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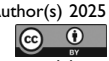

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Reaching consensus on outcomes for evaluating strengths-based approaches in adult social care and social work: A Delphi study conducted in England

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Abstract

• *Summary:* To advance our understanding of how we can best evaluate strengths-based approaches, we aimed to establish: (1) What the relevant outcomes are in strengths-based approaches in adult social care and social work in England; (2) How feasible it would be to measure them; and (3) Which tools and methodologies may be used in outcome measurement and evaluation. We used a Delphi consensus exercise to refine and reduce the long list of outcomes which had been identified in previous work as potentially useful in the evaluation of strengths-based approaches. The Delphi process consisted of two rounds (Rounds 1 and 2). The strengths-based outcomes were divided into five levels of measurement: relevant

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for a person who accesses social care and social work; relevant for unpaid or family carers; relevant for the community; relevant for the workforce in adult social care or social work; and relevant for organizations in adult social care and social work.

- *Findings:* Fifteen experts completed Round 1 and 11 completed Round 2. At the conclusion of the Delphi consensus exercise, the expert panel agreed that 26 outcomes (66.7%, out of 39 considered) were both relevant and feasible to measure as part of an evaluation of strengths-based approaches in adult social care and social work. The panel also identified eight outcomes as relevant but not feasible to measure.
- *Application:* This study provides a set of outcomes that practitioners, researchers, and policy makers can consider when evaluating strengths-based approaches in adult social care and social work.

Keywords
Social work, strengths-based approaches, social care, evaluation, long-term care

Background

The adoption of strengths-based approaches in social work and social care for adults in the U.K. has been an embedded dimension of policy and practice (Caiels et al., 2021). This is the case at least since the 2014 Care Act which places a general duty on local authorities to promote wellbeing of people in need of care and support services (Department of Health and Social Care, 2023). Strengths-based approaches are a core part of the Act's statutory guidance; it refers explicitly to "the person's strengths and capabilities" and to "co-producing services with people who are receiving care and support to foster mutual support networks" (Department of Health and Social Care, 2023). Strengths-based approaches have been embraced by the Chief Social Worker for Adults in her 2017–2018 Annual report "From strength to strength" (Department of Health & Social Care, 2018) and are an integral part of the Professional Capabilities Framework for social work (in England) (BASW, 2018) and Social Work England's Professional Standards (Social Work England).

Despite substantial support for strengths-based approaches in both the policy and practice domains, it remains unclear which circumstances and for what groups of users they might be effective with, and precisely what impact they have (Caiels et al., 2021; Caiels et al., 2024; Price et al., 2020). The complexity of strengths-based approaches themselves makes any evaluation of effectiveness challenging (Caiels et al., 2021). This complexity takes a number of forms: including the absence of a clear consensus regarding the definition of strengths-based approaches (see Table 1), target populations, and intended outcomes (Caiels et al., 2021, 2024; Price et al., 2020). As such there is little agreement about how to evaluate the impact of strengths-based approaches, evaluation tools, and criteria regarding what constitutes evidence, and the most effective methods for assessing and measuring outcomes (Caiels et al., 2021, 2024; Price et al., 2020).

A recent systematic review (Price et al., 2020) confirmed the limited evidence base around the "effectiveness" of strengths-based approaches and the extent to which improved outcomes

Table 1. Examples of definitions of strengths-based approaches.

Source	Definition
Social Care Institute for Excellence (SCIE) (Social Care Institute for Excellence (SCIE), 2015)	Strengths-based practice is 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. As such, it concerns itself principally with the quality of the relationship that develops between those providing and those being supported, as well as the elements that the person seeking support brings to the process (Duncan, 2000). Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services (Morgan & Ziglio, 2007).
Strengths-based approach practice framework (Department of Health & Social Care, 2019)	Strengths-based approach/practice is: an approach "how to carry interventions"; holistic and multidisciplinary; collaborative; proportionate; appropriate to the individual circumstances = flexible; alligned with risk enablement and positive risk taking; a focus on "what matters to you" and "what is strong"; identifying personal, family, and community strengths and support the individual in linking with them; supporting community development; applicable to any intervention, setting, type, or level of need and profession.
Strengths-based approaches Perspectives from practitioners (Caiels et al., 2024)	Strengths-based approaches can be understood as a philosophical position on social work and social care practices that translates into a practice or organisational "methodology." As such strengths-based approaches not only inform face-to-face practice (e.g., assessments) but are "a golden thread that runs through all the work we do" including informing relationships between colleagues (teamwork), management practices, external relationships, service provision, and commissioning of services. The key goal of

(continued)

Table 1. Continued

Source	Definition
	this approach to practice is to identify resources/strengths/assets that exist in the user's "world" (including the user themselves, their family and friends, the community, social care services, and the NHS). Once the resources/strengths/assets are identified and adequate interventions (e.g., care plan, goals for individuals) are implemented the expectation is that positive outcomes will be facilitated.
Research evidence on different strengths-based approaches within adult social work: a systematic review (Price et al., 2020)	Strengths-based approach 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.
Supporting older people using attachment-informed and strengths-based approaches (Blood & Guthrie, 2018)	Proposed the following seven principles: 1. Collaboration and self-determination 2. Relationships are what matters most 3. Everyone has strengths and something to contribute 4. Stay curious about the individual 5. Hope 6. Positive risk-taking 7. Build resilience

for people using social care and social work services, their families, and communities could be attributed to strengths-based approaches as compared to "usual services or approaches." Although the review identified 15 U.K. studies, their quality was considered poor (Price et al., 2020). For strengths-based approaches to gain purchase in the adult social care field it is critical that work exploring the shape, nature, and effectiveness of strengths-based approaches is done and that confidence about what constitutes evidence is built (Stevens et al., 2024). There is therefore a need to develop appropriate methods, frameworks, and strategies for evaluation of the implementation (process evaluation) and effectiveness (outcome evaluation) of strengths-based approaches in adult social care and social work.

Aims

As a first step in advancing our understanding of how we can best evaluate strengths-based approaches, we aimed to establish:

1. what *the relevant outcomes* are in strengths-based approaches in adult social care and social work in England;
2. how feasible it would be to *measure* them;
3. which *tools and methodologies* could be used in outcome measurement and evaluation.

Methods

Study design

This study is the third stage of a larger project that focused on strengths-based approaches in adult social care and social work in England. The first stage included a scoping review of 72 sources that highlighted how strengths-based approaches have been embraced by policy makers and practitioners and widely adopted in practice, but also that questions remained about their definition, effectiveness, feasibility, and how they should/could be evaluated (Caiels et al., 2021). The second stage included analysis of free-text answers collected via an online survey completed by 32 participants (social workers, managers, and commissioners). Of these, 10 participants also took part in one-to-one interviews to gain further insight into their answers. The study concluded that strengths-based approaches had been adopted in a fluid, flexible way and are relevant for everyone involved in or in receipt of social care or social work. Participants also identified a range of outcomes they perceived as resulting from strengths-based approaches in their area of work. Evaluation varied and included small-scale qualitative and quantitative data collection within local authorities (in England local authorities are responsible for adult social care) (Caiels et al., 2024). In the third stage (of this study) we used a Delphi consensus exercise (Hasson et al., 2000) to refine and reduce the broad list of outcomes identified in the previous work (Caiels et al., 2021, 2024; Price et al., 2020; Sugavanam et al., 2021) to a "core set of outcomes" which, longer term, could potentially be used in the evaluation of strengths-based approaches. It consisted of two rounds (Rounds 1 and 2) (see Figure 1). Whilst we originally planned to capture strengths-based approaches in both adult social care and social work, all three stages of the project, including the present study, primarily captured approaches as applied in social work rather than in wider social care. This is because strengths-based approaches are being applied much more explicitly in the adult social work arena.

The Delphi consensus exercise is designed to elicit a "consensus of opinion" from a group of experts. Participants remain anonymous and provide feedback as part of the iterative process (Hsu & Sandford, 2007; Keeney et al., 2006). The initial list of outcomes for the expert panel to consider included outcomes identified in our previous work (Caiels et al., 2021, 2024). We combined them with outcomes drawn from two studies that were published since 2021: a core outcome set for trials and evaluative studies in adult social care (Sugavanam et al., 2021); and a systematic review of research evidence on different strengths-based approaches within adult social work (Price et al., 2020). Therefore, the initial step in the standard Delphi consensus exercise to identify the "items for inclusion" was not considered to be relevant as, in effect, this groundwork was completed as part of our previous work on strengths-based approaches (Caiels et al., 2021, 2024). Currently, there is no clear agreement on how many rounds of Delphi consensus exercise need to be held (Rowe & Wright, 2001) but the majority of the studies we reviewed conducted two to three rounds (Belton et al., 2019).

