# What makes us healthy?

## The asset approach in practice: *evidence, action, evaluation*

By Jane Foot

**The follow-up to 'A glass half-full: how an asset approach can improve community health and well-being'**

# Foreword

## by Professor Sir Michael Marmot

The English Review 'Fair Society, Healthy Lives'[1] brought together the best available global evidence on health inequalities. That evidence highlighted that health inequalities arise from social inequalities in the conditions in which people are born, grow, live, work and age. In England, the poorest people can expect to become ill or experience disability 17 years earlier than the most well off, and can expect to die seven years earlier.

The evidence is clear: health inequalities are driven by underlying social factors and action is required to address these causes of the causes. This includes early years care, education and training, housing and place-shaping, work and employment, transport and the environment and prevention. It requires robust partnership working at a national and local level. The White Paper Healthy Lives, Healthy People adopts and endorses many of the recommendations of the review and in particular transfers many public health functions from the NHS to local councils. This is a positive move and opens up opportunities for local authorities to lead local partnerships in finding local solutions which empower local people and communities by creating the conditions within which they can exercise greater control over their lives and health.

The review highlights that the health and wellbeing of people is heavily influenced by their local community and social networks. Those networks and greater social capital provide a source of resilience. The extent to which people can participate and have control over their lives makes a critical contribution to psychosocial wellbeing and to health. Taking an asset-based approach at a local level fosters greater local confidence and self-esteem for people and communities. It moves beyond routine consultation, opening the way for radical reform in taking upstream preventative action to foster individual and communal health, wellbeing and resilience, and building local confidence, capacity and capability to take action as equal partners with services in addressing health inequalities.

This paper builds on an earlier publication 'A glass half-full: how an asset approach can improve community health and wellbeing' and is both stimulating and challenging. It promotes different ways of engaging local communities in co-producing local solutions and reducing health inequalities.

**Professor Sir Michael Marmot**
Chair of the Strategic Review of Health Inequalities in England

1 Marmot M, Allen J, Goldblatt P, Boyce T, McNeish D, Grady M, and Geddes I (2009) Fair Society,Healthy Lives.Marmot Review

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Author – Jane Foot



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His website is located at www.assetbasedconsulting.net

I am honoured that Professor Sir Michael Marmot has written the forword in support of an asset based approach to challenging health inequalities. Lynne Friedli, Antony Morgan and Jude Stansfield were generous with their time and support of the work and the writing. I am also grateful to the five authors of the specially commissioned articles that make up Chapter two, and introduce Chapter four which make a powerful argument for asset based working.

Jane Foot and Trevor Hopkins would like to thank all those who participated in the second seminar on assets approaches at Warwick University in Autumn 2010, and those who contributed examples of their work and thinking.



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# Introduction

## by Jane Foot and Trevor Hopkins

Since we wrote 'A Glass Half Full' in 2010, interest in asset based working in health and wellbeing has mushroomed. It is being implemented and tested in many local areas and in both professional and community settings. The asset approach has found its way into reports, guidance and research on the future of public health, social care and wellbeing. 'Co-production for health – a new model for a radically new world' NHS National Colloquium (2011) has "promote an asset based approach to communities to understand and harness their assets and resource" as one of its key messages. 'Improving outcomes and supporting transparency – the public health outcomes framework for England' Department of Health (2012) recommends an indicator for "social connectedness" and refreshed Joint Strategic Needs Assessments should include information on assets and strengths. In late 2010 Dr Harry Burns, Chief Medical Officer for Scotland, launched 'An Assets Alliance Scotland' with the express purpose of improving the health and wellbeing of people in Scotland.

A purely deficit based approach, targeted on the needs of the 'worst', has demonstrably not reduced the social gradient in health; health inequalities remain stubborn and in most areas the gap is growing. (Marmot 2010). There is a growing recognition that we need to concentrate our efforts as much on improving and sustaining good health and positive wellbeing as we do on identifying risk, preventing illness and reducing premature death. The new Health & Wellbeing Strategies recognise that good health is not solely down to the NHS and that councils and partners have a pivotal role influencing and safeguarding the material, social and psychosocial determinants of health. Working with communities as equal partners that bring strengths and assets to the table, rather than seeing them as places of need and deficiency, helps to mobilise all the resources in an area to promote and protect sustainable health and wellbeing.

'What makes us healthy?' responds to the many requests for help we have received from public health, local government services and community organisations. They wanted more information on the evidence for the beneficial effects of assets such as social relationships and networks on health and wellbeing; ideas about how to put asset principles into practice; and help with assessing whether the new ways of working are having an impact. We hope this publication will inspire and support those who want to look again at what they are doing to improve health and wellbeing and to tackle health inequalities.

Asset based working is not an alternative to properly funded public services. It challenges how those services are designed and delivered and requires a recasting of the relationship between commissioners, providers, service users and communities. It puts a positive value on social relationships and networks, on self confidence and efficacy and the ability to take control of your life circumstances. It highlights the impact of such assets on people's wellbeing and resilience and thus on their capacity to cope with adversity including poor health and illness. These are things that need nurturing and supporting more than ever.

Jane Foot and Trevor Hopkins

February 2012

# Key messages: What makes us healthy?

**"Focusing on the positive is a public health intervention in its own right"[2]**

1. This publication argues that asset principles help us to understand what gives us health and wellbeing. It makes the case for developing ways of working that protect and promote the assets, resources, capacities and circumstances associated with positive health for everyone.
2. The research evidence for the positive impact of community and individual assets such as resilience, self determination, reciprocity, social networks and social support on health and wellbeing is well known and at least comparable to that of more familiar social determinants of health such as housing, income and the environment.
3. 'Asset thinking' challenges the predominant framing of health as the prevention of illness and injury, instead, looking at it as the promotion of wellness. It is possible to 'get ill better' because good wellbeing tends to mean that people seek help earlier and recover quicker.
4. Asset working can promote mental wellbeing which is both a cause and a consequence of inequality and physical ill health. Positive feelings about one's life, self-esteem, control, resilience and a sense of purpose influence levels of mental wellbeing. The capacity and motivation to choose healthy behaviours is strongly influenced by mental wellbeing as well as by socio-economic factors.
5. Work to improve health-enhancing assets has not only to focus on psychosocial assets but also on the social, economic and environmental factors that influence inequalities in health and wellbeing. There is a debate about the balance to be struck between tackling socio-economic disadvantage, tackling risk factors and developing resilience and wellbeing.
6. Asset-based approaches complement services and other activities that are intended to reduce inequalities in life chances and life circumstances, and which meet needs in the community.
7. The defining themes of asset-based ways of working are that they are place-based, relationship-based, citizen-led and they promote social justice and equality.
8. To evaluate health asset-based activities requires a new approach. Instead of studying patterns of illness, we need ways of understanding patterns of health and the impact of assets and protective factors. Methods that seek to understand the effects of context, the mechanisms which link assets to change, and the complexities of neighbourhoods and networks are consistent with the assets approaches. The participation of those whose assets and capacities are being supported will be a vital part of local reflective practice.
9. Assets require both whole system and whole community working. Instead of services that target the most disadvantaged and reduce exposure to risk, there is a shift to facilitating and supporting the wellbeing of individuals, families and neighbourhoods. It requires all agencies and communities to collaborate and invest in actions that foster health-giving assets, prevent illness and benefit the whole community by reducing the steepness of the social gradient in health.

2 Professor Sarah Stewart-Brown, Professor of Public Health at Warwick Medical School speaking at a conference on 'Measuring Well-being' 19 January 2011 at Kings College

# Chapter one: Introduction

How we understand health and wellbeing determines the way we respond to it. In 1948, the World Health Organisation[3] asked: "What makes us healthy? What brings us complete physical, mental and social wellbeing not merely the absence of disease and infirmity?" This is still a relevant and often neglected question which is particularly timely for local government as they take responsibility for promoting health and wellbeing.

This publication argues that asset principles can help us to understand what makes us healthy and gives us wellbeing in a new way. It makes the case for developing ways of working that promote the assets, resources, capacities and circumstances associated with positive health for everyone.

## Who is this publication for ?

The scope of this follow up to 'A glass half-full' (Foot & Hopkins IDeA 2010) was defined at a two-day learning event with elected members and practitioners from local government, public health, and those in the community sector who have seen the value of the assets approach and now want to implement it in their area. While the principles are not new, it is early days in the work to systematically apply them to improve health and wellbeing. If these ideas are to influence health and wellbeing strategies locally and nationally, more information on the evidence base, local examples of action and robust ideas for evaluation are required.

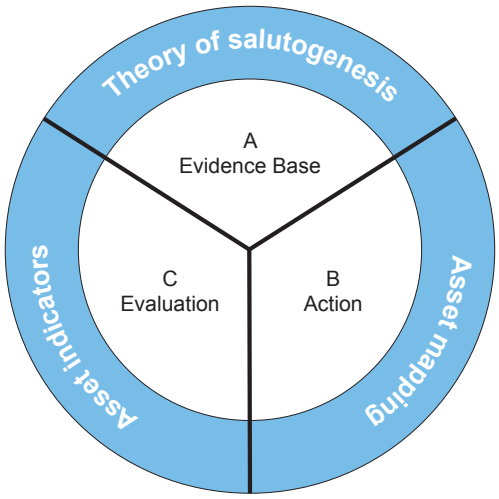



**Figure 1** – Morgan & Ziglio Revitalising the Public Health Evidence base; An Asset Model. In Morgan et al eds Health Assets in a Global Context. Springer 2010.

**Chapter two** summarises the debates and evidence for the impact of factors such as resilience, community networks, and social relationships on health and wellbeing. It contains four short pieces by distinguished researchers and analysts on 'what we know' about how an assets approach can improve health and wellbeing.

**Chapter three** outlines 15 examples of the new ways of working that are explicitly based in assets principles. It answers the question: What does it look like on the ground?

**Chapter four** tackles the tricky issue of how to evaluate asset-based approaches. It makes a start by suggesting some tried and tested frameworks that are consistent with asset principles and outcomes, and can be used to measure positive health.

3 https://apps.who.int/aboutwho/en/definition.html

## What is an assets approach?


'A glass half-full' (2010) introduced the assets principles:

- Assets are any resource, skill or knowledge which enhances the ability of individuals, families and neighbourhoods to sustain their health and wellbeing. "Assets can include such things as supportive family and friendship networks; intergenerational solidarity; community cohesion; environmental resources for promoting 'physical, social and mental health'; employment security and opportunities for voluntary service; affinity groups; religious toleration; life-long learning; safe and pleasant housing; political democracy and participation opportunities; and, social justice and equity." *(Hills et al. 'Asset based interventions; evaluating and synthesising evidence of effectiveness').*
- Assets approaches make visible, value and utilise the skills, knowledge, connections and potential in a community. They promote capacity, connectedness, reciprocity and social capital. The aim is to redress the balance between meeting needs and nurturing the strengths and resources of people and communities.
- Asset working seeks ways to value the assets, nurture and connect them for the benefit of individuals, families and neighbourhoods. Instead of starting with the problems, it starts with what is working, what makes us feel well and what people care about. The more familiar deficit approach starts with needs and deficiencies and designs services to fix the problem and fill the gaps. This creates dependency and people can feel disempowered. *(In Morgan et al eds Health Assets in a Global Context. Springer 2010).*

## The value for local government

Local government and their partners, local communities and neighbourhoods play a pivotal role in creating the conditions for good health and wellbeing for all, and in addressing the social determinants of health inequalities[4]. The changes in health governance and the focus on the material and psychosocial wellbeing of the whole population[5] offer an opportunity to local government to shape a new approach to achieving their goals.

The Health and Social Care Bill 2011 proposes powerful local mechanisms that can take the lead in the positive health agenda.

- The health and wellbeing boards will be able to bring together all parts of the public and voluntary sector who together can act on the social conditions that make us ill and the key factors determining inequality.
- The new health and wellbeing strategies can articulate how the wider influences on health such as housing, planning, environment, as well as health assets such as social networks and resilient communities, can be mobilised to improve wellbeing.

4 The social determinants of health and the role of local government (LGID 2010) www.idea.gov.uk/idk/core/page.do?pageId=17415112

5 The Role of Local Government in promoting wellbeing (LGID, nef, NMHDU 2010) http://www.nmhdu.org.uk/silo/files/the-role-of-local-government-in-promoting-wellbeing.pdf

- The new joint strategic needs assessments (JSNAs) will include information on both the needs and the assets in the area, and support commissioning strategies that actively seek to promote health assets as well as meet needs.
- Health scrutiny and local Healthwatch bring transparency, accountability and community involvement into the heart of local conversations about what can be done to improve health and wellbeing.

This framework makes local government particularly well placed to think differently about health and wellbeing goals and to engage with individuals, families and communities about what makes them healthy and gives them wellbeing. Asset-based approaches offer a relevant and effective way to sustain health-giving assets and support families and communities to mobilise their resources for their own wellbeing. It requires all agencies and communities to collaborate and invest in actions that foster health-giving assets, prevent illness and benefit the whole community by reducing the steepness of the social gradient in health.

## Local action for health and wellbeing

The Marmot Review 2010 demonstrated that the 'conditions in which people grow, live, work and age' have a powerful influence on our health, our life expectancy and how long we will live with life-limiting illnesses. These same conditions not only make us ill but they determine our access to health services and influence our lifestyle choices. The impact of social conditions can be seen in the continuing and striking social gradient in health. That is, the poorer your circumstances the more likely you are to have poor wellbeing, spend more of your life with life-limiting illness, and die prematurely. If social factors are the key determinants of inequality then they can be tackled through social action by governments, civil society and communities.

As we have seen, traditional risk-based and targeted programmes such as smoking cessation, healthy eating and encouraging physical activity are not enough to bring about health and wellbeing in a community. They do not give sufficient recognition to the fact that individuals, families and neighbourhoods are a potential health resource and not just consumers of health services.

Local strategies for health should identify and strengthen health assets both because they act as a buffer or source of resilience to risks to health, and because of their positive impact on health and wellbeing:

- Assets that promote or protect health include family and friendship support networks, community participation and solidarity, social justice and equity. The evidence on the links between subjective feelings of wellbeing or life satisfaction and improved health is becoming better known. Positive feelings about one's life, self-esteem, control, resilience and a sense of purpose influence levels of mental wellbeing which in turn impacts on physical and mental ill health.
- The capacity and motivation to choose healthy behaviours are strongly influenced by mental wellbeing as well as by socio-economic factors.

- Reciprocity, supportive networks and other indicators of social capital promote and protect both individuals and communities from conditions that reduce their wellbeing. “Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely.“ (Marmot 2010).
- Community building is a core activity for asset-based working. It is argued that a strong sense of community and solidarity, active citizens and empowered and democratic organisations can create solutions that are outside the capacity of public services. It strengthens the ability of individuals and communities to act as co-producers of health rather than consumers of health services, reducing demand on scarce resources.
- Services that exacerbate poor self-esteem, isolation or dependency are challenged to achieve a better balance between meeting needs through professional care and building on the existing capacities and resources of individuals, families and neighbourhoods.
- Assets are more than individual or community skills and resilience. Social or material assets such as level of income, housing, and educational achievement also determine levels of wellbeing. Lack of social justice and the unequal distribution of material assets not only affects individual health and feelings of wellbeing but also is correlated with levels of crime, drugs, violence, and the lack of cohesion that affects the majority. (Wilkinson & Picket 2009).

## A better balance between needs and assets

Assets are not the only answer to improving health and wellbeing and reducing health inequalities. In Chapter two, Friedli and Bartlett show there is a debate about the strength and weakness of asset-based working and its contribution to improved health and wellbeing and reduced health inequalities. Asset practitioners argue that their work intentionally sustains and nurtures the health-giving factors that act together to increase physical and mental wellbeing and support healthy behaviours. The challenge for local practitioners is to ensure that asset-based approaches complement, rather than replace, services and other activities intended to reduce inequalities in life chances and life circumstances.

# **Chapter two:** What we know – the evidence

There is growing evidence for the importance of health assets – broadly defined as the factors that protect health, notably in the face of adversity – and for the impact of asset-based approaches (that is, ways of working that promote and strengthen health assets). This chapter brings together four specially commissioned pieces by respected researchers giving their perspective on the research literature on both health assets and asset-based approaches.

- Mel Bartley: what we know about resilience.
- Mike Grady: what we know about social determinants, stress and social capital.
- Lynne Friedli: what we know about mental health and wellbeing.
- Tom Hennell: what we know about 'getting ill better': wellbeing, health and health behaviour.

Finally, this chapter provides a summary of the findings of a recent meta-analysis which looked at the strength of the evidence on the relationship between social networks and mortality. It also highlights the 'best buys' recommended as a result of an economic analysis of the impact and cost effectiveness of actions to prevent poor mental wellbeing and mental illness.

## What we know about resilience

**Professor Mel Bartley, Economic and Social Research Council Priority Network on Human Capability; Joint Director of the International Centre for Lifecourse Studies in Society and Health;[6] Editor of 'Capabilities and Resilience: Beating the Odds'[7]**

We know from many studies that people who experience socioeconomic disadvantage have much poorer prospects throughout their life course. There are, however, quite a few people who go through periods of poverty, unemployment, family breakdown and other social disadvantages and yet show resilience and go on to lead healthy and rewarding lives. This raises two questions: what are the underlying obstacles and barriers to 'doing well in the face of adversity' and what are the factors that research has found to encourage resilience over the life course?

### Early life

Adverse experiences in early life can influence subsequent development, and the ways in which individuals respond to stressful events occurring later in life. Yet early adversity does not necessarily lead to maladjustment.

