Glasgow Centre for Population Health

BRIEFING PAPER 9 CONCEPTS SERIES

Asset based approaches for health improvement: redressing the balance

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KEY MESSAGES:

- The shortcomings of taking a 'deficits' or 'treatment' approach to the delivery of public services, coupled with the impending cuts to public service provision, have given a renewed impetus to finding better ways of working.
- Assets can be described as the collective resources which individuals and communities have at their disposal, which protect against negative health outcomes and promote health status. Although health assets are a part of every person, they are not necessarily used purposefully or mindfully.
- An asset based approach makes visible and values the skills, knowledge, connections and potential in a community. It promotes capacity, connectedness and social capital.
- Asset based approaches emphasise the need to redress the balance between meeting needs and nurturing the strengths and resources of people and communities.
- Asset based approaches are concerned with identifying the protective factors that support health and wellbeing. They offer the potential to enhance both the quality and longevity of life through focusing on the resources that promote the self-esteem and coping abilities of individuals and communities.
- Asset based approaches are not a replacement for investing in service improvement or attempting to address the structural causes of health inequalities.
- Measuring the impact of asset based approaches on health outcomes is complex, and evidence of the effectiveness of these approaches at present largely comes from case studies and small scale exploratory research.
- The move to including asset based approaches as an integral part of mainstream service delivery will require a change in individual and organisational attitudes, values and practice.

INTRODUCTION

For too long, it can be argued, professionals have concentrated on the problems, needs and deficiencies within communities. How we understand health and wellbeing determines the way we respond to it. Typically a community is seen from the perspective of its largest deficit. Assessing and building the strengths of individuals and the assets of a community opens the door to new ways of thinking about improving health and of responding to poor health.

Although many public health programmes have achieved considerable success in reducing mortality and morbidity, they often fail to capitalise on interventions that address the social context and conditions in which people grow, live, work and age, all of which have a powerful influence on health. Many of the key assets required for creating the conditions for health lie within the social context of people's lives and therefore have the potential to contribute to reducing inequalities.

Despite extensive efforts to improve health, concern continues to grow over the widening gap in health inequalities in Scotland and the UK as a whole and new thinking about how to address this more effectively is developing. For example, one of the key messages of The Marmot Review - Fair Society, Healthy Lives (2010; p.15) is that *"Effective local delivery requires effective participatory decision-making at local levels. This can only happen by empowering individuals and local communities"*. Asset based approaches provide an ideal opportunity for public bodies and their partners to respond to this challenge. Health services and local public services are all facing cuts in funding. Demographic and social change means that more people are going to be in need of help and support (Foot and Hopkins, 2010). New ways of working with individuals and communities will be needed if inequalities in health and wellbeing are to be prevented from widening further.

The recently published Commission on the Future Delivery of Public Services (Christie, 2011; p.viii) report has also highlighted and reinforced the need for new ways of working. The report clearly states that *"irrespective of the current economic challenges, a radical change in the design and delivery of public services is necessary to tackle the deep-rooted social problems that persist in communities across the country"*. To achieve this goal, a key objective of the reform programme must therefore be to ensure that *"public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience"* (Christie, 2011; p.26). Central to this reform process is the empowerment of individuals and local communities by involving them in designing and delivering the services they use and the requirement for public services to work in partnership with other organisations and communities to improve outcomes.

The aim of this briefing paper is to present the current evidence and thinking on asset based approaches for health improvement, the background and rationale for these approaches, and the practical challenges of adopting these approaches in reality. It is also hoped that this paper will help stimulate policy makers, practitioners and researchers to think differently about how they might minimise the risks of widening health inequalities and approach the goal of improving the health of communities and populations. The discussion which follows summarises the thinking and propositions found in the literature and a range of sources of evidence on asset based approaches for health improvement. This will be further explored and tested through practical application and implementation of these approaches in Scotland.

WHAT IS AN ASSET?

"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing and to help to reduce health inequalities. These assets can operate at the level of the individual, family or community and population as protective and promoting factors to buffer against life's stresses" (Morgan and Ziglio, 2007; p.18).

Assets can therefore be described as the collective resources which individuals and communities have at their disposal, which protect against negative health outcomes and promote health status. These assets can be social, financial, physical, environmental, or human resources, for example employment, education, and supportive social networks (Harrison *et al.*, 2004).

Practically speaking assets can therefore be (Foot and Hopkins, 2010):

- the practical skills, capacity and knowledge of local residents
- the passions and interests of local people that give the energy to change
- the networks and connections in a community
- the effectiveness of local community and voluntary associations
- the resources of public, private and third sector organisations that are available to support a community
- the physical and economic resources of a place that enhance wellbeing.

