

Strengths-based Social Work with Older People: A UK Perspective

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Social work in the UK and US had similar origins with a historical focus on both community-based work, similar to Jane Addams' settlement house, and individual casework/care management aligned with Mary Richmond's approach to care (Gollins et al., 2016). The visit by Jane Addams in the 1880s to Toynbee Hall, a settlement house founded in London in 1884 to assist the poor through providing opportunities that would lead to social reform, is often cited as a key inspiration for the inception of social work in the US (Addams, 1910). In Addam's description, there was an early recognition of a need to balance focus on youth and older people and to create intergenerational capacity in strengths. That interest remains present today and, with burgeoning numbers of people growing older globally (WHO, 2018), countries have responded in varying ways to this challenge to prepare for the future. Often this is driven by a need to reconcile competing agendas. The move to personalisation and personal budgets under recent UK Governments was an attempt to shift control of care to individual choices, a strengths view, but at the same time, those budgets were being reduced in line with Government austerity measures. This policy and practice environment has shaped the conceptualisation of and approaches to strength-based practice for older people in the UK in ways that are different from the US.

This chapter will provide background on the UK policy and practice context for strengths-based approaches and on the work of G-8—a group of gerontological social work academics who advocate for strengthening practice, education and

research in work with older people. It looks specifically at a strengths approach to assessment and care planning and at older people's perspectives on strengths. It concludes with examples of strengths-based practice from research into innovative services employing this approach with older people.

STRENGTHS-BASED APPROACHES IN SOCIAL WORK WITH OLDER PEOPLE IN THE UK

Tight eligibility criteria for statutory services in the UK mean that the older people seen by social workers are likely to be in the fourth age, have complex needs and/or be experiencing a crisis (Ray et al., 2015). Often described as 'frail', it is important to see this contested term as signalling a need for services across the health and social care boundary, rather than assigning older people to a defined patient category (Pickard, 2018). Some older people will have dementia or memory concerns. It is easy in these circumstances to ignore the emotional and psychological strengths that an older person, and their family, may have and to focus instead on deficits and *needs*. After all, for most of their life, they are likely to have faced adversity, adapted effectively to change, and developed coping skills that retain potency in even the most difficult of circumstances (Milne, 2020).

The strengths approach suggests that older people can manage change and do so positively, especially through supportive relationships with friends, family, professionals and other care networks. There are five key factors that support strengths (Nelson-Becker, Chapin, & Fast, 2013).

- Acknowledgement that every older person has strengths, some developed at earlier ages and some that may develop later in the life course is key. Recognizing and developing these strengths facilitates hope.
- The traditional medical model of assessment and intervention may limit rather than increase capacity. Older people maintain capacities to learn, grow, and change.
- A collaborative approach can be therapeutic and empower an older person to achieve aspirations.
- Older people should continue to participate in decisions and determine the direction of the helping process unless they no longer have mental capacity.
- Identifying or co-constructing environmental assets and resources is an important task for older service users, carers, and professional helpers. The larger society should also support ageing together well.

Strengths-based approaches which honour older people as the experts about what they want and need serve to empower older service users and their families as they deal with crisis and difficulty in settings which may be inherently disempowering.

However, for adult care services in the UK where concerns with cost containment and managing risks to vulnerable service users are paramount, implementing strengths-based approaches requires appropriate education and support for practitioners.

A recently developed framework for strengths-based practice for social work with adults aims to drive forward effective practice in this area. It addresses key areas: knowledge and co-creation, theories and methods, skills, experience, and values and ethics (Department of Health and Social Care, 2019). In order for social work professionals to better harness this approach, there is an emphasis on self-reflection, supervision, and quality assurance to sustain an appropriate professional practice. Effective practice with older people specifically is a long-standing concern in UK social work. Before examining the policy and practice context for strengths-based approaches with older people, we outline the development and purpose of the Gerontological Social Work Special Interest Group (The G8).