We decided that the Delphi consensus exercise would be conducted across a maximum of two rounds (Pandor et al., 2019; Woodcock et al., 2020). These enabled us to have adequate reflection on group responses and to incorporate free-text responses from Round 1 to 2. We also recognized that the Delphi process places demands on already busy and time-constrained professionals, and we wanted to ensure maximum participation.

Participant recruitment

Figure 2 shows the flow of participants through the Delphi consensus exercise. For our panel "expert" was defined as: "an individual familiar with strengths-based approaches as well as (the concept of) measurement / evaluation of social care and social work in the adults' field." They were all located in England. Participants were identified using a purposive sampling strategy. This included drawing on our existing networks, for example, the Project Advisory Group that was established as part of the first and second stage of the larger project detailed above, and authors of key papers on strengths-based approaches. Potential participants were initially approached informally via email. This was followed up by two reminders (first after 4 weeks, second after 6 weeks) if they did not respond to the initial contact.

Once we had established a group of potential panel members, we sent them a formal invitation to take part in the consensus exercise: this explained the purpose of the study, how the Delphi process would work and the expected time commitment.

Data collection

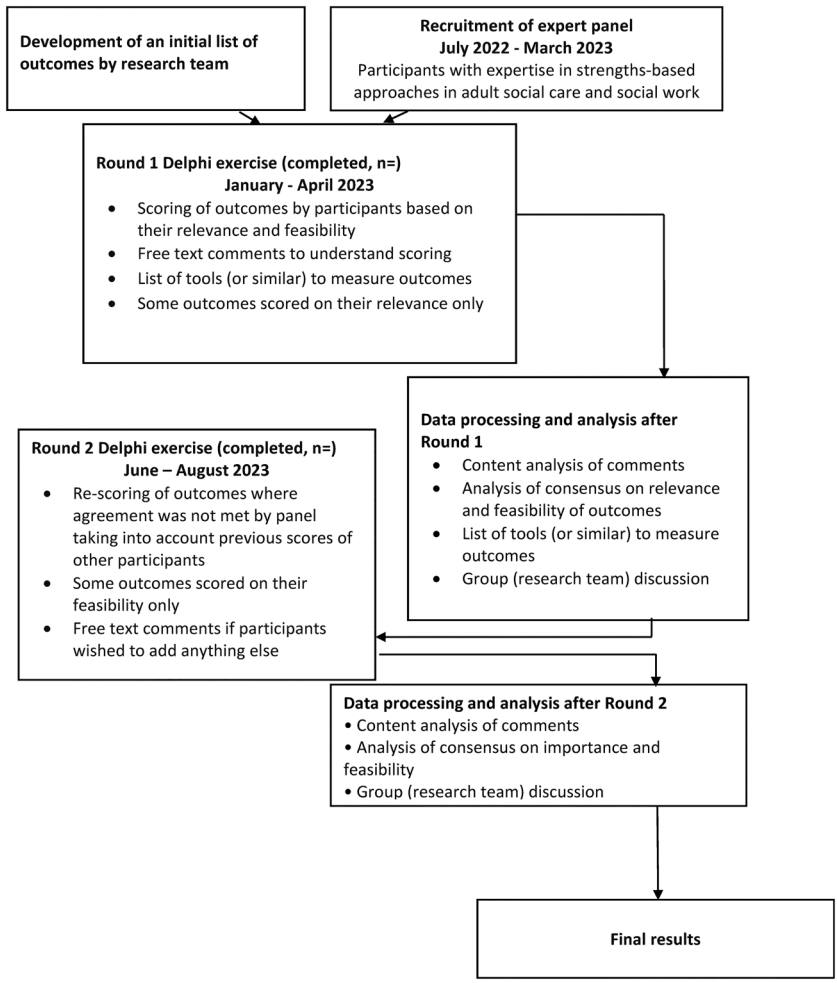
All data were collected online using the Qualtrics XM Platform. Prior to beginning data collection, we piloted the questionnaire with four researchers working in adult social care from the University of Kent. None of these researchers were involved in the development of the questionnaire. We also piloted the questionnaire before Round 1 with a public and patient involvement member. We recruited the public and patient involvement member from the Public Involvement and Engagement Group that was set up as part of the NIHR Policy Research Unit in Adult Social Care. This member supported all three stages of the larger project described above and was involved in a range of activities including membership of the Project Advisory Group.

Prior to the commencement of each round, we sent participants an email outlining the tasks for the upcoming round, along with a web link to the online consensus exercise. Additionally, prior to Round 1, we provided to the participants a brief summary detailing the current perspectives on evaluating strengths-based approaches in social care and social work. To ensure active participation, we utilized the Qualtrics XM Platform™ to send two reminders at 2-week intervals during each of the two rounds. We also followed these up with emails to maximize opportunities for engagement.

Round 1

The Round 1 questionnaire consisted of two parts. In the first part, we asked participants to provide background characteristics (e.g., job title, gender, regional location, area of expertise, and experience with strengths-based approaches).

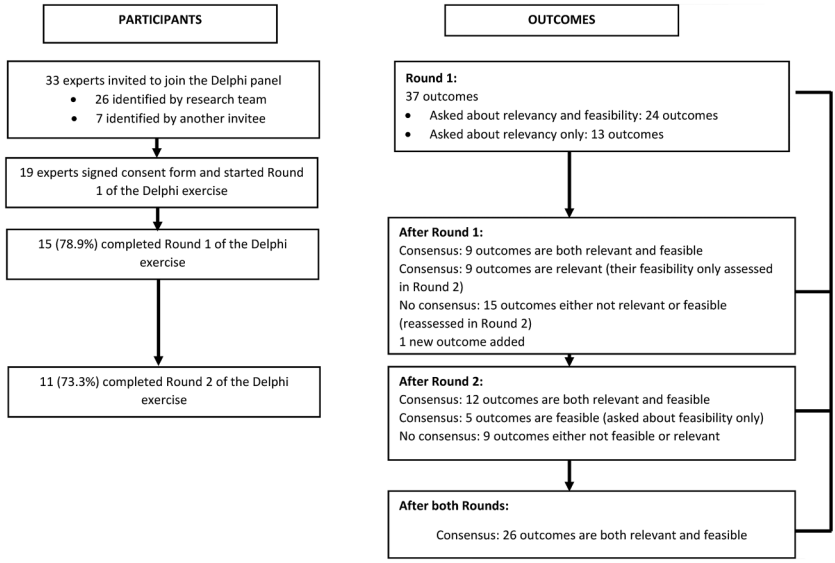
Figure 1. Summary of the Delphi exercise.



The second part of the Round 1 questionnaire focused on five different levels of measurement:

1. Strengths-based outcomes relevant for a person who accesses social care and/or social work;
2. Strengths-based outcomes relevant for unpaid or family carers;
3. Strengths-based outcomes relevant for the community;
4. Strengths-based outcomes relevant for the workforce in adult social care or social work;

Figure 2. Flow of participants and questions through the study.



5. Strengths-based outcomes relevant for organizations in adult social care and/or social work.

Each level of measurement included a different set of questions—this reflected the quantity and status of evidence. For example, service user outcomes have been more extensively researched, resulting in a greater number of identified outcomes compared to those for the workforce or for communities.

For strengths-based outcomes relevant for a person who accesses social care and social work, we included the following outcomes: resilience; sense of empowerment; sense of hope, possibility, or optimism; goal attainment; self-esteem; self-efficacy; sense of independence; feeling of control/ability to make choices; dignity; feeling of belonging/connection; quality of an interpersonal relationships; participation in community activities or resources; life satisfaction; wellbeing; functional ability; health-related quality of life; trust in social work and/or social care; an individual's needs are met; and level of satisfaction with a service. We asked participants to rate the relevance of each outcome on a 5-point Likert scale from "not at all relevant" to "very relevant." In addition, we asked how feasible or difficult it would be to measure this outcome (e.g., using existing tools) on a 5-point Likert scale from "very difficult" to "very feasible." Lastly, we asked whether the participant was aware of any tools to measure the outcome, and if so, to provide details of these. Each question included space for free-text comments in which participants could explain the rationale for their rating. At the end of this section, we offered participants an opportunity to add anything else about strengths-based outcomes relevant for a person who accesses social care/social work services.

