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Does implementing strengths-based approaches improve adult social care outcomes in England? An econometric analysis of the Care Act 2014

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ABSTRACT

Background: Population ageing and strained healthcare budgets are making adult social care a pressing global challenge. In England, the Care Act 2014 reformed provision of social care by encouraging strengths-based approaches—which emphasize individual and community assets over deficits (i.e., weaknesses, limitations, needs, or problems). Subsequent commissioning and integration initiatives diversified practice, yet quantitative evidence on outcomes remains scarce.

Objective: To estimate the effect of the 2014 Care Acton adult social care outcomes across local authorities in England.

Methods: Partial proportional odds regression models were estimated on repeated cross-section survey data from 2010 to 2019 on a large representative sample of adult social care outcome recipients in England ($n = 1659,564$). Six dependent variables capturing service effectiveness and recipients' experience with social care services, and several controls including age, sex, subjective health status, and region fixed effects, were considered.

Results: Estimates indicated that the reform led to improvements in recipients' perceived quality of life, safety, and control over daily activities. Other dimensions, particularly satisfaction with the care and support services received, also improved but to a lesser degree and showing lagged effects. Distributional effects were observed, where the positive mean changes in service effectiveness and recipients' experience were mostly driven by improvements at the lower end of the outcome spectrum.

Conclusions: Reforms incorporating strengths-based approaches can improve recipients' reported outcomes and therefore alleviate the significant human and economic burden of adult social care. Future research should expand on this study and ultimately improve decision-making and outcomes for care recipients and providers.

Research in Context

What is already known about the topic?

Strengths-based approaches to adult social care have been advocated in place of traditional deficit-based care methods. Whereas several theoretical and implementation models have been developed, the current evidence base for their effect on adult social care outcomes at the population level is limited.

What does this study add to the literature?

This study provides quantitative evidence for change in adult social care outcomes following the implementation of the Care Act 2014 in England, a reform that incorporated key elements of strengths-based practice. Evidence is provided specifically on service effectiveness and recipients' experience with social care services across English local authorities.

What are the policy implications?

Findings from this study suggest that population-level reforms incorporating strengths-based approaches like the Care Act 2014 in England may serve as effective equity-enhancing interventions in adult social care policy.

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1. Background

Adult social care supports older people, working-age adults with disabilities, and those with mental or physical illnesses, covering needs from personal care to community participation [1]. With aging populations and rising multimorbidity, demand for adult social care is increasing worldwide [2]. The European Pillar of Social Rights stresses affordable, accessible long-term care [3]. In England, adult social care is funded through central grants and local revenue like council tax, shared between local authorities and the NHS [4]. Spending has risen 15% in real terms since 2015–16 [5], highlighting growing pressures on sustainability.

Over time, researchers and practitioners have raised concerns about rising thresholds for statutory support being offered at 'too late a stage, addressing needs when they are acute and not before' [6,7]. These concerns contributed to the Care Act 2014′s emphasis on prevention and strengths-based practice as alternatives to reactive, deficit-focused models of care.

From traditionally being under the remit of local authorities as the entities responsible for both commissioning and delivering services, in England the provision of publicly-funded adult social care has undergone several organizational changes over the last three decades, culminating with the 2014 Care Act [8]. That piece of legislation permitted local authorities to delegate some of their functions by outsourcing them to the private or non-statutory sector, hence allowing for more flexibility and efficiency in the delivery of care coordination services. Although the 2014 Care Act mandates local authorities to prevent the need for care and support, the guidance gives each authority the right to establish its own interpretation of prevention and the variety of actions necessary to fulfill this obligation, with consequent heterogeneity of practices and impacts on adult social care outcomes [9].

Following the enactment of the Care Act, a range of commissioning models and integrated care approaches were introduced to reconfigure service provision across local authorities. These included partnership arrangements with voluntary and community sector organizations, the use of framework agreements and spot purchasing with independent providers, and the establishment of multidisciplinary teams to enhance collaboration between health and social care professionals. Along with alternative cost-cutting approaches such as combining NHS and social care budgets [10] and integrating health and social care services [11], commitment to preventative approaches in adult social care has been outlined in the 2014 Care Act through the implementation of strengths-based approaches [12].

The Care Act 2014 was not exclusively a reform to implement strengths-based approaches, though. It also introduced significant changes to eligibility frameworks, carer entitlements, and local authority commissioning powers. However, given that the Act explicitly required local authorities to carry out their responsibilities in ways closely aligned with the principles of strengths-based practice and that its implementation prompted the widespread adoption of strengths-based models across English local authorities [12,13], in this study we refer to the Act as a population-level example of a strengths-based reform.

As opposed to conventional approaches which typically often focus on addressing problems and challenges, 'strengths-based' or 'asset-based' approaches focus on identifying and leveraging resources to empower individuals to achieve their desired outcomes by cultivating self- esteem, competence, and resilience and emphasizing what is functioning well and promoting personal growth through positive relationships and community support [13]. Strengths-based approaches can be defined as social provision models that systematically identify and leverage the assets, capabilities, and resources that exist within individuals, families, and communities, rather than concentrating primarily on problems, limitations, and unmet needs [14,15]. Whereas the Care Act did not explicitly mandate local authorities to adopt a strengths-based approach in their practice, it did require local authorities to carry out their care and support responsibilities in a manner that closely resembles and includes the fundamental aspects of a strengths-based approach [16]. Since the Care Act 2014, implementations of several strengths-based care models have been reported from across local authorities in England, such as Asset-Based Community Development (focuses on community strengths, not deficits and encourages collaboration and empowerment), Local Area Coordination (supports individuals using local resources and networks, ensuring practical, person-centered solutions), and the Three Conversations Model (structured dialogue for understanding, action, and reflection, providing a framework to explore understanding, plan action, and reflect on outcomes), yet current evidence regarding their effect on adult social care outcomes is much limited [13,17].