Gerontological social work special interest group (The G8): History and priorities

The Gerontological Social Work Special Interest Group was formed following the British Society of Gerontology Conference of July 2010. The academic programme included a gerontological social work workshop and symposium that focused on the challenges for social work in light of an ageing population. Prof. Barbara Berkman of Columbia University—a leader of the Hartford Gerontological Social Work programs—was one of the symposium speakers. With support from Brunel University London, a special interest group of approximately eight academics from University Social Work Departments from across the UK began to meet two to three times per year. The group became known as the G8.

The priorities for G8 are to: (1) collaborate with key local and national stakeholders and decision-makers to develop gerontological social work leaders and to inform and build communities and integrated services for an ageing population; (2) infuse gerontological knowledge and skills into social work education to develop a practitioner workforce capable of engaging in innovative and effective practice with older people, their families and communities; and (3) increase social work involvement in high-quality research and knowledge mobilisation activities to promote and extend the evidence-base that underpins both social work and interdisciplinary gerontological practice. Advocating for the value of gerontological social work is a defining dimension of the G8's role.

Collectively, the G8 has published a number of articles (Lloyd et al, 2014a; Richards et al, 2014; Ray et al, 2015), reports (Milne et al., 2014a, 2014b), and delivered papers at a range of academic conferences. Members have also contributed to practitioner-oriented events and guidance, to the development of specialist competencies for social workers working with older people, and to related resources, for example, an online 'case study' entitled 'Working with Complexity' (British Association of

Social Workers, 2018a, 2018b).¹ Members of the group are also involved in research; we turn to the findings of some of this work later in this chapter. We are committed to extending our research portfolio and to expanding our group to include academics from all four UK nations. We continue to seek funding from social work and policy-related sources to enable us to develop our activities further.

The UK context: Policy and practice developments

Strengths-based practice tends to be presented in UK policy and practice as a new departure from procedural approaches based on needs and deficits. However, the central premise of engaging with people in partnership to recognise and build on their strengths to improve their situation is not new to social work and some aspects of strengths-based social work can be more accurately seen as *reclaimed* or *rediscovered*, rather than new (Gollins et al., 2016). Before we proceed to examine strengths-based social work with older people more specifically, it is useful to provide a brief historical and policy context to strengths-based social work in the UK.²

Historically, social work with older people has been seen as a *Cinderella service*, attracting lower levels of interest, status, resources, specialist training and research funding compared with other areas of practice (Richards et al, 2014; Ray et al, 2015). Although quality of life for older people undoubtedly improved after the introduction of the welfare state in the 1940s, support for older people prior to the community care reforms of the 1990s consisted of a limited range of options from a prescribed list of services provided directly by local authorities, mainly featuring *home help*, daycare and residential homes. Such services were often seen as isolating older people from their communities and fostering dependency and institutionalisation (Means et al., 2002).

One of the features of strengths-based approaches is harnessing community resources. Community work was one of the main pillars of social work practice in the 1970s, alongside casework and group work, though how far it engaged with older people is questionable. Like other social work approaches, tensions existed between community work as a traditional or professional intervention to help individuals adjust to mainstream society and as a more radical model that sought to transform power relationships and empower local people (Mayo, 1998). The Barclay Report of 1982, commissioned by the Conservative (Thatcher) government to review the roles and tasks of social workers, took a step towards more strength-based approaches in expressing the preference of the majority of the Committee for Community Social Work as distinct from the *safety-net* or *welfare state* model of provision:

The Working Party believes that if social needs of citizens are to be met in the last years of the twentieth century, the personal social services must develop a close working partnership with citizens focusing more closely on the community and its strengths. (Barclay Report, 1982, p. 198)

However, the Committee also noted the resource implications of the community model, fearing that:

... by promoting a community approach we may tempt politicians to believe the community can do everything and do it without funds. We cannot emphasize too strongly that a community approach is not cheap ... it will only give value if it is well resourced. To underfund a community approach is to run the risk of discrediting the entire notion of shared care. (Barclay Report, 1982, p. 216)

There was also dissent within the Committee about how far a community approach should go, questioning, in particular, its compatibility with the specialisation required for social workers to fulfil their statutory duties effectively. The government rejected a community social work model in favour of a narrower, more specialist role for social workers. Over time, with the rejection of the community model, community work within or commissioned by the statutory sector became confined to short-term projects with specific and limited performance objectives (Mayo, 1998).