6 www.ucl.ac.uk/capabilityandresilience/Intro.htm; www.ucl.ac.uk/icls/

7 www.ucl.ac.uk/capabilityandresilience/beatingtheoddsbook.pdf

### Parental warmth

Studies show that children need their parents to provide warmth and structure. People who have had a warm and secure relationship with their parents in childhood may have better mental health regardless of their social or economic circumstances in later life.

### Secure attachment

A warm parental style promotes resilience in part because of its relationship to 'attachment style'. A person's attachment style is the way in which she or he feels about relationships. Some people feel quite safe and trusting towards others while at the other extreme some people are very anxious or may avoid closeness for fear of being let down. Styles of attachment develop from early relationships with parents and carers and are maintained into adult life. Securely attached people seem to be better able to deal with difficulties that arise as they go through life.

### Poverty during parenthood

Because poverty and disadvantage influence the ways parents behave with their children, they can also have an indirect influence on how resilient they are if they meet problems later on. Families that feel economically secure are more likely to create a warm environment for children.

## Education

The longer a child remains living in poverty, the greater the risk to educational progress. Even for children who do well in early school years, growing up in a poor area can mean that their progress is slowed down. However, studies have found that these negative effects of family disadvantage can to some extent be decreased.

### Parental support and expectations

It is beneficial if parents support children in their school work and have high but reasonable expectations.

### Schools that foster resilience

What is also needed is a stimulating and well-funded school with an encouraging work ethos, which offers opportunities for activities outside the normal school curriculum. Where this is available, and where fellow students have a positive attitude towards education, it can make a lot of difference.

### Support for self-esteem

To increase the chances of educational success in children and young people who face difficulties at home, they need to be offered support that improves their psychological wellbeing. Self-confidence and self-esteem inspire greater motivation to overcome difficulties with school work that all children face.

### Support for aspirations

If parents and teachers of less advantaged children support their aspirations and feelings of self-confidence and self-esteem, then these children are more likely to turn things around, even after initially dropping out of school.

## Adult working life and relationships

Is having a good job important enough to sacrifice family life? In fact, research has shown that men and women pursuing a career and delaying parenthood are not more satisfied with their lives at age 30 than men and women already living as a two parent family. For some, a sense of fulfilment and accomplishment is just as well achieved through family life.

**Happiness does not depend only on income and status**

Traditionally people have been thought of as resilient if they overcome adversities and still manage to achieve a high income or occupational status. However, what seems to be more important for life satisfaction is being happy at work and participating in social relationships. High income and occupational status are less important.

**Supportive working relationships**

The importance of the quality of relationships both at work and at home needs to be recognised in the work environment. Work teams where there are good relationships between workmates are more productive and have lower levels of sickness absence. The same is true of working arrangements where allowance is made for giving support and care to family members.

### Importance of relationships across the life course

At older ages, it is the quality of longer-term relationships that protect people against the onset of physical limitations that come with age. One warning that comes from the research on resilience is that providing self-help groups and other forms of deliberate provision for people who have already fallen into adversity is often too late. It is the quality of longer-term social relationships that protect health and wellbeing.

One reason that good, accessible and affordable public transport is a health asset is that it makes social contact easier for a wide range of people regardless of their income, age or disabilities.

### Using community assets to promote resilience

The priority that people place on relationships may be regarded as a 'health asset'. There is quite a lot of evidence to suggest that kindly and supportive feelings towards others are very widespread in society. What is needed from policy is to remove all barriers to the expression of these feelings, and provide as much facilitation as possible. We are still learning how best to do this, because the great value of these assets has only recently been appreciated.

## What we know about social determinants, stress and social capital

**Dr Mike Grady is a Senior Research Fellow at University College London, a member of the Marmot Review Team and an expert in the impact of community development on health and wellbeing.**

'Closing the gap in a generation'[8] is a major review of health inequalities undertaken on behalf of the World Health Organisation (WHO), and set out a new global agenda for health equity addressing the growing health inequalities gap. Action was identified across three domains: improving daily living conditions; tacking the inequitable distribution of power, money and resources; and measuring and understanding the problem of heath and inequality and the impact of actions on it.

Fair Society, Healthy Lives, the strategic review of health inequality policy in England, built on this WHO report.[9]

8 Marmot M (2008) Closing the gap in a generation. WHO

9 Marmot M, Allen J., Goldblatt P., Boyce T., McNeish D., Grady M., and Geddes I. (2009) Fair Society, Healthy Lives. The

Focusing on the social determinants of health the review presented clear evidence that:

- the conditions in which people are born, grow, live, work and age are responsible for health inequalities
- early childhood in particular impacts on health and disadvantage throughout life
- the cumulative effects of hazards and disadvantage throughout life produce a finely graded social patterning of disease and ill-health
- negative health outcomes are linked to the stress people experience and the levels of control people have over their lives and this stress and control is socially graded
- mental wellbeing has a profound role in shaping physical health and contributing to life chances, as well as being important to individuals and as a societal measure.[10]

Individual health and wellbeing is significantly influenced by the circumstances of people's lives, their access to services, their work and income and by the place and the communities within which people live their lives. Those lives are fundamentally affected by stress, by the strength of communities and by the level of social capital available.

Low level stress, isolation and depression are marked features of communities facing abrasive multiple deprivation[11] with a clear association between deprivation and common mental health disorders for manual socio-economic groups[12] and suicide rates for deprived communities significantly higher than in the least deprived areas.[13] The most powerful sources of such stress can be identified as low social status, lack of a social network and stress in early life.[14] The lack of social support is identified as a particular problem in the most disadvantaged communities where 45 per cent of people identify some or severe lack of support. People who are socially isolated have a significantly greater chance of dying prematurely, while social networks provide and promote greater levels of resilience to illness.[15]

While definitions of social capital vary, there is a broad consensus that social capital encompasses the role of informal and formal networks, group membership, trust, reciprocity and civic engagement.[16] Levels of social capital are shaped by the ability of specific communities to have a voice and participate in and influence decision-making. Communities with less social capital are perceived as being less safe with lower levels of trust and reciprocity.[17]

There is growing evidence of the interconnectedness of health and social capital. People with stronger social networks are healthier and happier.[18] Participation in activity which improves overall life skills improves self-confidence and self-esteem. It appears that what is important is the increased social contact and social support

Marmot Review.

10 Marmot M et al. (2009) op cit.

11 Young Foundation (2009) Sinking and swimming: understanding Britain's unmet needs. http:/youngfoundation.org/files/images/YFneedsreport_screen.pdf

12 Office for National Statistics (2003) The mental health of Older People. ONS. London

13 Dunnel K. (2008) Diversity and different experiences in the UK. National Statistician's Article on Society. ONS. London.

14 Wilkinson R and Pickett K. (2009) The Spirit Level. Penguin. London.

15 Halpern D (2004) Social Capital .Polity Press .Cambridge.

16 Harper |R. (2001) Social Capital: A review of literature. Office of National Statistics.

17 Home Office (2001) Citizen Survey: People, Families and Communities. London. HMSO.

18 Grady M Community Development for health improvement. Doctoral thesis www.mdx.ac.uk

which fosters greater self-confidence and social status and a reduction in isolation and depression.[19] The connection is clear: individuals need communities and communities need engaged participants to thrive.[20] This means extending opportunities for participation, and actively addressing the inequalities gap which undermines the solidarity which binds citizen and wider society.

"A politics of the common good would make the case for building the infrastructure of civic life, drawing people out of gated communities and into the common space of shared democratic citizenship."[21]
Such a radical role would see the public sector creating the conditions within which individuals and communities take control over their lives and health.[22] This means creating active engagement with individuals and communities to mobilise local action in both defining local issues and developing local solutions. The aim would be empowerment of citizens in a more asset-based approach, focused on co-production of health and wellbeing as equal partners with communities.[23] This approach would promote change in existing political and professional power structures, extend democratic participation and maximise capacity and social capital. If the social determinants of health inequalities are early years development, education and training, work and employment conditions, housing, place-shaping and sustainability, then a whole system partnership approach is essential. Such partnerships would help to redefine the problems of health inequalities, foster shared values and collective use of resources to deliver more preventive approaches and the refocusing of priorities onto early intervention and outcomes for citizens.

The evidence from the WHO review and the English review of health inequalities highlights that social inequalities underpin health inequalities. Effective responses need to be radical, scaled up and systematic across the whole system if the social gradient in health and the social determinants of health are to be addressed. Broad action by all partners to engage and empower individuals and communities is essential. This should have a focus on co-production of health, wellbeing and resilience, building social networks and social capital to extend community support.

## What we know about: mental health and wellbeing

**Dr Lynne Friedli, Mental Health Promotion Specialist, Author of 'Mental Health, resilience and inequalities', World Health Organisation Regional Office for Europe, Denmark 2009[24]**

A focus on assets has helped to highlight the importance of mental health and wellbeing as a resource that underpins resilience. A key strength of asset-based approaches is to recognise the significance of psychological factors and to put people and relationships at the centre of improving health. The risk is that asset-based approaches can minimise

19 Bynner J. and Hammond C. (2004) The Benefits of Adult Learning: quantitative insights in Schuller T et all (Eds) The Benefits of Learning: the impact of learning on health, family life and social capital.

20 Friedli L. (2009) Mental Health, resilience and inequalities. World Health Organisation Regional Office for Europe. Denmark

21 Sandell M.(2009) A new politics of the common good. Lecture 4: Reith Lectures 2009.p11. http://downloads.bbc.co.uk/cmhttp/radio4/transcript/2009/20096/reith/anewpolitics.rft. 09.07.09

22 Marmot M. et al(2009) op cit.

23 Foot J. and Hopkins T.(2010) A glass half-full.

24 www.euro.who.int/document/e92227.pdf

the importance of poverty, inequality and poor housing and their negative impact on the mental wellbeing of communities. The marked social gradient in both mental illness and levels of mental wellbeing suggests a clear relationship between psychological distress and the material circumstances of people's lives. In acknowledging the importance of mental wellbeing, asset-based approaches also need to address inequalities in mental health.

### Mental wellbeing is an asset

There is abundant evidence that the skills and attributes associated with mental wellbeing are a core asset, protecting and enhancing the lives of individuals and communities. Mental wellbeing contributes both to improved outcomes, for example in educational achievement and physical health, and to resilient practices. This might include building social networks, as a response to adversity, or individual or collective resistance to factors that undermine health, for example racism, age discrimination or environmental hazards.

### Mental wellbeing and public mental health influence life chances

Mental wellbeing includes subjective wellbeing (how we feel about ourselves and our lives), social wellbeing (relationships and connections) and sense of meaning or purpose. Levels of mental wellbeing influence quality of life and life chances independently from the presence or absence of mental illness. Efforts to support mental wellbeing are central to the recovery agenda and to addressing the discrimination experienced by people with mental health problems.

### Mental health as a determinant as well as an outcome

Mental wellbeing and mental illness are generally seen as outcomes. For example, poor mental wellbeing is much more common among people living in deprived neighbourhoods or on a very low income, and factors like poverty, racism and abuse in childhood significantly increase the risk of depression and schizophrenia (McManus et al 2009). However, evidence from longitudinal studies shows that mental health is also a determinant, influencing physical health, recovery from illness, educational attainment, health behaviour, criminal activity, employment and earnings, as well as social relationships, engagement and sense of belonging (Friedli and Parsonage 2009). Poor mental health contributes to poorer outcomes in many areas of life, often reinforcing inequalities, because those who are most disadvantaged are most likely to experience mental illness and poorer mental wellbeing (McManus et al 2009). So, mental health is both a consequence and a cause of inequalities (Friedli 2009).

### Are psychosocial assets as important as material assets?

By their nature, asset-based approaches focus on strengths and in particular, on resilience or what enables some individuals and communities to survive, adapt and flourish in the face of adversity (see Bartley above). This has led to a greater emphasis on psychological assets (such as confidence, self-esteem, self-efficacy), on family and social relationships and the view that 'wellbeing does not depend solely upon economic assets' (Sen 2010). The importance of psychosocial assets is also central to the critique of the environmental and social costs of consumerism and materialism (Layard & Dunn 2009).

These themes come together in calls to recognise and value the contribution of the core economy of friends, neighbours and civil society.[25]

Both assets approaches and the wider wellbeing debates[26] are strongly associated with a non-materialist position; that money does not matter as much as relationships, sense of meaning and purpose and opportunities to contribute. From another perspective, what matters most is not so much what we have, but what we have relative to others: the impact on wellbeing of inequalities.

### Inequalities affect how people feel about themselves and others

Many studies show a relationship between levels of inequality (the gap between rich and poor) and prevalence of mental illness (Pickett & Wilkinson 2010). The mental health impact of inequalities has been explained in terms of status anxiety and the profound effects of being made to feel of no account, as well as how stark differences in income and wealth undermine social connections, social cohesion and the quality of civic society (Marmot 2010; Wilkinson & Pickett 2010). In this analysis, inequalities greatly exacerbate the stress of coping with material hardship.

Arguably, the differences in life chances and opportunities in Britain today erode precisely the assets that communities need to survive adversity: resilience and collective efficacy. For this reason, an emphasis on individual psychological attributes may reinforce inequalities, if it fails to acknowledge the links between how people feel and the circumstances of their lives.

25 Cahn E (2001) No More Throwaway People: The Co-production imperative Washington DC: Essential Books

26 www.ons.gov.uk/well-being

### Assets approaches benefit mental health

Relationships, community and the opportunity to shape our own lives have been described as 'real wealth' (Alakeson 2010; Centre for Welfare Reform). These themes are central to some very profound shifts in thinking that have emerged mainly from the disability rights movement, users and survivors of psychiatric services and community activists (Cahn 2004; Stephens et al 2008).

Asset-based approaches contribute to mental wellbeing by:

- strengthening opportunities for people and communities to shape their own lives, for example with personalisation and self-directed support, co-production, expert patient and recovery-oriented practice
- supporting 'whole person' approaches which address health and other needs in the context of people's lives
- acting on 'nothing about us without us' and reminding statutory authorities of the 'duty to involve'
- insisting on policy and practice which express genuine respect for those facing hardship and value their skills, experience and contribution
- integrating mental wellbeing, for example through mental wellbeing impact assessment (see below).

### Bringing it all together

The challenge is to ensure that asset-based approaches complement, rather than replace, efforts to reduce inequalities in life chances and life circumstances. Although reducing income inequality is a matter for central government, there is considerable scope for increasing equitable access to assets that support wellbeing.

Such assets might include: green space, blue space (rivers and lakes), land for growing, public squares and buildings, cultural treasures, transport, fresh food, cooking and other skills and affordable credit.

An emphasis on resilience can result in a failure to address inequalities, but it need not. Respect for people's strengths, endurance and resistance in the face of adversity could enhance, not distract from, the struggle for social justice.

There are many collective traditions of making meaning out of adversity and building strength through a shared analysis of inequalities in privilege, power and resources. Feminism, civil rights, trades unions, gay liberation, disability rights and the survivor movement have all understood mental distress as a symptom of oppression. One of the 'hidden costs of individualism' may be the failure to recognise that people's own mental wellbeing can be enhanced by opportunities to act in solidarity with others (Friedli 2011).

## What we know about 'getting ill better': wellbeing, health and health behaviour

**Tom Hennell, Strategic Analyst, Department of Health - North West**

When we are asked whether we are 'well', we tend to answer in terms of 'not being ill'. We are thinking of wellness in one dimension, with wellbeing at one end and illness at the other. Equally, when we are asked about what makes us healthy, we think of the 'things that are bad for you' at one end of a single dimension and 'things that are good for you' at the other. These immediate responses are reflected in two general tendencies in public health policy:

- a tendency for the promotion of health and wellbeing to be framed largely in terms of the prevention of illness and injury rather than the promotion of wellness
- a tendency for health policy interventions to be focused initially on encouraging people to withdraw from risk rather than on removing risk from the environment.

By thinking about data from the Adult Health Survey for England 2006 in a different way, we can look at health and wellbeing in a new way.

### Getting ill better

For this analysis, the adult population is allocated in the two dimensions of wellness and illness. People who self-report a limiting long-term illness are defined as having become 'ill'. A statistical estimate of 'being well' is constructed by combining more than forty wide-ranging social, economic, educational and household characteristics.[27] We then allocate people into the four categories of 'well not ill', 'well ill', 'unwell ill' and 'unwell not ill' (see figure 2 and figure 3 overleaf).

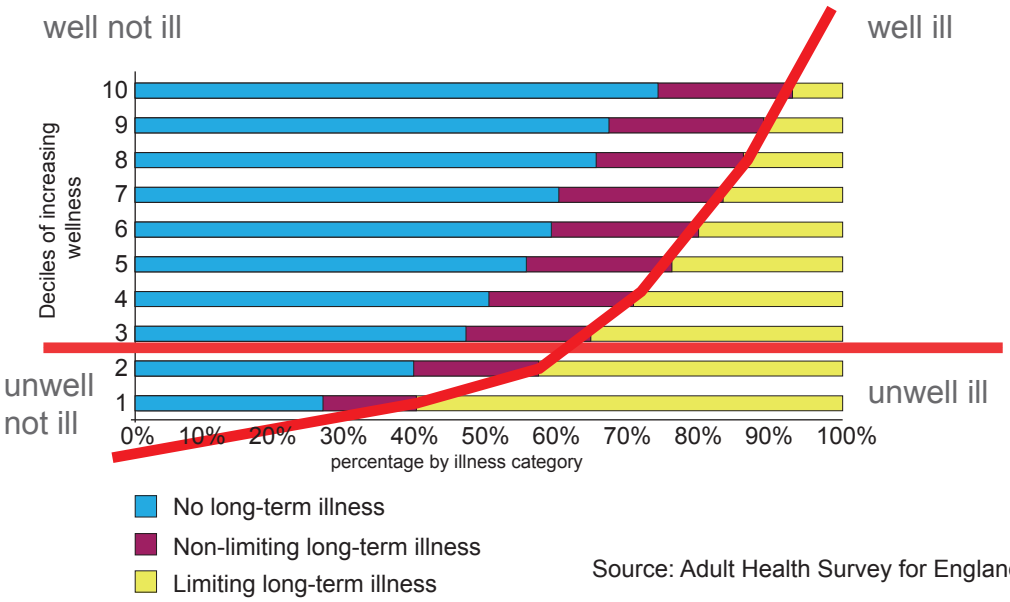
When we do this, we find:

### Getting ill better and recovering sooner

Many people who report long-term illnesses or disabilities – who are 'ill' – are in other respects 'well'. Their feelings of wellbeing allow them to access the resources required to treat their condition, or otherwise to achieve a high degree of management over any consequential limitations the illness may create. We describe this experience as 'getting ill better, and recovering sooner'. They are 'well ill'.

