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Supporting Meaningful Implementation and Evaluation of Strengths-Based Approaches in Adult Social Care: A Theory of Change for The Three Conversations

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Abstract

There is much policy support internationally for 'strengths-based approaches' which work collaboratively with people seeking support. Such approaches aim to recognise the strengths in individuals, those around them, and their communities, to support people to be independent and focus services and support where most needed. However, there is little evidence of how such approaches work in practice or whether they are effective. The Three Conversations (3Cs) is one such approach. Development of practice and future evaluation requires that these approaches are better understood and articulated. To address this challenge, we worked collaboratively with three UK local authorities to understand how 3Cs is operating in practice, and how its evaluation could be considered. We used interviews and workshops with staff, carers and people receiving services, data collected by sites, and wider consultation to develop a theory of change setting out how 3Cs is thought to best operate and be implemented.

We identified potential benefits and pitfalls when implementing 3Cs, and barriers to successfully incorporating 3Cs as 'business as usual'. The theory of change, presented in this article, can be used to support implementation of strengths and relationship-based practice and its meaningful evaluation, and has relevance beyond The Three Conversations.

Keywords: evidence-based practice, relationship-based practice, social work practitioners, social care, strengths-based

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Introduction

The past twenty years have seen growing reference to 'strengths-based approaches' in social work internationally, as well as in other 'human services', including psychology and education (Pulla *et al.* 2024). They have become a common feature of national policies (Ponnuswami *et al.* 2012). Recent policy reforms in the UK, where this research was conducted, have promoted strengths-based approaches in adult social care (Care Act 2014; Department of Health & Social Care 2019). Such practice approaches have been presented as a means of addressing perceived over-bureaucratisation and under-personalisation of services, argued to have resulted from 'Case Management' or 'New Public Management'-style approaches to public sector reform (Saleebey 1996; Chenoweth 2012; Reiter and Klenk 2019). In these reforms, an initial focus on quasi-markets, which appeared unsuccessful in raising standards, was followed by a growing prioritisation of permissions, paperwork and processes as ways of monitoring and assuring quality of services (Dent *et al.* 2017; Reiter and Klenk 2019). These trends are argued to have resulted in too much focus on people's deficits, fostering excessive practitioner-client dependency and constraints on practitioners' freedom to work creatively and respond to those seeking support in a timely, person-centred and relationship-focused way.

In contrast, 'strengths-' or 'asset-based' approaches, set out to recognise and make use of the strengths (or resources) in individuals, those around them, and their communities, to support people to be independent, and focus services where they are most needed (Department of Health & Social Care 2019; Caiels *et al.* 2021). The Three Conversations (3Cs) is one such approach (see Box 1). There is scepticism, however, about strengths-based approaches (Caiels *et al.* 2023): some argue that they offer nothing new, and are in fact 'traditional social work', others argue that strengths-based approaches, by aiming to make more use of informal, family, and community resources, are really a cost-cutting exercise, and an excuse for denying people statutory services (Haynes 2019).

Box 1. The Three Conversations (3Cs).

Under 3Cs the intention is to provide services that work collaboratively with people seeking support and their networks. 3Cs aims to reframe how social care services are conceived, organised, and experienced by supporting frontline professionals to work with people in a strengths-based, relationship-focused way, right from initial contact. The approach has been developed by, and is promoted by, the organisation Partners4Change and been implemented, to varying degrees, in over 25 Local Authorities in England (http://partners4change.co.uk/the-three-conversations/). The approach involves Local Authorities making changes to their systems in adult social care so that contacts do not begin with assessment of eligibility but instead concentrate on listening and making a connection with the person seeking support and their carers (Conversation One phase). For people in crisis, practitioners are asked to stick with people to work out and implement an emergency plan, and to bring in other support as needed, rather than closing cases at the point of referral (Conversation Two phase, which may precede Conversation One when needed). Eligibility for statutory services is only formally assessed at the Conversation Three stage, if this phase is needed, where longer-term support needs for 'building a good life' are discussed. Partners4Change share a set of Rules with implementing sites to support the approach (see Box 2).