This study evaluated how a set of adult social care outcomes evolved following the implementation of the Care Act 2014 across local authorities in England, contributing with new population-level quantitative evidence on the effects of a reform incorporating strengths-based approaches to inform policy decision-making.

1.1. Theoretical models of social care provision

Strengths-based approaches in adult social care focus on recognizing and building individuals' strengths, assets, and resources rather than emphasizing deficits. Key models include the Strengths Perspective and asset-based community development [17], with the former widely applied across professional domains [14,18–20]. Saleebey [15] outlined six guiding principles: everyone possesses inherent strengths; adversity can foster resilience; growth and change are always possible; professionals should balance power dynamics with clients; all environments hold resources; and caring relationships are vital [19]. This approach promotes empowerment, resilience, and collaboration, encouraging clients to recognize their own abilities and potential. In therapy and case management, the Strengths Perspective reframes clients as active agents of change, enabling them to use their strengths to overcome challenges and achieve goals [21]. It fosters hope, agency, and more positive professional-client relationships.

Strengths-based practice encompasses several distinct but related models that have been implemented across social care settings. First, developed by Kretzmann and McKnight [22], the asset-based community development model contrasts the traditional needs-based development as the latter is deemed disempowering, to adversely affect social capital, and fosters dependency. Put simply, this model suggests that if communities can recognize and mobilize their assets and strengths, they can lead themselves to a better future [23]. This can be achieved by empowering the community and seeing community members as "producers" of programs and a common vision, instead of "consumers of services". Initiatives grounded in this model focus on enhancing group capabilities via participatory and collaborative methods, and bolstering civil society by harnessing local resources, community mobilization and social capital [24]. Second, the Three Conversations Model restructures initial contacts to focus on "What matters to you?", "What's strong in your life?", and "What would a good day look like?" rather than traditional needs assessments [25,26]. Lastly, Local Area Coordination emphasizes building informal community connections and preventing escalation to formal services [27]. These approaches share common features: person-centered planning, collaborative goal-setting, asset mapping, and emphasis on informal support networks over formal service provision.

1.2. Empirical evidence

Evidence for strengths-based approaches in adult social care remains limited [13]. A review found no quantitative studies on their impact, with only a few qualitative studies exploring acceptance and implementation [28–30] highlighted the importance of safety, social connections, and participation in everyday life for well-being among

homeless individuals, underscoring the role of social care in fostering inclusion. Ahuja et al. [28] identified key factors for successful implementation: cultural change, practitioner development, leadership, and adaptability. Similarly, Caiels et al. [17] reported positive outcomes, including enhanced well-being, satisfaction, and professional interactions, but also noted challenges such as structural incompatibility, limited workforce, and heavy workloads. Overall, while strengths-based approaches show promise, further evidence and system-level adaptation are needed to ensure sustainable, scalable implementation in adult social care.

2. Methods

2.1. Data

We gathered data from the Personal Social Services Adult Social Care Survey, a national survey conducted every year in England [31]. This survey collects information on the opinions and experience of adults who receive long-term support and care funded and managed by social care services using stratified sampling. Weights – which are calculated to ensure the returned questionnaires are representative of the eligible population – are obtained by dividing the size of the eligible population by the number of respondents in each local authority for each stratum [32]. This repeated cross-sectional survey is designed to monitor adult social care outcomes at the population level and understand how services are affecting and perceived by the recipients, hence enabling policy and service development and evaluation. The questionnaires are administered by local authorities with Adult Social Services Responsibilities throughout district health authorities located all around England. We analyzed a ten-year period including the survey waves from 2010 to 2019, hence purposively excluding the years after 2019 as service use, service availability, and users' opinions may have been altered by the COVID-19 pandemic.

2.2. Variables

Our empirical analysis considered a set of six dependent variables to capture service effectiveness and the recipients' experience with social care services. As for the first construct, the following three questions were considered:

- *Quality of life*: 'Do care and support services help you to have a better quality of life?' (answer: yes or no).
- *Control*: 'Do care and support services help you in having control over your daily life?' (answer: yes or no).
- *Safety*: 'Do care and support services help you in feeling safe?' (answer: yes or no).

The three service effectiveness outcomes were recorded as binary responses and retained as such for analysis. Each was coded as 1 (yes, the service helps) or 0 (no, the service does not help), and modelled using binary logistic regression.