The implementation of the 1990 NHS and Community Care Act saw the metamorphosis of social workers into *care managers*, with a role limited to assessing need and setting up and reviewing *care packages*. Social policy was driven forward by neo-liberalist ideology and its belief in the value of the social care *market*. Central government funds were transferred to local authorities on condition that the majority of this funding was spent on purchasing services in the independent sector. Whilst the purchasing of services remained with local authorities, the provision of services was contracted out to external providers. Assessments under the new system of care management were to be *needs-led* rather than *service-led*. In line with the consumerist model enshrined in the Conservative government's policy, older people with needs that met the eligibility threshold would be enabled to choose services to meet their assessed needs from the mixed economy of welfare services. There were glimmers of strengths-based thinking in this care management model. The Department of Health commissioned a report to guide practitioners carrying out the new tasks of needs-led assessment and care management. The report presented three models: questioning, procedural and exchange models, each seen as more or less applicable in different situations (Smale et al., 1992). The exchange model was advocated as the best initial approach for practice, adopting the stance that everyone is the expert on their own problems and that the worker's role is to act as a guide and resource in problem-solving, rather than a provider of solutions. Many of the concepts discussed in the report reflect strength-based thinking, such as the centrality of relationships and *joining with* people, the building of bridges between people, resources and communities and the worker's role in developing local resources. However, although the exchange model seeks to harness social and community resources, its starting point is *the dependency needs of the service user and others* (Smale et al., 1992, p.17), rather than their strengths and resources.

The managerialism and marketization that characterised social policy, driven by the concern to contain rising social care spending, rendered the exchange model difficult to use in practice (Tanner, 1998, Sullivan, 2009). Instead, assessments were typically characterised by the procedural model, framed around establishing eligibility for a narrow range of needs (primarily personal care). Eligibility criteria and other cost-containing measures, such as block contracting with private providers, undermined the policy goals of facilitating choice and independence.

Disillusionment with community care and the positive reporting of disabled people's experiences of direct payments, whereby service users with eligible needs received a payment that they could use to spend on services of their choice, invested hope in a new policy of personalisation. Rooted in the disability movement, personalisation is underpinned by the notion that access to resources enables people to exercise their rights and responsibilities as citizens. Personalisation was taken forward by the New Labour government as a way of shaping services around the needs and preferences of the individual service user by offering choice and control (Department of Health, 2005). However, neoliberal principles, including a belief in the market as a viable mechanism to deliver care to 'consumers' provided the continuing backcloth to personalisation, as it did to community care before it (Jordan and Drakeford, 2012). Crucially, personalisation was seen as a way of promoting 'independence, wellbeing and choice' at *no additional public cost*. At the heart of personalisation were two contradictory principles, the fair distribution of scarce resources to those in need and a shift from intensive and crisis help to early intervention and preventive services. Without any additional funding and at a time of growing social need, trying to meet the high level need and develop new preventive services within existing resources was highly problematic (Jordan, 2000).

From 2010, a Conservative-led coalition government set in motion a stringent set of measures that went far beyond containing social care expenditure to drastically cutting it under the banner of austerity. Government policy espoused the notion of the Big Society, characterised by themes of consumer choice and the responsibilities of citizens to meet their own welfare needs and those of others via active roles within their families and local communities (Cabinet Office, 2010). There was a heightened emphasis on *doing more with less* and a prevention agenda that partly focused on further retrenchment of the role of the state, promoting the use of ordinary community services that could be accessed by all and harnessing the assets of individuals, families and communities (Clark, 2011). In a climate of reduced services and tightened eligibility criteria for access to services, only older people with very high levels of need are likely to receive local authority support.