For strengths-based outcomes relevant for unpaid or family carers, we asked participants to rate each outcome (burden placed on carers; carer's quality of life) in the same way as described for strengths-based outcomes relevant for a person who accesses social care and/or social work. Additionally, we asked participants about how they think family carers are conceptualized or viewed by strengths-based approaches. We asked them to rate the following statements on a 5-point Likert scale from "strongly disagree" to "strongly agree": (1) "Unpaid (or family) carers will be considered as a resource (or strength) when the person they care for is assessed using a strengths-based approach"; (2) "There is a risk that more will be expected of unpaid (or family) carers when the person they care for is assessed using a strengths-based approach"; and (3) "Unpaid (or family) carers are likely to gain access to higher levels of support from social care services for themselves when the person they care for is assessed using a strengths-based approach." Each question included space for free-text comments, in which participants could explain the rationale for their rating. The foundation for asking these questions is the ambiguous status of family carers in relationship to strengths-based approaches (Bolton, 2019). On the one hand, there exists a policy expectation that carers will not be exploited as a "free resource" (Department of Health & Social Care, 2019) and on the other hand, there are concerns that this is precisely what is happening in many situations (Bolton, 2019). At the end of this section, we asked participants whether they would like to add anything else about strengths-based outcomes that may be relevant for unpaid or family carers.

Regarding strengths-based outcomes relevant for the community, we asked participants to rate one question on a 5-point Likert scale from "not at all relevant" to "very relevant." This was "Given the emphasis strengths-based approaches have on the use of community resources, how relevant do you think it is to include the availability and range of resources as an outcome of strengths-based approaches in adult social care and social work?." The question also included space for free-text comments, in which participants could explain the rationale for their rating. They could also add free text relating to anything else about strengths-based related outcomes that they considered relevant for the community level.

Strengths-based outcomes relevant to the workforce in adult social care or social work included two subsections. First, we asked participants to rate the relevance of each outcome (worker's autonomy; level of trust; level of bureaucracy and paperwork) on a 5-point Likert scale from "not at all relevant" to "very relevant." In addition, we asked how feasible or difficult it would be to measure these outcomes on a 5-point Likert scale from "very difficult" to "very feasible." Lastly, we asked whether the participant was aware of any tools to measure the outcome, and if so, to provide information about these. Once again, each question included space for free-text comments, in which participants could explain the rationale for their rating. Second we asked participants to select which of these (if any) they think should be considered as outcomes of applying strengths-based approaches for the social care or social work workforce: staff morale; professional identity; job satisfaction; sickness levels and turnover of the staff; relationships and connections; awareness of available resources; and public perceptions of social work and social care. At the end of this section, we asked participants whether they would like to add anything else about strengths-based outcomes relevant to the social care or social work workforce.

Lastly, for strengths-based outcomes relevant for the organization in adult social care or social work, we asked participants to rate the relevance of each of the following outcomes on a 5-point Likert scale from "not at all relevant" to "very relevant": preventing or delaying the need for more costly/statutory service; service users can have easier, quicker access to the right support; cost-effectiveness; level of complaints from people with care and support needs and families; and cultural shift as evidenced by different use of language (e.g., in organizational mission statements, purpose and value statement, with service users, between colleagues, etc.). The question included space for free-text comments in which participants could explain the rationale for their rating. We also asked participants whether they would like to add anything else; we were particularly interested to hear whether it is useful to capture organizational dimensions when evaluating strengths-based approaches in adult social care or social work and how we might capture related outcomes.

Initially, Round 1 was open for completion over a 4-week period, accompanied by two reminders at 2-week intervals. We extended the deadline for an additional month and sent a reminder at the 2-week point.

Consensus of opinion/agreement

The ultimate goal of the Delphi exercise was to elicit a "consensus of opinion" from a group of experts. Given the absence of a universally agreed-upon threshold for measures of consensus, we established a consensus level a priori (Hasson et al., 2000), following a similar approach in other studies. Each outcome required a minimum agreement of 70% (Pandor et al., 2019) in both relevance (combined scores of relevant and very relevant), and feasibility (combined scores of feasible and very feasible) to achieve consensus. Only the outcomes that had *not* achieved consensus for *both* relevance and feasibility in Round 1, as per the defined criteria, were asked about again in Round 2 (Helms et al., 2017; Lau et al., 2022). As is consistent with the Delphi consensus exercise process we revisited questions about *both* relevance and feasibility for outcomes where consensus had *not* been reached in *one or both* of these dimensions. However, as described in Round 1, we did not ask about both relevancy and feasibility for all outcomes. For strengths-based outcomes relevant for the community (one outcome) (Table S1 in the supplemental material) and those relevant for organizations in adult social care and social work (five outcomes) (Table S2 in the supplemental material), we asked about their relevancy *only* in Round 1. This is because the evidence on outcomes relevant for communities and for organizations is limited, and we wanted to first ascertain whether the expert panel considers these two sets of outcomes relevant before asking about feasibility. These outcomes required a minimum agreement of 70% in their relevancy in Round 1 (combining scores of relevant and very relevant) to achieve consensus in Round 1.

Round 2

At the beginning of Round 2, we provided participants with a document that included all the outcomes assessed in Round 1, along with an indication of whether consensus had been

reached for each outcome. Additionally, we shared with them a list of tools or frameworks recommended/suggested by panel members in Round 1 for measuring each outcome.

We then asked participants about the outcomes for which consensus had *not* been reached in Round 1. For each outcome asked about in Round 2, we provided participants with two scores: the median score calculated based on responses from the expert panel in Round 1 and with the participant's own individual score. They were given the opportunity to revise their previous response if they wished.

For strengths-based outcomes relevant for the community (one outcome) (Table S1 in the supplemental material) and strengths-based outcomes relevant for organizations (five outcomes) (Table S2 in the supplemental material), we *only* asked about their feasibility in Round 2 *rather* than asking about both relevance and feasibility. This was because at Round 1 the panel agreed they were *all* relevant (combining scores of relevant and very relevant). This approach aimed to minimize the burden on participants by avoiding repetitive questions for outcomes where consensus had already been reached in Round 1 (for a complete list of details, please see Tables S1,S 2, and S3 in the supplemental material).

Round 2 was open for participants over a 4-week period in the first instance, with two reminders sent automatically at 2-week intervals. We extended this period for an additional month with one fortnightly reminder. No further rating rounds were conducted even if consensus was *not* reached following Round 2. This is because the aim of the exercise was not to achieve consensus on all outcomes but rather to refine, reduce, and distil the broad list of outcomes identified in previous work (Caiels et al., 2021, 2024; Price et al., 2020; Sugavanam et al., 2021).

Analysis of data

We used descriptive statistics to present quantitative data collected in Rounds 1 and 2. Descriptive statistics (e.g., median and frequencies) are reported for representing the group opinion. The analysis from free-text responses will be reported and discussed in a separate article. To achieve final consensus each outcome required a minimum agreement of 70% (Pandor et al., 2019) in *both* relevance (combined scores of relevant and very relevant) and feasibility (combined scores of feasible and very feasible).

Results

Characteristics of participants and response rates

We initially invited 33 experts to participate in the consensus exercise. Twenty-four (72.7%) agreed to participate in Round 1. Out of these, 19 began the survey, and 15 (78.9%) completed it. Only those who completed Round 1 were able to participate in Round 2. Of the 15 participants who completed Round 1, 11 participants (73.3%) started and completed Round 2. Figure 2 shows participants' journey and the questions in Rounds 1 and 2. Table 2 shows the participant profiles for each round.

Twelve out of 15 participants indicated their area of expertise as "adult social care and social work," with some providing additional information about their specific areas of

work or role. These included: older adults; impact assessment; homelessness; special education needs; Housing First; direct payments; safeguarding; knowledge mobilization; integrated social care; mental health; family/network approaches; and leadership.