In regards to the recipients' experience, the following three questions were considered:

- *Care satisfaction*: 'Overall, how satisfied are you with the care and support services you receive?' (answer: 1 "Very dissatisfied" 2 "Quite dissatisfied" 3 "Indifferent" 4 "Quite satisfied" 5 "Very satisfied").
- *Social contact*: 'Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?' (answer: 1 "Little" 2 "Some" 3 "Adequate" 4 "As much as I want").
- *Information access*: 'In the past year, have you found it easy or difficult to find information and advice about support, services or benefits?' (answer: 1 "Very difficult" 2 "Fairly difficult" 3 "Fairly easy" 4 "Very easy").

These three experience outcomes were recorded as categorical variables, coded 1 for low values and 4 or 5 for high values, and modelled using ordered logistic regression.

For the multivariable regression analyses, the following control variables were identified from the survey datasets based on previous literature and relevance: gender, age group (dummy variable, below or above 65 years old), ethnicity (dummy variable, White or non-White), health status (ordinal variable, very bad, bad, fair, good, very good), type of questionnaire (dummy variable, standard or 'easy read' for individuals with learning disabilities) and local authority of residence. To examine the distributional effect of the 2014 Care Act on the identified adult social care outcomes across local authorities in England, we applied an empirical strategy based on two econometric approaches (see **Appendix**).

2.3. Statistical analysis

Summary statistics and graphic representations were used to describe the sample characteristics and levels adult social care outcomes over time. Logistic and ordered logistic regression models were estimated to assess the effect of implementing the Care Act 2014 on service effectiveness and recipients' experience, respectively.

To evaluate distributional effects of the reform, we employed partial proportional odds regression models, appropriate given the ordinal nature of the outcome measures. These models relax the proportional odds assumption of standard ordinal logistic regression, allowing the effects of selected covariates to vary across outcome thresholds while constraining others to remain constant, thereby providing a more flexible assessment of how the reform influences different points of the outcome distribution [33]. Were estimated to examine the heterogeneity in the effects of the main explanatory variable (i.e., implementation of the Care Act 2014) and the identified control factors across the different levels of the outcome variables. To mitigate the risk of omitted variable bias and ensure a more accurate estimation all relevant control variables were included in the regression models. To address the issue of heteroskedasticity, robust standard errors were computed and clustered at the local authority level, providing more reliable confidence intervals and hypothesis tests. Statistical significance was set at $p < 0.05$. All analyses were performed using STATA 16 software [34].

3. Results

3.1. Descriptive statistics

Table A (Appendix) shows that around 60% of the sample of respondents was over 65 years old and female, 87% self-identified as White and generally in fair overall health. Around 19% used an 'easy read' version of the survey questionnaire which is designed for respondents with learning disabilities. A quarter of all respondents lived in the London area, with the distribution of respondents broadly overlapping that of the general population based on population density.

Fig. 1 illustrates the time trend of the three outcomes associated with service effectiveness, namely, quality of life, control and perceived safety. This graph shows an overall upward trend, with values stabilizing following the implementation of the Care Act in 2014. Feeling safe accounts for the largest overall increase, then levels off, together with the other two outcomes, after the year 2014. Recipients' experience with the social care services, as measure by care satisfaction, social contact and information access shows a broadly comparable trend, although improvements are registered one year following the implementation of the Act. Furthermore, comparatively, information access starts and ends with the lowest average values showing a steeper rebound trajectory following the legislation (Fig. 2). Breaking down the trends shown in the previous chart by outcome level, Figure A **(Appendix)** highlights a certain degree of heterogeneity in trend across outcomes levels, indicating a potential distributional effect induced by the implementation of

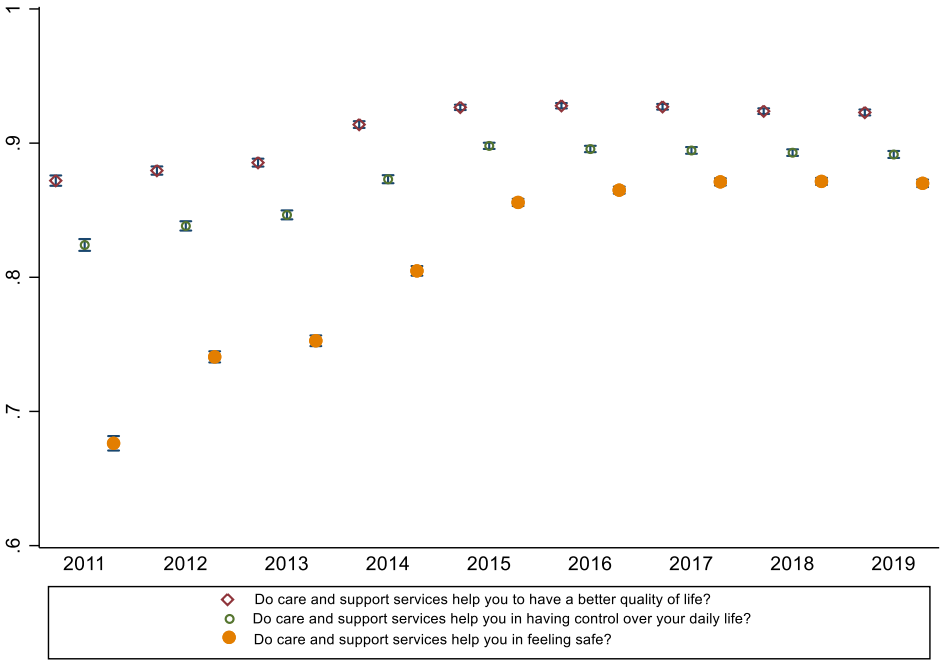

Fig. 1. Service effectiveness over time.