Thus, the shift of responsibility from central government to local citizens coincided with harsh cuts in welfare services and it is in this context that strengths-based approaches have flourished in social care policy and practice. The emphasis on supporting people to recognise and build on their own abilities and capacities and that of their social networks and communities can, superficially at least, be seen

as aligning with key political messages and the current economic context. Tensions exist with radical social work's view that social economic and political factors are at the heart of many of the problems which social workers deal with and critics argue that these structural issues have to be targets of change if we are to address causes rather than surface problems (Cowger, 1998). Given that strengths-based approaches draw heavily on the use of community resources, it is also salutary to recall the Barclay Report's (1982) warning, noted above, that failing to fund community approaches adequately risks *discrediting the entire notion of shared care*.

Legal and professional requirements

The legal underpinning for a focus on strengths came with the implementation of the Care Act 2014. The Care Act introduced a wellbeing principle, giving local authorities a duty to promote wellbeing, over and above any responsibilities to provide services to meet a need. Assessment moved beyond identifying the need for services provided by the local authority, as under previous legislation, to the more active role of helping prevent, reduce, or delay the development of needs and helping people to achieve outcomes by means other than the provision of local authority care and support. The statutory guidance states:

At the same time as carrying out the assessment, the local authority must consider what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve. In considering what else might help, authorities should 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.* (*emphasis added*). (Department of Health, 2014: para 6.33)

Although the Care Act (2014) does not include a duty to use strengths-based approaches, it has been described as the 'perfect framework' for this approach to social care provision (Department of Health and Social Care, 2019, p. 50). The duty to promote wellbeing, broadly defined under nine different areas, and the shift away from the provision of services to a requirement to meet needs lends itself if the practice is undertaken in the spirit of the legislation, to more holistic and person-centred approaches. The statutory guidance also emphasises the importance of community resources, particularly in relation to preventative support, and *recognises that modern care and support can be provided in any number of ways* (Department of Health, 2014, para 1.9). This further opens the door for strengths-based working. Through the application of the Care Act (2014), practitioners are being encouraged to practice in a more individual, less prescriptive and less service-focused manner and to look beyond traditional service provision. Strengths-based approaches provide them with the framework to do this.

As well as the legal responsibilities to take account of strengths, there are also significant professional obligations to adopt strengths-based approaches. The first

standard of the professional threshold that social workers are required to meet for registration as a social worker is the ability to *Promote the rights, strengths and wellbeing of people, families and communities* which includes the requirement to *Value each person as an individual, recognising their strengths and abilities* (Social Work England, 2019, 1.1). Strengths are similarly highlighted in the Professional Capabilities Framework for social work education and professional development which sets out under nine domains the capabilities that social workers should demonstrate at different stages of their career (British Association of Social Workers [BASW], 2018a).

BASW has also led on the development of a related set of professional capabilities specifically for social workers working with older people and one of these is that social workers ‘have developed expertise in rights and strengths-based work with older people and their carers, families, networks and communities’ (BASW, 2018b, p.11). The necessity of a strengths-focus is also referred to in the Knowledge and Skills statements which set out what social workers working with adults are expected to know. This includes under the heading *person-centred practice* that social workers,

...should work co-productively and innovatively with people, local communities, other professionals, agencies and services to promote self-determination, community capacity, personal and family reliance, cohesion, earlier intervention and active citizenship.

(Department of Health, 2015: para 3)

ASSESSMENT AND PLANNING IN A STRENGTHS APPROACH

Good quality assessment has long been recognised as the cornerstone of effective social work practice. As a dynamic process that is undertaken with the older person and their carer and/or significant others, it provides the foundations upon which successful interventions are built. Under the Care Act 2014, the threshold for accessing an assessment is set relatively low. The duty to undertake an assessment applies *where it appears to the local authority that an adult may have needs for care and support* (Care Act 2014 s. 9 [1]).