Asset based approaches value the capacity, skills and knowledge and connections in individuals and communities. They focus on the positive capacity of individuals and communities rather than solely on their needs, deficits and problems. These assets can act as the foundation from which to build a positive future. The identification and mobilisation of an individual's or a community's assets can help them overcome some of the challenges they face.

The literature identifies the antecedents of health assets, both innate and acquired, as an individual's genes, values, beliefs and life experiences (Rotegard *et al.*, 2010). This means it is possible to identify health promoting or protecting assets from across the domains of health determinants including our personal and individual characteristics, our social circumstances, the environmental conditions in which we live and work, the behavioural choices we make and the health services we engage with.

Health and development assets span individual, community and organisational levels (Morgan and Ziglio, 2007). Identification of assets across these three levels would, as a minimum include at the:

- *individual level*: resilience, self-esteem and sense of purpose, commitment to learning
- *community level*: family and friendship or supportive networks, intergenerational solidarity, community cohesion, religious tolerance and harmony
- *organisational level*: environmental resources necessary for promoting physical, mental and social health, employment security and opportunity for voluntary service, religious tolerance and harmony, safe and pleasant housing, political democracy and social justice.

Although health assets are a part of every person, they are not necessarily used purposefully or mindfully. The literature supports the premise that health assets, either internal or external, can be leveraged and utilised in challenging situations, but how and if they are used depends on the individual (Rotegard *et al.*, 2010).

BUILDING ASSETS

Asset based approaches or positive approaches for improving health are not new. This concept has developed widely over the last few decades and such approaches are used by different health disciplines. Early psychiatry literature refers to the importance of 'assets' as a foundation for managing change (Beiser, 1971), and the health assets concept was introduced to nursing practice in the 1980s (Barkauskas, 1983). The term 'health asset' is also used in psychology (Petersen and Seligman, 2004), social sciences (Kolm, 2002) and more extensively in public health (Murray and Chen, 1993; Halfon and Hochstein, 2002; Friedl *et al.*, 2005). The public health literature focuses on developmental and environmental aspects of health assets discussed in the context of individuals (early childhood, youth), family and community (French *et al.*, 2001; Atkins *et al.*, 2002; Murphey *et al.*, 2004; Kegler *et al.*, 2005).

Community development approaches, founded on asset principles and participatory in nature, have operated in diverse contexts around the world under a range of names for many years. These include: Strengths Based Approaches (USA), Sustainable Livelihoods Approach (UK), Paulo Freire Liberation Theology (Brazil), Self Reliance Movement (Tanzania, East Africa) and Training for Transformation (South Africa) (O'Leary *et al.*, 2011). As information and practitioners move around the world, these approaches continue to evolve and adapt to local contexts.

Asset based approaches are already operating effectively in a number of areas across Scotland. Many examples of asset based work may not use 'asset' terminology but may use other terms such as 'community engagement', 'community development', 'enablement', 'recovery', 'self-management', 'community empowerment' and 'mutuality' to describe their approach. These terms all however share the key features of asset based approaches which value the positive capacity, skills and knowledge and connections in a community.

REBALANCING ASSETS AND NEEDS

Asset based approaches are concerned with identifying the protective factors that support health and wellbeing. They offer the potential to enhance both the quality and longevity of life through focusing on the resources that promote the self-esteem and coping abilities of individuals and communities (Morgan *et al.*, 2010).

Traditionally, health care services have focused on identifying the actual or potential health problems of individuals and providing interventions to solve, alleviate, or prevent those problems. At a population level, this more familiar 'deficit' approach focuses on problems, needs and deficiencies – such as deprivation, illness and health damaging behaviours. It designs services to fill the gaps and fix the problems. From this perspective, the primary emphasis of problem oriented care is on professional observations and interventions on behalf of the individual, with little focus on enhancing the individuals' strengths and capabilities (Rotegard *et al.*, 2010). Furthermore, this perspective pays little attention to an individual's experiences, preferences, perspectives and knowledge. As a result, individuals can feel disempowered and dependent on services; people can become passive recipients of services rather than active agents in their own lives (Foot and Hopkins, 2010). Accentuating the positive capabilities and nurturing the strengths and resources of people may therefore allow them to identify problems and activate solutions for health and wellbeing that promote their self-esteem and resilience, leading to less reliance on professional services and to improved health outcomes.

Understanding people in totality also resonates with earlier articulations of the social model of health (Dahlgren and Whitehead, 1991) which challenged the deficit approach of the medical model, and proposed the need for services to be more aware and recognise the impact of people's wider environment and individual experiences and choices on health (WHO, 1986).