27 The North West Mental Wellbeing Survey includes indicators that have been combined to measure wellbeing www.nwph.net/nwpho/publications/NorthWestMentalWellbeing%20SurveySummary.pdf

**Figure 2 – Wellness and illness**




Source: Adult Health Survey for England 2006

**Figure 3** Proportion of adults in each category

| >>>> being well >>>> | | |
|---|---|---|
| | Well not ill 66% | Well ill 14% |
| | Unwell not ill 9% | Unwell ill 11% |
| | >>>> becoming ill >>>> | |

**Source**: Adult health survey for England 2008

## Barriers to becoming ill

Many people who are 'unwell' (those who say they have very poor wellbeing) nevertheless appear not to have defined themselves as having become 'ill'. These are people who may not seek or take advantage of treatment: they are unwell not ill.

## Poor wellbeing, poor recovery

Many people who are 'unwell' and report themselves to be ill appear to find it much more difficult then to manage their condition, and are consequently much more at risk of becoming permanently disadvantaged by it. They are 'unwell ill'.

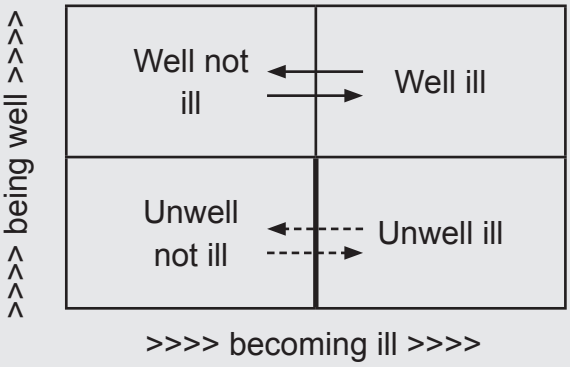
In particular, we find that:

- of those who report having a doctor's diagnosis of a chronic medical condition (such as diabetes) those who have poor wellbeing are much less inclined to self-report having diabetes as an illness
- of those who self-report any chronic medical condition, those who have poor levels of wellbeing are much more inclined to report their condition as continuing to limit their activities or the work that they do.

## Unwellness, inhibition and health inequalities

These two particular findings suggest that poor wellbeing results in systematic inhibitions, firstly reducing the ability to recognise they are ill and when ill, reducing the ability to get better. That is, for some people, the 'downside' of accepting or reporting they are ill may be much greater – especially if it results in an increased risk of losing employment, or disrupting family relationships. At the same time, the 'upside', in the form of access to care and support, may be much less apparent. People may, therefore, present themselves for treatment later, with a greater risk of their life being limited by disability and increased premature mortality. But having become ill, people with poor wellbeing appear inhibited against being able to manage their condition so as to achieve recovery and independence. We show the way that these inhibitions operate to reduce people's control over their health in figure 4. This appears to be a mechanism linking poor wellbeing to health inequalities. We do indeed find that in areas with poor wellbeing, reported illness incidence rates are lower than expected, but duration of illness is longer, and consequential mortality is greater.

**Figure 4** Poor wellbeing and inhibitions against becoming 'ill' and 'not well'




## Trading off – health assets and health risks

Just as we can separate the dimensions of wellbeing and illness, this analytical approach allows us to distinguish in the survey data between the dimensions of health assets and health risks. Characteristics that are associated with higher wellbeing (for example participation in local groups and feelings of belonging) are taken to be health assets. Health risk is based on known clinical associations, for example smoking. When we do this, we find that:

- some health characteristics are associated with reduced wellbeing and increased health risks, for example active and passive smoking
- some health characteristics are associated with increased wellbeing and increased risk at the same time, for example being overweight is associated with good wellbeing but obesity is associated with risk
- some characteristics by contrast are associated with reduced wellbeing and reduced risks, for example, when teenagers are restricted to recreation under parental supervision.

Our findings are summarised in figure 5.

The trade-off of assets and risks is especially complex for alcohol consumption, particularly within the predominant drinking culture in England. Alcohol consumption by under 16s is always associated with poorer wellbeing. However, in adults (other than those who do not drink for religious reasons) higher wellbeing is strongly associated with social drinking at moderate levels.

**Figure 5**

## Assets and risks

| Assets \ Risks | Increased | Reduced |
|---|---|---|
| Increased | **High wellbeing/high risk**<br>Body mass overweight<br>Adult social drinking at hazardous levels<br>Teenagers making their own way to school<br>Teenagers cycling and walking<br>Light adult recreational participation<br>Adults attempting to quit smoking<br>High adult time commitment to home life<br>Going out at night | **High wellbeing/low risk**<br>Body mass normal weight<br>Adult social drinking at moderate levels<br>Teenagers abstaining from alcohol<br>Non-smoking – adults and teenagers<br>High recreational participation<br>Joining local groups (esp. sports and religious)<br>Social contact and trust with neighbours<br>Adult satisfaction with work/life balance<br>Continuing participation in education<br>Satisfaction with long-term relationships |
| Reduced | **Low wellbeing/high risk**<br>Body mass obese or underweight<br>Adult drinking at harmful levels<br>Any underage alcohol consumption<br>Cigarette smoke, active and passive<br>Sedentary lifestyle<br>Not joining local organisations and groups<br>Low recreational participation<br>Sub-standard housing or neighbourhood<br>Worklessness in adults of working age<br>Living alone | **Low wellbeing/low risk**<br>Adults abstaining from alcohol<br>Teenagers taken to school by parents<br>Teenage use of parents' car transport<br>Teenage recreation at home<br>Adult mistrust of teenagers 'hanging around'<br>Parents' mistrust of non-household adults<br>High adult time commitment to work<br>Staying in at night |

While the ideal in any circumstance may be to encourage behaviours that both increase health assets and reduce health risk, there are circumstances where no such option is apparent. Teenagers who walk or cycle to school will always be at higher risk of road traffic injury, but they have a much lower likelihood of being assessed as having poor wellbeing on a standard measure of strengths and difficulties.

**Individuals do not exist in isolation; social factors influence individuals' health though cognitive, affective, and behavioural pathways.**

In 2010, an international meta-analysis of data across 308,849 individuals, where they were followed for an average of 7.5 years, indicates that individuals with adequate social relationships have a 50 per cent greater likelihood of survival compared to those with poor or insufficient social relationships.

The analysis concludes that: "The quality and quantity of individuals' social relationships has been linked not only to mental health but also to both morbidity and mortality [and] it is comparable with well established risk factors for mortality" such as smoking, alcohol, body mass index and physical activity. This is consistent across other demographic factors such as age, sex, cause of death.

It also reports that there is "a 50 per cent increased likelihood of survival for participants with stronger social relationships". This is "strongest for complex measures of social integration [including a variety of relationship types] and lowest for binary indicators of residential status [such as living alone versus with living with others]."

How does this effect happen? The study concludes that there are two hypotheses:

- Stress buffering, where relationships provide support and resources (information, emotional or tangible) that promote adaptive behavioural or neuroendocrinal responses to acute or chronic stressors (such as illness or life events).
- Social relationships may encourage or model healthy behaviours, so that being part of a social network is typically associated with conformity to social norms relevant to health and social care. In addition being part of a social network gives individuals meaningful roles that provide self-esteem and purpose to life.

Meta analysis of 148 independent studies in international literature investigating the association between social relationships and mortality.

*(Social relationships and mortality risk: a meta-analytic review. Holt-Lunstadt, Smith, Bradley Layton. Plos Medicine July 2010, Vol 7, Issue 7. www.plosmedicine.org doi:10.1371/journal.pmed.1000316)*

**Best buys for mental wellbeing**

A study for the All Wales Mental Health Promotion Network and Welsh Assembly uses economic analysis to make the case for greater investment in both promoting mental wellbeing and preventing mental illness. Their recommended 'best buys' for cost effectiveness are:

- Supporting parents and early years with parenting programmes to improve skills and the home learning environment, and pre-school education.
- Supporting lifelong learning with school-based programmes to promote mental health and increased educational opportunities for adults.
- Improving working lives with workplace-based programmes to promote mental wellbeing and reduce the impact of the workplace on mental health.
- Positive steps for mental health with changes in lifestyle, such as diet, exercise, alcohol, which impact on mental health as well as physical health. Social support and contact are factors in mental wellbeing.
- Supporting communities and environmental improvements to the natural world, the built environment and public spaces all influence mental health; access to green spaces is associated with reduced health inequalities.

See Chapter four for a summary of the methodology.

*(Promoting mental health and preventing mental illness: the economic case for investment in Wales. Freidli & Parsonage (2009) www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20%28English%29.pdf)*

# **Chapter three:** What it looks like – putting asset-based approaches into action

"Asset-based approaches offer one means of contributing to [social determinants of health and inequality] goals by recognising that traditional epidemiological risk factors approaches to health development such as programmes on smoking cessation, healthy eating and physical activity are insufficient on their own to ensure the health and wellbeing of populations. In particular, many of the solutions to addressing the social determinants of health rely on the ability of professionals to recognise that individuals, communities and populations have significant potential to be a 'health resource' rather than just a consumer of health care services."[28]

This chapter features fifteen examples of how people and organisations that explicitly recognise the potential power of an asset-based approach are working with communities and transforming services. These changes are often small scale, exploratory and in their early stages:

1. Asset mapping
2. Toronto framework for mapping community capacity
3. Joint strategic needs and assets assessment
4. Timebanking
5. Social prescribing
6. Peer support
7. Co-production
8. Co-production and outcomes-based commissioning
9. Supporting healthy behaviours
10. Community development to tackle health inequalities
11. Network building
12. Resilient places
13. Asset-based service redesign
14. Assets – embedding it in the organisation
15. Workforce and organisational development

28 Page ix, Preface to Morgan Davies Ziglio ed. Health Assets in a Global Context (2010 Springer) www.springerlink.com/content/978-1-4419-5920-1#section=736251&page=1&locus=9

Asset-based practice is being implemented in many local areas and in many contexts. Improved wellbeing has been made an explicit goal of policy. The assets perspective offers practical and innovative ways to impact on the positive factors that nurture health and wellbeing.

Asset mapping is the essential starting point to transforming the way that services and communities work together and this information can be integrated into a JSNA. It is often paired with co-production, timebanking, or social prescribing which embody asset principles. The essential role of community development in releasing community capacity and strengthening networks is increasingly being recognised; communities and councils are working together to create more resilient and connected places.

The insights that come from the assets perspective are influencing new ways of working and newly conceptualised services. All of this challenges organisations and staff to adopt whole system and appreciative models of change.

The examples illustrated here are not models that can be copied or scaled up without adaptation. The very nature of the assets approach means that it is a bottom up way of working, with each community or neighbourhood combining their assets and defining their aspirations in very local circumstances. A change in our way of seeing the world – seeing it as a glass half full rather than half empty – transforms what we do. What is important is to listen, experiment and facilitate; this will lead to new thinking and exciting possibilities.

**Defining characteristics of asset-based approaches**

This chapter contains a wide range of different working models and initiatives that embody asset principles. Some explicitly acknowledge their asset or roots. Some reflect longstanding innovatory practice in health and social care and some are relatively new. There are common principles that bring together and underpin these asset-based approaches:

- Asset-based – values assets and associations
- Place-based – works in the neighbourhood as the space in which networks come together and shared interests are negotiated and acted on
- Relationship-based – creates the conditions for reciprocity, mutuality and solidarity
- Citizen-led, community-driven – empowers individuals and communities to take control of their lives
- Social justice and equality – enables everyone to have access to the assets they need to flourish; equality and fairness are both determinants of wellbeing.

## Where to start

**The Asset Approach to Living Well: the ten key 'asks' to creating a whole system approach.**

This is based on the experience of the North West Assets Alliance, bringing together public health practitioners from all sectors, and is what whole system asset working requires to be successful.

1. Understand health as a positive state and its determinants as those factors that protect and promote good health and wellbeing, rather than describing health as disease and the risk factors for ill-health.
2. Describe the population's health through the assessment of assets, that is, looking at the presence of good health and wellbeing and indicators on what creates and influences good health, rather than needs assessment that only includes information on disease, death and risk factors for illness.
3. Map community assets. This would include the valuable resources and places, the strengths, knowledge and skills of people, understanding what the community define as assets using asset mapping approaches.
4. Sustain and build assets within communities through continuous community development and approaches that empower citizens and communities. Enable communities to connect and utilise their assets.
5. Assess individual strengths when working to improve personal outcomes (through services and personalisation) and provide interventions that release personal assets and build on people's strengths and the assets in their local community.
6. Community budgets and commissioning that builds on existing community assets and provides professional input to enhance assets and provide additional support where needed.
7. Adopt organisational development and service improvement approaches that appreciate and build on what's already working well.
8. Map health assets within and across organisations to understand the internal and external resources, skills and strengths.
9. Share and exchange assets between public, private and community bodies to improve efficient use of resources and give power to communities.
10. Research and monitoring that incorporates the evaluation and development of asset-based outcomes, indicators and measures.

*The Health & Well-being Alliance. (www.nwph.net/hawa/)*

## 1. Asset mapping

This is one of the core methods of asset working. Because public services have traditionally been focused on deficits, problems and needs, there is an absence of systematic knowledge about the wealth of experience and practical skills, knowledge, capacity and passion of local people and associations, and the potential for communities to become equal partners.

Many public services, community groups and individual community activists are using asset mapping methods to raise awareness, mobilise new resources, and as a community development and empowerment tool. Through face to face conversations with individuals and small groups they are making the assets in an area visible, enabling people and organisations to appreciate the resources they have and mobilising people to make use of them.

In this context, we are not just talking about assets in the sense of buildings such as schools and offices, although such assets can be under-utilised and have the potential for use for wider community aims.[29] In this work, assets are individual, family and community strengths and resources as well as the skills and resources held by associations and organisations working in the area. (See 'A glass half-full' for definitions and a map of potential assets). They can include supportive networks, community cohesion, access to green spaces, community hubs, affordable housing, secure jobs and opportunities to participate.

A systematic picture of the assets in the area is an essential first step to projects such as social prescribing or co-production, and one of the results of timebanking. A richer picture of an area can inform service redesign and make the case for investment in voluntary groups and community activity. It can be done on a small scale to stimulate community action as in the Sale West and Ashton example. In contrast, Wakefield have developed and tested a relatively larger scale process of mapping that is integrated with the JSNA refresh and has influenced local commissioning.

**Assets that support community action**
The Sale West and Ashton Partnership of people who live and work on the area's estates did an assessment of their assets and needs. Assets which are being mobilised include community orientated local schools, a large GP practice in a smart new building with aspirations to be a community resource, a local publican who has the vision to make a difference for local people, and an energetic community vicar, who has a strong heart for partnership working. As a result of this assessment, residents are now producing and delivering a newsletter to every door, a Christmas dinner was held for vulnerable residents and a 40th anniversary celebrating the stories of people who live on the estates has taken place.

29 O'Leary, Burkett & Braithwaite (2011) Appreciating Assets. IACD & Carnegie UK Trust. www.carnegietrust.org.uk

## Wakefield: Growing communities from inside out

NHS Wakefield District and Wakefield Council's Joint Public Health Unit piloted an asset and co-production approach as part of the national JSNA refresh programme. Using A Glass Half Full, they explored the use of asset mapping to provide a rich picture of local people's assets and how knowledge of those assets could support co-production and inform a community based commissioning framework. This work complemented the research previously completed on the issues and needs.

### Their headline conclusions include:

- The pilots are felt to have "demonstrate[d] the purposefulness of the Asset Based/Co-production approach and its potential to legitimately inform and influence future strategy and planning".
- The use of asset based methodologies was "empowering" for communities and "their active participation in a more positive process which emphasised the talents, strengths and resiliencies within the community was clearly extremely rewarding"
- While the use of purely asset based events was positively received by both communities, this was possible because of the extensive and prior discussions about issues and needs. Particularly in areas where life is harder and assets are fewer, community engagement methods will be needed that gather information on both assets and on needs.
- The new JSNA process – gathering information about both assets and needs – is complementary to an asset based and co-production model. This "richer picture" provides "opportunities to develop a different commissioning framework, one which enables coproduction working and builds and strengthens community assets to best address 'needs'"

### What the pilots did

The two neighbourhood pilots focused on mental health and mental wellbeing, partly because these are key pathways to inequality (see Friedli above) and partly because local research at the lower super output area (LSOA [30]) level showed a clear correlation between areas with high levels of deprivation as measured by the Index of Multiple Deprivation (IMD) and those with a high prevalence of people reporting feeling 'downhearted and low'. The asset mapping was carried out by a variety of means, using five questions:

- What makes us a strong community?
- What do we do as a community to make people feel better?
- What makes this a good place to be?
- What factors help us to cope in times of stress?
- What makes us healthy in mind, body and spirit, as a community?