Box 2. The rules of The Three Conversations (Partners4Change, 2021)

1. Always start conversations with the assets and strengths of people, families and communities
2. Always exhaust Conversations 1 and 2 before having Conversation 3, and test this out with colleagues
3. Never plan long term in a crisis
4. Stick to people like glue during Conversation 2—there is nothing more important than supporting someone to regain control of their life
5. No hand-offs, no referrals, no triage, no waiting lists
6. We are not the experts—people and families are
7. Know about the neighbourhoods and communities that people are living in
8. Always work collaboratively with other members of the community support system.

The Department of Health & Social Care (2019) and the Chief Social Worker for Adults for England (Romeo 2017) have explicitly stated that strengths-based approaches are *not* motivated by the need to save money. Nevertheless, in times of severely constrained resources and growing need in adult social care there is a danger that any new approaches will not be able to function as planned; it has been argued that the benefits of strengths-based approaches will be limited if the broader focus of services remains on eligibility and resource management (Slasberg and Beresford 2017).Reviews have concluded that strengths-based approaches, including 3Cs, are poorly defined, and that it is not known whether, in what contexts, or how they work (Staudt *et al.* 2008; Tew *et al.* 2019; Price *et al.* 2020; Caiels *et al.* 2021). Price *et al.* (2020) recommended that future research needs to capture the content and 'fidelity' of strengths-based initiatives; if we do not know what aspects have been implemented, how can effectiveness usefully be

considered? The UK Department of Health and Social Care (2021) suggests that a lack of evidence on successful implementation and effectiveness of new and innovative approaches is a barrier to the wider identification and adoption of successful practices (Davis and Hobbs 2022). Given the plethora of influences affecting the outcomes of people using social care, there is an attribution problem: how could one tell if any observed changes were due to the strengths-based approach (Staudt *et al.* 2008; Caiels *et al.* 2021)? Additional challenges for evaluation of 3Cs in particular include the flexibility of the approach, the 'bottom-up' implementation, so that each authority's version is bespoke, the highly personalised nature of conversations, goals and aims, and the fact that this is a complex intervention set in the context of other changes in practice and resources, including austerity policies and the coronavirus disease 2019 (COVID-19) pandemic.

There is, then, a need for deeper understanding of how strengths-based approaches operate in practice, and what the impacts are. In line with other authors' calls to develop ways of understanding and assessing strengths-based practice, we sought to develop a theory of change for 3Cs, detailing how it is seen to work in practice, what it aims to achieve and how outcomes could be considered (Foot and Hopkins 2010; Caiels *et al.* 2021; Silarova *et al.* 2024). This article sets out the resulting theory of change for The Three Conversations.

Methods

To develop a theory of change for The Three Conversations, the study involved a collaboration with three local authority case study sites where 3Cs is being used in adult social care. In line with guidance on the evaluation of complex interventions (Skivington *et al.* 2021), the theory of change constitutes a first step in unpacking the workings of 3Cs. The aim was to present a detailed explanation of how the approach works, or should work, in practice, to support future evaluation and implementation. This articulation of the practice needed to be grounded in the model of 3Cs as set out by Partners4Change (Boxes 1 and 2) and in the experience of implementing it in practice.We talked to practitioners in many different roles, including frontline social workers, occupational therapists, care coordinators, finance and data managers, local area coordinators, team managers, transformation and project leads and senior managers. This provided perspectives across the three case sites on organisational issues related to implementing and operating 3Cs, as well as of frontline practice enacting 3Cs with clients.

We also spoke to people seeking and/or receiving support, carers and representatives of the voluntary sector in each site. Our public advisory group comprised people with lived experience of either receiving services

or being a carer of someone with support needs. The group played a key role, participating in, and advising on, our research activities. We also obtained important input, feedback and advice from our study steering group, consisting of practitioners, academics and representatives from the public advisory group.