Likewise, most vulnerable or marginalised communities in our society, as well as having needs and problems, also have social, cultural and material assets. Identifying and mobilising these assets and strengths can help them overcome the challenges they face. A growing body of evidence shows that when services begin with a focus on what communities have (their assets) as opposed to what they do not have (their needs) a community's efficacy in addressing its own needs increases, as does its capacity to lever external support (Foot and Hopkins, 2010). Asset based approaches support the building of local networks that create reciprocity, mutual help, supportive friendships and the capacity to act together in their shared interests. Such approaches rally and foster the resources in every community. A strong sense of community, active citizens and empowered and independent organisations and networks can create solutions to activate change. They can strengthen the ability of individuals and communities to act as co-producers of health rather than simply consumers, reducing demand on scarce resources. An asset based approach may also help communities to develop a greater confidence and a stronger voice with which to engage with systems in addressing structural causes of injustice and inequalities.

Asset based approaches do not replace investment in improving services or tackling the structural causes of health inequalities. They may however reduce demand and dependency on services in the long term and bring about more effective and efficient services. The case for asset working rests on achieving a better balance between responding to needs, providing the services that only public services and governments can do, and respecting the resources and potential of asset rich individuals and communities.

ASSETS IN ACTION

Adopting an asset based approach to traditional epidemiological risk factors could provide new ways of challenging health inequalities, improving wellbeing, changing attitudes, strengthening local communities and complementing mainstream service delivery.

Reducing health inequalities

Reducing the gap in health inequalities is a matter of fairness and social justice. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health (Marmot, 2010). In Scotland, extensive and far-reaching efforts to improve health and wellbeing over the last few decades have produced steady improvements in health. However the healthy life expectancy of the most deprived communities has increased at a slower rate than that of the most affluent communities (Scottish Government, 2009) so the gap is getting wider. Current approaches are not working, or are not working well enough to reduce health inequalities.

While there is an extensive body of evidence describing which groups and populations suffer the worst health and what the social, behavioural and environmental risk factors are, there is little definitive evidence on how best to act to reduce the gap between populations and improve health and wellbeing. As reported in a number of national and international reviews, there is a lack of evidence about the effectiveness and cost-effectiveness of policies, programmes and projects in reducing inequalities in health (Scottish Government, 2008; WHO, 2008).

While an asset based approach will not on its own tackle health inequalities, a number of asset principles may provide support towards achieving that goal alongside existing efforts. These include (Foot and Hopkins, 2010):

- targeting appropriate areas or communities to work in
- allowing time for communities to realise and acknowledge their individual and collective assets and to rebuild their confidence and networks
- using asset based methods or techniques that enable local people to take the lead
- rebuilding trust with communities by making changes in services.

However, on the other hand, it is also conceivable that the adoption of asset based approaches may increase health inequalities. There is evidence that more advantaged groups in society find it easier to change their health behaviours due to better access to resources such as time, finance and the coping skills to uptake health promotion advice and preventative services (Macintyre, 2007). It will therefore be important to carefully consider what approaches are encouraged and the methods and techniques which are used to engage communities and individuals to prevent increasing health inequalities. Some of the most powerful influences on behaviour change are friends and family, and a collective sense of self-esteem, helping people believe that it is possible to take positive actions to improve health and wellbeing (Foot and Hopkins, 2010).

Improving wellbeing

The concept of wellbeing is about lives going well. It is the combination of feeling good and functioning well (Hubbert, 2009). Feelings of happiness, contentment, enjoyment, curiosity and engagement are characteristics of someone who has a positive experience of life. Equally important for wellbeing is our functioning in the world. Experiencing positive relationships, having some control over one's life and having a sense of purpose are all important attributes of wellbeing (Hubbert, 2009). These 'assets' determine an individual's level of personal wellbeing and their ability to interact and engage with the community and world around them.

In recent years, there has been a noticeable shift of focus in the wellbeing research literature from an emphasis on disorder and illness (deficits approach) to a focus on wellbeing (assets approach). In a review of the evidence on how individuals can improve wellbeing, the New Economics Foundation (Aked *et al.*, 2008), as part of the UK Government's Foresight project, identified five actions to improve wellbeing that individuals could be encouraged to build into their lives:

1. *Connect* – developing strong relationships and social networks
2. *Be active* – more exercise and play improves wellbeing
3. *Take notice* – self-awareness and the importance of developing social and emotional literacy
4. *Keep learning* – social interaction, self-esteem and feelings of competency
5. *Give* – reciprocity, trust and helping others – studies show that co-operative behaviour activates the reward area of the brain.

Community and neighbourhood empowerment, that is "*the process whereby people work together to make change happen in their communities by having more power and influence over what happens to them*" (Scottish Government, 2009; p.18.) also has the potential to improve the wellbeing of individuals and communities. Furthermore, work by The Young Foundation on happiness and wellbeing demonstrated that successful community empowerment can be achieved in three ways: giving control – by giving people greater control to influence decisions; supporting contact – by facilitating social networks and regular contact with neighbours; and building confidence – by enabling people to have confidence in their capacity to control their own circumstances (Bacon *et al.*, 2010).