Fig. 2. Time trends in recipients' experience.

the Act.

3.2. Regression analysis

Table 1 reports results from the logistic (binary and ordered) regression estimating the effect of implementing the Care Act 2014 on

Table 1
Logistic regression models.

Variables	qlife	ctrl	safe	care_satisf	contacts	inform
2014 onwards	0.4158***	0.3615***	0.3988***	0.0376**	0.0113	−0.0049
	(0.0348)	(0.0282)	(0.0372)	(0.0160)	(0.0140)	(0.0171)
Non-White	0.1011***	−0.0633***	0.0426	−0.2524***	−0.0806***	−0.0981***
	(0.0268)	(0.0234)	(0.0346)	(0.0183)	(0.0140)	(0.0154)
Female	0.1302***	0.1137***	0.1208***	0.0448***	0.0361***	0.0068
	(0.0125)	(0.0098)	(0.0093)	(0.0072)	(0.0066)	(0.0070)
Over 65	0.1633***	0.1881***	0.1995***	0.0039	0.3323***	0.3059***
	(0.0176)	(0.0174)	(0.0188)	(0.0124)	(0.0135)	(0.0127)
Good	−0.1045***	−0.1114***	−0.2777***	−0.6252***	−0.6755***	−0.8785***
	(0.0305)	(0.0210)	(0.0209)	(0.0146)	(0.0132)	(0.0190)
Fair	−0.5471***	−0.4315***	−0.7042***	−1.1881***	−1.4026***	−1.5125***
	(0.0326)	(0.0208)	(0.0222)	(0.0166)	(0.0136)	(0.0221)
Bad	−1.1557***	−0.9085***	−1.1792***	−1.5768***	−2.1855***	−2.0989***
	(0.0351)	(0.0221)	(0.0260)	(0.0180)	(0.0165)	(0.0257)
Very Bad	−1.5624***	−1.2897***	−1.3876***	−1.7340***	−2.6657***	−2.5421***
	(0.0353)	(0.0249)	(0.0298)	(0.0246)	(0.0244)	(0.0332)
Easy read	0.9886***	0.5507***	1.5452***	0.2064***	0.6409***	0.3244***
	(0.0338)	(0.0243)	(0.0311)	(0.0194)	(0.0141)	(0.0186)
Cassr	<0.001	0.0004	0.0007	0.0004	0.0002	<0.001
	(0.0003)	(0.0003)	(0.0006)	(0.0002)	(0.0002)	(0.0002)
E	0.1514**	0.1420**	0.0552	0.1308***	0.1202***	−0.0622
	(0.0716)	(0.0614)	(0.1058)	(0.0441)	(0.0342)	(0.0435)
EM	0.2380**	0.3479***	0.5145***	0.2439***	0.1074**	−0.0825
	(0.0932)	(0.0865)	(0.1733)	(0.0662)	(0.0443)	(0.0614)
NE	0.3703*	0.6269***	0.8461**	0.5685***	0.4313***	0.2652**
	(0.2120)	(0.1909)	(0.3669)	(0.1505)	(0.1066)	(0.1102)
NW	0.1362	0.2753**	0.4106	0.3746***	0.2419***	0.0840
	(0.1452)	(0.1303)	(0.2618)	(0.1006)	(0.0730)	(0.0791)
SE	0.1941***	0.2054***	0.2109**	0.1069***	0.0493**	−0.0203
	(0.0536)	(0.0471)	(0.0956)	(0.0384)	(0.0244)	(0.0301)
SW	0.3343***	0.1979***	0.0772	0.1892***	0.0931**	0.0113
	(0.0682)	(0.0648)	(0.1387)	(0.0572)	(0.0378)	(0.0410)
WM	0.3042***	0.3756***	0.5075**	0.3057***	0.2292***	−0.0347
	(0.1170)	(0.1046)	(0.2027)	(0.0822)	(0.0598)	(0.0629)
YH	0.1397	0.3748**	0.5567*	0.3923***	0.2691***	0.0408
	(0.1889)	(0.1682)	(0.3063)	(0.1292)	(0.0900)	(0.0954)
year	−0.0033	0.0102*	0.0654***	0.0003	0.0080***	−0.0073**
	(0.0057)	(0.0054)	(0.0076)	(0.0026)	(0.0025)	(0.0035)
Constant	8.7254	−19.1391*	−130.9363***	na	na	na
	(11.5192)	(10.9475)	(15.2548)	na	na	na
/cut1	na	na	na	−3.8807	12.5542**	−18.1965***
	na	na	na	(5.2090)	(5.0900)	(6.9952)
/cut2	na	na	na	−3.0616	14.2430***	−16.8242**
	na	na	na	(5.2106)	(5.0904)	(6.9968)
/cut3	na	na	na	−2.0210	15.8977***	−14.6830**
	na	na	na	(5.2104)	(5.0902)	(6.9974)
/cut4	na	na	na	−0.3409	na	na
	na	na	na	(5.2111)	na	na
Observations	470,932	483,417	481,089	533,547	535,611	380,696

Robust standard errors in parentheses.
*** $p < 0.01$,.
** $p < 0.05$,.
* $p < 0.1$.