Selection of the case study sites

We aimed to recruit three sites in the UK where 3Cs was being practiced beyond the 'honeymoon' phase of initial implementation and was considered 'business as usual'. This was balanced with the need for sites that did not consider themselves to have drifted from intended 3Cs practice. Partners4Change provided a sampling frame of twenty-nine local authorities they had worked with to implement 3Cs and their view on whether sites still practiced in a 3Cs way. In several cases a restructure, or a new head of service, had led to the abandonment of the approach. We aimed to recruit sites which had implemented 3Cs about two years previously, and were in varied geographic contexts. We invited and discussed participation with six sites; three declined, feeling it was not the right time to take part. The eventual three UK sites were: a London council, a Northern city council and a Local Authority in the South.

Data collection and analysis

Data collection methods comprised:

- Eleven online theory of change workshops across the three LA sites to explore local understandings of the processes by which 3Cs is expected to affect outcomes for people seeking support. Four of the workshops took place in site A, four in site B and three in site C. An average of five practitioners attended each workshop.
- In-depth interviews with an additional twenty-three local authority staff across the three case study sites, including team managers and senior managers, to explore understandings of how 3Cs operates in practice. Eleven interviews (with thirteen people; two were two-person interviews) took place in site A, eight interviews in site B, and five in site C.
- An exploration of how the type of data collected by local authorities relating to adult social care could contribute to evaluation and monitoring of 3Cs practice.
- Ten qualitative interviews with people who had been in contact with services to explore their experiences of what was important in interactions with services (one in site A, five in site B and four

in site C). This was below our target sample of ten per site. Sites put us in touch with the desired number of people who had experienced 3Cs so we could invite them to be interviewed, but the majority either did not want to take part, or could not subsequently be contacted.

- Interviews with staff from Partners4Change, including the Director, the lead staff member for each case study site, and staff members with other relevant roles, to discuss their experiences in supporting implementation of 3Cs in the sites, and obtain their feedback on our emerging findings. Observation of adult social care staff meetings, interviews with a key voluntary sector partner to adult social care, and consultation with carers or carer representatives in each study site.

Most workshops and interviews were recorded and transcribed where recordings were not made, notes were taken and written up immediately afterwards. Notes were made live on screen with participants at the practitioner workshops. Transcriptions and research notes were entered into an Nvivo project for analysis (QSR International Pty Ltd 2018).

We analysed the data with the primary aim of developing the theory of change. We followed the approach of De Silva and Breuer (De Silva *et al.* 2014; Breuer *et al.* 2022) setting out to identify and understand the following key elements of 3Cs:

Rationale: why, theoretically, the approach should work;
Activities: the necessary parts of the approach;
Outcomes: what each set of Activities aims to achieve;
Indicators: how the Outcomes could be assessed;
Assumptions: what needs to be in place for all this to work.

The research team met regularly to discuss their analyses and develop a shared understanding of the theory of change across the data sets. In addition, our analysis examined evidence about the points at which key components of the approach could get lost from practice, summarised as 'Danger Points' in the results. Analysis included consideration of the extent to which local practice adhered to the 'Rules' from Partners4Change as the key principles underlying 3Cs (see Box 2).

The detail of the emerging theory of change developed in this iterative way. We discussed draft components with sites, public advisors and other participants as we went along. Once we had a complete first draft of the theory of change we approached three additional LA sites to take part in discussions about whether and how our findings fitted with their own experiences, and whether and how the theory of change might be useful to them. One of the invited sites that had originally declined participation became involved at this stage, with two further sites, one of which was considering implementing 3Cs. The two new sites already using 3Cs

each had more than three years' experience of implementation by this time.

Because of difficulties contacting people who use services through the study sites, we organised four additional workshops with help from two service user representative organisations. We conducted two workshops with carers and two with people who use services to gain further input into the developing theory of change and study findings. As well as informing the development of the theory of change, further findings concerning the perspectives of people who use and deliver services on the 3Cs Rules are written up in more detail separately (Carlisle *et al.*, forthcoming).