DEVELOPING AN ASSET BASED APPROACH

An asset based approach, as presented here aims to redress the balance between evidence of effectiveness about 'what works' derived from the identification of problems (a deficit approach) to one which puts emphasis on positive attributes. Asset based approaches can jointly identify and activate solutions which promote the self-esteem of individuals and communities leading to less dependency on public services.

Asset based approaches add value to the deficit approach:

- by identifying the range of protective and health promoting factors that act to support health and wellbeing
- by promoting the population as a co-producer of health rather than simply a consumer of health care services
- by strengthening the capacity of individuals and communities to realise their potential for contributing to health development
- by contributing to more equitable and sustainable social and economic development (Morgan and Ziglio, 2007).

Subsequent policies and initiatives may be more effective in tackling inequalities by taking account of the positive attributes already existing in individuals and communities rather than being based on a foundation of negative outcomes.

In reality, however, both approaches are important although further work needs to be done to redress the balance between the more dominant deficits approach and the emerging and less well known and understood asset based approach. An asset based approach provides a framework for establishing a new understanding of how to collect and synthesise evidence (based on the theory of salutogenesis) to demonstrate the benefits of asset based approaches for population health and how to utilise examples of effective practice that strengthen individual and community capacities, promote independence and autonomy and help to reduce the gap in health and life chances (Morgan and Ziglio, 2007).

WHAT THEORY UNDERPINS TAKING ASSET BASED APPROACHES FOR HEALTH IMPROVEMENT?

Asset based approaches for evidence informed public health recognise that interventions which focus on the needs or problems of populations are not sufficient for bringing about sustainable and equitable results. An asset based approach draws on a number of perspectives to help us understand the causes and mechanisms of inequities in health and potential solutions. This includes drawing on the theory of salutogenesis to investigate the key (salutogenic) factors or health assets that support the creation of health rather than the prevention of disease. In particular, it promotes the possibilities for individuals and communities to be co-producers of health rather than simply consumers of health care services. In doing so it emphasises the need for a focus on positive ability, capability, and capacity leading to less reliance on professional services, and reductions in the demand for scarce resources.

This perspective allows us to identify those factors which keep individuals from moving towards the disease end of the spectrum (Lindström and Eriksson, 2006). It can also help us to identify the combination of 'health assets' that are most likely to lead to higher levels of overall health, wellbeing and achievement. Specifically, the concept embraces the need to focus on people's resources and capacity to create health (Morgan and Ziglio, 2007). It is argued that the more individuals understand the world they live in, the more they can utilise the resources they have themselves and around them to maintain their own health.

Salutogenesis

Creating positive health, or *salutogenesis*, and developing ways to use this concept in health care has grown steadily over the past two decades, and has influenced discussions about how health is maintained and how health care is delivered. A salutogenic approach provides a particular perspective to the way health is viewed, which is centred on the discovery and use of personal resources (or assets), either inside a person or in the environment, that maintain a healthy status. This is opposed to the traditional view of health care, which focuses on the search for the causes of disease. In particular, theories about salutogenesis aim to explain why some people fall ill under stressful conditions and others do not.

The *salutogenic* approach has been described as a deep personal way of being, thinking and acting, a feeling of inner trust that things will be in order independent of whatever happens (Lindström and Eriksson, 2005). The core salutogenic concepts are *Generalised Resistance Resources (GRRs) and a Sense of Coherence (SoC)*. GRRs are biological, material and psychosocial factors which make it easier for people to understand and structure their lives. They include factors such as money, social support, knowledge, experience, intelligence and traditions. It is believed that if people have these kinds of resources available to them or in their immediate surroundings, there is a better chance they will be able to deal with the challenges of life (Lindström and Eriksson, 2005). While GRRs identify important 'ingredients', a sense of coherence (SoC) provides the capability to use them.

SoC is a positive way of looking at life alongside an ability to successfully manage the many stresses encountered throughout life. SoC is described as a mediator between a GRR (or asset) and an outcome of improved health and wellbeing, coping and control. SoC may therefore be the part of self-awareness (mobilisation) that releases one's health assets.

Three types of life experiences shape an individual's sense of coherence (Antonovsky, 1993):

- *comprehensibility* (life has a certain predictability and can be understood)
- *manageability* (resources are enough to meet personal demands)
- *meaningfulness* (life makes sense, problems are worth investing energy in)

More recently, a fourth concept has been added, *emotional closeness,* which refers to the extent to which a person has emotional bonds with others and feels part of their community (Sagy and Antonovsky, 2000).

A recent systematic review came to the conclusion that the salutogenic model is a health promoting resource in that it defines the means by which individual resilience may be improved and people may be helped to feel physically and mentally healthy, with a good quality of life and sense of wellbeing (Eriksson and Lindström, 2006). However, while the salutogenic approach provides us with a theory through which we can understand how health comes about and can be maintained, there is little evidence at present of how salutogenic concepts can be put to good use in policies to help people and communities.