Participants had a range of experience in relation to engagement with strengths-based approaches. These included: conducting research on strengths-based approaches; delivering presentations on strengths-based approaches; developing and delivering training; creating practice handbooks and strengths-based frameworks; integrating strengths-based approaches into social care practice (e.g., during assessments, reviews, support planning, and working in partnership with people); consultancy work; assisting social care organizations in enhancing their practice and leadership through strengths-based approaches; and assessing social work effectiveness reviews. Given the participants' background and expertise, it is important to highlight that the vast majority of the data gathered from participants related to social work rather than social care more broadly.

Reaching an agreement on outcomes and their feasibility for evaluation of strengths-based approaches in adult social care and social work in England

The full list of outcomes considered in Rounds 1 and 2, and the level of agreement per outcome, is shown in the in the supplemental material (Tables S1–S3).

At the end of Round 1, the panel had reached consensus on the relevancy and feasibility of nine out of the 24 outcomes identified for evaluating strengths-based approaches in adult social care and social work (Table S1 in the supplemental material). These nine outcomes were integrated into the final list (Table 3) and were not considered in Round 2. The remaining 15 outcomes were amended based on suggestions from the expert panel and entered into Round 2. Amendments included: (a) relabeling the term "burden placed on carers" to "demands placed on carers"; (b) evaluating "the level of bureaucracy and paperwork" as two separate outcomes in Round 2; and (c) providing additional definitions for some outcomes where the panel indicated a need for further clarity, for example, for "sense of independence" we added the following definition as suggested by a member of the expert panel: "being enabled and having the support in order to live a self-directed life." Based on feedback received in Round 1, we included "social isolation of unpaid (family) carers" as an additional outcome to be assessed in Round 2.

In the case of strengths-based outcomes relevant for the community (one outcome) (Table S1 in the supplemental material), and strengths-based outcomes relevant for organizations in adult social care and social work (five outcomes) (Table S2 in the supplemental material), the panel reached a consensus that *all* of these outcomes were relevant. Thus, in Round 2, we focused solely on assessing their feasibility.

In Round 1, we asked the panel whether the following should be considered as strengths-based outcomes relating to the social work or social care workforce: staff morale; professional identity; job satisfaction; sickness levels; turnover of staff; relationships and connections; awareness of available resources; and public perceptions of social work and social care. As 70% of the panel membership selected staff morale, job

Table 2. Characteristics of the participants in the expert panel for Round 1 and Round 2 respectively.

	Round 1 ($n = 15$)		Round 2 ($n = 11$)	
Characteristic	*N*	%	*N*	%
Gender				
Male	3	20.0	3	27.3
Female	11	73.3	7	63.6
Prefer not to answer	1	6.7	1	9.1
Professional background				
Academic	8	53.3	5	45.5
Social worker/principal social worker/manager[a]	4	26.7	3	27.3
Other (e.g., director; head of growth and impact)	3	20.0	3	27.3
Geographical location/place of work				
London	4	26.7	3	27.3
North East	1	6.7	0	0
North West	1	6.7	1	9.1
East Midlands	2	13.3	1	9.1
West Midlands	2	13.3	2	18.2
South East	1	6.7	1	9.1
East of England	1	6.7	0	0
South West	3	20.0	3	27.3

[a]Team manager/practice development manager.

satisfaction, and relationships and connections in Round 1, we proceeded *only* to assess their feasibility in Round 2.

At the end of Round 2, the expert panel reached consensus on the relevance and feasibility of 12 out of 16 outcomes for evaluating strengths-based approaches in adult social care and social work (Table S1 in the supplemental material). Regarding the outcomes exclusively assessed for feasibility in Round 2 (Tables S1 and S3 in the supplemental material), the panel reached agreement that five out of the nine outcomes are feasible to measure.

At the conclusion of the Delphi consensus exercise, the expert panel agreed that 26 outcomes (66.7%, out of 39 considered) were *both* relevant and feasible to measure as part of an evaluation of strengths-based approaches in adult social care and social work (Table 3). The panel also identified eight outcomes as relevant but *not* feasible to measure. These were: (a) for a person who accesses social care and social work: resilience; dignity; (b) for the community: the availability and range of community resources; (c) for the workforce in adult social care or social work: level of bureaucracy; level of paperwork; and (d) for organizations in adult social care and/or social work: preventing or delaying the need for either more costly and/or statutory services; cost-effectiveness; and cultural shift as evidenced by different use of language. The panel did not reach consensus on the relevance or feasibility of measuring

Table 3. Final list of outcomes that are relevant and feasible to measure as part of the evaluation of strengths-based approaches.

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for a person who accesses social care and social work		
Resilience	Relevant but not feasible to measure	• 3 Conversations (*The Three Conversations®*) • Brief resilience scale (BRS) (*Brief Resilience Scale (BRS)*) • Resilience Assessment Questionnaire (RAQ 8) (*Resilience Assessment Questionnaire (RAQ 8)*) • The Nicholson McBride Resilience questionnaire (NMRQ)—abbreviated version (*The Nicholson McBride Resilience Questionnaire (NMRQ)*) • Qualitatively in terms of analyzing people's own accounts of their resilience or via participatory approaches, e.g., PhotoVoice (*PhotoVoice*) • Building upon resilience in child and family, e.g., Boingboing (*Boingboing*) • Question on their ability to understand and reach individual's internal resources
Sense of empowerment	Yes	• Think Local Act Personal "I statements" (*Think Local Act Personal "I statements"*) • Family Group Conferences (*Family Group Conferences*) • The ICECAP (*ICECAP Capability Measures)* • Study by Noordink et al. (2021) provides an overview of 49 instruments and its core features, with which empowerment can be measured in different target populations within social work • Study by Cyril et al. (2016): systematic review that evaluated the measurement properties of quantitative empowerment scales and their applicability in health promotion programs • Qualitatively (e.g., when asking how they feel) in terms of the language they use, e.g., feeling in control or not in control; able to make choices • Vignettes • Family and Group Conferencing (FGC): approach in adult social care that offers an inclusive approach in which people can plan for their care and support on their terms (*Family and Group Conferencing in adult social care and*

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for a person who accesses social care and social work		
		mental health: exploring how it works and what difference it can make in people's lives)
Sense of hope, possibility, or optimism	Yes	• Simple scoring (how likely do you think this is to happen…) • Asking people how they feel about the future • The Employment Hope Scale (EHS) (*Employment Hope Scale (EHS-21)*) • Adult Hope Scale (AHS) (*Adult Hope Scale (AHS)*) • Measuring hope: validity of short versions of four popular hope scales (Pleeging, 2022): The Adult Trait Hope Scale (ATHS); The Herth Hope Index (HHI); The Locus Of Hope Scale (LOHS); The Comprehensive Hope Scale (CHS) • Qualitative methods, such as using colors to express feelings or creative methods such as art or creative writing
Goal attainment	Yes	• Goal Attainment Scaling (GAS) (*Goal Attainment Scaling (GAS)*) • The ICECAP (*ICECAP Capability Measures)* • Research in Practice outcomes focused tools (*Research in Practice outcomes focused tools*) • As part of review of support plans/monitoring calls • Outcomes Star™ with adaptation (*Outcomes Star™*) • Those used by reablement services and in recovery models for adults with mental, ill health, or substance misuse issues • The Care Act gives a framework to focus on goals for people
Self-esteem	Yes	• The ICECAP (*ICECAP Capability Measures*) • The Rosenberg Self-Esteem scale (*The Rosenberg Self-Esteem scale*)
Self-efficacy	Yes	• The Research Self-Efficacy scale (Holden et al., 1999) with adaptation • General Self-Efficacy—Schwarzer (GSES) (*General Self-Efficacy—Schwarzer (GSES)*) • Measuring Self-Efficacy with Scales and