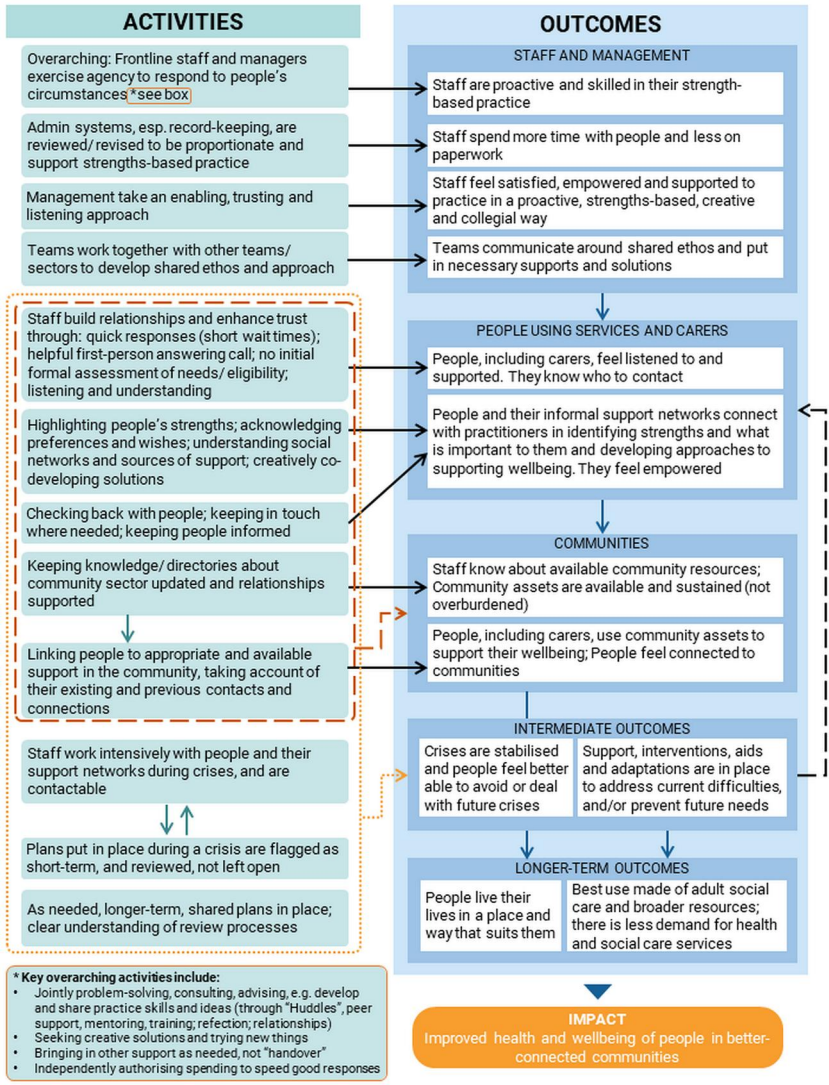
Ethics approval was given by the UK Health Research Authority Research Ethics Committee (21/IEC08/0024).

Findings

The theory of change we developed for 3Cs is shown in Box 3. The theory of change represents our analysis of what stakeholders contributing to this research (adult social care staff, including front-line practitioners and managers; people who use services and carers; voluntary sector) told us about how The Three Conversations works, or could work, in practice, and what is, or could be, achieved at each step. The theory of change was felt to be useful in assessing whether key features of the approach are in place and are having the intended effect. It can be used in considering practice implementation, for example as a practical roadmap, and to inform monitoring of progress.First, the *Rationale* summarises the underlying theory of why 3Cs should work (see, e.g. Glasby *et al.* 2013; Department of Health & Social Care 2019; Caiels *et al.* 2021). The detail about the *Activities* that take place as part of a well-functioning 3Cs approach are shown on the left of the Activities and Outcomes diagram. The diagram shows, on the right, how each outcome needs to be achieved for the next step to work, and on the left, the Activities needed to make these *Outcomes* happen. The top of the diagram, for example, shows the workplace practices required for people to be able to work in a creative, supportive and strengths-based way, including 'huddles', the regular collaborative and supportive staff meetings where issues and creative solutions are discussed.

The theory of change model proposed by Breuer *et al.* (2022) identifies the 'ceiling of accountability', where the intended outcomes are beyond the scope of the 'project', in this case, beyond the scope of 3Cs practice. The ultimate impact aimed for here beyond the 3Cs ceiling of accountability, is articulated as 'Improved health and wellbeing of people in better-connected communities'.