WHY DOES SCOTLAND ENDORSE THIS APPROACH?

To embed and endorse asset based approaches in Scotland the identification and strengthening of health assets need to be key components in national and local health and social policies.

Asset based approaches build on a long history of investment by the Scottish Government and NHS Scotland in community led approaches to health improvement. Specifically these approaches and ways of thinking have been highlighted and reinforced by the 2009 Annual Report of the Chief Medical Officer (Scottish Government, 2010). The Chief Medical Officer asks whether 'it is time to (consider a) change' in the methods we currently use to improve health and to move to more upstream asset based approaches to improve health outcomes. He proposes that asset based approaches may provide the necessary step change in health creation which Scotland needs to accelerate gains in healthy life expectancy across the population.

From a Scottish health policy point of view, clear support for and links to an asset based approach are already evident as detailed in the examples below:

- **Equally Well**
  The 2010 Review of Equally Well, the Ministerial Task Force on Health Inequalities, promotes asset based approaches as a means for tackling the underlying causes of health inequalities (Scottish Government, 2010). Many of the Equally Well test sites are adopting asset based approaches when working with local individuals and communities.
- **Scottish Government community led initiatives**
  Community led approaches to health improvement focus on supporting communities experiencing disadvantage and poor health outcomes. Support and investment to communities is provided through the delivery of the Community Health Exchange (CHEX) and the Health Issues in the Community (HIIC) capacity building programme.
- **Assets Alliance Scotland**
  To provide support and endorsement for embedding asset based approaches in Scotland, in December 2010, the Scottish Government, in partnership with the Scottish Community Development Centre (SCDC) and the Long Term Conditions Alliance Scotland (LTCAS), held an event designed to take forward the Assets Alliance in Scotland (SCDC, 2011). Initiated and supported by the Chief Medical Officer for Scotland, the event recognised that asset based approaches are not new and that many initiatives in Scotland already demonstrate working this way. Communicating and promoting the value of an assets based approach, enhancing and further developing what already exists, and the Alliance being a central point for knowledge and experience exchange were some suggestions on the future form and key functions of a meaningful, productive and influential Assets Alliance in Scotland.

- **Mental health improvement**
  Mental health improvement is a national public health priority for Scotland. Recognising an individual's assets is a key principle underpinning good mental wellbeing. The concept of mental wellbeing includes both how people feel – their emotions and life satisfaction – and how people function – their self acceptance, positive relations with others, personal control over their environment, purpose in life and autonomy (Scottish Government, 2009).

  Until recently, there had been no assessment of the overall mental health of Scotland's population, without which it is difficult to determine whether mental health is improving in Scotland. There is now however a growing number of scales designed to measure positive mental health and wellbeing (Parkinson, 2008) and the distinction between measuring mental illness and measuring mental health is now formally recognised in Scotland, in the Warwick and Edinburgh Mental Wellbeing Scale (WEMWBS) (Parkinson, 2006).

To further embed this approach in mainstream service delivery, community development and engagement, and policy and practice, Scotland must continue to recognise and build on the positive aspects and collective abilities of individuals and communities instead of focusing on the negatives, and support individuals and communities to have more control over their own circumstances.

IMPLEMENTING ASSET BASED APPROACHES: PRACTICAL CHALLENGES

Implementing asset based approaches in Scotland will be a complex undertaking and will require capacity and commitment to work across traditional professional and organisational boundaries. It is unclear from the evidence available at present how the underpinning concept and supporting theory will translate into effective practice and how adopting this approach will impact on how services are currently organised, undertaken and delivered. This will require public services and their partners to reframe their models of service delivery in health, social care and beyond. The move to including asset based approaches as a normal part of the way services are delivered will require a change in individual mindset and in organisational values, attitudes and beliefs. This important step may pose a major challenge as shown with previous experience of organisational change and restructuring and the introduction of the personalisation agenda in England (HM Government, 2007). For many staff and professionals this represents a new way of working, and training and skills development will be required, a further demand on our public services within the current economic climate.

Adopting an asset based approach is community led, long term, open ended and has less certain, unpredictable outcomes, which are likely to take time to emerge. This approach is not a 'one size fits all' approach and will require careful negotiation on an individual basis when working with communities and the building of trust between community members and professional staff. The nature of an asset based approach means that it is a bottom up way of working, with each community recognising and combining their assets and defining their ambitions in a very local way. It will also be important to distinguish between the 'needs' that can be met by family, friends and social networks, those that will be best met through cooperation between services and communities, and those that can only be delivered through mainstream services. This will not happen on its own; it will need to be mapped, planned and commissioned.