six adult social care outcomes. Recipients' quality of life (mean 0.4158 SD 0.0348), control over daily life (mean 0.3615 SD 0.0282), and safety perception (mean 0.3988 SD 0.0372) improved in 2014–2019 compared to the previous five years. Improvements in care satisfaction were smaller (mean 0.0376 SD 0.0160), with no significant changes in level of contact or ease of accessing information. Non-White recipients reported lower effectiveness and experience, particularly care satisfaction (mean −0.2524 SD 0.0183), except for quality of life (mean 0.1011 SD 0.0268) and safety (mean 0.0426 SD 0.0346, non-significant). Females and those over 65 experienced better outcomes in quality of life, safety, and control, though older age was also associated with greater social contact (mean 0.3323 SD 0.0135) and information access (mean 0.3059 SD 0.0127), but not care satisfaction.

Self-perceived health was positively associated with all outcomes, showing a steep health-related gradient. Learning disabilities were linked to better outcomes, especially safety (easy read, mean 1.5452 SD 0.0311). No differences were found by local authority, though regional heterogeneity existed, with London as reference: higher values were observed elsewhere, notably versus the North East for safety (mean 0.8461 SD 0.3669), control (mean 0.6269 SD 0.1909), and care satisfaction (mean 0.5685 SD 0.1505).

Table 2 shows partial proportional odds models assessing heterogeneous effects across care satisfaction, social contact, and information access. For care satisfaction, the Care Act 2014 effect (mean 0.0376 SD 0.0160) was driven by a shift from "Very dissatisfied" to higher levels (mean 0.1866 SD 0.0448). Consistently negative effects of non-White ethnicity were observed across all thresholds, indicating lower probabilities of transitioning into higher levels of care satisfaction, social contact, and information access, with coefficients ranging from (mean −0.1457 SD 0.0365) to (mean −0.2617 SD 0.0177) for care satisfaction, (mean −0.0929 SD 0.0259) to (mean −0.0581 SD 0.0139) for social contact, and (mean −0.0495 SD 0.0214) to (mean −0.1353 SD 0.0162) for information access, with particularly pronounced disadvantages in the upper categories, while differences in health status primarily

Table 2
Partial proportional odds regression models.