Box 3. Theory of change for The Three Conversations.



RATIONALE

1. By addressing needs and crises early, tailoring support better to people's lives and drawing on existing strengths, in the person and their networks, you can make more effective use of limited resources, reducing unnecessary dependency on services and calls on other services in the future
2. Relationship-building leads to better communication, shared understanding and engagement, resulting in better outcomes for people and systems

INDICATORS
Indicators can be collected in relation to the five areas of outcomes:

- Staff and management
- People using services and carers,
- Community
- Intermediate outcomes
- Longer-term outcomes

Detail on example indicators related to each outcome are in Supplementary Table S1
The suggested indicators can be collected using:

i. Surveys
ii. Conversations
iii. Feedback/complaint systems
iv. Audits
v. Routine data collection systems.

Outcome indicators collected via i.-iv. should be set against key indicators from v., namely 'Conversion rate' (reductions in proportion of people coming to adult social care who receive Long Term Care packages) and 'Returners rate', that is, the proportion of people whose contact with adult social care ends, that return within a given period (such as 3 months, 1 year).

ASSUMPTIONS
The following are assumed to be in place for 3Cs to work:

1. There is a consensus, including amongst senior management, that previous performance-management-based systems are not working, and a new approach is needed
2. Community resources exist, and can be sustained, supported, and made use of (i.e. they can meet demand)
3. Carers are not overburdened
4. Current IT systems can support the changes needed
5. 'Paperwork'/documentation that is needed to communicate/arrange resources/intervention within teams and with other teams/services/sites are in place (kept or replaced) e.g. staff can access the information they need to take a role with the person seeking support
6. Other teams/sectors are on board (e.g. because they were included in initial discussions) (e.g. brokerage, commissioning; NHS, and housing services). They share the ethos and do not create barriers to implementation (e.g. by requiring Assessment, or giving people seeking support different expectations)
7. The process is compliant with legal frameworks and staff understand this
8. The process does not affect people's rights to formal assessment and support; formal assessments can be conducted if people wish
9. New staff members are trained, informed, and mentored to support working effectively within the approach, with reflective support as they develop their 3Cs practice
10. Everyone has equal access to support from Adult Social Care

Each Outcome in the diagram can potentially be assessed or measured, to help in considering whether 3Cs is working as intended. We developed a collection of *Indicators* which can be used to consider whether

each Outcome is being achieved (summarised in Supplementary Table S1). Indicators can be collected using surveys, conversations, complaint and feedback systems, and audits. These indicators can be examined alongside routinely-collected data such as 'Conversion rate', that is, the proportion of 'cases' coming to adult social care that result in a package of Long-Term Care, and 'Returners', that is, people returning to adult social care following 'case closure', within a defined period (three months and one year are example definitions used in study sites). Sources of indicators include local authority staff and systems, community organisations and people using services and seeking support, including carers. However, feedback needs to be sought in a meaningful way. We heard, from both people who use services and carers, about a disinclination to share honest feedback with services, sometimes because they do not believe it will lead to any change, and sometimes from fear of reprisals in terms of services received.

The Assumptions are factors outside the direct remit of Three Conversations practice but are seen as necessary for 3Cs to work optimally. There was evidence of each of these assumptions not being met in the sites, but they are considered essential to the most effective operation of the approach. We found the first assumption to be a commonly-held view: 'There is a consensus, including among senior management, that previous performance-management-based systems are not working and a new approach is needed'. There was a widespread belief that current ways of measuring performance do not encourage best practice, and may not be compatible with making the most cost-effective use of limited resources. 3Cs is explicitly articulated as a solution to this problem, by beginning with completely redesigning recording systems and documentation (or 'paperwork') and prioritising relationships and trust of frontline practitioner expertise.

New '3Cs' recording systems were developed bespoke in each study site, tending to be based around open-response written descriptions of conversations that had taken place. Whilst some individuals and teams worked well with the new documentation, many felt it was difficult to use, and that the necessary information was not always recorded. There was also concern that the new documentation was not 'locked for editing' and therefore could be changed by others; levels of distrust meant practitioners were sometimes concerned that records may not end up being an accurate depiction of interactions with users of services. Some felt they had therefore not adequately 'covered their backs' and could potentially have blame laid at their door for negative occurrences, or that procedures were not compliant with safeguarding requirements.