To continue tackling the growing health divide, asset based approaches should be embedded alongside, and be complementary to, traditional health promotion interventions and existing efforts to improve health and wellbeing. The adoption of asset based approaches will not on their own tackle health inequalities and should therefore be recognised as one component in a multi-faceted approach to accentuating positive capability and encouraging the participation of individuals and communities in the health development process. Working to improve health enhancing assets must not only focus on the psychosocial assets such as skills, confidence and self-esteem but also on the social, economic, cultural, physical and environmental factors that influence inequalities in health and wellbeing.

Asset based approaches are not a no-cost or money saving option. Investment in the development of individuals and communities requires both long term commitment and finance, and involves targeting those communities which are fragmented and poor in terms of social capital and local support networks (SCDC, 2011). Investment will be required to strengthen and support local networks and associations, and it will take time to build up local confidence and a sense of empowerment. Embedding asset based approaches requires a change in the way public services are delivered, moving to a model of co-production (effective collaboration and mutual responsibility) and devolving control from decision makers to individuals and communities. A mobilised and empowered community will not necessarily choose to act on the same issue that health services or local councils see as the priorities (Foot and Hopkins, 2010). This may also require a move away from a culture of Government led governance structures and performance management measures. Professional staff and services have to be willing and open to sharing power: instead of doing things to or for people, they have to help a community do things for itself. Struggling communities cannot be expected to achieve change on their own. An opportunity exists, in a time of financial restraint, to invest long term in communities rather than dealing with problems when they arise (SCDC, 2011).

While adopting the principles of asset based approaches for health improvement will lead to new kinds of community based working, these principles could also be utilised to refocus and redesign many existing mainstream services to become more person centred, in a way which is empowering and which can ultimately lead to reduced dependency on public services.

DEVELOPING AN EVIDENCE BASE FOR ASSET BASED APPROACHES

The development of the early evidence base for public health interventions was influenced by deficit or treatment models of health. However there is now a large and growing body of research and systematic review evidence to inform and guide public health interventions and health improvement approaches. Much of the emerging evidence described as taking an asset based approach to community development and improving community circumstances comes from case study research, small scale evaluations and exploratory primary research.

In terms of *individual assets*, there are at present a limited number of robust evaluations of actions aimed at strengthening individual capacities as a way of creating healthy communities and individuals (Morgan and Ziglio, 2010). The evidence for the mental health impacts of interventions relating to many individual and community assets was reviewed to inform the development of Scotland's mental health improvement outcomes framework (NHS Health Scotland, 2010). In terms of primary research on the associations between

individual assets and health outcomes, a large systematic review showed that sense of coherence was strongly related to health and seems to be a health promoting resource, which strengthens resilience and develops a positive subjective state of health (Eriksson and Lindström, 2006). A strong sense of coherence has also been shown to be related to a lower rating of stress for given life events (Amirkhan and Greaves, 2003), to be a predictor of onset of depression (Sairenchi *et al.*, 2011) and to be related to less emotional distress and lower levels of anxiety (Hart *et al.*, 1991). There is also a growing evidence base that recognises resilience as an asset to avoid high risk behaviour or the ability to prosper in the face of deprived socioeconomic circumstances (Bartley, 2006). It has been stated that strategies that promote resilience and other psychological resources, such as sense of coherence and self-esteem, will also contribute to problem reductions and prevention (Stephens *et al.*, 1999).

In terms of *community assets*, a body of evidence of association supports the positive role of social relationships and social networks on mental health and mortality and morbidity (Holt-Lunstad *et al.*, 2010). Current evidence also indicates that the quality and/or quantity of social relationships in developed countries are decreasing and, despite increases in technology, people are becoming socially more isolated. Social relationships are believed to be associated with protective health effects through more direct means, such as cognitive, emotional, behavioural and biological influences that are not explicitly intended as help or support (Holt-Lunstad *et al.*, 2010). In addition, being part of a social network is said to give individuals meaningful roles that provide self-esteem and a purpose in life (Cohen, 2004). Furthermore, individuals with a number of types of social relationships and networks live longer, have less cognitive decline with aging, greater resistance to infectious disease and a better prognosis when facing chronic life-threatening illnesses (Cohen and Janicki-Deverts, 2009). Evidence is also available that disadvantaged communities which are more cohesive are likely to maintain health (Kawachi *et al.*, 1997). Health and community cohesion are said to be inextricably linked. Health tends to decline (with premature mortality and increased morbidity, particularly in stress related conditions) in communities where levels of interaction are low and where people feel insecure. In more cohesive communities the reverse is true and it is much easier for public services to develop a dialogue with local people and to be sure that services are meeting local needs (Institute of Community Cohesion). Where conditions are favourable, social and community cohesion increases social capital and reduces health inequalities (The Smith Institute, 2008).