Variables	Very dissatisfied **care_satisf**	Quite dissatisfied **care_satisf**	Indifferent **care_satisf**	Quite satisfied **care_satisf**	Little **contacts**	Some **contacts**	Adequate **contacts**	Very difficult **inform**	Fairly difficult **inform**	Fairly easy **inform**
2014 onwards	0.1866***	0.0732**	0.0735***	0.0275*	0.1153***	0.0155	−0.0004	0.1769***	0.0763***	−0.1255***
	(0.0448)	(0.0326)	(0.0224)	(0.0161)	(0.0296)	(0.0188)	(0.0144)	(0.0382)	(0.0220)	(0.0179)
Non-White	−0.1457***	−0.1323***	−0.2063***	−0.2617***	−0.0929***	−0.1118***	−0.0581***	−0.0495**	−0.0693***	−0.1353***
	(0.0365)	(0.0288)	(0.0240)	(0.0177)	(0.0259)	(0.0158)	(0.0139)	(0.0214)	(0.0200)	(0.0162)
Female	0.1116***	0.0425***	0.0633***	0.0416***	0.0772***	0.0005	0.0589***	0.0293***	0.0202**	−0.0051
	(0.0209)	(0.0150)	(0.0102)	(0.0073)	(0.0126)	(0.0088)	(0.0073)	(0.0111)	(0.0084)	(0.0092)
Over 65	0.7505***	0.5508***	0.2857***	−0.0678***	0.6740***	0.4701***	0.1644***	0.4220***	0.3703***	0.2147***
	(0.0289)	(0.0220)	(0.0168)	(0.0121)	(0.0183)	(0.0148)	(0.0124)	(0.0161)	(0.0143)	(0.0148)
Good	0.0156	−0.1770***	−0.3769***	−0.6362***	−0.3107***	−0.4501***	−0.7113***	−0.1487***	−0.4141***	−0.9256***
	(0.0589)	(0.0431)	(0.0262)	(0.0146)	(0.0364)	(0.0202)	(0.0137)	(0.0281)	(0.0184)	(0.0193)
Fair	−0.6075***	−0.8859***	−1.1206***	−1.1948***	−1.2542***	−1.3297***	−1.4127***	−0.7954***	−1.1149***	−1.5875***
	(0.0581)	(0.0422)	(0.0255)	(0.0168)	(0.0381)	(0.0203)	(0.0136)	(0.0316)	(0.0224)	(0.0212)
Bad	−1.6441***	−1.8050***	−1.7613***	−1.4940***	−2.3432***	−2.1781***	−2.0059***	−1.5399***	−1.7888***	−2.0026***
	(0.0542)	(0.0414)	(0.0261)	(0.0180)	(0.0357)	(0.0222)	(0.0167)	(0.0363)	(0.0237)	(0.0279)
Very Bad	−2.4311***	−2.3192***	−2.0762***	−1.5056***	−3.0988***	−2.5469***	−2.0834***	−2.2680***	−2.1732***	−1.9308***
	(0.0565)	(0.0414)	(0.0291)	(0.0212)	(0.0410)	(0.0261)	(0.0222)	(0.0417)	(0.0284)	(0.0333)
Easy read	1.2475***	0.8512***	0.1150***	0.1900***	0.5974***	0.8009***	0.5231***	0.0544*	0.0336*	0.5098***
	(0.0516)	(0.0343)	(0.0251)	(0.0188)	(0.0270)	(0.0185)	(0.0140)	(0.0302)	(0.0196)	(0.0196)
cassr	0.0005	0.0004	0.0003	0.0004	0.0002	0.0001	0.0003*	0.0001	0.0000	0.0000
	(0.0005)	(0.0004)	(0.0003)	(0.0002)	(0.0002)	(0.0002)	(0.0002)	(0.0003)	(0.0002)	(0.0002)
E	0.3598***	0.2868***	0.1930***	0.1094**	0.1897***	0.1195***	0.1082***	0.0225	−0.0265	−0.1122**
	(0.0861)	(0.0670)	(0.0532)	(0.0433)	(0.0490)	(0.0432)	(0.0308)	(0.0568)	(0.0489)	(0.0436)
EM	0.5211***	0.4149***	0.2791***	0.2248***	0.1587**	0.0824	0.1076**	0.0549	−0.0582	−0.1330**
	(0.1223)	(0.0955)	(0.0803)	(0.0649)	(0.0713)	(0.0515)	(0.0441)	(0.0819)	(0.0730)	(0.0596)
NE	1.0133***	0.8574***	0.6769***	0.5344***	0.5590***	0.3619***	0.4484***	0.4473***	0.3348**	0.1875*
Variables	Very dissatisfied **care_satisf**	Quite dissatisfied **care_satisf**	Indifferent **care_satisf**	Quite satisfied **care_satisf**	Little **contacts**	Some **contacts**	Adequate **contacts**	Very difficult **inform**	Fairly difficult **inform**	Fairly easy **inform**
	(0.2905)	(0.2462)	(0.1906)	(0.1460)	(0.1536)	(0.1290)	(0.1019)	(0.1688)	(0.1355)	(0.1027)
NW	0.5599***	0.4552***	0.3805***	0.3614***	0.2918***	0.1910**	0.2562***	0.2045*	0.1324	0.0220
	(0.1913)	(0.1599)	(0.1252)	(0.0981)	(0.1075)	(0.0856)	(0.0704)	(0.1198)	(0.0966)	(0.0748)
SE	0.3459***	0.2264***	0.1712***	0.0881**	0.0932**	0.0676**	0.0310	0.1036**	0.0233	−0.0843***
	(0.0634)	(0.0471)	(0.0397)	(0.0389)	(0.0363)	(0.0266)	(0.0239)	(0.0447)	(0.0354)	(0.0287)
SW	0.4978***	0.3823***	0.2616***	0.1693***	0.1603***	0.1193***	0.0709*	0.1154*	0.0657	−0.0513
	(0.0952)	(0.0870)	(0.0660)	(0.0566)	(0.0579)	(0.0439)	(0.0365)	(0.0614)	(0.0517)	(0.0410)
WM	0.5378***	0.4793***	0.3611***	0.2830***	0.2751***	0.1847***	0.2365***	−0.0277	−0.0081	−0.0565
	(0.1640)	(0.1329)	(0.1049)	(0.0799)	(0.0846)	(0.0693)	(0.0581)	(0.1023)	(0.0775)	(0.0584)
YH	0.7385***	0.5523***	0.4230***	0.3731***	0.3036**	0.1874*	0.2969***	0.1786	0.0714	−0.0132
	(0.2444)	(0.2094)	(0.1637)	(0.1252)	(0.1303)	(0.1088)	(0.0854)	(0.1442)	(0.1156)	(0.0901)
year	−0.0567***	−0.0391***	−0.0184***	0.0053**	−0.0305***	0.0017	0.0155***	−0.0671***	−0.0404***	0.0382***
	(0.0076)	(0.0051)	(0.0039)	(0.0025)	(0.0050)	(0.0032)	(0.0026)	(0.0092)	(0.0041)	(0.0041)
Constant	117.7810***	81.8267***	39.6070***	−9.5536*	64.6938***	−1.6479	−30.8005***	137.8172***	82.9373***	−76.9011***
	(15.3519)	(10.3146)	(7.9342)	(5.0747)	(10.0920)	(6.3852)	(5.2605)	(18.5512)	(8.2816)	(8.2871)
Observations	533,547	533,547	533,547	533,547	535,611	535,611	535,611	380,696	380,696	380,696

Robust standard errors in parentheses.
*** $p < 0.01$,.
** $p < 0.05$,.
* $p < 0.1$.

affected transitions from lower to higher categories. Age over 65 showed a middle-distribution effect, with upward shifts from the bottom (mean 0.7505 SD 0.0289) and slight downward shifts from the top (mean −0.0678 SD 0.0121). Local authority had no effect, but regional differences were concentrated in lower categories (e.g., North East: very dissatisfied, mean 1.0133 SD 0.2905). Similar heterogeneous patterns were observed for social contact and information access. Region and age influenced upward shifts from the bottom categories. Females had positive shifts from lower levels of social contact (bottom: mean 0.0772 SD 0.0126; second-highest: mean 0.0589 SD 0.0139) and information access, despite non-significant mean effects. Implementation of the Care Act 2014 positively affected social contact via upward shifts from the bottom category (little: mean 0.1153 SD 0.0296) and information access via a bunching effect from bottom and second-last levels (very difficult: mean 0.1769 SD 0.0382; fairly difficult: mean 0.0763 SD 0.0220), offset by negative effects from upper categories (fairly easy: mean −0.1255 SD 0.0179).