Our analysis identified a number of themes concerning when and how there appeared to be divergence from the approach represented in the Theory of Change, where practice is not implemented as planned, key features get lost, or unintended consequences are experienced.

Understanding these issues has informed the components of the theory of change above, but our collaborators and practitioners consulted about our draft findings found it useful for these to be set out as a separate list of 'danger points'.

Major danger areas in practicing 3Cs

1. The time spent on 'Paperwork'/documentation is widely perceived not to have reduced; staff are completing parallel sets of documentation in some cases—pre-3Cs documentation (e.g. case notes) and the new Conversations documentation.
2. Managers, including team managers, did not always support the ethos and may not be sufficiently supported to work in a listening, trusting, and strengths-based way themselves.
3. Huddles and reflection meetings do not always continue and the reflective process around new and creative ways of working gets lost.
4. Frontline staff and team managers' ability to make spending decisions (to support quick responses and creative, person-centred practice) did not continue. (In some cases these were later reintroduced).
5. Quick responses to people seeking support often did not happen (however, some teams did make this work, getting rid of waiting lists).
6. There can be reluctance to give out practitioner contact details to people seeking support, or using services, leading to waste of time and effort when people have to go back to initial contact centres, and undermining relationships.
7. Performance management targets may continue to create perverse incentives (e.g. pressure to close Conversation 1s; pressure to close cases/refer instead of keeping overview/checking back).
8. Lack of staff time can lead to Conversation 2s being left open longer than necessary, sometimes resulting in high spend on care support where no eligibility assessment has taken place.
9. Initial work on 'directories' of local support was not maintained and/or not made available to communities.
10. 'Checking back' on whether support was working out often did not happen, particularly at Conversation 1 phase.

Discussion

Understanding 3Cs as a complex intervention requires a better articulation of its elements and their interactions, both internally, in adult social

care practice, and within the environment in which they are implemented. Towards this goal we developed, in collaboration with sites and advisors, a theory of change. This is intended to guide future implementation, monitoring and evaluation; supporting consideration of the extent to which key components of 3Cs are being followed, and to which preconditions and outcomes are being met. The overall structure of the theory of change provides a rational framework for analysing practice issues contributing to the outcomes seen.

How managerialism and a focus on compliance in social work has led to a 'blame culture' and practitioners' 'self-defence mechanisms' and 'self-protection strategies' has been much discussed (MacDonald 1990; Munro 2011, 2016; Trevithick 2014). 3Cs is intended in part to address these difficulties and develop more trusting workplaces and relationships. However we found practitioners were frequently completing dual sets of paperwork, both the previous 'case notes' and the new 3Cs paperwork, so a key intended outcome of reducing paperwork was often not met. This is likely to have an impact on the relationship work with clients, and, hence, on outcomes.

It has been argued that the effective adoption of a strengths-based approach requires wholesale changes in service culture (Foot and Hopkins 2010; Foot *et al.* 2020). The Three Conversations attempts to support such a culture change, however our danger points and assumptions highlight the scale of this challenge.

The focus on creativity, reflected in the Activities and Outcomes of the theory of change, is intended to be a counter to a focus on compliance and managerialism. Here, collaborative engagement with people seeking support, supportive co-working and management, and some autonomy over small amounts of spending, are seen as allowing practitioners more freedom to take risks and discuss alternative solutions. These ideas have been conceptualised as 'positive risk-taking'. Risks can be weighed up in relation to what is important to the individual including, for example, the risk of loss of freedom or loss of social interaction, against the risk of a fall (Faulkner 2012). For individuals, choice over risk-taking has been seen as key to dignity, and relational techniques have been suggested as solutions for negotiating ethical complexities around risks (Marsh and Kelly 2018). The role of interpersonal trust in facilitating creative solutions that prioritise the perspectives of people seeking support has been demonstrated, and perceived interpersonal trust in the workplace can potentially be assessed (Robertson and Collinson 2011).