Historically, older people have not always fared well in relation to assessment practices. Not only has the process of assessment and the requirement to demonstrate eligibility for services led to a deficit approach, where the focus is upon what an individual cannot do, work with older people has also tended to be routinised and agency centred (Richards, 2000). Good quality assessments require a high level of skill from practitioners but the complexity of this task when working with older people has been under-recognised. In addition to core social work skills, practitioners in this area also require sound knowledge and understanding of the impact of ageing amongst diverse groups of older people; awareness of the losses and changes of

later life, and the renegotiations and reinventions that are part of managing the challenges of this life stage.

Despite the Personalisation agenda (see above) which promoted giving individuals choice and control, negative and restricted cultural assumptions about the ways of life open to older people have remained (Carr, 2013). These assumptions along with paternalistic and risk-averse approaches held by practitioners have resulted in older people not always having this promised choice and control (Moran et al., 2013). Differences in personal budgets, the funding that the local authority provides to meet care needs, have also been found with older people typically receiving less than other service user groups and being restricted to basic or traditional forms of support such as help with personal care (Moran et al., 2013; Newbronner et al., 2011).

The recent emphasis upon strengths-based approaches to assessment may be seen as an opportunity to reinvigorate social work practice with older people, to move away from ageist assumptions and place older people on a more even footing with other service user groups. The practice framework and handbook published by the Department of Health and Social Care (2019) sets out the aims of assessment under a strengths-based approach as follows:

...to identify:

- *the person's own strengths, wishes and priorities at various levels.*
 - *the strengths of the person's supporting network such as their family, friends and neighbours.*
 - *their wider network of support, for example, local groups, voluntary organisations, corner shops, the local cafe or library.*
- (Department of Health and Social Care, 2019, p. 42)

The practice framework also stresses that there is no one-size-fits-all model and that the individual, who is the expert in their own situation, should be at the centre of the process throughout. Overall, the approach should protect the individual's independence, resilience, ability to make choices and wellbeing (Social Care Institute for Excellence, 2015). In order to achieve these aims and work in a strengths-based way, the importance of relationships and meaningful conversations is also emphasised (Department of Health and Social Care, 2019; Social Care Institute for Excellence, 2015). Such conversations might include elemental questions to enable identification of strengths over deficits (Nelson-Becker, 2018; Nelson-Becker, Chapin, & Fast, 2013) through the use of open language that does not privilege problems. Examples of such questions are:

- What does a good day look like for you? How do you spend your time? (Normal activities)

- What matters most to you in life? (Life satisfaction, meaning, spiritual foundations)
- Who is important to you? What kind of support do you receive? (Social support)
- What has worked well for you previously? (Coping skill inventory)
- What is going well for you now? (Present-oriented strengths and disposition)
- What do you hope for? Why do you wake up each day? (Visioning and ikegai³)

(adapted from Nelson-Becker, Chapin, & Fast, 2013, p.169)

STRENGTHS-BASED PRACTICE WITH OLDER PEOPLE WITH COMPLEX NEEDS

There are aspects of social work with older people that present additional challenges to the successful application of strengths-based approaches. Increases in UK life expectancy have resulted in many older people living with long term health conditions and associated complex needs. For a small number of older people, dependency is a reality and a high level of daily support is required (Ray et al., 2015). When the level of need exceeds the support available from personal networks and local communities, formal service provision is the only option. However, in many communities, financial austerity measures mean that local resources are reduced or not available and it is often those who are least able to provide for their own care who have the greatest need for care (Lloyd, 2010).

In strengths-based approaches to assessments, individuals are, quite rightly, seen to be the experts in their situation and should play an active part in the assessment process and any intervention. However, individuals may lack insight into their needs or be unable or unwilling to play an active part in this process. If an individual is not fully able to participate, practitioners are advised to overcome barriers wherever possible and to ensure *that all the necessary and appropriate tools are used to maximise involvement* (Department of Health and Social Care, 2019, p. 27).