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for a person who accesses social care and social work		
		Questionnaires (*Measuring Self-Efficacy with Scales and Questionnaires*) • Research in Practice tool for resilience skills (*Research in Practice tool for resilience skills*)
Sense of independence	Yes	• The ICECAP (ICECAP Capability Measures) • Activities of Daily Living (*Activities of Daily Living*)/ Instrumental Activities of Daily Living (*Instrumental Activity of Daily Living*) • For example, doing difficult tasks independently (going to the GP unaided)
Feeling of control/ ability to make choices	Yes	• TLAP "I" statements from Making It Real 2018 (*TLAP "I" statements from Making It Real 2018*) • The ICECAP (*ICECAP Capability Measures*)
Dignity	Relevant but not feasible to measure	• Observation—e.g., maintaining individuals' privacy • Embedding human rights in assessment for care and support: Frontline Briefing (2020) (*Embedding human rights in assessment for care and support: Frontline Briefing (2020)*)
Feeling of belonging/ connection	Yes	• Social network tool (*Social network visualizer*) • Asset mapping (*Asset Mapping*) or activity logging • Ecogram (*Ecogram*) • Number of local activities engaged in each month • The number of people they feel they can contact if something happens • Statements in TLAP (*Keeping family, friends and connections: active and supportive communities*) and ABCD (*The Asset-Based Community Development*) on what is feeling connected, so could be a question of giving a set to individuals to tick yes/no • The ICECAP (*ICECAP Capability Measures*) • The Lubben Social Network Scale (LSNS) (*Lubben Social Network Scale*) • Relevant tools/approaches from the Link Worker model and Local Area Coordinator activity
Quality of an	Yes	• Genograms (*Genogram*) • Photographs

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for a person who accesses social care and social work		
interpersonal relationships		• The Social Provisions Scales (*The Social Provisions Scales*) • Questions from Office for National Statistics (*Office for National Statistics*) • Social network analysis (*Social Network Analysis*) • TLAP "I" statements from Making It Real 2018 (*TLAP "I" statements from Making It Real 2018*) • Ecogram (*Ecogram*) • Care Quality Commission standards of care when thinking about how a care-giver's relationship is working
Participation in community activities or resources	Yes	• Compiling a list of resources and frequencies—how often one visits or engages • Asset mapping (*Asset Mapping*) or activity logging • A checklist on typical days/weeks and then asking if the level of participation is what the person wants • The ICECAP (*ICECAP Capability Measures*) • The ICECAP-O (*ICECAP-O*)
Life satisfaction	Yes	• Happiness scales (*Happiness scales*) • The Warwick-Edinburgh Mental Wellbeing Scales—WEMWBS (*The Warwick-Edinburgh Mental Wellbeing Scales—WEMWBS*) • The ICECAP (*ICECAP Capability Measures)* • In general, how satisfied are you with your life? • The WHOQOL World Health Organisation quality of life scale (*The WHOQOL World Health Organisation quality of life scale*) • The Satisfaction With Life Scale (SWLS) (*The Satisfaction With Life Scale (SWLS)*)
Wellbeing	Yes	• The WHOQOL World Health Organisation quality of life scale (*The WHOQOL World Health Organisation quality of life scale*) • Measuring Well-Being: A Review of Instruments (Cooke et al., 2016) • The ICECAP (*ICECAP Capability Measures*) • The Warwick-Edinburgh Mental Wellbeing Scales—WEMWBS (*The Warwick-Edinburgh Mental Wellbeing Scales—WEMWBS*) • Measuring the well-being of people with

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for a person who accesses social care and social work		
		dementia: a conceptual scoping review (Clarke et al., 2020) • Wellbeing domains on any care plan
Functional ability	No	NA
Health-related quality of life	Yes	• 36-Item Short Form Survey (SF-36) (*36-Item Short Form Survey (SF-36)*) • EQ5D (*The EQ-5D*) • ONS Measuring National Wellbeing program includes question on health (*UK Measures of National Well-being user guide*)
Trust in social work and/or social care	Yes	• Adapted questions from Trust in government, UK 2022 (*Trust in government, UK: 2022*)
An individual's needs are met	Yes	• Values in Action Inventory of Strengths (*Values in Action Inventory of Strengths*) • Outcomes Star™ (*Outcomes Star™*) • Outcomes-based tools, care plans and reviews
Level of satisfaction with a service	Yes	• Care Quality Commission collects this information in their State of Care report (*State of Care*) • Feedback/satisfaction surveys • Marketing research • Satisfaction surveys from government, local government surveys, questionnaires from local authorities
Strengths-based outcomes relevant for unpaid or family carers		
The burden placed on carers: in Round 2 renamed as demands placed on carers	Yes	• Carer Experience Scale (CES) (*The Carer Experience Scale*) • The Zarit Burden interview (*Zarit Burden Interview*) • The Carers Assessment of Difficulties Index, Carers Assessment of Satisfactions Index and the Carers Assessment of Managing Index (CADI-CASI-CAMI) (McKee et al., 2009)
Carers' quality of life	Yes	• The Care Act: Wellbeing (*The Care Act: Wellbeing*) • The WHOQOL World Health Organisation quality of life scale (*The WHOQOL World Health Organisation quality of life scale*) • Adult Carer Quality of Life Questionnaire (AC-QoL) (*Adult Carer Quality of Life Questionnaire (AC-QoL)*); ASCOT-Carer (*ASCOT-Carer*)

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for a person who accesses social care and social work		
Social isolation: introduced for Round 2 based on the feedback from Round 1	Yes	• Carer assessments • The ICECAP-A (ICEpop CAPability measure for Adults) (*The ICECAP-A (ICEpop CAPability measure for Adults)*) • Outcomes Star™ (*Outcomes Star™*) • Informal Caregiving, Loneliness and Social Isolation: A Systematic Review: provides an overview of measures on social isolation and loneliness in unpaid carers (Hajek et al., 2021)
Strengths-based outcomes relevant for the community		
The availability and range of community resources	Relevant but not feasible to measure	• Asset mapping (*Asset mapping*)
Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for the workforce in adult social care and/or social work		
Worker's autonomy	Yes	• Self-efficacy in Social Work Organisational Resilience Diagnostic (*The Social Work Organisational Resilience Diagnostic (SWORD): Workbook*) • Burnout scales (*Valid and Reliable Survey Instruments to Measure Burnout, Well-Being, and Other Work-Related Dimensions*) and compassion fatigue scales (*Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009)*) • BASW's "Social Worker Wellbeing and Working Condition Good Practice Toolkit" (*BASW's "Social Worker Wellbeing and Working Condition Good Practice Toolkit"* • Measures of worker satisfaction (e.g., Karasek, 1979)

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for the workforce in adult social care and/or social work		
Level of trust between social care/ social workers and the people they support	Yes	• Adapted questions from Trust in government, UK 2022 (*Trust in government, UK: 2022*) • Conceptualizations of Trust: Can We Trust Them? (Whipple et al., 2013)
Level of bureaucracy (after Round 1 bureaucracy and paperwork were assessed separately in Round 2) Level of paperwork (after Round 1 bureaucracy and paperwork were assessed separately in Round 2)	Relevant but not feasible to measure	• Business process mapping • Activity diaries • The Employer Standards Health Check (*The Employer Standards Health Check*) • Social Workers' Experiences of Bureaucracy: A Systematic Synthesis of Qualitative Studies (Pascoe et al., 2023)
Staff morale	Yes	• For an example see: English care home staff morale and preparedness during the COVID pandemic: A longitudinal analysis (Brainard et al., 2023)
Professional identity	No	NA
Job satisfaction	Yes	• Determining dimensions of job satisfaction in healthcare using factor analysis (Karaferis et al., 2022) • The Efficient Measurement of Job Satisfaction: Facet-Items versus Facet Scales (Lepold et al., 2018)
Sickness levels and turnover of the staff	No	NA
Relationships and connections	Yes	• Social network tool (*Social network visualizer*) • Ecogram (*Ecogram*)
Awareness of available resources	No	NA
Public perceptions of social work and social care	No	NA
Strengths-based outcomes relevant for organizations in adult social care and social work		
Preventing or delaying the need for more costly/statutory services	Relevant but not feasible to measure	No tools identified
Service users have easier, quicker access to the right support	Yes	No tools identified

(continued)

Table 3. Continued

Outcomes	Final consensus	Suggested tool
Strengths-based outcomes relevant for the workforce in adult social care and/or social work		
Cost-effectiveness	Relevant but not feasible to measure	• For more detail see Economic evaluation (EE) in Adult Social Care (*Economic evaluation (EE) in Adult Social Care*)
Level of complaints	Yes	• Number of complaints submitted
Cultural shift	Relevant but not feasible to measure	• The Quantitative Measurement of Organizational Culture in Health Care: A Review of the Available Instruments (Scott et al., 2003)

five outcomes related to strengths-based approaches. These were: (1) functional ability for a person who accesses social care and social work; (2) professional identity; (3) sickness levels and turnover of staff; (4) awareness of available resources; and (5) public perceptions of social work and social care.