In summary, the Care Act 2014 improved outcomes, particularly for those initially dissatisfied, while effects varied by ethnicity, age, gender, health, and region, with stronger impacts for lower baseline categories. Heterogeneity analyses reveal that average effects may obscure substantial differential benefits across recipient subgroups and outcome levels.

Robustness checks using a one-year lag (Table B, **Appendix**) showed similar patterns, with quality of life (mean 0.2262 SD 0.0279), control (mean 0.2554 SD 0.0242), and safety (mean 0.3520 SD 0.0340) effects slightly attenuated, while effects for care satisfaction, social contact (mean 0.0939 SD 0.0148), and information access (mean 0.0687 SD 0.0172) increased and became significant, suggesting immediate impact on effectiveness but delayed effects on experience. Extending post-exposure to 2015–2019 (**Table C**) showed larger upward shifts across levels for social contact and information access, with no negative effects for higher categories. Event study results (**Table D**) revealed a positive break post-2014 for control, social contact, and safety, while quality of life showed a constant effect. Information access displayed a mixed trend, and care satisfaction followed a non-linear pattern, peaking

around 2014 then declining. Panel analysis at health district level (**Table E**) confirmed these findings, supporting the robustness of the Care Act 2014 effects across outcomes.

4. Discussion

4.1. Main findings

This paper aims to contribute to the currently scant base of quantitative evidence for the effect of implementing strengths-based approaches on recipient-reported adult social care outcomes. To this end, we conducted a longitudinal econometric analysis of a large sample of data from the Personal Social Services Adult Social Care Survey - which monitors social care outcomes and other relevant factors at the local authority level annually – to assess the impact that implementing the Care Act 2014 had on a set of social care outcomes in England.

The findings suggest that the implementation of the Care Act 2014 was associated with measurable improvements in several key social care outcomes, most notably in perceived quality of life, control over daily life, and feelings of safety. These are associated with the Act's emphasis on strengths-based approaches, which aim to empower individuals and support their independence. The improvements observed may, therefore, reflect the broader shift in statutory guidance towards preventative care, the promotion of wellbeing, and greater user involvement in care planning [12].

The heterogeneity in the pattern and sustainability of outcome improvements across domains points to underlying variations in how the Act was implemented at the local level. This is consistent with earlier evidence highlighting the discretionary nature of prevention under the Act, which allowed local authorities to interpret and operationalize key provisions differently [9]. Such variability likely influenced the speed and depth of changes in practice, particularly where services were already under strain due to funding pressures [11]. That improvements in satisfaction with care, social contact, and access to information were more modest or lagged suggests that systemic constraints — such as staffing levels, provider market stability, and cross-sector integration — may have limited the scope of change in these domains [7].

Of particular note is the distributional impact of the reform, with improvements driven largely by a reduction in very poor outcomes rather than a uniform shift across the entire population. This aligns with a pro-equity interpretation of the Act's impact, suggesting that the policy may have succeeded in addressing the most acute deficiencies in service experience and care delivery. Such a finding is important, given the long-standing concern that support is often provided too late or only once needs become critical [6]. Targeting those at the bottom end of the outcome distribution may reflect an implicit reprioritization by local authorities, focusing resources on individuals with the highest unmet needs — a pattern echoed in previous studies of post-reform care delivery [35].

A notable finding is the absence of significant associations at the local authority level, despite the Care Act granting individual councils considerable discretion in implementing strength-based approaches. This suggests that local authority-level variation in service supply or commissioning decisions did not translate into measurable differences in recipient-reported outcomes, at least not beyond what is captured by regional fixed effects. One interpretation is that the Act's legislative baseline effectively narrowed between-authority disparities, producing a degree of convergence in outcomes regardless of how individual councils operationalised their obligations. Notably, regional differences do persist, with recipients outside London, and particularly in the North East and Midlands, reporting better outcomes on several dimensions. This pattern may reflect structural differences in population need, housing conditions, or the relative integration of health and social care across NHS regions, rather than local authority policy choices per se.

Nevertheless, the gradual return to pre-reform levels in some outcome areas raises important questions about the durability of these improvements and whether there has been sufficient long-term investment in care infrastructure. Short-term funding initiatives, ongoing workforce challenges, and rising demand may have limited the ability to maintain early progress [10]. These findings highlight that while policy reforms are an important first step, they need to be supported by sustained funding, investment in the workforce, and consistent oversight of how policies are implemented locally.

To the best of our knowledge, this is the first study quantitatively examining the impact of implementing strengths-based approaches at a population level. We believe that this article makes a relevant and original contribution to the evidence base for public policy aimed at improving adult social care, particularly from the demand-side perspective (i.e., recipients). Study findings provide an example of a strengths-based reform which led to improvements in desired adult social care outcomes. Overall, they support the implementation of strengths-based approaches to enhance the effectiveness of social care services for adult recipients. These findings also unveil the heterogeneous impact that a legislation such that of the Care Act 2014 can have on a set of desired social care outcomes. We believe that these findings are of particular importance for policymakers considering implementing population-level strategies to tackle the limitations of traditional approaches to adult social care and fostering an academic and policy debate on the optimal strategy to tackle this issue at the local and international level.