30 Lower Super Output Areas are smaller than a ward and contain a minimum of 1000 people or 400 households. See ONS Neighbourhood statistics.

The methodology included a world café event, digital photography, face to face conversations and discussions in local groups. Full transcripts were made; this detailed evidence base gives a rich picture of what the community saw as their assets, how they saw them being supported and reinforced, and how they think they contribute to wellbeing. This process also helped the community appreciate their assets and their potential, and helped the agencies to see the potential value of the resources in the community. The new economics foundation (nef) 5 Ways to Wellbeing - connect, be active, take notice, learn, give – was chosen as the framework for first analysis of the information: what was seen as an asset, how it was reinforced, and what was the impact of the assets. A second analysis brought together the needs data with the assets data and developed an understanding of the commissioning opportunities to build or strengthen community assets.

'Growing Communities Inside Out. Piloting an asset based approach to JSNAs within the Wakefield District: methods and findings.' (2011 LGA, Wakefield NHS, Wakefield Council) This contains a full write up of the piloting process, the information gained and the two analyses carried out.
(*http://www.idea.gov.uk/idk/core/page.do?pageId=32356192)*

'Developing a Rich and vibrant JSNA. Capturing community asset growth within the JSNA – key learning from a trial project' was commissioned by the Department of Health (2011 LGA, NHS Wakefield, Wakefield Council 2011) This summarises the learning from the asset pilots and it implications for JSNAs that reflect both community strengths as well as their needs.
*(http://www.idea.gov.uk/idk/core/page.do?pageId=32356192)*

## Assets for empowerment: learning points

As experience of asset mapping in the UK grows, there are some learning points:

## The importance of connecting – not just collecting

Many projects start by listing all the associations, the public services and the facilities in an area. While this inventory is useful knowledge, it does not achieve the overarching developmental aims of asset mapping, which is to reveal the invisible and overlooked assets held by individuals and associations and to connect them to opportunities like mutual help and co-production where those assets can improve wellbeing for themselves and for others. It is through the conversations about assets and resources that staff and citizens see how they could work together differently.

## Asset stripping

Some agencies have proposed that assets such as volunteers or networks in a community could substitute for services that are being withdrawn or reduced. There is a danger that this can turn into 'asset stripping' where the resources in the community are used to meet organisational agendas rather than promote the wellbeing of their own community. Without a conscious commitment to sustaining and nurturing the assets in an area in the long term, and to engaging in fully participative discussions about making use of those assets, people will soon get disillusioned.

## An agreed and positive purpose

Asset mapping to reveal and mobilise hidden assets – whether individual, family, neighbourhood or formal organisations – is time consuming. It is more effective if there is a specific outcome or topic in mind, whether

that is derived from a community consultation or from an analysis of local data. For instance, a concern with the isolation of older people would start with supporting older people to have face to face conversations with each other about what resources they have between them, and what help they need from others. Then they can look for other resources that can help them.

### Social assets are crucial

Wellbeing is affected not just by psychosocial capacities – see Friedli above – but also by social, economic and environmental assets: the availability of decent homes, secure jobs and income, affordable transport and access to green spaces. These assets are unequally distributed and this fact affects how everyone feels about their lives (Wilkinson & Picket 2009). Asset mapping should also generate conversations about ways to improve access to material assets; car pools, using empty properties, homesharing,[31] small community providers,[32] credit unions, maximising local economic opportunities such as local purchasing, and shopping in locally-owned shops.[33] These are all activities that rely on local assets, build networks and can help tackle the effects of deprivation locally.

### Unequal distribution of assets and the capacity to make use of them

Initiatives such as asset mapping, which aim to capture the strengths and resources of communities, will also highlight inequalities. People have varied access to valued assets; they may have fewer opportunities to influence decisions on fair allocation of scarce resources and miss out on opportunities to have valued roles and to make a meaningful contribution. All asset-based working should actively ensure that it is engaging with a wide range of people and voices.

31 www.naaps.org.uk/en/homeshare/

32 www.naaps.org.uk/en/small-community-services/

33 See www.pluggingtheleaks.org/index.htm

## 2. The Toronto framework for mapping community capacity

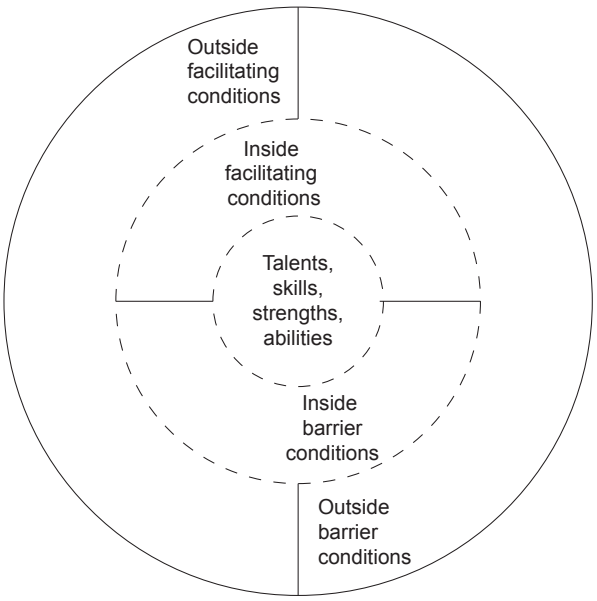
The Toronto research's[34] definition of community capacity is:

"The potential of a community to build on its strengths in order to work towards and achieve its goals and dreams, given both facilitating and barrier conditions coming from inside and outside the community."

Researchers at the Centre for Health Promotion at Toronto University worked with communities and community workers in four areas of the city that had been negatively-labelled and marginalised. The objective was to put asset based community development (ABCD) principles into practice by developing a model and possible indicators of residents' assets and community capacity by using the communities' own experiences and understanding. Researchers talked to residents and community-based workers about how they described their community, what events and activities they had done together and what their talents and skills were. They asked about what had facilitated and what had acted as barriers to the events and activities the community had undertaken.

34 Working with Toronto Neighbourhoods toward developing indicators of community capacity S.F. Jackson, S. Cleverly, B. Poland, D. Burman, R. Edwards and A. Robertson at Centre for Health Promotion, Department of Public Health Sciences, University of Toronto. Health Promotion International Vol 18 No 4. Oxford University Press 2003. pp 339-350. http://heapro.oxfordjournals.org/content/18/4/339.full.pdf+html

**Figure 6** Community capacity model




The resulting conceptual model of community capacity and the framework for systematically mapping capacity has much to offer UK practitioners.

It includes social, environmental and economic assets as well as individual and collective psychosocial strengths; they can be changed to reflect local perceptions of the significant markers of community capacity.

An assessment is made of the internal and external facilitators and barriers to community capacity. Community capacity does not just come from within the community; local government and other agencies play an important role in facilitating or constraining the growth of community capacity. In some communities, internal conflicts can be a barrier to local action.

The framework can be also used to identify and develop indicators for tracking changes. (see chapter four.)

Applying the conceptual model, the Toronto researchers collated information on five elements:

1. The different affiliations of participants, for example what associations they belong to, their ethnicity, the languages spoken, how long they have lived in the area plus variables like age range and gender.

2. A site description from the perspective of the residents – both positive and negative. This includes such comments as ‘a safe place’, ‘a multicultural place’, ‘strong community spirit’, ‘everyone knows everyone’, as well as the negative image from those in the surrounding area, and how local people with drug addiction or who are homeless are marginalised.

3. The talents and skills of individuals who live in the community and how it contributes to their ability to effect change.

4. Indicators of overall community capacity, linked to the ability of the community to include and deal with the conflicting interests and work together for the common good.

5. Indicators of the facilitators or barriers to community capacity that come from within the community itself, as well as from external organisations and regulations.

(The tables for Elements 3, 4 and 5 are quoted in full in Appendix 1.)

# 3. A joint strategic assets assessment?

The proposals for significant changes in health governance, a joint health and wellbeing strategy, health and wellbeing boards and clinical commissioning groups, would mean a step change in the importance and function of JSNAs.[35] Most areas will need to review their local process from first principles and this offers an opportunity to achieve a better balance of information between needs and assets and to enable co-production with a wider range of community-based providers and associations.

"While a focus on 'needs' is inevitable, it is only one part of an effective strategy to improve health and wellbeing and reduce health inequalities. It is also important to build on local strengths […] the time is right to achieve a better balance between a needs approach based on relative inequalities and deficits, and an approach based on community assets and the strength of local networks. This is necessary if we are to build a more informed picture of health inequalities and engage local communities in transforming their health and wellbeing." [36]

The JSNA and asset-based approaches "should not be seen as separate entities but complementary processes that enable a richer, more intelligent and better informed tool for improving health and turning around health inequalities and their effects on individuals and local communities."[37]

Several areas have explored ways of collecting, analysing and including data on assets which can match the traditional data on needs and deficits and can influence commissioning strategies. Wakefield (see above) used community engagement approaches in two priority neighbourhoods. The NHS North West commissioned research on a process and framework that could help local commissioners know more about the strengths and resources that could be included in the commissioning plans. This was informed by the many asset initiatives in the region[38] and their report recommends:

- High level buy-in of the very different approach. A strength-based approach has implications for both the organisation and the providers in a locality.
- A whole system approach which includes community groups as equal partners
- The use of asset mapping as well as appreciative and community development tools. This requires the identification of resources and an appropriate methodology.
- Gathering information on assets as well as a community's perception of the challenges and opportunities. Once the assets are analysed they can be aligned with the JSNA data.
- Assets can influence the what and how of commissioning and co-production, including investment in developing and sustaining assets.

35 See Joint Strategic Needs Assessment; A springboard for action (LG Group 2011).

36 Foreword by the Cllr David Rogers OBE, Chairman, LGG Health and Wellbeing Board in Joint Strategic Needs Assessment: A springboard for action. (LGID 2011)

37 Growing communities from inside out - an NHS Wakefield and District asset-based approach to JSNA – Jane Greetham (February 2011) www.idea.gov.uk/idk/core/page.do?pageId=32356192

38 Development of a method for Asset Based Working. DH, NHS NW, CPC February 2011. http://www.nwph.net/hawa/writedir/da0dNW%20JSAA.pdf

The report concludes that taking an assets approach to the JSNA "could therefore make a significant contribution to:

- tackling the social determinants of health and reducing health inequalities
- focusing on health and wellbeing outcomes
- strengthening JSNAs
- fostering co-production of health and the provision of health and social care
- building the Big Society vision of empowered communities
- supporting the systematic engagement of communities in partnership
- maximising the role of the voluntary, community, civil and faith sectors
- enabling greater condition management, self care and care closer to home
- improving individual and community resilience in challenging times
- improving demand management and service efficiency".

### Joint strategic assets and needs: commissioning for impact on the social determinants of health and wellbeing

The expanded role of local government outlined in the Health & Social Care Bill (2011) suggests a JSNA/JSAA methodology that starts upstream of the traditional JSNA process and informs the commissioning of the much wider range of activities that impact on the social determinants of health and health inequalities.

The first step is to engage councillors, community and staff in conversations about what would improve health and wellbeing locally in the light of the Marmot principles of looking upstream at the 'causes of the causes'. This is more than consultation or data collection. Health Scrutiny has found that working alongside communities, focusing on the positive and on health giving factors, enabled them to gain new understandings and develop shared solutions.[39]

A whole system approach to prioritising resources and outcomes would consider the data on issues and needs alongside other intelligence about assets, strengths and aspirations. It would take account of the resources and contributions of not just the public sector but also registered social landlords, schools and colleges, businesses, and social enterprises who play a part in producing wellbeing.

A commissioning strategy which includes commitments to social value, co-production and equality principles[40] and overseen by the health and wellbeing board is required. This strategy should influence the clinical commissioning groups as they commission medical care and preventative work. It would inform the strategies of those commissioning care and prevention services in the community as well as housing, educational or environmental provision. It would promote investment in those associations that contribute to health-giving factors by caring for family and neighbours, or building social capital and networks.

39 Peeling the Onion. Learning, tips and tools from the Health Inequalities Scrutiny Programme (CfPS & LGID 2011)

40 See below re Coproduction and Outcomes Commissioning.

# 4. Timebanking

The core economy "constitutes the real work of society which is caring, loving, being a citizen, a neighbour and a human being." (Edgar Cahn, Founder of Time banking)

"You give an hour of help and earn one time credit. The person receiving your help owes one time credit. They pay back by helping someone else. The circle of care and mutual support expands: more people means more skills to share."[41]

Timebanking creates relationships, activity, networks and mutuality that build community, as well as 'buying' time, services and skills that people could not otherwise afford. The basic principle of the 'time economy' is simple. Everyone has something to contribute: time, skills, care, resources. People deposit time when they give practical help to someone and withdraw time when they need something done. Everyone's time is valued equally.

Time banks have developed from the original idea of person-to-person exchange, such as the Rushey Green Time Bank (RGTB), into facilitating exchanges between public agencies and individuals (see the Spice organisation below) and between small voluntary and social enterprise organisations. Councils are encouraging local timebanks to collaborate so their members can give time to and access credits with other time banks in the area. This builds links across different neighbourhoods, makes them more sustainable and means they have more to offer members. Camden Shares is an example of this umbrella role.

41 Simon (2010) Your Money or Your Life; Time for Both. P 29

### Person to person

This is the original model where the exchange of time is between individuals. They are usually groupings of between 50 and 500 people and locally based.

Rushey Green Time Bank (RGTB) was set up 11 years ago by a local GP, as an alternative method of treatment for patients suffering from depression and isolation. Uniquely the RGTB is hosted in the GP surgery and many of the members have been referred by their doctor. They report that the scheme has increased member's social networks, self-esteem and improved their symptoms of poor health. RGTB is currently exploring a joint venture with Hyde Housing to set up a community time bank in a new social housing development.

### Agency to person

Like person to person timebanking, this community currency scheme works on a simple hour-for-hour exchange. An individual earns a credit by giving an hour to their community and uses that credit for an hour of community events, training or leisure activities offered by partner agencies.

The Spice organisation in South Wales wants to build better relationships between public agencies and the local population and encourage people to get active in their community. Everyone has something to contribute and credits are a way to thank people for that contribution in a way that generates a cycle of more community activity and more volunteering. Credits are earned by working in the community such as running a mother and toddler group, befriending, organising a panto, being a school governor,

or running a self-help group. The credits are exchanged for leisure and other activities donated by local businesses, such as cinema tickets or use of the gym, usually when there is spare capacity. Or they can be used for local services such as further education classes and training.

"Community services are often straining to deal with social problems that have accumulated downstream. People often come into contact with public and third sector services when they have developed a problem and need support. This can generate a negative relationship and promote a culture of dependency. By engaging with people 'upstream' positively as active and acknowledged contributors to the community and by empowering citizens, service providers can often ease pressure on 'downstream' resources focused on problem solving and dependency."[42]

### Agency to agency

Camden Shares encourages local businesses and public agencies such as the University of London and Sadler's Wells Theatre, social enterprises, small businesses, voluntary organisations and networks of freelancers to participate in the local timebanks. They have meeting rooms, office space, skills and training, time and resources such as a minibus that can be 'traded' in the time economy model. This helps with the sustainability of local businesses and builds local economic benefits.[43]

Local government can encourage timebanking as part of their strategy of building social networks and helping people on low incomes. An evaluation of timebanking[44] found that aside from the practical benefits, it attracts a wider range of people than volunteering schemes and has a positive effect on levels of self-confidence and trust locally. People make new friends and connections which would not occur naturally, for example when a school exchanges with a care home.

42 See New Start October 09, and Spice Looking Back. A Review of the Community Time Credit Systems that have given birth to Spice (University of Wales Newport 2009) www.justaddspice.org/docs/Spice_Looking_Back.pdf

43 See www.camdenshares.org.uk and www.pluggingtheleaks.org/

44 www.timebanking.org/documents/Publications/The-time-of-our-lives.pdf. Two year evaluation, published as The time of our lives: using time banking for neighbourhood renewal. Seyfang & Smith. Nef 2002

## 5. Social prescribing

Social prescribing links patients in primary care with non-medical sources of support within the community. These are usually local voluntary groups or community organisations that have signed up to the scheme. Many social prescribing schemes use asset mapping tools in order to identify the potential sources of support so that GP practices and others can refer their patients. It connects people to the assets on their doorsteps.

Research[45] in the North West found that prescriptions were being written for exercise and sport, book clubs, places to take part in the arts, green gyms, volunteering, mutual aid, befriending and self-help, advice on debt, legal problems and parenting support. The benefits included:

- increased awareness of what would improve wellbeing and how to take positive steps towards this
- increased uptake of healthy activities by vulnerable and other groups
- increased levels of social contact among marginalised groups.

Psychosocial, social and cultural interventions can play an important role in helping people with poor mental wellbeing as well as common mental health problems such as anxiety and depression.

The Wellbeing Project in Halton and St Helens[46] is an award-winning social enterprise that offers social prescribing to people with mental health concerns. They run community-based courses, self-help groups, training and leisure activities and connect people with sources of support.