Finally when considering research in relation to *organisational or population assets*, it is well established that adult health and health related behaviours tend to be worse in more disadvantaged areas, even after controlling for individual characteristics, such as income and education. This has been associated with the broad idea that, in general, environmental characteristics in poorer areas are detrimental to health and healthy living and do not promote physical, mental and social health (Macintyre *et al.*, 1993). Living in safe and pleasant housing has also been recognised as being not just of benefit to the occupiers but also to the wider community and to society, by improving community cohesion and connectedness, reducing crime, improving employment opportunities and educational achievement (Steptoe and Feldman, 2001). Furthermore organisational assets such as volunteering have been shown to convey individual health benefits in addition to wider social benefits. Positive effects are found for life-satisfaction, sense of purpose, self-esteem, self-rated health, and for educational and occupational achievement, functional ability, and mortality. Studies of youth volunteering also suggest that volunteering reduces the likelihood of engaging in problem behaviours such as school truancy and drug abuse (Wilson, 2000; Post, 2005).

PUTTING ASSET BASED APPROACHES INTO PRACTICE: METHODS FOR IDENTIFYING ASSETS

A number of methodologies are available for supporting the identification, collection and measurement of asset based approaches in the community. The selection of methods and techniques presented below are not restricted to asset working, however their principles and objectives focus on identifying and sharing the values of discovering and mobilising what individuals and communities have to offer. These different methods are often used in combination with one another.

- **Asset Based Community Development (ABCD)**

  Asset Based Community Development (ABCD) is an approach to community based development founded on the principles of appreciating and mobilising individuals and community talent, skills and assets (rather than focusing on problems and needs) and is community driven development rather than development driven by external agencies (Cunningham and Mathie, 2002). ABCD draws on:

  - *Appreciative* inquiry which identifies and analyses past successes, strengthening confidence and inspiring action
  - The recognition of *social capital* (the connections within and between social networks) and its importance as an asset
  - *Participatory approaches to development* based on the principles of empowerment and ownership of the development process
  - Collaborative community development models that place priority on making the best use of the community's resource base
  - Efforts to strengthen *civil society* by engaging people as citizens in community development, making local services more effective and responsive (Mathie and Cunningham, 2002).

  The ABCD process involves the community in making an inventory of assets and capacity, building relationships, developing a vision for the future, and leveraging internal and external resources to support actions to achieve it. Building on the skills of local people, the power of local associations and the supportive functions of local institutions and services, asset based community development draws upon existing strengths to build stronger, more sustainable communities for the future. By encouraging pride in achievements and a realisation of what they have to contribute, communities create confidence in their ability to be producers not recipients of development (Foot and Hopkins, 2010).

- **Asset mapping**

  Asset mapping is one of the key methods of asset working. It is described as a process of building an inventory of the strengths and contributions of the people who make up a community prior to intervening. Asset mapping reveals the assets of the entire community and highlights the interconnections among them, which in turn reveals how to access those assets (Kretzmann and McKnight, 1993). It enables individuals to think positively about the place in which they live or work and challenges individuals to recognise how other people see and experience the same community.

Asset mapping involves documenting the tangible (physical assets e.g. parks, community centres, churches) and intangible (personal assets e.g. experiences, skills, knowledge, passion) resources of a community, viewing it as a place with assets to be preserved and enhanced, not deficits to be remedied. Beyond developing a simple inventory, this 'mapping' process is designed to promote connections or relationships between individuals, between individuals and organisations, and between organisations with other organisations. Asset mapping has been promoted as a positive, realistic and inclusive approach to building the strengths of local communities towards health improvement for all (Guy *et al.*, 2002).

- **Co-production**

Co-production essentially describes an equal and reciprocal relationship between service provider and service user that draws on the knowledge, ability and resources of both to develop solutions that are claimed to be successful, sustainable and cost-effective, changing the balance of power from the professional towards the service user (SCDC, 2011). It involves the active input by the people who use the services, as well as, or instead of, those who have traditionally provided them, (Needham and Carr, 2009) effective collaboration on what to do and taking mutual responsibility for agreed actions. The key characteristics of co-production exemplify asset based principles (Stephens *et al.*, 2008):

- Recognising people as assets rather than as problems
- Building on people's existing skills and resources
- Promoting reciprocity, mutual respect and building trust
- Building strong and supportive social networks
- Valuing working differently, facilitating rather than delivering
- Breaking down the divisions between service providers and service users.

Co-production means involving individuals and communities in collaborative relationships with more empowered frontline staff who are able and confident to share power and accept user expertise (Needham and Carr, 2009). Co-produced services work with individuals in a way that treats individuals as people with unique needs, assets and aspirations, but also as people that want support that fits around them (Slay and Robinson, 2011).