Tools to measure outcomes for evaluation of strengths-based approaches in adult social care and social work in England

As part of Round 1, we asked panel members if they knew of examples of any tools that could be used to measure outcomes as part of evaluating strengths-based approaches. Participants were encouraged to consider all types of approaches or tools (both qualitative and quantitative) when responding.

The examples listed by the expert panel are included in Table 3. These also include other tools known by the research team.

Conceptualization of unpaid or family carers in strengths-based approaches

Following Round 2, the expert panel reached consensus (at least slightly agreed) around two carer-related statements: "Unpaid (or family) carers are considered as a resource (or strength)" and "There is a risk that more will be expected of unpaid carers" in the context of strengths-based approaches. The panel neither agreed nor disagreed about the third statement that, "Unpaid carers are likely to gain access to higher levels of support" when applying strengths-based approach (Table 4).

Discussion

The aim of this article was to advance our understanding of how we can best evaluate strengths-based approaches in adult social care and social work. We used the Delphi

consensus exercise to elicit agreement among 15 experts in strengths-based approaches in adult social care and social work on what the relevant and feasible outcomes are in strengths-based approaches in adult social care and social work in England. In addition, the expert panel suggested tools and methodologies that may be used in outcome measurement and evaluation.

As emphasized above, practitioners (Caiels et al., 2024), professional bodies (BASW, 2018; Social Work England), and policy-makers (Department of Health & Social Care, 2018, 2023) widely embrace strengths-based approaches in adult social care and social work. Despite this, the current evidence base supporting improved outcomes for adults using social care services, their families, and wider communities relating to the adoption of strengths-based approaches remains limited (Caiels et al., 2021; Price et al., 2020). This paucity of evidence is attributed to the numerous challenges relating to evaluating strengths-based approaches in adult social care and social work (Caiels et al., 2021, 2024; Price et al., 2020). These challenges include a lack of consensus about the definition of strengths-based approaches and the difficulty of attribution, that is, knowing whether improved outcomes for the service user were a result of the strengths-based approach, and if so which elements of the approach used accounted for the improvement in outcomes. There is also confusion about whether a strengths-based approach is an intervention, a conceptual model, and/or an ideological position (Caiels et al., 2021). Another challenge relates to determining who the beneficiaries of strengths-based approaches are: individuals who draw on social care and social work services, their families, the wider community, practitioners, and/or social care organizations.

Given the importance of evaluation studies as foundational sources of evidence for policy-makers, commissioners, and funding organizations, there is a pressing need to delineate what outcomes the adoption of a strengths-based approach can reasonably be expected to deliver for which beneficiary/ies and how feasible these outcomes are to measure. This study sought to establish agreement on which outcomes are both relevant *and* feasible to measure for individuals who draw on social care and social work services, their families, the wider community, practitioners, and/or social care organizations to inform the design of studies to evaluate strengths-based approaches. Using a Delphi process, an expert panel achieved consensus on 26 outcomes deemed both relevant and feasible for measurement across individuals who draw on social care and social work, their family carers, communities, workforce, and organizations. The study also offered insight into how these outcomes could be measured, using both qualitative and quantitative methods.

In addition to specific evidence about outcomes, our study offers some other interesting new findings. Whilst confirming that individuals who draw on social care and social work can benefit from the adoption of a strengths-based approach, we also identified that family carers, wider communities, social workers, and social care organizations can be positively impacted too. We have also highlighted how family carers are conceptualized in strengths-based approaches, an issue that is rather opaquely referred to in existing literature.

While this study was conducted in England, the shared policy and practice context of the rest of the U.K., and similar contexts in other countries in Europe and beyond, make it very likely that our findings will have resonance beyond the English context. In addition, as the majority of the outcomes that the experts considered as part of this Delphi study

Table 4. Statements for unpaid (family) carers.

	Round 1		Round 2	
Outcome/other	*N* = 15	Overall consensus	*N* = 11	Overall consensus
Strengths-based outcomes relevant for unpaid or family carers				
Unpaid (or family) carers considered as a resource (or strength)				
Strongly disagree	0		0	
Slightly disagree	0		0	
Neither agree or disagree	5		1	
Slightly agree	5		7	
Strongly agree	5		3	
Median	4 (slightly agree)		4 (slightly agree)	
Consensus met	No	Reassessed in Round 2	Yes	Yes
Risk that more will be expected of unpaid carers				
Strongly disagree	3		1	
Slightly disagree	1		1	
Neither agree or disagree	3		1	
Slightly agree	6		6	
Strongly agree	2		2	
Median	4 (slightly agree)		4 (slightly agree)	
Consensus met	No	Reassessed in Round 2	Yes	Yes
Unpaid carers likely to gain access to higher levels of support				
Strongly disagree	1		0	
Slightly disagree	2		2	
Neither agree or disagree	9		8	
Slightly agree	1		1	
Strongly agree	2		0	
Median	3 (neither agree or disagree)		3 (neither agree or disagree)	
Consensus met	No	Reassessed in Round 2	No	No

were identified in a previous scoping review of international literature (Caiels et al., 2021), this increases the likelihood of wider relevance.

Limitations of the study

The study has a number of limitations. We did not attempt to preference weight the 26 outcomes, that is, some being more relevant than others; neither did we analyze what relationships may exist between outcomes. Also, while we included all tools and methodologies suggested by the expert panel, we did not assess their psychometric properties—specifically their feasibility, reliability, and validity for application in adult social care and/or social work. We did not explore the potential costs of conducting an evaluation. These issues need to be explored in future research.

It is noteworthy that the majority of participants, due to their background and expertise, were associated with social work rather than social care more broadly. This observation mirrors our previous work (Caiels et al., 2021, 2024) which highlights how social care is a very broad and multi-dimensional and multi-disciplinary field. Strengths-based approaches are more easily conceptualized in one-to-one social work encounters; they have also been embraced by social workers (BASW, 2018) in a way that is much less visible in the wider field of social care. Consequently, we suggest that the outcomes established in this study are considered in the context of social work with adults rather than social care more broadly.

We acknowledge that the size of the panel was modest and that, despite several reminders, there was some attrition in participation. This is not surprising given the immense pressure on the social work sector, where individuals often have very limited time. In response to feedback during Round 1, which highlighted the length and time-consuming nature of the Delphi consensus exercise, certain adjustments were made for Round 2. Specifically: free-text questions; questions about outcomes already achieving consensus in Round 1; and queries regarding potential tools for outcome measurement were omitted. However, it is also important to note that there is no agreement on the minimum panel size required for content validity in Delphi studies. Recommendations vary from 5 to 30 participants (Bolton, 2019; Lau et al., 2022; Woodcock et al., 2020), but in general it is agreed that the response rate of each Delphi round should not fall below 70% which this study achieved (Kilroy & Driscoll, 2006).

Conclusion

In conclusion, this study provides a set of outcomes that practitioners, researchers, and policymakers can consider when evaluating strengths-based approaches in adult social work, and with some additional work, adult social care too. These outcomes are categorized into five levels of measurement, these being strengths-based outcomes relevant for: individuals accessing social care and social work; family carers; the community; the workforce in adult social care or social work; and social work/care organizations.

The study represents a first step in advancing our understanding of how we can best evaluate strengths-based approaches, particularly in social work with adults. Future research should establish whether the tools and methodologies proposed by the expert

panel are feasible, reliable, and valid. It should also explore the relative significance of the 26 identified outcomes, the interrelationships between these outcomes, and the potential costs associated with any evaluation. While this study focuses on one part of the overall evaluation process—outcome evaluation, there is also a need to develop appropriate methods, frameworks, and strategies for evaluation of the implementation (process evaluation) of strengths-based approaches, and find ways to include the perspectives of people who use adult social care and social work and their family carers.

Ethical approval

Ethical approval for this project was given by the University of Kent Research Ethics Committee (Ref: SRCEA 0278) and e-consent was obtained at the beginning of data collection.

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Authors' contributions

All authors contributed to developing and testing the Delphi survey. BS analyzed the data. All authors reviewed and interpreted the results. BS wrote the manuscript with input and final review by JC, AM, and JB-B. JC led the overall study.

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Supplemental material

Supplemental material for this article is available online.