In Bradford, GP-funded health trainers have adopted social prescribing. This benefits the patients who get help with social issues that are affecting their health: 48 per cent of patients worked on a personal health action plan and 87 per cent made progress on their chosen goals. GPs can refer patients to the health trainers rather than prescribe anti-depressants, and there is evidence that patients are not coming to the GP as often with problems that are primarily social rather than medical.[47]

## 6. Peer support

There is a long history of peer support between people with long-term illnesses or who have shared an experience such as alcohol misuse. These rely on the assets, skills and knowledge in the community and the recognition that local people can offer help in ways that are sometimes more effective than professional help. Befriending schemes have been shown to be effective ways of reducing isolation and exclusion which in turn improves wellbeing.[48]

Through the Knowsley Volunteer Family Mentor scheme, 35 local residents have volunteered to be trained to give help and encouragement to local families to help them increase their stability, confidence, self-esteem and resilience so that they can start

45 Friedli L, with Catherine Jackson, Hilary Abernethy and Jude Stansfield (2009) Social prescribing for mental health: a guide for commissioning and delivery. Manchester CSIP North West Development Centre. http://www.mhne.co.uk/files/MHNE126.pdf

46 www.wellbeingproject.co.uk/index.htm

47 An Evaluation of social prescribing health trainers in south and west Bradford. White, Kinsella & South (2010) Yorkshire and Humberside Regional Health Trainers Hub/ Leeds Metropolitan University.

48 www.thinklocalactpersonal.org.uk/BCC/BuildingTheBigSociety/SelfDirectedSupport

to tackle their circumstances themselves. The evaluation found that families respond better to help from people in their own community than to professional help; they have benefited from taking up training, applying for jobs, getting help with drug use or health issues for example. The volunteers also benefit by using the training they receive as the springboard to get qualifications and jobs.

As a result of Sale West and Ashton Partnership's asset mapping exercise, they have set up an 'alcohol human library'. This community-based project offers residents with risky drinking habits support from volunteers who themselves have had problems with alcohol in the past. These volunteers can use the 'asset' of their previous struggles and experiences to help others in similar situations; they can help someone understand what causes them drink, help prevent risky drinking and offer support with the issues that people face.

In Chesterfield, as a result of a health scrutiny exercise using appreciative inquiry, an ex-alcoholic is running a surgery in the new GP practice.

## 7. Co-production

"People's needs are better met when they are involved in an equal and reciprocal relationship with professionals and others, working together to get things done."
new economics foundation – 'Right Here, Right Now – Taking co-production into the mainstream', July 2010

Co-production is a fundamentally different approach to achieving locally defined outcomes and to delivering public services. It fully involves users and communities in the planning, design and delivery of services and better outcomes. (see 'A glass half-full'). The assets of individuals, families and neighbourhoods are valued for their contribution and this contribution is as significant as the role of professional services. This insight transforms services and the support for community networks. It challenges service planning, evaluation and commissioning to support co-production.

The key characteristics of co-production[49] exemplify asset principles:

- it recognises people as assets rather than seeing them as problems
- equal participation and partnership between providers and users is at its heart
- it actively builds on people's existing capabilities and assets
- a key objective is to promote mutuality and reciprocity
- the process of co-production breaks down barriers between professionals and recipients
- the role of professionals is to facilitate rather than deliver.

"Co-production offers a route to more empowering, effective, preventative and cost-efficient services. 'Providers' and 'users' work together with carers and others in an equal and reciprocal partnership, pooling different kinds of knowledge and skill. Professionals will need to change the way they operate – working with people, rather than doing things to or for them."[50]

49 Nef/NESTA (2010) Right Here Right Now. Boyle & Harris (nef 2009) The Challenge of Co-production.

50 Nef(2010) Cutting It

### Co-production plus?

Co-production is compatible with and arguably enriched by combining it with asset mapping and appreciative inquiry. This starts upstream of the service design and delivery arrangements and involves service users, families and neighbourhood groups as equal partners in defining the outcomes and the whole system participants.

### Defining the outcome

Using appreciative inquiry and whole system events, discover the outcome that local people care about – which may not be the same as the priorities of the public bodies. By phrasing it as a positive statement – for example talking about creating 'a place of opportunities for all young people' rather than talking in terms of deficits by saying 'reduce the number of NEETS' – the focus of attention is shifted. Plans are made to create opportunities rather than to fix people. By taking time to involve people in defining the vision, new relationships and understandings are built that will support co-production in the long run.

### Looking at the resources available to achieve that positive outcome

Starting with the outcome, map the assets and resources in the area that are or could be available. This highlights the public, private and community partners – often from outside the usual service silos – who should be invited to be at the 'co-production' table. Local knowledge about issues, levels of needs and the local context will also be a necessary part of the picture.

### What do we do more of, less of, differently?

A strategy planning process – including all the players locally – assesses how best to achieve the agreed outcomes, making best use of the skills, resources and assets available. What do we know about what works? Who must do more, or less, or what should be done differently? The consequences are likely to include redesigned services. It may include for instance redirecting investment into community networks or activities that nurture local assets.

### Enabling co-production

Finally, a 'co-production plan' formalises the agreement about who will do what. This will inform the financial planning by the different partners and the joint commissioning plan about what actions and activities will be funded. How will the different partners be held accountable for their contribution to the plan?

Community-based participants will need support with time or resources to make their contribution to this process and to play their part in achieving the outcomes. The process of engagement between professionals and community in itself builds the networks, skills and relationships that are essential for co-production to be effective.

## 8. Outcomes-based commissioning

"The approach of co-production can be incorporated across the entire commissioning framework, within the pre-qualification questionnaires, the invitations to tender, evaluation and monitoring criteria. Providers will be expected to show their understanding of the approach, and demonstrate how they might use the approach in service delivery." [51]

The transformative potential of co-production is not best served by traditional procurement

51 nef: unpublished report for Surrey Services for Young People

models where providers are contracted to deliver a service defined by its inputs and outputs, with little mention of the wider outcomes and how they could be achieved, and little or no requirement to build on assets and capacity within the community. Councils and health services are now combining outcomes-based commissioning with co-production[52] when they want to utilise and build on local assets:

- The commissioning framework defines the long-term changes that are wanted. An example would be the aim that young people have confidence.
- Because the activities are not specified, potential providers are incentivised to be innovative and flexible about how they go about achieving the outcomes.
- Co-production is specified as an approach that providers must develop, meaning they are required to work closely with clients, their families and communities using co-production and other participative approaches to make best use of their assets.
- New providers can emerge bringing their local networks and knowledge of the area
- Commissioners can specify that providers develop preventative approaches to service delivery to stop more acute needs arising in future.
- Wider social and environmental outcomes can be built into the assessment of value for money, and the monitoring framework.
- Commissioning is designed around outcomes rather than service silos.

Kirklees Mental Health Partnership used an outcomes-based specification for the mental health advocacy service and mental health carers options service.

The providers were required to base the service on the 'principles of co-production' and recognising 'the assets of the individual'. The specification sets out a number of expectations of the service. For example, it set out that people will not be seen as passive recipients of the service, that they have 'assets with value and expertise', they will be enabled to 'explore their potential to the fullest, push the boundaries, take risks and maintain or regain increasing control over their daily lives'.
*(http://www.yhip.org.uk/silo/files/mental-health-carers-options-service--service-specification.doc)*

The six co-production principles underpin the specifications, and each one details the expected outcomes under those headings.

The service is monitored through a consultative forum with 50 per cent representation of service users and 50 per cent from the different agencies, using quantitative data on client details, a framework of personal, community and economic outcomes and the use of the Outcomes Star (see chapter four) as a tool for tracking change with vulnerable clients.

52 Nef have published a number of publications on co-production and asset based working. See their current project: Transforming Young People's Services: introducing co-production and commissioning for outcomes www.neweconomics.org/projects/transforming-young-peoples-services-introducing-co-production-and-commissioning-for-outcome

Also LGID, nef, NMHDU 2010 contains recommendations about aligning commissioning and procurement processes with health and wellbeing outcomes. http://www.idea.gov.uk/idk/core/page.do?pageId=23692693

Surrey County Council, in the context of funding reductions, has adopted an outcomes-based commissioning framework and co-production approach to working with young people. They plan to stop directly delivered services and devolve responsibility for designing and delivering the outcomes to providers in partnership with young people, their families and communities. The co-production process has included an asset mapping exercise with local young people to identify the resources of individuals and organisations that could help support young people's aspirations. An outcomes-based commissioning process will be used to deliver the agreed changes.

## 9. Supporting healthy behaviours

Risky health behaviours remain an important cause of ill-health. As Tom Hennell has illustrated (Chapter two) there is not a simple correlation between health risks, health assets and levels of wellbeing. It is not always possible to both increase health assets and reduce health risk, because people often make trade-offs depending on their circumstances. Starting with an assets approach supports an increased focus on understanding how and why people make positive and healthy choices and how those choices can be supported.

### Why don't people smoke?

Campaigns to stop smoking have successfully increased the numbers of those who don't smoke from 48 per cent of the population in 1948 to 79 per cent in 2008, mainly because of the increasing number of people who have never smoked. Salford Health, Wellbeing and Social Care Scrutiny commissioned an appreciative inquiry to explore why people choose not to smoke. It asked what people's motivations and drivers were. What could the council and other partners do to support non-smokers who live in an area with high levels of smoking and foster a culture of not smoking?

The scrutiny panel concluded there were things they could do to make it easier for people to be non-smokers, especially young people:

- encourage young people's own campaigns about smoking and the tobacco industry
- support work in schools on peer support and confidence building, and open conversations about difficult issues such as peer pressure
- support hobbies, interests and activities that would be impaired by smoking
- work with parents and the smoke-free homes project run by Unlimited Potential[53] on the health impacts and the affect on home life.

"Scrutiny found that if you look at something from a solution-focused point of view you see different things from different perspectives and gain a broader overview. Using appreciative inquiry is empowering, a problem which appeared intractable is no longer so […] The feedback from this piece of work for all those involved has been really positive."[54]

53 Unlimited Potential is a social enterprise committed to the assets approach. www.unlimitedpotential.org.uk/

54 Report by Salford Health, Wellbeing and Social Care Scrutiny; Appreciative Inquiry – health inequalities and smoking.

In Salford, stories were collected from non-smokers about what had motivated them, making contact via family networks, high schools, community groups. Most people had a story to tell about what had encouraged them. For example, stories included:

- I came from a family where smoking and other issues caused arguments, most of my friends smoked and I wanted to be different. I also wanted to prove I could do better. I enjoyed singing and had other motivations that I could use to resist peer pressure to smoke and I am confident.
- People who don't smoke have to be quite strong.
- I was so involved in dancing that I never wanted to smoke. Dancing gave me the initiative to stay healthy.
- I have never been shackled to anything and have been able to make my own choices.
- Smokers were a big influence [in my decision to not smoke]. I didn't want to be like them with yellow fingers and smelling of smoke.
- I saw members of my family become very ill with smoking and I didn't want that.

## 10. Community development to tackle health inequalities

"Community organising is the process by which people who live in proximity to one another come together in a democratic association to decide and act on their common interests. There are two paths to community power: organising to hold outside institutions accountable for meeting needs, and mobilising the community's own capacity to address local needs and to realise its vision."[55]

In Chapter two, Mike Grady shows that levels of social capital – informal and formal networks, group memberships, trust, reciprocity and civic engagement – correlate with levels of wellbeing and health inequality. Local agencies have a large part to play in creating the conditions in which individuals and communities can flourish and take control over their lives and their health. Community development is one way to build networks, social capital and collective empowerment which create resilience and sustainability.

"[Empowerment is] the outcome of engagement and other activities. Power, influence and responsibility is shifted away from existing centres of power and into the hands of communities and individual citizens."[56]

### Asset-based community development (ABCD)

"Truly empowered communities […] are those that identify, connect and utilise their own assets."[57]

55 Jim Diers, ABCD Institute, launching the NESTA Neighbourhood Challenge. 23/12/2011. see also Diers (2004) Neighbor Power: Building Community the Seattle Way. University of Washington Press.

56 The ideal empowering authority: an illustrated framework, LG Improvement and Development, UK (2010).

57 Jim Diers (2004) Neighbor Power. Building Community the Seattle Way. Seattle. University of Washington Press.

ABCD is the core activity for asset practitioners – see 'A glass half-full'.

The basic steps of ABCD are:

- map the assets, identifying the gifts and capacities of individuals, associations and institutions
- intentionally build connections between residents so that they can mobilise and act together
- bring the community together to develop a vision and plan.

It is not specific to health and wellbeing outcomes. The aim is to strengthen community through the realisation of their own resources and connections.

"Asset-based community development contributes not solely to the dignity of the individual but also to the vitality of the neighbourhood and ultimately to the health of democracy. For individuals it offers genuine, not impersonal services. For neighbourhoods it creates a strong sense of community; takes a holistic, community directed approach to development; and builds on sustainable and formerly underutilised resources, [it] transforms passive clients and customers into active citizens."[58]

### The Health Empowerment Leverage Project (HELP)

In 2010, the Department of Health funded the Health Empowerment Leverage Project to test the business case for the use of community development in health. The Project's aim was to use community development to promote better collaboration between health agencies and local communities and improve social participation and strengthen social networks.

The hypothesis was that community development produces significant improvements in the health and well-being of local communities and consequent savings to health and other budgets. HELP applied the transformative community development approach in three PCTs in Devon, Solihull and Wandsworth.

Transformative community development – the seven steps model

1. Establish a residents and service providers learning set.
2. Run joint workshops and learning sets to develop their skills.
3. Organise 'listening events' for residents and services, including exchange visits.
4. Create a formal partnership that links the community with the services.
5. Establish monthly public partnership meetings.
6. Collect evidence of change, social capital, organisational, key indicators.
7. Embed sustainability - coordination, facilitation and communications.

The TCD model used by the HELP team was originally developed by two health visitors who confronted intense levels of need on their patch in Cornwall, and decided something had to be done to revive community spirit, improve social relations and give people confidence that together they could do something to improve their lives. The impact on health, wellbeing, crime and education was remarkable 'see A glass half full'

58 Jim Diers (2004) Neighbor Power. Building Community the Seattle Way. Seattle. University of Washington Press.

## HELP in Solihull: 'from apathy and anger to positive energy'

The initial contact with the HELP team was made by the GP Lead commissioner who invited them to run a workshop on community development and health inequalities for the Care Trust (PCT). This led to the GP attending the multi-agency Neighbourhood Management team and their decision to work with HELP in the Smiths Wood area. This was one of the most disadvantaged areas and with few community groups. It was described by front line staff as "heavily stigmatised, a history of poor engagement with service providers, low social capital and correspondingly high levels of poor health and anti social behaviour". Residents were perceived to be "mistrustful, angry and hard to engage…leading chaotic lives". A major regeneration programme over the preceding five years had resulted in significant resident discontent and disengagement.

Over 12 months (Feb 2010 to Feb 2011) the HELP team followed the seven step model of TCD (see chapter three).

**Steps 1 and 2: Gathering**

The HELP team introduced the idea of TCD in meetings with local agencies and in four public meetings with residents. After initial hostility, the residents realised this was intended to increase their influence and they could see visible signs of the new commitment from the local agencies.

**Step 3: Listening**

A 'listening event' attracted 60 residents and 20 providers to look at 'what is good in the area and what is not so good'. They identified the main priorities as tackling anti social behaviour, rebuilding community spirit and improving the environment. Agencies and residents committed to working together as equals to address the issues.

**Step 4 and 5: Towards partnership**

Smiths Wood Area Neighbourhood Network (SWANN) was established in July 2010 as a resident organisation with service providers attending, and meeting separately. Police, local council, health trainers, a public health analyst, the voluntary sector umbrella body, fire service, head teachers, housing officers, transport manager and park rangers are all involved with SWANN.

**Step 6: Positive outputs**

There is visible evidence of the change in relationships in the area as well as in services and local facilities. The council has provided two empty shops as a community hub which has been refurbished by volunteer residents. Residents have been trained in committee skills and computer skills to help with running SWANN.

Activities in the first 18 months include a phone advice service, swap shop, Christmas food hampers and party, a mobile dental unit, health trainer sessions. Local voluntary organisations such as Age Concern, churches and a poverty action group have got involved in the area.

**Step: 7**

The Regeneration Company has given SWANN an empty shop as a community hub which has enabled them to provide advice and support services and easily accessed information on housing and health issues. The project and approach has gained national recognition: the Department of Health has given the Solihull GP Commissioning Consortium £35,000 to continue the work.

# 11. Network building

Assets are of most value if they are connected and mobilised, and this happens through networks, informal links and connections. While asset mapping can reveal the assets in an area, detailed network mapping highlights where an individual's or a community's networks are weak or do not connect different communities or to organisations, and where work is needed to strengthen them.

The Royal Society of Arts (RSA) Connected Communities project[59] – drawing on the research that 'reveals the striking extent to which social networks affect our behaviour and wellbeing' – has piloted a method of mapping networks in local areas. The method is effective with individuals and with informal groups; it enables them to reflect on their own networks and how to make better use of them.

The research in Bristol and Lewisham found that:

- "A quarter of our respondents could not name anyone in their social network who they thought was a) good at bringing people together or b) could help them contact someone with influence, power or responsibility to change things locally."
- "Being retired, unemployed, living in certain areas, and having few connections in general all made it more likely that people would be disconnected from local influence."
- "One in fifty of our respondents did not know anybody in their local area that supported them or helped them to make changes in any way."
- 'Familiar strangers' like postmen and dustmen appear to be under-utilised community resources: in the RSA case study more people recognise and find value in their postman than their local councillor.
- Community hubs, including pubs and sports clubs, are an important aspect of community resilience and empowerment, but the best hubs are often unexpected ones: the gardening centre and a big supermarket were the best at linking people who were otherwise unconnected.

The conclusion is that strong networks are key to empowerment, participation and wellbeing. Without them a community cannot help itself or engage with others to improve their lives.