3Cs is of great interest to many working in adult social care as a potential part of solutions for improving practice given the extreme demographic and financial challenges facing statutory adult social care (Roberts *et al.* 2018). Reconciling the aims of strengths-based practices in general with pressures on budgets is unlikely to be easy and may

adversely affect the goals of practice. Moore, indeed, has suggested that an over-simplistic understanding of what constitutes a strengths-based approach can lead to implementation that focuses more on protecting overstretched services, than on improving quality through collaborative working with people seeking support (Moore 2022). We found that practice often drifts from key aspects of the intended approach, as implementation scientists have highlighted (Ogden and Fixsen 2015), and our Danger Points set out some of the ways this happens with 3Cs. Practice drift may be partly due to the difficulty of defending an approach which can appear to cost more 'up front' as people seeking support are helped initially without the need for an assessment; intensive support, before eligibility assessment has taken place, is included by Partners4Change as a key component of 3Cs and a key factor in providing effective preventative help (see Box 2, Rule 4). The theory of change, however, includes the need to 'check back' with people, and that emergency support put in (without eligibility assessment) as part of Conversation 2 must be seen as short-term. We found that emergency support was not always reviewed in a timely fashion, and that communication with people receiving this support was not always clear, leading to costly support being left in place without review, and/or confusion when support is removed or when people are asked to pay for support (following Conversation 3) previously provided free of charge.

Updated guidance on evaluating complex interventions from the Medical Research Council highlights the value of theory-based approaches to evaluation and recognises that broader and less-precise findings may be of most use to policy and practice (Skivington *et al.* 2021). There is wide acknowledgement that it is difficult to evaluate practice solely on the basis of available statistics such as budget and costs, conversion rate (proportion progressing to a long-term care plan), and proportion of returners, and that new approaches are needed (Foot 2012; de Andrade and Angelova 2018; Price *et al.* 2020; Caiels *et al.* 2021). Only some sites look at these metrics, which can be useful, but do not give a full picture, and can be misinterpreted. Reductions in costs and care packages could be simply the result of withholding needed care, and reductions in the numbers of returners could be because people have lost hope that they will receive help. Because of the degree and variety of changes over time and in different geographic areas, there are no ideal comparator times or places with which to compare practice or establish control groups for evaluations. This leads to a problem attributing any changes to the implementation of a new approach such as 3Cs. Because of practice drift, it would be unclear what evaluation based solely on these types of outcomes would be showing—as it may be that key parts of 3Cs are not in place. A framework for understanding fidelity issues (such as our theory of change) allows comparison of key aspects of consistency of practice and a rationale for evaluating its

impact on outcomes, but some practice, particularly at the micro-level of interactions, remains somewhat hidden and most likely variable across contexts.

Briefly mentioned in our results is the ceiling of accountability for 3Cs; the concept is useful in highlighting the limitations and constraints within which social care operates (Breuer *et al.* 2022). Whilst the activities undertaken as part of 3Cs are intended to ultimately contribute towards improved health and well-being of people in better-connected communities, many other factors aside from adult social care will be relevant, and there may be a significant time lag. Other authors, as well as our respondents, have noted the difficulties of operating in a relationships and strengths-based way in an underfunded and overburdened system, and in a society where people seeking support may be lacking in both the relational resources important to strengths-based approaches and the material and monetary resources necessary for a reasonable standard of living (Daly and Westwood 2018). Whilst successful transition to a more preventative, person-centred, and relationship-based approach could contribute to improved health and well-being in better-connected communities, a simple causal relationship is unlikely, and difficult to prove.

We suggest, therefore, that the higher-level metrics referred to above (conversion rate and returners rate) need to be set against more fine-grained consideration of whether and how the approach is operating in practice. The meaning of these metrics, and any changes in them, can be better explored within the broader framework of the theory of change and the range of indicators. The theory of change details the key activities we found to comprise the 3Cs approach, and what outcomes should be expected at each point of the process. Collecting indicators of these outcomes involves understanding the experiences of those receiving and delivering services. As noted, this is not straightforward; we found people who use services, including carers, express a reluctance to answer surveys, or to give their true views when they do, because of feelings of distrust, a belief that it would be a waste of their time, as no one would act on the findings, and/or a fear of reprisals. The difficulties of obtaining meaningful feedback from users of services have been identified elsewhere in the literature, and Willis *et al.* (2016) have suggested qualitative methods might be more relevant.

