe in crisis), assuming they have exhausted 'Conversation 1' (i.e. about existing assets, aspirations and connections). They can approve a longer-term personal budget ('Conversation 3') through discussion with colleagues, who will first make sure that there is no Conversation 1 or 2 solution (Kirin, 2016).

There are further examples of good practice in Think Local Act Personal (2015) (especially in section 2.4).

It is also important that the forms and recording systems in use reflect a strengths-based approach. This does not mean that challenges and problems should not be recorded, but rather there should be space to record the answers to some of the strengths-based questions considered above. Graybeal (2001) advises workers on how they might 'infiltrate, influence and transform' medical or deficit-based assessment forms and processes.

> **Might people (and especially family members) feel that the responsibility for care is simply being pushed onto them?**

In a blog for Research in Practice for Adults - **www.ripfa.org.uk/blog/the-role-of-social-work-in-supporting-strengths-based-approaches-with-older-people** - Alisoun Milne (2017) describes this outsourcing of risks and responsibilities onto users and carers as the 'Treatment Burden'. Clearly this can increase as eligibility thresholds rise, but what can practitioners do to reduce the risk of service users feeling that services have deserted them?

The principle of collaboration is key here: we need to enter into an honest dialogue about what is and what is not potentially available from services, and work with people to plan how best to bring together a care and support plan which draws on informal as well as formal support. Good reflective listening can help to tune into and test out what might be getting in the way of support between families and friends.

Pride and fear of 'being a burden' can sometimes prevent older people from asking for support from families that they might be very willing to give. There may be financial or practical barriers: a family member might be too busy with their own children first thing in the morning, but could pop in later in the day. Where transport or finances are a barrier, could Attendance Allowance, a direct payment or a community transport scheme be relevant?

There may, of course, be significant relational issues in families, often due to unresolved trauma and loss. Suggestions for practical skills and approaches for social care staff can be found in *Supporting older people using attachment-informed and strengths-based approaches* (Blood and Guthrie 2018).

Sometimes, resolving these may go beyond the scope of your time, mandate and expertise, in which case you might consider a referral for family (systemic) therapy, counselling for individual members or a Family Group Conference (see above). Sometimes families do not want to address these issues, and this should be respected.

> **How can I be expected to deliver strengths-based practice in a workplace culture which feels increasingly untrusting and blaming of its staff?**

See also the Research in Practice for Adults Evidence Review on *Working with complexity* (Baim et al, 2018):

www.ripfa.org.uk/resources/publications/evidence-reviews/working-with-complexity-evidence-review-2018

The ability of workers to practise in strengths-based ways is influenced by the cultures of the organisations in which they work. Despite the increasing focus upon strengths-based practice, if services are commissioned, performance managed and inspected in a way which is risk averse, looks for quick fixes, and values outputs over outcomes, it will limit workers' potential to embrace strengths-based approaches (Stanley, 2016; Blood and Guthrie, 2018).

For an organisation to adopt strengths-based practices, the following commitments are necessary:

> Managers at all levels need to work collaboratively to share responsibility for coping with uncertainty and risk.

> Managers at all levels need to model a strengths-based approach with the workforce, and take care to use language which communicates this.

> Supervision needs to be reflective and relationship-based.

> Issues of power hierarchies need to be acknowledged, both within the staff group, and between workers and the adults and families they work with.

> Internal processes which govern assessment and the allocation of scarce resources need to recognise and build upon the strengths of the workforce and the organisation.

> A whole-organisation practice-framework needs to be developed, which promotes strengths-based and relational practice (Stanley, 2016).

The following table summarises what needs to happen at team-level (practitioners and team leaders) and in organisations (senior managers and commissioners) in order to embed strengths-based approaches:

Individual level
> Actively participate in reflective supervision, both individual and team.
> Consider your own strengths, as a person and as a professional.
> Build your professional networks.
> Strive to maintain hope and realistic optimism, by reminding yourself of small successes.
> Let other people know what you appreciate about them.
> Take your own professional development seriously – seek out opportunities for continuous learning.
> Consider what actions you can take to support your emotional resilience.
> Participate in conversations within your organisation about workload.
> Reflect upon your own personal value base, and remind yourself about the ways in which your work is congruent with your personal values.

Team-level
> Strengths-based communication skills and language.
> High quality strengths-based supervision.
> Opportunities for reflective practice, in relation to the seven principles outlined above.
> Knowledge of local resources (community and voluntary sector, other council departments and outside of 'services').
> Caseload management which allows time where it is most needed for relationship building.
> Performance management and case supervision which supports innovation.
> Forms and paperwork which capture a balanced picture of individuals and families.