The RSA project is now working with local groups to trial network-based interventions initially to address local problems, and in future to affect behaviour change. A further four year project focusing on networks and mental wellbeing is being set up in seven areas across England.

**Bumping places**
Jim Diers, a leading figure in 'Asset Based Community Development' and formerly Director of Seattle Department of Neighbourhoods describes how they deliberately created ' bumping' places in social spaces, parks and housing developments, so that people could bump into each other informally which would help create the informal networks that support community actions.

59 Connected Communities: How social networks power and sustain the Big Society (2010) Rowson, Broome and Jones. Communities Connected: Inclusion, Participation and Common Purpose (2011) Morris & Gilchrist both at //www.thersa.org/projects/connected-communities

## 12. Resilient places, flourishing places

Resilience: The ability of individuals, families and neighbourhoods to cope positively with change, challenge, adversity or shock.

Resilience is a term much used at the moment. As Mel Bartley sets out in Chapter two, it is one of the critical health assets at an individual, family and neighbourhood level. Most importantly, individual, family and neighbourhood resilience can be impacted on by public policy. It can be increased and sustained by local government and health agencies actions, or it can be undermined by poorly designed educational, social and economic policies.

"An approach that values assets identifies the skills, strengths, capacity and knowledge of individuals and the social capital of communities […] It provides a different story of place that is a positive and outcome focused picture that values what works well and where health and wellbeing is thriving. Community pride and spirit is therefore higher and people are engaged in solutions that are more sustainable for that community, with use of outside support where it is needed most."[60]

A sense of place and belonging are important health assets; interventions that improve the resilience of a place and value its role in the resilience of individuals and families are important areas for action. The quality of the natural and built environment as well as the accessibility of green spaces contribute to wellbeing; they create opportunities for physical activity, relaxation, leisure, places to bump into people and events that bring people together. Good connections with neighbours and the ability to work together all help make a community more resilient as well as improve the social and environmental circumstances.

"Flourishing communities are those where everyone has someone to talk to, neighbours look out for each other, people have pride and satisfaction with where they live and feel able to influence decisions about their area. Residents are able to access green and open space, feel safe going out and there are places and opportunities that bring people together."[61]

Gateshead, Rochdale and Knowsley are working at different scales, but they are all using asset principles and appreciative tools to reenergise trust and collaborative working in the neighbourhood.

60 Living Well (2010) NW SHA www.nwph.net/hawa/details.aspx?pid=103&type=rep&id=2227

61 Introduction by Dr Ruth Hussey to A glass half-full (LGID 2010).

## Bensham and Saltwell Alive - creating get-together opportunities

Bensham and Saltwell Alive[62], a neighbourhood group in an area of Gateshead has continued with their assets and appreciative approach to building a resilient place. In 2010, the community asset mapping project found 145 people willing to share their skills, and showed that there were local skills and interests that could be connected. By creating 'get-together' opportunities for individuals such as creating an allotment, cooking classes, a film club and an over-50s singles club, they have increased the social networks and activities. A celebration of cultural interests – called 'K Alive Oscope' – saw residents of all ages acting, singing and dancing on the stage of a small neighbourhood theatre. Individuals have grown in confidence and in their willingness to participate and take on responsibilities for their community.

In order to embed and reinforce this way of working with partners, three half-day awareness sessions were held to learn about assets approaches, appreciative inquiry and ABCD, and 57 people from 24 services and organisations attended. It has inspired changes in the way both voluntary and statutory organisations work in the community to make opportunities for the assets and strengths to flourish. One example is a pilot initiative looking at how to broaden the connections with adults with learning disabilities living in the neighbourhood, who currently use a day centre outside the neighbourhood they live in.

"This is a slow burner – it has to go at the pace that individuals are comfortable with which is not necessarily the speed of change that governments anticipate. It is important to support opportunities for informal networks and interactions to take place; these are the settings that help people feel better about themselves and gain confidence, before it is realistic to expect citizens to be actively interested and involved in more formal networks and associations." David Andrew, Bensham and Saltwell Alive Steering Group.

62 www.gateshead.gov.uk/People%20and%20Living/neighbourhoods/central/BenshamandSaltwellAlive/BenshamandSaltwellAlive.aspx

## Rochdale – What would it look like if we got it right?

When the mainstream media dubbed Lower Falinge the 'sicknote capital of England' they managed, at a stroke, to bring national notoriety to an estate already struggling against serious social and economic difficulties. Dave Broome of Rochdale Council describes how they used appreciative methods to bring about a radical transformation in the residents' self confidence and their willingness to get involved:

"Lower Falinge was blighted with bad publicity which hurt both residents and frontline staff who were working to make it as good as possible. The local strategic partnership had all the data and we thought we knew what the problems were. But we wanted to find out what the people who lived there thought and get a clear picture from their perspective as to our starting point.

We did 200 face to face interviews with residents and lots of interviews with frontline staff. The issues that came up were crime, health, safety, people not accessing services; in some respects these were what we expected. But we also wanted to know what the dream was. What would it look like if we got it right?

We organised a meeting using appreciative inquiry and invited residents, staff from different agencies, managers and councillors. There were 87 people in one room. They all worked on a 'dream'; not the council's dream or the residents dream but the dream put together and shared by everyone in the room. There were people in the room all talking about their best experiences, whether it was living in a village in Ethiopia or managing a service in the area, and how they could build on those to help Lower Falinge be a 'place they could be proud to live and work in'.

The appreciative inquiry approach was important because it brought everyone together, on an equal level with everyone else which is so important if we are to get things right. There was no hierarchy. Everyone was valued for what they brought. We did drama, singing, story telling – it was fun and people connected with each other.

Then we organised an event to design a future statement – what would we all do about the elements that would make Falinge better?

This covered work, skills, health, housing, belonging, accessible services etc. And we made plans for now, for the medium and long terms. Again we had a wide mix of people and we had fun. We were doing serious work but in a fun way and a constructive way. Residents did it together with the services, not just saying what they wanted but asking others what they wanted to happen. This made it more than a plan, it was what everyone had dreamt and designed together. And from that we could see what was important to transform the estate, for example bringing services together and locating them on the estate, raising aspirations.

Next we held a world café event with 125 people present. And we used that to prioritise what we would do first. What was moving about the day was that services put their hands up at the meeting and said what they would do. And it got infectious so that everyone was saying what they would do to make the Falinge dream come true. It was a very powerful moment and a proud moment for everyone in the room.

Has it had an effect? Yes lots of good things have happened, with the landlord, police, youth service, employment services all making changes. And we have seen a 42 per cent drop in crime, a 29 per cent drop in antisocial behaviour and people are connecting to services and receiving support to progress, and confidence and pride in Lower Falinge has grown.[63] *(www.explorefalinge.org)*

## Knowsley: 'It is a light bulb moment. You can't measure it but you can see the results'

"We realised that we needed to rebuild the relationships between the council staff and the residents and understand what motivates our communities. In spite of all the regeneration money we had not really worked closely enough with the community as a whole; this gap had created something of a dependency culture in some areas and with some families trust had broken down. Although all our new buildings and services were in response to issues that local people had raised and the data was telling us they were needed, they were not always being used to their full potential. Our approach was based on the perception that the community lacked the necessary knowledge and insight or was unwilling to contribute. That has turned out to be wrong." Ken Harrison, Knowsley Area Relationship Director.

Knowsley's North Huyton Neighbourhood used the Connected Communities programme as a learning laboratory to work on improving the relationship between public agencies and the community, rather than focusing on 'fixing' the communities. The first step was richer information on the assets and dynamics in their community so that they could review the way they worked in the area. This led them to whole system thinking and the use of appreciative and strength or asset-based approaches to reconnect staff and services with the community and to change how neighbourhood services are delivered in the Page Moss area of Knowsley.

63 Lower Falinge In Focus Project is an award-winning community engagement process. Video case study of Lower Falinge, see www.nwtwc.org.uk/champions/features/index.php?pid=10. They are a North West Community Empowerment Network Champion www.nwtwc.org.uk/uploads/documents/awardcasestudies.pdf There is also a website documenting change and developments at: http://explorefalinge.org/

## Knowsley – fixing the organisation not the community

**A richer picture of the community**
Relying on traditional data such as the Index of Multiple Deprivation (IMD) and the Place Survey had led to the use of stereotypes and misunderstood needs to design services. They needed a richer picture of the community which understood the strengths, connections, history, beliefs and values. To get this they have used several different tools to get a deeper understanding of people's different values and motivations: not just what choices people make but why they do and how they see themselves. For instance in parts of Knowsley many people put a very high value on stability and so emphasising the changes in their area was unlikely to be positive and in many cases it eroded trust.[64]They conducted in-depth interviews with volunteer families to get a deeper understanding of the lives, attitudes and behaviours of residents, using community insight and a deep dive ethnographic study. And appreciative conversations were conducted informally across the estate, including the youth service holding group conversations with young people.

**A 'Big Conversation'**
An appreciative inquiry was designed to prepare the ground for organisational change and to give frontline workers a voice in how to create good relationships with residents and service users. A planning meeting with people from across the whole system designed a one-day event titled 'Unleashing the potential of frontline workers'. They agreed the appreciative questions were:

- What is it that makes a brilliant frontline experience, changes the life of the resident and satisfies the worker?
- What makes that kind of working possible?
- What would we need to do to make that experience more prevalent in our everyday practice?

Some 64 people from all parts of the system attended. In the morning face to face conversations got everyone talking to each other, based on the idea that 'if you can get the system in conversation with itself, that is where the change will happen'. In the afternoon, they took the learning from the morning and explored what it would take to make the ideal a reality. They have now co-produced a simple community plan which has been agreed by the local area partnership board and the community.

The report to the North Huyton Partnership Board (July 2010) said:

"This piece of work has demonstrated that organisations need to trust in people's capabilities to be bigger than their job, to act on behalf of the organisation as a whole for the better of the communities they serve."

"Not only did the event provide a rich picture of Page Moss but it also told a powerful story of the pride, loyalty and commitment that frontline workers felt about their organisations and community they serve and in the tasks they undertake."

64 See Values Mode and Cognitive Edge at www.thecampaigncompany.co.uk/vmdescription.html

"The habit of staying separate from one another (residents, members, strategic/ operational managers and frontline workers). Although having the whole system in the room is risky and invites a certain degree of increased conflict, the rewards are well worth the price. What we saw was that people's sense of isolation and disenfranchisement dramatically decreases and their views and judgements of each other started to disappear or at least decreased in nature and their ability to think about the good of the whole increased."

The results of this new approach are widespread:

- Significant changes have been adopted or were recommended in performance management, decision-making and rewards systems that would empower frontline staff and inspire and motivate them to be 'highly productive, innovative and creative'.
- Street cleaning and grounds maintenance frontline staff are transforming their own services. Instead of command and control management and rigid schedules, they are given greater powers and flexibility to respond to the community which leads to much better outcomes and higher productivity.
- Community champions have been recruited from people who are already active in the community, for example those running a football team. In return for them going out to talk to and support people on the estate to get involved in community life, their group gets access to the community chest.
- Community resilience work means schools in Knowsley have been working on improving 'mental toughness' and they are now looking at what lessons could be applied to build greater community resilience.
- A peer family mentoring scheme.

Based on interview with Ken Harrison, Knowsley Area Relationship Director who led the project, and with Cliodhna Mulhern of Flowstone, who facilitated the project.

## 13. Asset-based service redesign

"There are things that only a community can do – so get out of their way. There are things that a community can do, with some help – so offer to help. There are things that only government can do – so do them." Cormac Russell, ABCD Institute.

A powerful way to implement asset principles is to review the policies, practices and the services that are delivered to client groups who have been defined almost solely in terms of their deficits, and who often feel cut off from the wider community. This work continues in the tradition of the 'social model' of disability and discrimination which has been very influential in the fields of learning and physical disability, for instance. The focus of attention is on integrating people with disabilities or dementia into the community, removing the social barriers that make their lives difficult and building the community assets and resources that can support them.

## Dementia capable communities: 'a community which is good for someone with dementia is a community that is good for everyone'

Two thirds of people with dementia live in their own homes in the community, and participate in everyday activities. One third live in long-term care settings which are also part of local neighbourhoods and communities. The quality of the communities they live in is an essential part of any strategy concerned with wellbeing, with breaking down stigma and isolation, and with supporting independence as long as possible. Campaigners and professionals working with people with dementia and their carers are using an assets approach to develop the concept of a 'dementia capable communities'[65] and nurture the assets that make a place safe, welcoming and enabling to people with dementia. The characteristics of such a place are:

- Safe physical environment, in which people can go out to shop or walk in the park in knowledge that they will not be in danger
- Suitable built environment – creating safer pedestrian spaces and road networks, open spaces and signage, as well as adapting people's homes
- Local facilities – both day and residential centres which enable people to retain and build networks of friends and sustain participation in familiar events and places, and which welcome and support carers as well as other local people
- Adopt practices that actively empower people with dementia to have a voice, retain their self-esteem and stay in control of their lives as long as possible[66]
- Support services that are designed to acknowledge and incorporate the individual's histories, strengths and needs. Activities such as memory clubs, life stories and 'singing for the brain' help as do other communal activities such as gardening clubs and befriending, for example.
- Social networks are nurtured, with old friends and new, which enable the person with dementia to offer their skills as well as receive help. Such networks also bring together people of all ages.
- Local groups for carers and families to support each other
- Local neighbourhood schemes or volunteer champions – not necessarily carers – who go out and encourage a welcome response in shops, pubs and buses. This can proactively challenge stigma and help to normalise living well with dementia.
- Employ 'navigators' – people who ask 'what would improve your life?' rather than 'what services can I refer you to?'

This kind of approach involves training for the professionals – including doctors – to challenge old assumptions based on the deficit or medical model; active support for cross-sector collaboration; and local commissioning and investment plans that support the policy.

65 Developing Dementia Capable Communities – A framework for Action: Rippon SP & Goodchild C. 2010 www.innovationsindementia.org.uk

66 Stockport NHS's EDUCATE is a self help and awareness project for dementia. www.stockportpartnership.org.uk/HWBP/partnership_news_educate.html

### People with mental health problems

People with mental health problems and their neighbours share many of the same concerns about the local area and how it affects their wellbeing. The Manchester Alliance for Community Care (MACC) is exploring how to put asset principles into practice in relation to people with mental health problems. This has led them to work that builds links between people with mental health problems and their neighbourhoods that can lead to greater inclusion. MACC and the North Manchester 5 ways 2 Mental Health and Wellbeing Network has asset mapped the public and voluntary sector services and the community resources which contribute to improved mental health and wellbeing. Services specifically for those with mental health problems as well as universal services such as libraries were identified. But they found that a very high value was put on parks, local shops, the bakery, the fruit and vegetable shop, markets and community churches which contribute to their experience of a friendly and accepting neighbourhood. This is not just true for people with mental health problems but for everyone in the area with an interest in positive mental wellbeing. Highlighting the value and shared importance of these shared assets creates a stronger and more inclusive sense of community.[67]

## 14. Assets – embedding it in the organisation

Many councils and others have adopted wellbeing as a strategic outcome but struggle to know how to embed this into their service delivery and ways of working.[68] Assets approaches offer a way to do this, but it requires some significant organisational changes in systems, attitudes and ways of working. One of the major challenges is how to embed such a far-reaching set of principles in local agencies. Learning from the experience so far, a whole system approach and the use of appreciative tools in both organisational and community settings are valuable and effective.

### Whole system change

The Asset Approach to Living Well[69] is the North West NHS's call to action to reduce inequalities through prioritising wellbeing and adopting an assets approach that strengthens the factors that protect and enable health. Under the auspices of the NHS North West, a multi-agency group of public health, local government and voluntary sector organisations have been developing and co-ordinating different initiatives. These include a mental wellbeing survey, health scrutiny using appreciative inquiry, social prescribing, community development and many other initiatives. (See 'A glass half-full' for more information, and Chapter one.)

In preparation for the transition of some aspects of public health into local government, they have produced a policy commitment that argues for a whole system assets approach to be taken by the proposed health and wellbeing boards. They used their experience to describe the 10 key steps that have to be taken if an assets approach is to be integrated into local services and community life.

67 www.macc.org.uk

68 For more information including how the Five Ways to Wellbeing can be designed into services see The role of local government in wellbeing (LGID, nef, NMHDU 2010)

69 NHS NW, 2010, Living Well across communities: prioritising wellbeing to reduce inequalities, Manchester, NHS NW

**Figure 7**


**Appreciative methods for community-led change as well as organisational change.** Until recently appreciative inquiry (AI) was more often used as an organisational development tool in companies and organisations. It is increasingly being used with residents as part of a large group or whole system conversation that includes residents, councillors and staff and everyone affected by the topic.

The North West Together We Can network of community organisations has been exploring the power of appreciative inquiry involving communities, public agencies and voluntary organisations in whole system change, strategic planning, service redesign, neighbourhood renewal and problem-solving. Case studies from Salford, Trafford, Rochdale, Knowsley, Manchester and Cumbria show how that this way of working has changed the way they feel about their neighbourhood and services, and had a positive impact on staff and services.[70]

SupportNet in Nottingham is one of the Department of Health's Building Community Capacity exemplars and they used AI to bring people together - disabled and non-disabled residents, frontline professionals and strategic leaders – to plan how care and support will develop in the future.[71]

70 Mulhern & Emanuel (2011) Working with Possibility: Appreciative Inquiry in the North West www.nwtwc.org.uk/uploads/NWTWC-appreciative-Inquiry.pdf

71 www.thinklocalactpersonal.org.uk/BCC/BuildingTheBigSociety/

**The experience of SupportNet: where people care for each other using appreciative tools in a neighbourhood setting**

What are the key features of this way of working?