Challenges, limitations and conclusions

It has been suggested that strengths-based approaches pay insufficient attention to the possibility that people with less access to power and resources may be less able to benefit from an approach like 3Cs (Friedli 2013). As Friedli puts it in a critique of asset-based approaches: ‘as

material inequalities grow, so the pursuit of non-material explanations for health outcomes proliferates' (Friedli 2013). Funding pressures in adult social care have led to higher levels of self-funding, poorer quality care, and more pressure on families, particularly for older adults, who can be more hidden in society (Glasby *et al.* 2021). Even within the relatively disadvantaged population eligible for funded social care there remains a steep social gradient in unmet need, and changes to funding mechanisms mean the most deprived local authorities have seen the biggest revenue reductions (Burchardt *et al.* 2020). There is also evidence of ethnic inequalities, with lower levels of satisfaction reported by ethnic minority service recipients and unpaid carers (Burchardt *et al.* 2020; Brimblecombe and Burchardt 2021). Concerns about inequality in who benefits from these approaches were occasionally raised in our research, and are reflected in our final listed Assumption, that everyone eligible has equal access to support from Adult Social Care. Future research should explore how to move towards making equal access a reality, and how this can be measured. Additional efforts to gain and address meaningful feedback from people who seek support and/or are involved with services are also needed. The absence of more detail on these aspects is a limitation of our study.

This research involved attempting to gain in-depth understanding of how practice was perceived to be operating in three sites; the approach was mainly qualitative. Methodological limitations include the small number of sites, the reliance on practitioners volunteering to participate, and the difficulty of recruiting people who were receiving support within the case study sites, that is, who should have been receiving support within a 3Cs approach. Austerity policies, the COVID-19 pandemic and other socio-economic and political developments meant the research took place during a time of growing budgetary constraints, at the same time as increasing levels of need in the community, demand for services, difficulty in filling staff vacancies and temporary, or sometimes permanent, closure of many voluntary and community sector services (Curry *et al.* 2023). Whilst we were successful in recruiting a broad range of practitioners, and compensated for low levels of participation from local service users through additional workshops with service user representatives outside our sites, important voices will have remained unheard. We found that practice varied widely within sites, with different teams adopting the approach to different degrees. However, the issues we raised and included in the theory of change and the danger points, were recognised across sites. We held additional discussions and testing in separate Local Authority sites and with a range of interested parties, including a very involved public advisory group.

Whilst noting the unprecedented claims on resources, recent updates from social work leaders continue to support practice that works collaboratively alongside people seeking support, their carers, and their

communities; the pandemic is seen as having heightened awareness of the benefits of strengths- and asset-based perspectives and the benefits of collaboration with health and community sectors and of community-led approaches to support (Romeo 2022). We have contributed to addressing the identified need for more precise explanations of the nature of a strengths-based approach to inform more rigorous implementation and evaluation (Price *et al.* 2020; Caiels *et al.* 2021). We suggest that evaluations can draw on our theory of change to gain understanding of how such approaches are working in practice, and what is being achieved. In discussions with stakeholders, we have understood that the theory of change may have relevance beyond the 3Cs approach, to understanding strengths and relationship-based practice more broadly. We have identified and set out aspects of The Three Conversations which seem essential for the approach to work as planned, but which are found to be vulnerable to dilution over time, including keeping record-keeping proportionate, keeping the voluntary sector involved and sufficiently supported, getting, and keeping, staff on board with the approach and maintaining freedoms for frontline staff within systems which seek to keep tabs on spending. Monitoring and evaluating practice against the theory of change can contribute to keeping these efforts on track and can contribute to making the case for preventative support.

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Supplementary material

Supplementary material is available at *British Journal of Social Work Journal* online.

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