Organisation-wide
> Willingness to delegate financial decision-making (to certain limits) to team/service managers.
> Training for panel members on strengths-based principles/ensuring that the voices of service users are included.
> Performance management which focuses on outcomes and quality, not just outputs and quantity.
> Forms and paperwork which capture a more balanced picture of people.
> Investment in learning and development for staff in relation to strengths-based approaches.
> Consider commissioning (and evaluating) approaches such as Asset-Based Community Development, Local Area Coordination, Family Group Conferencing and/or Circles of Support.
> A whole-organisational framework to promote and communicate the approach, including role-specific training, practice guidelines and jargon-free messages to the public around what they can (and cannot) expect from services. See, for example, Wigan Council's work on The Deal – **www.wigan.gov.uk/council/the-deal/the-deal.aspx** – which is a whole-council approach, including a Deal for Adult Social Care which aligns with strengths-based principles.

References

Adamson C, Beddoe L and Davys A (2012) 'Building resilient practitioners: Definitions and practitioner understandings'. *British Journal of Social Work* 44(3), 522-541.

Baim C and Morrison T (2011) *Attachment Based Practice with Adults*. Brighton: Pavilion.

Baim C, Duffy S, Ford D, Griffiths R, Pike L and Sutton J (2018) *Working with complexity: Evidence Review*. Dartington: Research in Practice for Adults.

British Association of Social Workers (BASW) (updated 2014) *The Code of Ethics for Social Work*. Birmingham: British Association of Social Workers.

Blood I (2013) *A Better Life: Valuing Our Later Years*. York: Joseph Rowntree Foundation

Blood I (2016) E*nablement in dementia: Practice Tool*. Dartington: Research in Practice for Adults. Available online: **www.ripfa.org.uk/resources/publications/ practice-tools-and-guides/enablement-in- dementia-practice-tool-2016**

Blood I, Copeman I and Pannell J (2016) *Hearing the Voices of Older People in Wales: What Helps and Hinders as We Age?* Cardiff: Social Services Improvement Agency.

Blood I and Guthrie L (2018) *Supporting older people using attachment-informed and strengths- based approaches*. London: Jessica Kingsley Publishers.

Blood I and Wardle S (2018) *Positive Risk and Shared Decision-Making*. Cardiff: Social Care Wales.

Carter R (2018) 'Social workers voice concerns over the influence of funding panels in adults' services'. *Community Care* 21 March, 2018. Available online: **http://comcaredev.communitycare. co.uk/2018/03/21/social-workers-voice-concerns- influence-funding-panels-adults-services**

Clarke CL, Wilkinson H, Keady J and Gibb CE (2011) *Risk Assessment and Management for Living Well with Dementia*. London: Jessica Kingsley Publishers.

Cooper M (2008) 'The facts are friendly'. *Therapy Today* 19(7), 8-13.

Cooperrider DL and Srivastva S (1987) 'Appreciative inquiry in organizational life'. *Research in organizational change and development* 1(1), 129-169.

Crittenden PM, Dallos R, Landini A and Kozlowska K (2014) *Attachment and family therapy*. London: McGraw-Hill Education (UK).

De Jong P, Kelly S, Berg IK and Gonzales L (2012) Building strengths-based tools for child protection practice: A case of "parallel process". Available online: **https://muskie.usm.maine.edu/helpkids/telefiles/ may25/SB tools article.pdf**

Department of Health and Social Care (2018) *Using the Care Act Guidance*. London: Department of Health and Social Care.

Department of Health and Social Care (2019) *Strengths-based social work: Practice framework and handbook*. London: Department of Health and Social Care. Available online: **www.gov.uk/government/publications/strengths- based-social-work-practice-framework-and- handbook**

Epston D and White M (1990) *Narrative means to therapeutic ends*. New York: WW Norton.

Faulkner A (2012) *The Right to Take Risks: Service Users' Views of Risk in Adult Social Care*. York: Joseph Rowntree Foundation.

Finlayson S (2015) *Stop Worrying About Risk*. Sheffield: Centre for Welfare Reform. Available online: **www.centreforwelfarereform.org/library/by-az/ stop-worrying-about-risk.html**

Foundation for People with Learning Disabilities (2015) *A Guide to Circles of Support*. London: Mental Health Foundation. Available online: **www.mentalhealth.org.uk/sites/default/files/a-guide-to-circles-of-support.pdf**

Gray M (2011) 'Back to Basics: A Critique of the Strengths Perspective in Social Work'. *Families in Society* 92, 1, 5-11.

Graybeal C (2001) 'Strengths-based Social Work Assessment: Transforming the Dominant Paradigm'. *Families in Society* 82, 3, 233-242.

Guthrie L (2018a) *Risks, rights, values and ethics: Frontline Briefing*. Dartington: Research in Practice for Adults.

Guthrie L (2018b) *Person-centred approaches to adult mental health: Frontline Briefing*. Dartington: Research in Practice for Adults.