- An AI brings together the whole system – that is, everyone who plays a part and could play a part – to develop productive relationships and build a community that will act together in the interests of all. This community can be everyone who lives or works in a neighbourhood, or with a particular client or interest group.
- Everyone is invited as equals to bring their gifts, talents and ideas, to be accountable, to participate, to express dissent, and to own what emerges from the meeting.
- The purpose is to find out what really matters to the people in the room, what's the 'dream' ideal outcome, what people are ready to do, and where the energy for making change is. This is not just establishing facts, but finding out where assets such as knowledge, motivation and passion exist.

The underpinning beliefs:

- that the wisdom about what and how to change is already in the room - the job of the AI practitioner is to create the conditions for that wisdom to emerge and be heard
- that change starts to happen as the conversations take place, because by talking to each other in this way relationships and attitudes start to change
- that if you predetermine the outcome of the meeting, you will miss out on new perspectives and innovative solutions

What might a neighbourhood or organisation want to achieve with AI?

- To build and sustain a lasting network of relationships and trust that has the ability to make changes happen in the service or the area
- For people to feel included, valued and able to contribute to a collective wisdom that inspires changes
- To make fundamental and systemic changes in practices, attitudes and relationships which together transform outcomes

What does it require from practitioners who act as the hosts?

- Hosting is the term used for the role of the practitioner who convenes the meeting and creates 'enough structure to avoid chaos but not too much to stifle creativity'.
- It's best not to work alone, and a good idea to create a safe practice ground - through training and learning from experienced practitioners.
- Preparation and intention are key to creating the right conditions. Take time to write a good invitation and 'positive question' that will draw people in. Only call a meeting if there is a purpose and an intention to change.
- Establish a core group to steer the process, to do the 'harvesting', that is, identify the learning from the events, and to take ownership of the change process. The group should represent all the different perspectives and interests in a balanced way.
- Use a model to loosely structure the process. For instance AI uses 'define, discover, dream design, delivery'.

Model the qualities you ask of others. Pay attention to what is happening and what is needed, be adaptable and open to emerging themes, contribute as an open-hearted human being as well as wearing your professional hat.

Build in the harvesting from the start. Keep full records of conversations, workshops and events including quotes, photos and graphics that will help participants to 'make sense' of the themes, new understandings, connections, ideas and proposals. Help them feedback to the wider community.

Pay attention to the venue. Create the right conditions for good conversation. For instance how you layout the room, and how you show people they are welcome, is important. Refreshments, flowers, and a colourful environment all help.

*(Courtesy of www.wrmatters.co.uk who are working with SupportNet.)*

## 15. Workforce and organisational development

"The success of an asset approach is reliant on gaining buy-in from all staff and partners. Buy-in is as much about the value base that underpins co-production work, as the process itself. The asset and co-production approach requires fundamental organisational culture change in relation to values and attitudes at both strategic and frontline levels. Such fundamental change needs to be supported by a co-ordinated approach with partner agencies and organisations working collaboratively across the district."[72]

The shift from a using a deficit-based approach to an asset-based one has far reaching consequences for organisations and the staff who work in them. The attitudes and skills of the workforce are critical to the effective embedding of the new asset-based values and culture. New roles, new relationships and new ways of working are all part of the new culture.

### Staff have assets too

The appreciation of the assets of staff, who bring knowledge, passions, skills and networks to the delivery of services, is an important initial step. Their attitudes and behaviours are key to any innovation. New styles of leadership and management are needed to actively build on that resource to improve services; for instance the Knowsley approach of working collaboratively with the frontline staff to involve them in redesigning their own services (see above).

### Personalisation and more

There are both cultural and organisational parallels between the transformation of public health and wellbeing services and the work done on implementing the vision for social care and the personalisation agenda. These may provide useful learning for the integration of asset principles.

Only a footstep away? the Skills for Care Workforce Development Report[73] on the implications of personalisation draws attention to the need for new ways of working, an expanded knowledge base and

72 Growing Communities Inside Out. Piloting an asset based approach to JSNAs within the Wakefield District: methods and findings. (2011 LGA, Wakefield NHS, Wakefield Council) http://www.idea.gov.uk/idk/core/page.do?pageId=32356192

73 Hudson & Henwood (2010) Only a footstep away? neighbourhoods, social capital and their place in the big society. www.skillsforcare.org.uk

an upgrading of core skills which will be required to deliver the transformation of care and personalisation agenda.

The Building Community Capacity project – originally part of the Department of Health Putting People First programme but now part of the Think Local, Act Personal Partnership[74] – has distilled the experience of over 50 pilots into a set of 'strategic enablers' which are required to achieve this change of perspective and role.[75] These enablers include:

- elected members who see community capacity building as part of their role
- commissioning priorities that explicitly include building community capacity
- strong partnerships across the public sector, taking a place-based approach
- an equalities, rights-based approach to encourage wider participation in commissioning
- and delivery, including disabled and older people
- investing in user-led and carer organisations including helping them develop core business skills and expertise
- making community capacity building integral to personal budget support plans and the redesign of personalised services
- local community development capacity, neighbourhood management teams, schemes such as village agents, community connectors and facilitators
- supporting local reciprocal exchange schemes such as timebanks
- support to third sector infrastructure systems and practices.

(See Appendix two for more links)

### Innovation as a journey[76]

The well known 'recovery approach' has many similarities to assets thinking.[77] The concept of recovery refers to both the internal experience of people who describe themselves as being in recovery – hope, healing, empowerment, and connection – and to the external conditions that facilitate recovery such as a positive culture of healing, recovery-oriented services and human rights principles. The recovery approach promotes ways of working and strategies that systems, agencies, and individuals can use to facilitate recovery.

This thinking has been a source of innovation in many health and care services, but research by the National School of Government in two health trusts found that implementation has been held back by a "lack of know-how and capacity across service providers, particularly in mainstream services". The research stated: "While a new social enterprise that employs people with mental health disorders may co-design services, it is harder for established professional and institutional bodies to change their thinking and behaviour." Their work provides learning about how to support innovation into the mainstream, which includes the following points:

74 www.thinklocalactpersonal.org.uk/BCC

75 Practical Approaches to Improving the Lives of Disabled and Older People through Building Stronger Communities (DH 2010) www.thinklocalactpersonal.org.uk/_library/PPF/NCAS/Practical_approaches_to_Building_Stronger_Communities_12_November_2010_v3_ACC.pdf

76 Maddock & Hallam (NSG & BIS 2010 ) Recovery begins with hope. www.nationalschool.gov.uk/downloads/RecoveryBeginsWithHope.pdf

77 www.centreformentalhealth.org.uk/pdfs/recovery_toptips.pdf

- Leaders “change the rules, blur boundaries and motivate staff to work outside of their old roles”. Early champions took hold of the vision and set about persuading their colleagues and partners. They put collaboration and outcomes at the heart of the organisation.
- Systematic incorporation of recovery principles into the management functions such as performance appraisal supported service transformation.
- A network model of management blurred the boundaries between staff and users, between professionals and partners. Active users were in a position to influence decisions.
- A whole system and place-based approach led to more nuanced commissioning and holistic services.
- Changed attitudes and behaviours are key to any innovation, but it was found that unless middle managers and HR practices supported the learning, it could not be applied to practice.
- Peer support workers not only give confidence to users but also challenge behaviours and attitudes.

# **Chapter four:** Measuring positive health

## What do we know about evaluation?

**Professor Huw Davies is Professor of Health Care Policy and Management at the University of St Andrews, and is an expert on understanding the use of evidence in public organisations and policy.**

Evaluation approaches and methodologies must be tailored to the complexity of the task in hand. An asset-based approach to public health assumes certain system complexities that make more traditional evaluative methods – such as randomised control trials – less helpful and sometimes inappropriate.

Moreover, in developing action from evidence, we need to know much more than just 'what works' – or even 'what works, for who, where, and in what circumstances'.

We also need to 'know about' – to understand the nature, formation, natural history, interrelations and dynamics of social problems and social accomplishments. We need to 'know why' – to be able to link the values that underpin actions to the formation of policies, strategies and support mechanisms. And we need practical 'know-how' – the pragmatic knowledge about how to go about getting things done. Useful, actionable, knowledge on each of these will come from diverse methodologies, including participative methods such as action research, action learning and appreciative inquiry.

In contrast, traditional evaluative methodologies, such as randomised control trials, work best when we are asking simple questions of a defined intervention for a defined population – questions like 'can it work?' or 'does it work?' Such trials are best when we have a discrete separable intervention that interacts directly with individual subjects and that operates largely independently of context. Moreover, for such trials to make sense, there should be good grounds for assuming a degree of homogeneity of impact of the intervention on individuals, so that the task becomes one of estimating the mean effect size. When an intervention can have wildly different (and unpredictable) impacts on individuals and even more so in whole communities – with some gaining great benefits, while others suffer ill-effects – it makes far less sense to seek an estimate of 'average benefit'.

More often, in public health, and when taking an asset-based approach, context has a huge influence. Indeed we are intensely interested in the effect of context: does it increase or block effectiveness as it interacts with interventions or change strategies? In such cases, the evaluative task becomes one of trying to understand the mechanisms by which desirable outcomes are made more likely by the interaction of actions and context. And because of the complexity of such interactions, non-linearity may play a prominent role. That is, large interventions may elicit little response from the system, while small ones, quite unpredictably, may elicit major shifts.

An asset-based approach to public health, then, acknowledges the massive interconnectivity and complexity inherent in systems like neighbourhoods and communities. It conceives of 'good health' as emerging from dynamic networks of (semi-) independent sense-making actors, replete with feedback loops, where the actions of one set of actors can set the context for others in loops of infinite regress that are sensitive to historical contingencies. When conceived of in this way, the evaluative task is to try to understand the local assets (through 'asset mapping') and to figure out the dynamics that link these (individual and collective) assets to change.

It is important, then, that there is coherence between the ways in which the system is conceived and modelled, and the evaluative approaches and methodologies that are used. Developing an asset-based approach – and creating the evidence-base needed to inform its progression – will require a wide repertoire of investigative skills. These should draw on a wide and diverse set of theoretical constructs, conceptual categories and modelling frameworks (such as self-efficacy, resourcefulness, coping, individual and collective learning, to name but a few).

Investigative strategies should aim to produce locally-sensitive data for formative (rather than summative) learning, and as such will encompass stories, narratives and accounts of the lived experience in the system as well as more formal and structured data collation. Close participation from those whose assets and capacities are being supported, in processes of knowledge co-production, will also be vital. In this way, far from being something applied from outside, evaluation is kept embedded in the system and forms a critical part of local reflective practice.

## The context for evaluating asset-based approaches

The theoretical and research evidence for the positive impact of community and individual assets such as resilience, self-determination, social networks and social support on health and wellbeing is well known and at least comparable to that of more familiar social determinants of health such as housing, income and environment. In addition to this direct impact, evidence now shows that "interventions to maximise and take advantage of health assets can counter negative social and economic determinants of health, especially among vulnerable groups."[78]

The emphasis on positive health and reducing levels of health inequalities has led to a growing interest in asset-based working alongside needs-led approaches. Local practitioners are looking for advice on how to:

- measure and understand the pattern and connectedness of local assets in order to plan and design actions and activities that improve wellbeing
- evaluate actions and activities intended to support assets: do they work and are they worth investing in?

While the academic research is clear (see Chapter two) it is early days in the development of specifically asset-led approaches or the redesign of service relationships to nurture assets. Consequently local practice is small scale and exploratory, and evidence gathering is uneven.

78 WHO quoted in Friedli & Parsonage (2009)

Health Assets in a Global Context[79] brings together international evidence on "the rationale for asset-based approaches and provides a systematic way of thinking about how to build an evidence base which can help us understand the most important assets for health". The authors argue there is a need for new indicators and evaluation techniques which take account of the approaches and demonstrate the benefits of investing in them – but this remains 'work in progress'. It states: "A new paradigm is required for the evaluation of health asset-based approach.

The orthodox approach, based on the epidemiological discipline, has limited utility for evaluating the effectiveness of community assets, capabilities, risks and protective factors; and for the synthesis of evidence across studies." They argue that we lack a 'positive' or 'salutogenic' approach to understanding patterns of health directly analogous to the traditional epidemiological approach to studying patterns of disease in populations. And there is a "paucity of intervention research and evaluation of actions that aim at strengthening health assets as a way of producing healthy communities and individuals." [80]

Notwithstanding these gaps, this chapter suggests there are existing and tested evaluation methods that are appropriate for evaluating actions to improve assets as part of the 'chain of progress' towards improved health and social outcomes.

They can be used to contribute to our growing understanding of how assets produce health and wellbeing, and the evidence base for their effectiveness. And they can help improve the two key questions we should ask about activities aimed at improving health and reducing health inequalities: does it work and is it worth investing in?

### Measuring positive health – constraints and opportunities

One of the initial challenges for asset working is to find and collate data that measures positive health and wellbeing to counterbalance the more prevalent and established statistics on mortality, morbidity and conditions that describe individuals and communities in deficit terms.

As we have argued above, there is work to be done to develop and test ways to demonstrate the effectiveness of asset-based approaches and their impact on health and wellbeing to help practitioners overcome the theoretical and methodological difficulties.

79 Morgan et al. (eds) Health Assets in a Global Context: Theory, Methods, Action, Springer 2010

80 Morgan et al (2010) Introduction and Hills, Carroll & Desjardins "Asset based Interventions: evaluating and synthesising evidence of the effectiveness of the assets based approach to health promotion"

The issues include:

- The relative scarcity of data on positive health and wellbeing (compared to data on deficits, illness and death).
- Much of the data is only available at an individual level or at the level of a council area. This data does not align with peoples' sense of their neighbourhood. Aggregated individual data does not capture the quality, quantity or impact of community networks.
- The definition of success can be contested. What does an asset-rich individual, family or community look like in a particular place? How do residents define positive health? What does a healthy childhood look like? Such ideal models can be investigated by professional and academic research, but it is preferable that they are defined by the local community's view of what a healthy place to live would look like.
- While local initiatives might have a direct and measureable effect on the individuals who participate, information is needed on the impact of service changes or social networks on everyone who lives in the area.
- Evaluation of complex programmes needs to factor in the impact of the context and how this interacts with the programme's methodology to generate outcomes. (see Huw Davies above. Pawson & Tilley (1997) Realistic Evaluation. London: Sage)
- To understand the effectiveness of a programme, questions are needed about who it worked for and in what circumstances, as well as how and why it worked or did not work.
- Using participatory methods is the only way to gain a richer understanding of the complex ways in which actions on assets have an impact on personal and collective outcomes, and achieve a measure of transparency for local residents.
- Many of the interventions are experimental and evolve with learning about what works and what doesn't. This makes it difficult to assess progress against goals when these are adapting to unexpected consequences and outcomes. There is a need to approach evaluation as 'reflective practice'. Evaluation and learning are part of and integral to the evolution of the project.
- The timescale of the health outcomes. In fact many 'wicked' public health problems will never be 'solved' but can be made worse or better over a lifetime.
- While the data may help health and wellbeing boards to develop their strategies and track change over time, they are often not suitable for performance or project management.
- It is questionable whether a cost benefit analysis would support collecting and analysing detailed data on complex and multi-faceted changes. Stories and participative methods are more likely to capture the complexity and 'value' of activities such as volunteering, of being active in the community, the consequences of increased self-esteem or the effect of changes in attitudes of staff.

## Localised decision-making

The current emphasis on localised decision-making and the withdrawal of national targets provides an opportunity for a more responsive culture locally. The audience for measurement or evaluation of local interventions is shifting to local decision-makers and commissioners, particularly health and wellbeing boards and and clinical commissioning groups. The onus will be on them to justify their decisions in the context of local accountability and the competing calls on scarce resources.

Voluntary and community groups will be able to take a more holistic approach to positive health and wellbeing. Convincing evidence for a local councillor, GP or community partnership is likely to be less reliant on top-down targets and based more on the immediate and visible experience of change that can be seen on the ground. Participative models of design, planning and evaluation, real time evidence from testimony and story telling, localised data sets and perception surveys will hopefully carry much more weight in future.

Before setting out on designing an evaluation exercise, practitioners need to ask themselves:

- What is the context – who is the audience, what resources can be spared?
- What is the purpose – is it to improve an existing model of practice, is it to make an assessment whether the project worked, or is it to contribute to the development of innovation?
- Does the scale and nature of the evaluation reflect the scale and nature of the project? Will it deal with the complexity of the change processes?
- What are the appropriate methods given the purpose? Surveys are expensive, but by using questions that have been used before, you save time and gain comparability. Participative methods such as storytelling or community events are more inclusive but they need a robust framework for systematic analysis if they are to influence decision-makers.

This chapter is organised around two questions:

**Does it work?** There is a spectrum of models for answering questions about impact, ranging from high level national data sets to methods that ask about local and individual impacts. We will cover the following headings:

1. Measuring local wellbeing
2. Measuring mental wellbeing
3. Measuring community capacity
4. Storytelling
5. Outcomes Star

**Is it worth it?** There is a small field of methods for establishing cost effectiveness which in time will generate evidence about work that aims to strengthen both social and psychosocial assets. We will look at:

6. HELP's business case for community development
7. An economic case for building community capacity
8. Cost effectiveness of promoting mental wellbeing
9. Social return on Investment

## Does it work?

There is substantial and ongoing work to develop systematic measures of wellbeing which asset projects can draw on to define outcomes and measure impact in their local area. The sets of measures usually include health measures – often life expectancy – as well as factors that positively impact on health and wellbeing such as:

- self-reported health, for example how well people say they feel in their lives
- feelings of belonging in their neighbourhood
- feelings of being able to influence decisions

They also include indicators of the social determinants of health such as employment status, education, housing, and green space for example.