- **Appreciative inquiry (AI)**

Appreciative inquiry (AI) is a process for valuing and drawing out the strengths and successes in the history of a group, a community or an organisation. It is a method of consulting the community based on what is good about something as opposed to what is bad. AI works to create a positive mindset by talking about successes rather than being defined by past failures. The inquiry starts with appreciating the best of what is, thinking about what might be and should be, and ends with a shared commitment to a vision and how to achieve it (Foot and Hopkins, 2010).

- **Participatory appraisal (PA)**

Participatory appraisal (PA) is a methodology that creates a cycle of research, information collection, reflection and learning. It is a broad empowerment approach that seeks to build community knowledge and encourages collective community action. The key feature of PA is that local community members are trained to research the views, knowledge and experience of their neighbourhood. This allows local people to input their expertise into creating a shared future. Although these methods are mainly used to research needs and priorities, they can be used to collect information about local skills and resources in line with the principles of asset based approaches. Participatory appraisal aims to engage meaningfully with local residents, ensuring that they are listened to and prioritises their views. The opinions and concerns of local people have a central role in the process. These methods fit alongside other capacity building approaches by increasing skills and knowledge as well as building trust and confidence in the community.

MEASURING ASSETS: METHODOLOGICAL CHALLENGES

Asset based working and the development of an evidence base to support asset based approaches poses a number of practical and methodological challenges for researchers and practitioners. Although asset based approaches are not new there is the need to develop methods of evaluating practice and generating evidence of effectiveness that are robust enough to demonstrate that these approaches represent value for money if asset based working is to be widely implemented.

The development of the evidence base on asset based approaches needs to agree and articulate what the most important assets are for positive health and how policy and practice can support individuals, communities and organisations to utilise them for health gain (Morgan and Ziglio, 2007). The development of a new set of indicators used to evaluate programmes and initiatives that are developed to promote health and which will identify and communicate successes, and potential failures, are required to allow these approaches to be embedded in service delivery. There is also the requirement for agreed definitions of key assets and related concepts, such as connectedness, sense of purpose, social capital, community cohesion and community empowerment, to ensure consistency across the evidence base and allow transferability of research findings and approaches. Furthermore there is the important need for the evidence base to draw on and communicate the practical experiences of the people working most closely with communities to understand how these assets can be realised in real life settings. Finally, further research, is required to convince policy makers and planners of the economic benefits of investing in an asset based approach.

SUMMARY

Asset based approaches to health improvement are geared towards accentuating positive capabilities and activating solutions for health promotion action. Assessing assets alongside needs will give a better understanding of the health of individuals and communities and help to build resilience, increase social capital and develop a better way of providing services in the future. Assets driven work, if implemented successfully, could have a transformative effect on individuals, on social relationships between and among people, and with external agencies and organisations.

However, none of the ideas, concepts or techniques discussed here can be brought to practical value unless researchers, policy makers, professional staff and practitioners embrace positive approaches to health and importantly focus on health and wellbeing rather than ill health and disease. Redressing the balance between the asset and deficit approaches could help us unlock some of the existing barriers to effective action on health inequalities (Morgan and Ziglio, 2007). This re-balancing would help us better understand the factors that influence health and what can be done about them. Asset based approaches provide an opportunity to:

- make more explicit the concepts of wellbeing and its associated precursors
- demonstrate how they can be measured, and
- challenge professionals involved in health development to rethink their strategies for promoting health (Morgan *et al.*, 2010).

More careful investment might then bring the longer term gains required to promote the best health we can and help us manage the limited resources available in our health system.

The adoption of asset based approaches as an integral part of mainstream services has exciting potential and could help professionals think differently about how they approach the goal of improving the health of individuals, communities and populations. The move to focusing on the positive capacity of individuals and communities rather than solely on their needs, deficits and problems, could bring multiple long terms benefits for individuals, families, communities, public services and society as a whole.

LOOKING AHEAD

This briefing paper has presented an overview of the evidence on asset based approaches for health improvement. Although taking a positive approach to improving and sustaining health is not new, the preparation of this paper has raised a number of issues and challenges which are worthy of further consideration. These include:

- the measurement of assets and the practical application of research methods with communities
- evidence of the effectiveness of asset based approaches
- the applicability of asset based approaches in tackling health inequalities
- the practical and everyday challenges of adopting this approach
- the relevance of asset based approaches to a wider range of outcomes rather than only health improvement.

This paper has drawn together evidence available from a range of sources to give an overview of assets based approaches, and in doing so we are aware that we have not covered particular aspects in depth. To allow further discussion and debate and a focus on specific areas of interest, the areas outlined above will be explored further and presented in future briefing papers. However, in moving on from considering the available evidence to fully understanding the value and implications of asset based approaches we wish to engage with as wide an audience as possible and to open an opportunity for feedback, comment and learning from experience and practice. If you would like to contribute to this process please submit comments by e-mail to gcphmail@glasgow.gov.uk or by post to the address on the back of this paper.

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