References

36-Item Short Form Survey (SF-36). https://www.rand.org/health-care/surveys_tools/mos/36-item-short-form.html

Activities of Daily Living. https://www.ncbi.nlm.nih.gov/books/NBK470404/

Adult Carer Quality of Life Questionnaire (AC-QoL). https://carers.ripfa.org.uk/wp-content/uploads/adult-carer-qol-published-version-5571.pdf

Adult Hope Scale (AHS). https://ppc.sas.upenn.edu/sites/default/files/hopescale.pdf

ASCOT-Carer. https://www.pssru.ac.uk/ascot/carer-tools/

The Asset-Based Community Development. https://resources.depaul.edu/abcd-institute/resources/Pages/tool-kit.aspx

Asset Mapping. https://mycommunity.org.uk/how-to-create-an-online-map-of-community-assets

BASW. (2018). *Professional capabilities framework (PCF)*. Available at: https://new.basw.co.uk/training-cpd/professional-capabilities-framework-pcf

BASW's "Social Worker Wellbeing and Working Condition Good Practice Toolkit". https://www.exchangewales.org/wp-content/uploads/sites/14/2021/07/Presentation-for-BASW-workshop-23rd-June-2021.pdf

Belton, I., MacDonald, A., Wright, G., & Hamlin, I. (2019). Improving the practical application of the Delphi method in group-based judgment: A six-step prescription for a well-founded and defensible process. *Technological Forecasting and Social Change*, *147*, 72–82. https://doi.org/10.1016/j.techfore.2019.07.002

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

Boingboing. https://www.boingboing.org.uk/

Bolton, J. (2019). *New developments in adult social care*. Available at: https://ipc.brookes.ac.uk/files/publications/New_Developments_in_Adult_Social_Care.pdf

Brainard, J., Bunn, D., Watts, L., Killett, A., O'brien, S. J., Lake, I. R., Mumford, S., & Lane, K. (2023). English care home staff morale and preparedness during the COVID pandemic: A longitudinal analysis. *American Journal of Infection Control*, *51*(7), 792–799. https://doi.org/10.1016/j.ajic.2022.10.009

Brief Resilience Scale (BRS). https://ogg.osu.edu/media/documents/MB%20Stream/Brief%20Resilience%20Scale.pdf

Caiels, J., Milne, A., & Beadle-Brown, J. (2021). Strengths-based approaches in social work and social care: Reviewing the evidence. *Journal of Long-Term Care*, 401–422. https://doi.org/10.31389/jltc.102

Caiels, J., Silarova, B., Milne, A. J., & Beadle-Brown, J. (2024). Strengths-based approaches—Perspectives from practitioners. *The British Journal of Social Work*, *54*(1), 168–188. https://doi.org/10.1093/bjsw/bcad186

The Care Act: Wellbeing. https://www.hpft.nhs.uk/information-and-resources/care-act-2014/the-care-act-wellbeing/

The Carer Experience Scale. https://www.bristol.ac.uk/population-health-sciences/projects/icecap/ces/

Clarke, C., Woods, B., Moniz-Cook, E., Mountain, G., Øksnebjerg, L., Chattat, R., Diaz, A., Gove, D., Vernooij-Dassen, M., & Wolverson, E. (2020). Measuring the well-being of people with dementia: A conceptual scoping review. *Health and Quality of Life Outcomes*, *18*(1), 249. https://doi.org/10.1186/s12955-020-01440-x

Compassion Satisfaction and Fatigue (ProQOL) Version 5 (2009). https://socialwork.buffalo.edu/content/dam/socialwork/home/self-care-kit/compassion-satisfaction-and-fatigue-stamm-2009.pdf

Cooke, P. J., Melchert, T. P., & Connor, K. (2016). Measuring well-being: A review of instruments. *The Counseling Psychologist*, *44*(5), 730–757. https://doi.org/10.1177/0011000016633507

Cyril, S., Smith, B. J., & Renzaho, A. M. (2016). Systematic review of empowerment measures in health promotion. *Health Promot Int*, *31*(4), 809–826. https://doi.org/10.1093/heapro/dav059

Department of Health and Social Care. (2023). *Care and support statutory guidance. Using the Care Act guidance*. Available at: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Department of Health & Social Care. (2018). *Chief social worker for adults annual report: 2017–18 From strength to strength. Strengths-based practice and achieving better lives*. Available at: https://assets.publishing.service.gov.uk/media/5aaff66eed915d29d81f5f8f/Chief_Social_Worker_for_Adults_-_Annual_report_2018.pdf

Department of Health & Social Care. (2019). *Strengths-based approach: Practice framework and practice handbook*.

Duncan, B. L., & Miller, S. D. (2000). *The heroic client: Doing client-directed outcome-informed therapy*. Jossey-Bass.

Ecogram. https://carers.ripfa.org.uk/wp-content/uploads/Blank_Ecogram.pdf

Economic evaluation (EE) in Adult Social Care. https://arc-kss.nihr.ac.uk/document-download/143-evaluation-of-adult-social-care-julien-forder-arc-kss/file

Embedding human rights in assessment for care and support: Frontline Briefing (2020). https://www.researchinpractice.org.uk/adults/publications/2020/september/embedding-human-rights-in-assessment-for-care-and-support-frontline-briefing-2020/

The Employer Standards Health Check. https://www.local.gov.uk/our-support/workforce-and-hr-support/social-workers/employer-standards-health-check

Employment Hope Scale (EHS-21). http://philiphong.weebly.com/uploads/2/1/4/1/21418864/ehs___pebs__hong__2017.pdf

The EQ-5D. https://euroqol.org/eq-5d-instruments/

Family and Group Conferencing in adult social care and mental health: exploring how it works and what difference it can make in people's lives. https://www.birmingham.ac.uk/schools/social-policy/research/projects/family-and-group-conferencing-in-adult-social-care-and-mental-health.aspx

Family Group Conferences. https://frg.org.uk/family-group-conferences/

General Self-Efficacy—Schwarzer (GSES). https://www.drugsandalcohol.ie/26768/1/General_Self-Efficacy_Scale%20(GSE).pdf

Genogram. https://genopro.com/genogram/

Goal Attainment Scaling (GAS). https://www.kcl.ac.uk/cicelysaunders/resources#GAS

Hajek, A., Kretzler, B., & König, H. H. (2021). Informal caregiving, loneliness and social isolation: A systematic review. *International Journal of Environmental Research and Public Health*, *18*(22), 12101. https://doi.org/10.3390/ijerph182212101

Happiness scales. https://www.pursuit-of-happiness.org/science-of-happiness/measuring-happiness/

Hasson, F., Keeney, S., & McKenna, H. (2000). Research guidelines for the Delphi survey technique. *Journal of Advanced Nursing*, *32*(4), 1008–1015. https://doi.org/10.1046/j.1365-2648.2000.t01-1-01567.x

Helms, C., Gardner, A., & McInnes, E. (2017). The use of advanced web-based survey design in Delphi research. *Journal of Advanced Nursing*, *73*(12), 3168–3177. https://doi.org/10.1111/jan.13381

Holden, G., Barker, K., Meenaghan, T., & Rosenberg, G. (1999). Research self-efficacy. *Journal of Social Work Education*, *35*(3), 463–476. https://doi.org/10.1080/10437797.1999.10778982

Hsu, C., & Sandford, B. (2007). The Delphi technique: Making sense of consensus. *Practical Assessment, Research & Evaluation*, *12*(1), 1–8. https://doi.org/http://pareonline.net/pdf/v12n10.pdf

The ICECAP-A (ICEpop CAPability measure for Adults). https://www.bristol.ac.uk/population-health-sciences/projects/icecap/icecap-a/

ICECAP Capability Measures. https://www.bristol.ac.uk/population-health-sciences/projects/icecap/

ICECAP-O. https://www.bristol.ac.uk/population-health-sciences/projects/icecap/icecap-o/

Instrumental Activity of Daily Living. https://www.ncbi.nlm.nih.gov/books/NBK553126/

Karaferis, D., Aletras, V., & Niakas, D. (2022). Determining dimensions of job satisfaction in healthcare using factor analysis. *BMC Psychology*, *10*(1), 240. https://doi.org/10.1186/s40359-022-00941-2

Karasek, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative Science Quarterly*, *24*(2), 285–308. https://doi.org/10.2307/2392498

Keeney, S., Hasson, F., & McKenna, H. (2006). Consulting the oracle: Ten lessons from using the Delphi technique in nursing research. *Journal of Advanced Nursing*, *53*(2), 205–212. https://doi.org/10.1111/j.1365-2648.2006.03716.x