4.2. Strengths and limitations

While the analysis identifies significant associations between outcomes and the years before and after the reform—controlling for other observable characteristics—the causal impact cannot be confidently established due to unobserved factors and concurrent developments that may also have influenced the results. However, we conducted a series of regression analyses to estimate the effect that the implementation of the Care Act 2014 had on a set of desired outcomes which were selected based on previous research and policy relevance criteria. By doing so, we were able to consider several service-related and social dimensions that could be, in principle, positively impacted by the policy which fostered a strengths-based approach. We performed several sensitivity analyses and robustness checks, which made our empirical results more reliable and robust and enabled us to characterize the uncertainty in our findings. However, residual confounding cannot be fully ruled out, particularly from other initiatives such as social prescribing, which may have biased the estimated results. Whereas we avoided the risk of omitted variable bias by specifying all relevant control variables in our models, controlled for heteroskedasticity, and clustered standard errors to account for potential correlations within groups (i.e., local authorities), the Care Act 2014 did not mandate any given format or strict timing for implementing strengths-based approaches.

Furthermore, unobserved heterogeneity in other time-dependent changes at the organizational level – e.g., changes to the level of coordination between local authorities and the private sector – may also have occurred. Moreover, selection bias might have occurred which could have affected the representativeness of the sample and the generalizability of the results. Nonetheless, level of response for relatively constant across the surveys and we have no reason to believe that selection effects would systematically vary across waves. Hence, we can reasonably assume that any potential bias, if present, was consistent throughout the annual survey, likely representing more favorable views. If that is the case, then the reported results may be an underestimation of the actual impact of the Act.

We could not control for the level and quality of implementation of strengths-based approaches, as we relied on public monitoring data for our analyses, and retrospective data collection was neither feasible nor considered reliable when designing the study. Furthermore, we focused on the demand-side perspective in that we considered only recipient-level outcomes. However, the implementation of the Act required

structural changes at an organizational level, as well as adjustments to the workforce for aligning these changes with the intended outcomes of the Act and ensure that the intended benefits were fully realized, and its objectives met. These aspects of evaluation were beyond the scope of the present study. Finally, the analysis focused on England, and the specific characteristics of the decision-making and social care service provision context may not be directly comparable to other countries. Systematic differences in social care systems, cultural attitudes, and resource availability can significantly impact the applicability of these findings. However, the present study provides a foundational base on which future applied research can build.

4.3. *Implications for future research*

Future empirical research should expand the present evaluation to include qualitative aspects to enrich the understanding of how and why certain outcomes were achieved, offering more nuanced insights that can guide future policy. One valuable approach for enhancing this understanding is with the RE-AIM framework for policy evaluation [36]. By applying this framework, researchers can examine not only whether a policy achieves its intended outcomes but also how and why it works (or does not work) in practice. Specifically, to assess how well the policy addresses the needs of the target population, investigate how widely the policy or program is accepted and used by practitioners, assess the level of fidelity of the job training program's delivery and identifying barriers faced by both trainers and participants and evaluate the sustainability of the policy's effects over time. This would provide valuable insights which could be obtained via interviews with program participants and administrators.

Future research should consider replicating this study in different decision-making contexts to evaluate the generalizability of the findings. Where available, extending the presented analysis with more granular, individual-level data could provide deeper insights into the nuanced impacts of similar policies. Such detailed data could help unveil variations in how different population subgroups experience and respond to policy changes, thereby identifying specific factors that influence policy effectiveness and equity impacts. Comparable to previous research on the social gradient in health, having reliable information available at the household level and on socio-economic status could help identify any gradients in the benefits derived from the policy and assist in designing optimal public policy.

5. Conclusions

This study assessed the population-level impact of implementing strengths-based approaches on adult social care outcomes in England following the Care Act 2014. Results from this population-level econometric analysis – the first of this kind on the topic - indicate that strengths-based approaches have the potential for improving recipients' reported outcomes and therefore alleviate the significant human and economic burden of adult social care. These research findings should be of interest to international scholars and policymakers, as they provide valuable insights that could inform future research and policy development. Future quantitative and qualitative research should build on the present study to further examine adult social care implementation and policy assessment, particularly across different policy, institutional and cultural contexts, to assess the generalisability of these findings. This would support better decision making and improved equitable outcomes for both care recipients and providers.

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Ethical

This study utilized secondary data from the Personal Social Services Adult Social Care Survey. The data were analyzed in compliance with ethical guidelines, and no additional ethics approval was required as the data was anonymized and publicly available.

No permissions were necessary for the use of the images included in this manuscript. As corresponding author, I confirm that the manuscript has been read and approved for submission by all the named authors. All the authors contributed to the writing of the final manuscript.

CRediT authorship contribution statement

Paolo Candio: Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Francesco Salustri:** Writing – review & editing, Writing – original draft, Visualization, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation.

Declaration of competing interest

None.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.healthpol.2026.105682.

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