Ensuring that involvement is maximised requires particular sensitivity and self-awareness on the practitioner's part. When older people living with long term and complex conditions are labelled as frail and dependent, this limits the possibility of appreciating the complex ways in which strengths and abilities co-exist with needs and vulnerabilities. Stereotypes of older people with high support needs as passive and helpless obscure their strengths and resources and ignore the significance of how they make sense of their own situations. Moreover, the sovereign status ascribed to independence and autonomy in public and policy discourse means that dependency and frailty in old age are linked to notions of pity, blame, failure and burden (Grenier, 2007). A political focus on the unsustainable demands placed on health and social care services by an ageing society arguably invoked to

justify economic retrenchment has further reinforced the burden narrative (Lloyd et al., 2014a).

The intersection between advanced age, impairment and decline has been linked to the notion of the fourth age (Grenier, 2012), hypothesised by some like a black hole—an unknown and unknowable status characterised by loss of agency, dependency and indignity (Gilleard & Higgs, 2010). This hypothesis has been contested by a growing body of research which shows that there is little evidence to support an assumption that older people respond to problems less actively than young people (Richards, 2000) or that agency is lost (Grenier & Phillipson, 2017). Moreover, biographical and narrative research with older people with complex care needs consistently shows that older people are resourceful in maintaining their identities and adapting to change.

The strengths perspective within social work has made a clear contribution to an orientation designed to elicit well-being and satisfaction with life, no matter where one is on the health-illness continuum. Even in sub-optimal circumstances, this approach can keep people striving for or maintaining their best outlook on present conditions.

Older people's perspectives on strengths

Biographical and narrative research that places older people at its heart has contributed important insights about what being *strengths-based* means from the perspective of older people who are living with and managing complex health and care needs. A consistent message is that older people often draw on a lifetime's experience of problem-solving, using their internal resources to manage challenge and change (Richards, 2000; Ray, 2006; Tanner; 2010).

One such resource is life-long continuities that give shape to individual biographies and identities. In the face of sometimes rapidly changing needs, it is easy to overlook the importance for older people of continuities, such as relationships, routines, and habits of the heart, that can provide a foundation of stability and security from which to navigate the loss, change and disruption that may accompany ageing. Analysis of the narratives of older people with changing health and support needs draws attention to the importance of life themes in connecting experiences across a person's lifetime as well as contributing meaning, purpose and a stable sense of self (Tanner, 2010). Research with older couples married a lifetime, for example, highlighted how formal services were, at times, resisted or rejected by couples because they threatened the preservation of important individual and couple continuities (Ray, 2006).

An important resource for older people with high support needs is their access to narratives of coping. The dominance of 'strengths talk' (Tanner, 2010, p. 101) and perseverance by older people, can serve as a counterpoint to the realisation that their ability to cope and manage is likely to be severely or fundamentally compro-

mised (Lloyd et al., 2014b). Amongst participants identified as frail (Lloyd et al., 2019), participants recounted narratives of loss and their impact on personal coherence when highly valued aspects of their lives, such as a much-loved home, were threatened or lost. Recognition that a coping/managing narrative co-exists with anticipated and actual deterioration and loss is a critical element in supporting older people. The ways in which older people may be supported to continue to exercise agency and construct strengths-based narratives in the context of rapid and overwhelming change is an important consideration for practice.

Another source of strength consistently highlighted in narrative research with older people is their ability to adapt to change and challenges, such as deteriorating health and abilities (Tanner, 2010; Ray, 2006; Skilbeck, 2017; Lloyd et al., 2019; Lloyd et al., 2014b). Biographical experiences of mastery over challenging situations can build personal resources, strategies and skills that people bring into later life. However, the ability to adapt to change and loss cannot be seen as a straightforward reflection of individual strengths. The wider external environment and structural factors are critical, too, and may support or undermine the ability to withstand loss and disruption (Tanner, 2010; Lloyd et al., 2014b).