Keeping family, friends and connections: active and supportive communities. https://www.local.gov.uk/our-support/partners-care-and-health/autistic-people-and-people-learning-disability/support-people

Kilroy, D., & Driscoll, P. (2006). Determination of required anatomical knowledge for clinical practice in emergency medicine: National curriculum planning using a modified Delphi technique. *Emergency Medicine Journal*, *23*(9), 693–696. https://doi.org/10.1136/emj.2006.037309

Lau, P., Ryan, S., Abbott, P., Tannous, K., Trankle, S., Peters, K., & Reath, J. (2022). Protocol for a Delphi consensus study to select indicators of high-quality general practice to achieve quality equity and systems transformation in primary health care (QUEST-PHC) in Australia. *PLoS ONE*, *17*(5), e0268096. https://doi.org/10.1371/journal.pone.0268096

Lepold, A., Tanzer, N., Bregenzer, A., & Jiménez, P. (2018). The efficient measurement of job satisfaction: facet-items versus facet scales. *International Journal of Environmental Research and Public Health*, *15*(7), 1362. https://doi.org/10.3390/ijerph15071362

Lubben Social Network Scale. https://www.brandeis.edu/roybal/docs/LSNS_website_PDF.pdf

Mckee, K., Spazzafumo, L., Nolan, M., Wojszel, B., Lamura, G., & Bien, B. (2009). Components of the difficulties, satisfactions and management strategies of carers of older people: A principal component analysis of CADI-CASI-CAMI. *Aging Ment Health*, *13*(2), 255–264. https://doi.org/10.1080/13607860802342219

Measuring Self-Efficacy with Scales and Questionnaires. https://positivepsychology.com/self-efficacy-scales/#measure

Morgan, A., & Ziglio, E. (2007). Revitalising the evidence base for public health: an assets model. *Promotion & Education*, (Suppl 2), 17–22.

The Nicholson McBride Resilience Questionnaire (NMRQ). https://www.nwpgmd.nhs.uk/sites/default/files/resiliencequestionnaire.pdf

Noordink, T., Verharen, L., Schalk, R., Van Eck, M., & Van Regenmortel, T. (2021). Measuring instruments for empowerment in social work: A scoping review. *The British Journal of Social Work*, *51*(4), 1482–1508. https://doi.org/10.1093/bjsw/bcab054

Office for National Statistics. https://www.ons.gov.uk/

Outcomes Star™. https://www.outcomesstar.org.uk/

Pandor, A., Kaltenthaler, E., Martyn-St James, M., Wong, R., Cooper, K., Dimairo, M., & Booth, A. (2019). Delphi consensus reached to produce a decision tool for SelecTing Approaches for

Rapid Reviews (STARR). *Journal of Clinical Epidemiology*, *114*, 22–29. https://doi.org/10.1016/j.jclinepi.2019.06.005

Pascoe, K.-M., Waterhouse-Bradley, B., & Mcginn, T. (2023). Social workers' experiences of bureaucracy: A systematic synthesis of qualitative studies. *The British Journal of Social Work*, *53*(1), 513–533. https://doi.org/https://academic.oup.com/bjsw/article/53/1/513/6614522

PhotoVoice. https://photovoice.org/

Pleeging, E. (2022). Measuring hope: Validity of short versions of four popular hope scales. *Quality & Quantity*, *56*(6), 4437–4464. https://doi.org/10.1007/s11135-022-01316-w

Price, A., Ahuja, L., Bramwell, C., Briscoe, S., Shaw, L., Nunns, M., O'Rourke, G., Baron, S., & Anderso, R. (2020). *Research evidence on different strengths-based approaches within adult social work: A systematic review*. NIHR Health Services and Delivery Research Topic Report, Issue. https://doi.org/10.3310/hsdr-tr-130867

Research in Practice outcomes focused tools. https://outcomes.ripfa.org.uk/wp-content/uploads/2016/06/Defining-outcomes.pdf

Research in Practice tool for resilience skills. https://adultsdp.researchinpractice.org.uk/media/mlrnd4m1/tool14.pdf

Resilience Assessment Questionnaire (RAQ 8). https://www.ficm.ac.uk/sites/ficm/files/documents/2021-12/Short%20Resilience%20Questionnaire.pdf

The Rosenberg Self-Esteem scale. https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/Self_Measures_for_Self-Esteem_ROSENBERG_SELF-ESTEEM.pdf

Rowe, G., & Wright, G. (2001). Expert opinions in forecasting: The role of the Delphi technique. In J. S. Armstrong (Ed.), *Principles of forecasting: A handbook for researchers and practitioners* (pp. 125–144). Springer US.

The Satisfaction With Life Scale (SWLS). https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/SATISFACTION-SatisfactionWithLife.pdf

Scott, T., Mannion, R., Davies, H., & Marshall, M. (2003). The quantitative measurement of organizational culture in health care: A review of the available instruments. *Health Services Research*, *38*(3), 923–945. https://doi.org/10.1111/1475-6773.00154

Social Care Institute for Excellence (SCIE). (2015). *Care act guidance on strengths-based approaches*. https://www.scie.org.uk/strengths-based-approaches/guidance#footnote-label

Social Network Analysis. https://www.publichealth.columbia.edu/research/population-health-methods/social-network-analysis

Social network visualizer. https://socnetv.org/

The Social Provisions Scales. http://chipts.ucla.edu/wp-content/uploads/downloads/2012/01/Social-Provisions-Scale.pdf

Social Work England. Professional standards. Available at: https://www.socialworkengland.org.uk/media/1640/1227_socialworkengland_standards_prof_standards_final-aw.pdf

State of Care. https://www.cqc.org.uk/publications/major-report/state-care

Stevens, M., Clark, M., Carlisle, J., Brimblecombe, N., & MacGill, M. (2024). Supporting meaningful implementation and evaluation of strengths-based approaches in adult social care: A theory of change for the three conversations. *The British Journal of Social Work*, *54*(6), 2583–2602. https://doi.org/10.1093/bjsw/bcae055

Sugavanam, T., Caiels, J., Peters, M., & Fitzpatrick, R. (2021). The development of a core outcome set for trials and evaluative studies in adult social care. *Journal of Long-Term Care*, 438–445. https://doi.org/10.31389/jltc.98

The Social Work Organisational Resilience Diagnostic (SWORD): Workbook. https://www.researchinpractice.org.uk/all/news-views/2022/march/the-social-work-organisational-resilience-diagnostic-sword-workbook/

Think Local Act Personal "I statements". https://www.thinklocalactpersonal.org.uk/makingitreal/about/six-themes-of-making-it-real/

The Three Conversations®. http://partners4change.co.uk/the-three-conversations/

TLAP "I" statements from Making It Real 2018. https://www.local.gov.uk/our-support/partners-care-and-health/care-and-health-improvement/autistic-and-learning-disabilities/learning-disabilities/better-lives/tlap-i-statements-making-it-real-2018

Trust in government, UK: 2022. https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/bulletins/trustingovernmentuk/2022

UK Measures of National Well-being user guide. https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/ukmeasuresofnationalwellbeinguserguide

Valid and Reliable Survey Instruments to Measure Burnout, Well-Being, and Other Work-Related Dimensions. https://nam.edu/product/valid-and-reliable-survey-instruments-to-measure-burnout-well-being-and-other-work-related-dimensions/

Values in Action Inventory of Strengths. https://www.viacharacter.org/

The Warwick-Edinburgh Mental Wellbeing Scales—WEMWBS. https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs

Whipple, J. M., Griffis, S. E., & Daugherty, P. J. (2013). Conceptualizations of trust: Can we trust them? *Journal of Business Logistics*, *34*(2), 117–130. https://doi.org/https://doi.org/10.1111/jbl.12014

The WHOQOL World Health Organisation quality of life scale. https://iris.who.int/bitstream/handle/10665/77932/WHO_HIS_HSI_Rev.2012.03_eng.pdf?sequence=1

Woodcock, T., Adeleke, Y., Goeschel, C., Pronovost, P., & Dixon-Woods, M. (2020). A modified Delphi study to identify the features of high quality measurement plans for healthcare improvement projects. *BMC Medical Research Methodology*, *20*(1), 8. https://doi.org/10.1186/s12874-019-0886-6

Zarit Burden Interview. https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/zarit