Hammond SA (1998) *The Thin Book of Appreciative Inquiry: 2nd Edition*. Bend, OR: Thin Book Publishing Company.

Hingley-Jones H and Ruch G (2016) ''Stumbling through?' Relationship-based Social Work Practice in Austere Times'. *Journal of Social Work Practice* 30: 3, 235–248.

Hoole L and Morgan S (2011) 'It's only right that we get involved': Service-user perspectives on involvement in learning disability services'. *British Journal of Learning Disabilities* 39(1), 5-10.

Johnstone L and Boyle M with Cromby J, Dillon J, Harper D, Kinderman P, Longden E, Pilgrim D and Read J (2018) *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society.

Kirin C (2016) *How three conversations have changed the way we do social work*. Croydon: London Borough of Croydon. Available online: **www.communitycare.co.uk/2016/05/03/three-conversations-changed-way-social-work**

Konnikova M (2016) 'How people learn to become resilient'. *The New Yorker* 11 February 2016. Available online: **www.newyorker.com/science/maria-konnikova/the-secret-formula-for-resilience**

Macadam A and Savitch N (2015) 'Staying connected with circles of support'. *The Journal of Dementia Care* 23, 1, 32-34. Available online: **www.ndti.org.uk/uploads/files/Journal_of_Dementia_Care_Article.pdf**

McNamara R and Morgan S (2016) *Risk enablement: Frontline Briefing*. Dartington: Research in Practice for Adults. Available online: **www.ripfa.org.uk/resources/publications/frontline-resources/risk-enablement-frontline-briefing-2016**

Mental Health Foundation (2016) *Relationships in the 21st Century: The forgotten foundation of mental health and wellbeing*. London: Mental Health Foundation.

Miller WR and Rollnick S (2002) *Motivational Interviewing: Preparing People for Change* (2nd edition). New York: Guilford Press.

Morgan S and Andrews N (2016) 'Positive risk-taking: From rhetoric to reality'. *The Journal of Mental Health Training: Education and Practice* 11, 2, 122-132.

O'Leary P, Tsui M and Ruch G (2013) 'The boundaries of the social work relationship revisited: Towards a connected, inclusive and dynamic conceptualisation'. *British Journal of Social Work* 43, 1, 135–153.

O'Rourke HM et al (2015) 'Factors that Affect Quality of Life from the Perspective of People with Dementia: A Meta-synthesis'. *Journal of the American Geriatrics Society* 63: 24-38.

Pulla V (2013) *What are strengths based practices all about?* Australia: Charles Sturt University. Available online:
www.impetusglobal.com/wp-content/ uploads/2013/02/VenkatPullaSBP.pdf

Saleebey D (2000) 'Power in the people: Strengths and hope'. *Advances in social work 1*(2), 127-136.

Saleeby D (2005) *The Strengths Perspective in Social Work Practice. 4th edition.* London: Pearson.

Seligman ME (2002) 'Positive psychology, positive prevention and positive therapy'. *Handbook of positive psychology 2*(2002), 3-12.

Social Care Institute for Excellence (SCIE) (2015) *Care Act 2014: What is a strengths-based approach?* London: SCIE. Available online:
www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/what-is-a-strengths-based-approach.asp

Slasberg C and Beresford P (2017) 'Strengths-based practice: Social care's latest elixir or the next false dawn?' *Disability & Society* 32:2, 269-273.

Stanley T (2016) 'A practice framework to support the Care Act 2014'. *The Journal of Adult Protection* 18, 1, 53-64.

Stokes G (2008) *And Still the Music Plays: Stories of People with Dementia.* London: Hawker Publications.

Sweeney A, Clement S, Filson B and Kennedy A (2016) 'Trauma-informed mental healthcare in the UK: What is it and how can we further its development?' *Mental Health Review Journal* 21(3), 174-192.

Think Local Act Personal (TLAP) (2015) *Delivering Care and Support Planning.* London: TLAP. Available online:
www.thinklocalactpersonal.org.uk/Latest/ Delivering-Care-and-Support-Planning

Tse S, Tsoi E, Hamilton B, O'Hagan M, Shepherd G, Slade M, Whitley R and Petrakis M (2016) 'Uses of strengths-based interventions for people with serious mental illness: A critical review'. *International Journal of Social Psychiatry 62*(3), 281-291.

Vallelly S, Evans S, Fear T and Means R (2006) *Opening Doors to Independence: A Longitudinal Study Exploring the Contribution of Extra Care Housing to the Care and Support of Older People with Dementia.* London: Housing 21.

Williamson T (2010) *My name is not dementia: People with dementia discuss quality of life indicators.* London: Alzheimer's Society. Available online:
www.cardi.ie/userfiles/My_name_is_not_ dementia_report[1].pdf

Notes