An ecological perspective is helpful in identifying the role of the wider environment, including structures and systems, in bolstering or impeding the strategies of older people with high support needs. In terms of the interaction between the individual and social structures, it is clear that older people are concerned not to be a burden on families and care services (Tanner, 2010; Lloyd et al., 2014b). This position is likely to reflect older people's efforts to resist and refute constructions of old age as a time of need and dependency. In the dominant medical discourse, frailty is embodied in individuals rather than seen as influenced or created by structural factors and inequalities experienced across the life course (Grenier, 2007). This renders the significance of social and economic factors in addressing frailty invisible. A strengths-based practice is therefore undermined in two ways: older people with high support needs are seen as lacking agency, abilities and resources at a personal level and the potential contribution of resources in their social environment is overlooked.

This discussion of older people's perspectives highlights further significant points of tension that may undermine the potential in contemporary UK policy for strengths-based approaches to be employed in practice. First, considerable evidence about the factors that older people identify as important in promoting and supporting wellbeing (Glendinning et al., 2006) has not contributed to the transformation of service provision. Secondly, it is unhelpful that the voices of older people with high support needs continue to be substantially absent in public debates about social care and in policy and practice narratives (Lloyd et al., 2014a) as well as in-service development activities. Finally, exploratory evidence suggests that the foundation for social work education with a gerontological focus is uncertain (Richards et al., 2014). Although there is a significant body of gerontological research, including research exploring the experience of older people living with high support needs, this

remains substantially untapped in UK social work education and amongst qualified practitioners.

The current challenges associated with navigating the health and social care landscape for older people with complex needs and the tensions in contemporary social care policy and practice are undeniable. However, as the next section shows, there is growing evidence of excellent services and practices, sensitively delivered.

Examples of strengths-based practice in England: Promising and innovative practice

In 2018-19, we completed a small-scale exploratory study of promising and innovative practice in social work with older adults. The purpose of this study was to refocus attention on the knowledge, skills and values social workers bring to social care services for older adults and to identify the distinctive contribution social workers make to multidisciplinary teams and services based in secondary settings, such as hospitals. Over recent decades, as policymakers have concentrated on the challenges of preventing unnecessary hospital admission and delayed discharge of older people, social care services have become more narrowly focused upon older people's functional health and the role of hospital-based social work.

Five services across England participated in the study. These were targeted at providing care and support for older adults and included social workers as core members of social work-based and multi-disciplinary teams. A strengths-based approach was identified across the participating services as an integral dimension to individual practice and the remit of services. We adopted a case study approach to generate rich in-depth descriptions of each participating service and the role and contribution of its social workers. In each site, we conducted a thematic documentary analysis, examining the aims and objectives of the services and the role of professional social workers. We completed semi-structured interviews with 21 participants: 11 service managers and senior practitioners (6 with social work and 5 with clinical backgrounds), 8 social workers, and two other practitioners. Types of interventions provided included hospital-to-home discharge support; family group conferencing; early intervention support for older adults with long-term health conditions; and dementia wellbeing support for community-dwelling adults.

Across the core themes generated from qualitative data, the strengths-based approach was frequently cited as a prominent model for informing individual practice with older adults. Attention to human rights, a focus on service users' perspectives and wishes, and an emphasis on strengths-based practice were all distinct elements social workers brought to multi-disciplinary teams working with older people and their families. Person-centred and strengths-based approaches often went hand-in-hand as social workers sought to maintain a focus on the wishes and views of the older person with whom they were working. Adopting a strengths-based approach meant starting with what the service user was able to do and identifying ways in which they could be empowered to maximise their independence in an uncertain

future. This included recognising the supportive people around the service user and involving them in helping conversations. Rooted in the value of self-determination, a strengths-based approach was flagged as a way of moving beyond a deficit focus, and a vehicle for tapping into family, community, network and local resources.

There was some acknowledgement that social work practice had not always been strengths-focused and senior team members were keen to promote a strengths-based approach when identifying an individual's care and support needs:

I think sometimes social workers go in and really focus on what people can't do, and plug in their care package to meet that need. For me, the social workers in our team, we want them to think about what that person can really do and observe it. ... It's about our social workers thinking quite dynamically. (PB3, team manager, early intervention service)

Another social worker described a strengths-based approach as a more familiar perspective to newly-qualified social workers and spoke of the need to change the mindset of more experienced team members who had been practising from a very different approach:

What I find is, often strength-based is more aligned to newer workers. I think people who have worked in adult social work care a long time are very much more in a, 'We go in and fix things' kind of mentality. Whereas I think those coming out of university particularly know that we are not there to fix things. (PD2, social worker, hospital team)

There was also acknowledgement of the tensions between a strength-based approach being imposed by management as a 'cost-saving' mechanism for withholding or withdrawing services and the desire of social workers to maximise this approach to increase good outcomes for older patients:

I know we talk a lot about strengths-based models in social work, and I know that's come under some really heavy fire for being a way for local authorities to cut costs and shave packages of care down. I think of it more in terms of, the network that you have is the one you've already chosen, and you've had a lot of time in your life to choose that. (PD1, social worker, hospital team)

This highlights how long it can take for newer approaches to be embedded in individual practice and that some practitioners may need support to adopt this way of working.

To put a strengths-based approach into practice typically involved innovation in the way social workers applied communication and related skills to give services users a

voice, control and ownership over the care and support they received. This necessitated applying participatory approaches to core procedures, such as assessment:

The kind of model I use is strength-based. I'll go in, I'll speak to the person. I'll try and get a picture of their life. I always try and start off with that. It's not always possible if you have got really domineering family members sort of talking about all the things they perceive as going drastically wrong. (PD2, social worker, hospital team)

For one service (family group conferencing), recognising the strengths of each participating individual was a core part of the service's aims and this model of intervention was considered by team members as a good fit with a strengths-based approach.

There was, however, recognition that a strengths focus could be driven not by the service user but by the social worker. One practitioner emphasised the importance of being prepared for surprise and uncertainty and allowing opportunities for the service user's strengths to emerge through more unstructured conversations rather than being imposed through formal assessment:

I think that strength-based practice which is about just me endorsing strengths that I perceive in others that fit with my values and my own perspective, I don't think that's true strength-based work. I think to really work strengths based, you've got to be prepared to be surprised and you've got to be prepared to work with people in a way that is beyond your imagination as a professional. (PC3, social worker, group conferencing service)

Within hospital settings, there was acknowledgement that the voice of service users was often lost as medical professionals and family members made decisions about the care and arrangements of the individual. A strengths-based approach helped to bring back the focus on the individual and the social network around them, but it was important that social workers were prepared to defend their approach and to convince other, more sceptical, team members of its value. Knowledge of the law was crucially important and gave weight to decision-making, particularly where related to mental capacity and the assessment of individual capacity in relation to a particular decision.

Finally, the strengths-based approach was not applied in isolation. Social workers across the case study sites emphasised the significance of complementary approaches such as relational models of working and the need for knowledge and in-depth understanding of life-course theory, the complexity of human relationships and care, and support needs in later life. A strengths-based approach was one

integral dimension to social workers' practice frameworks that underpinned their application of other skills and bodies of knowledge.

SUMMARY

This chapter set out the policy and practice context for strengths-based approaches for gerontological social work in the UK. G8 is featured to demonstrate the efforts of a group of academics from across the UK who are mobilising the strengths from within the social work community to promote innovative and high-quality gerontological practice and research. Strengths-based practice is presented as a departure from a regulated environment for social work where strengths-based thinking features in social policy but is sometimes more challenging to realise in practice. A more recent re-emphasis on ecological perspectives, a focus on individual assets and resources within assessment and care planning, and the promotion of *strengths talk* within the practice encounter highlight current best practices characterised by a strengths orientation.

END NOTES

- ¹ A resource that aims to support people working in social care and health to improve outcomes for adults, their families and careers. Available at: <https://www.ripfa.org.uk/>.
- ² Devolution means that there are differences in policy and practice between England, Wales, Scotland and Northern Ireland that there is insufficient space to cover in this chapter.
- ³ Ikegai is a Japanese concept to capture the source (s) of value in one's life or a reason for living (Hasegawa et al., 2003).

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