Nationally, indicator sets are being developed which will be useful for local areas to establish their baseline position and comparative ranking and to track high level progress.

**The Marmot Review Indicators**
The London Health Observatory and the Marmot Review Team have produced baseline figures for some key indicators of the social determinants of health, health outcomes and social inequality that correspond to the indicators proposed in Fair Society, Healthy Lives. The indicators are available for upper tier councils in England, and local areas are compared to regional and national scores.[81]

The Yorkshire and Humber Public Health Observatory has taken the six critical policy themes from the Marmot Review and collated locally available data. Taking an assets approach and using routinely available data they have produced profiles for each upper tier council, containing a range of indicators on the wider determinants of health. Wherever possible these show the level of inequality and difference within a local area which is potentially of use in shaping local strategies and plans. The local profiles and the data sets can be found online.[82]

**The proposals for a Public Health Outcomes Framework (2012)[83]**
The new Outcomes Framework has two high level outcomes:

- Increased healthy life expectancy i.e. not only how long we live but how well we live at all stages of our lives.
- Reduced health inequality between people, communities and areas, through greater improvements in more disadvantaged communities.

There are a small number of positive health proposals and indicators of health assets. For instance, an indicator of social connectedness is to be developed. The indicator for 'self reported wellbeing' will use the WEMWBS framework initially and then be brought into line with the ONS Measuring National Wellbeing Programme.(see below)

81 www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx

82 The Big Opportunity Part Two: Acting on the Wider Determinants of Health. March 2011. www.yhpho.org.uk/resource/item.aspx?RID=106410

83 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

**The Office for National Statistics (ONS) Wellbeing Index.**

The ONS has been consulting widely[84] on what matters to people and how to measure national wellbeing. People of all ages have highlighted the importance of family, friends, health, financial security, equality and fairness in determining wellbeing. An individual's assessment of their own wellbeing is central to an understanding of national wellbeing; questions will cover their feelings of satisfaction with life, whether they feel their life is worthwhile and their positive and negative emotions, as well as relationships with family and community, mental and physical health, work and leisure including work life balance, environment and income The first set of national set of indicators will be published in Autumn 2011 for comment and further development.

Starting in April 2011, the Integrated Household Survey asked 200,000 people to rate – from one to 10 – responses to four questions:

- How satisfied they are with their life?
- How happy they feel?
- How anxious they feel?
- The extent to which their activities are worthwhile?

**Measuring social capital**

The ONS Social Capital Project site contains background information and references on the project, the results of the work and a 'Question Bank' that can be drawn on to measure local changes.

*(www.ons.gov.uk/about-statistics/user-guidance/sc-guide/index.html)*

84 http://www.ons.gov.uk/ons/rel/wellbeing/measuring-national-well-being/discussion-paper-on-domains-and-measures/measuring-national-well-being---discussion-paper-on-domains-and-measures.html#tab-Introduction

**Long-term changes**

Two national data sets which measured social capital and voluntary activity – the Place Survey Questions on social capital (particularly NI, 1-7 see 'A glass half-full' page 17) and the National Survey of Third Sector Organisations (www.nscsesurvey.com) – have been discontinued. However, local areas can continue to use the same survey questions to track local progress over time and by enlarging the sample would be able to make ward or estate comparisons.

**Ask positive questions of deficit data**

While much of the existing data tends to measure illness, deficits and needs, such data can also be analysed from an appreciative or positive perspective. Instead of focusing on the prevalence of risky behaviour such as patterns of smoking, local practitioners can ask questions about people who don't smoke, especially those who live in areas of high prevalence of smoking. What is it about their lives and environments that enables them to give up or never start? How can this learning and source of expertise be used to help others?

## 1. Taking the temperature of local communities: The Wellbeing and Resilience Measure (WARM)

This work[85] is a product of the Local Wellbeing Project. The Young Foundation, the IDEA/LGID and three councils were involved in the development and testing, and other councils have used it to inform service configuration and investment in community capacity.[86] It is an excellent starting point for any asset building project.

The advantage of the WARM framework of measures is that it is designed to be used to measure individual and community wellbeing and resilience in a neighbourhood. The premise is that 'the key to flourishing neighbourhoods is to boost local assets and social wealth, while also tackling

**The five stages of WARM**

"The first stage is to measure wellbeing. To do this we look at three domains:

- Self: the way people feel about their own lives, personal wellbeing and resilience, as well as other attributes such as income or health
- Support: the quality of social supports and networks within the community, which includes emotional support as well as broader personal support
- Structure and systems: the strength of the local economy, availability of local services, infrastructure and environment which support people to achieve their aspirations and live a good life.

These domains are dynamic and interact with each other.

The second stage measures resilience, by creating a map of assets and vulnerabilities in the community. Accurately identifying the assets, for example social capital, and the vulnerabilities, for example social isolation, helps estimate the capacity of a community to withstand shock and pinpoint where support should be targeted.

The third stage is a benchmarking process. We use national and council-wide data to draw out local trends in life satisfaction.

The fourth stage is about planning. We use the data provided from stages one to three to inform communities, commissioners and local partnerships about what is working well, and where further interventions are needed. This stage can also involve the public, political leaders, community organisations and business.

The fifth stage is about action – creating or redesigning local services to ensure they respond effectively to local needs and wishes.

The five stages of WARM is an iterative process. The process should be repeated over time to help identify the extent to which interventions have led to tangible improvements in life satisfaction."

85 Mguni & Bacon; www.youngfoundation.org

86 Building resilient communities. A Young Foundation report for Wiltshire Think Family Board, Vicki Sellick, Nina Mguni, Catherine Russell and Nicola Bacon (February 2010)

vulnerabilities and disadvantages'. The tool makes use of existing data and new local data to measure:

- current wellbeing as well as local circumstances or context
- assets or strengths such as social capital, confidence among residents, the quality of local services and availability of employment
- vulnerabilities such as isolation, crime, and unemployment
- subjective perceptions, for example satisfaction with GPs alongside objective factors such as the number of GPs in an area.

It recommends the use of a 'spider' presentation of the data to fully understand the complexity in an area.

## 2. Measuring mental wellbeing

Positive mental health and wellbeing is an important outcome of asset working for three reasons:

- Positive feelings of hope, satisfaction, confidence, sense of purpose and control are vital to the healthy functioning of all individuals; they are protective assets.
- Mental wellbeing "protects our physical health […] Poor mental health is both a cause and consequence of poor physical health and is associated with chronic illness, such as heart disease, and a range of health-damaging behaviours including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet."[87]
- Mental wellbeing "is a significant causal influence in the following domains: physical health and longevity, health behaviours, educational outcomes, economic productivity, risk of criminality and social engagement." [88]

Practitioners have access to a range of tools for assessing levels of mental wellbeing and the impact of their policies and services in promoting mental wellbeing.

### Mental wellbeing impact assessment; a toolkit. 'A living and working document'[89]

Mental wellbeing impact assessment checklist [90]

The impact assessment supports practitioners in all service areas, not just health, to understand how they can promote and protect the 'feelings and functioning of everyone' not just those who are currently in distress in their communities. Identifying the impact a particular policy, service, programme or project encourages practitioners to maximise the positive effects. It also enables them to identify local indicators to help them monitor the impact of reconfigured services or new initiatives.

The assessment has two elements that define three distinct but linked domains of wellbeing which are measurable using different tools and scales. It suggests possible indicators for each domain.

87 (NIMHE, 2005, Making it Possible: Improving Mental Health and Well-being in England, London: CSIP).

88 Friedli & Parsonage 2009 p25

89 www.nmhdu.org.uk/news/new-edition-of-the-mental-wellbeing-impact-assessment-toolkit/

90 www.nmhdu.org.uk/silo/files/mental-wellbeing-checklist-a4.pdf

| Domains of wellbeing | Measurable elements |
|---|---|
| subjective wellbeing and feelings of life satisfaction | positive feelings and belief |
| personal and social relationships and engagement in the community | positive functioning<br><br>the presence of emotional cognitive and social skills |
| occupation, activity and personal development | sense of meaning |

Based on the research evidence, it highlights four risk/protective factors that are linked to mental wellbeing; these exist at individual, family, socio-economic and environmental levels. So for instance, an individual's ability to control their own life is affected by their confidence in their abilities, access to knowledge about choices, the ability to live independently at home, their ability to participate in decisions about their life and community, and the availability of employment and financial security. The assessment toolkit also highlights the different factors by population characteristic and life course.

The four factors and the evidence for their impact in the toolkit are as follows:

1. **Enhancing a sense of control** - the ability to shape circumstances, self-determination and a belief in one's capabilities. Not only is a lack of control a cause of stress, but also people who feel in control are more likely to take control of their healthy behaviours.
2. **Increasing resilience and community asse**ts - not only the level of emotional resilience, but also the existence of personal and community assets such as physical health, good environment and levels of social capital in the community are key.
3. **Facilitating participation** - involvement in cultural and volunteering activities outside the household. Membership of clubs and networks are also important.
4. **Promoting inclusion** - participation, social support and social inclusion are significant factors in preventing mental health problems.

### Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)[91]

The WEMWBS is the gold standard for measuring positive mental health, and is widely used by policy makers and practitioners, such as the North West Mental Health Survey below. It is also proposed as the source for a new indicator in the Public Health Outcomes Framework.

"What differentiates WEMWBS from all existing measures of mental health is that it has been developed specifically to measure positive mental health - all the items represent positive thoughts or feelings. Its positive focus offers a vision of future population mental health and enables others to see where mental health promotion programmes might be headed."[92]

The WEMWBS asks 14 questions. People are asked how often they have these feelings, and are given the options of none of the time, rarely, some of the time, often, all of the time. There is a shorter scale that uses the seven questions highlighted with an asterisk.

91 © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved www.healthscotland.com/documents/1467.aspx

92 see NHS Health Scotland above

I've been feeling optimistic about the future*

I've been feeling useful*

I've been feeling relaxed*

I've been feeling interested in other people

I've had energy to spare

I've been dealing with problems well*

I've been thinking clearly*

I've been feeling good about myself

I've been feeling close to other people*

I've been feeling confident

I've been able to make up my own mind about things*

I've been feeling loved

I've been interested in new things

I've been feeling cheerful

### North West Mental Wellbeing Survey 2009[93]

In conjunction with the PCTs in the region, the NHS NW commissioned a face to face survey of 18,500 people on the subject of mental wellbeing in the region. The survey asked 44 questions covering a wide range of determinants such as feelings, relationships, health, life events, lifestyles and place, including the seven shorter scale WEMWBS questions. Additional questions about personal characteristics such as age, gender, ethnicity and place of residence, and social characteristics such as education and employment were also asked; IMD deprivation data was added later. This enabled the analysis to look at the prevalence and patterns of mental wellbeing under a number of headings.

The headline results from the survey included:

"There was no difference in levels of mental wellbeing between men and women. However, there were differences by age group, deprivation and ethnic grouping. For instance, levels of mental wellbeing were more likely to be high among:

- 25 to 39 year olds (least likely among 40 to 54 year olds)
- those living in the less deprived areas (least likely in the most deprived areas)
- non-white adults (less likely among white adults)."

## 3. Measuring community empowerment

Feelings of empowerment, being in control of one's life and able to influence decisions are important factors in both individual and community wellbeing. But measures of community capacity are notoriously difficult to capture.[94] While the feelings may be subjective, there are objective enablers and barriers to empowerment. The methods described above that measure mental wellbeing all include measures of individual empowerment. There is work on community development that offers ways to assess community capacity and effectiveness.

93 The summary and analysis is available at www.nwph.net/nwpho/publications/NorthWestMentalWellbeing%20SurveySummary.pdf OR www.cph.org.uk/publications.aspx The full technical report containing full charts and tables, is available here: www.nwph.net/nwpho/NorthWestMentalWellbeingSurvey.pdf

94 See the discussion in Knapp, Bauer, Perkins & Snell (LSE 2010) Building community capacity: making an economic case; and Paton (OUBS 2010) Building Community Capacity: reporting results. Both at www.thinklocalactpersonal.org.uk/BCC/EvidenceAndEvaluation

### The Toronto Indicators of Community Capacity[95]

The conceptual model as applied in four Toronto neighbourhoods (developed by Jackson et al and described in detail in Chapter three and Appendix one) provides a systematic way of mapping capacity and assessing barriers and enablers. The framework includes proposed indicators that were selected in the Canadian context to create a baseline of community capacity in a neighbourhood and measure the impact of changes in policy and investment. Any neighbourhood planning to use the framework would select indicators that were relevant to local circumstances.

Studies undertaken by the IDeA and the Young Foundation on happiness and wellbeing demonstrate that community and neighbourhood empowerment has the potential to improve the wellbeing of individuals and communities in three ways:

- **control**: by giving people greater opportunities to influence decisions, through participative and direct democracy rather than formal consultation exercises
- **contact**: by facilitating social networks and regular contact with neighbours
- **confidence**: by enabling people to have confidence in their capacity to control their own circumstances.

See Neighbourliness + Empowerment = Wellbeing (Young Foundation 2009)

95 Working with Toronto Neighbourhoods toward developing indicators of community capacity. Jackson et al at Centre for Health Promotion, Department of Public Health Sciences, University of Toronto. Health Promotion International Vol 18 No 4. Oxford University Press 2003. http://heapro.oxfordjournals.org/content/18/4/339.full.pdf+html

The researchers make the point that measuring community capacity has to do more than aggregate individual skills; it has to include aspects of community that come from collective action and connectedness.

## 4. Storytelling – sharing stories connects us

"Stories are woven into the fabric of our lives: they shape our sense of self, our sense of belonging to community and our sense of how the world works." [96]

Storytelling is a powerful way to understand and communicate the ways in which assets and asset-inspired programmes affect health and mental wellbeing. Many asset mapping and appreciative inquiry exercises have used stories to collect information about assets and an understanding of how they function in relation to health. There is increasing use of deep interviewing techniques and storytelling to elicit families' whole-life experiences and their perspectives on what would help them build their resilience and capabilities. It is an integral part of the discovery phase of an appreciative inquiry and is often used in the design stage as well.

Storytelling has gained respect as a tool of organisational change, and personal and professional development. It is a powerful tool in community development as well as with individuals and families.

- Stories talk of the 'how and why' of change and help people realise what has been achieved and what has still to change.
- Stories are accessible to a wide range of participants, especially using visual and arts methods.

96 Geoff Mead, Centre for Narrative Leadership.

- They are collective and participative – they embed shared learning and create links through shared experiences.
- Communities or families can create their own narrative of what is happening. Positive stories can counteract the stigmatising and marginalising stories from outside.
- Shared stories make meaningful connections between different sections of the community whether that is across generations or between different ethnic groups. For instance in Rochdale, Ethiopian people shared their idea of an ideal community as a contribution to the vision for the Falinge estate.

### Stories as evidence

Stories are a powerful source of evidence – alongside more statistical and quantitative data – for providers as well as commissioners. They enable a more rounded understanding of what is happening and what the connections are, in contrast to a tick-box or needs assessment exercise.

Many communities are using personal stories to get their ideas and experiences across to local decision-makers. A strong story can be very persuasive to local leaders and councillors.

Stories tell you the narrative behind the snapshot that indicators give you. It helps the community and researchers reflect on and understand what happened over a period of time; the 'theory of change' and what needs to be conserved or changed.

Stories enable researchers to test out their ideas about how change happens and what the important barriers and enablers are. They go below the level of programmes to talk in-depth to a small number of individuals and directly observe meetings and events.

Stories do not provide a model for change – they are particular to the specific circumstances and dynamics – but they have lessons for people who are planning change.

In-depth conversations with families or communities is a way of understanding the 'whole picture' of their experience and behaviours. The Young Foundation project in Wiltshire[97] used a 'day in your life' approach with families in crisis. They found that families were making 'rational choices' given their circumstances. Some had isolated themselves from neighbours, and some felt themselves to be powerless to change their lives. The project also used the WARM framework to assess the assets in the community that could be mobilised to provide low cost preventative work and to help families struggling with poverty and illness.

97 www.youngfoundation.org/blog/ageing/warm-wiltshire

## 5. Outcomes Star

Outcomes Star[98] is a template or tool for use in conversation between keyworkers, professionals and clients. The star template represents the 'steps on the journey' towards the five to 10 target outcomes which have been developed collaboratively by clients and professional staff. The outcomes are the 'positive' elements of an improved life, and the steps are descriptions of the kinds of changes necessary if the person is to fulfil their potential. The use of the star shape allows for the unevenness and complexity of peoples' development processes.

The target 'outcomes' are what asset practitioners would define as social and psychosocial assets. This makes it a potentially valuable tool for projects working to improve strengths at an individual or family level. It is free to download.

The first Outcomes Star was developed for projects working with homeless people to assess whether they were impacting on the core areas of change for people moving out of homelessness. Initially it was reworked for use with other vulnerable individuals such as users of alcohol and drugs, and people with mental illness, and women in refuges. More recently the concept has been applied to other arenas.

Each new application is developed through collaboration with managers, workers and service users who work together to identify the important outcome areas and the steps of change along the way.

## Is it worth it?

The business case for health improvement can be measured in terms of the impact on the population at large, the efficiency savings which councils and partners may be able to make by reducing costs or preventing costs in the future, and the impact of improved health on education and employment, for instance. In general it is considered more cost effective to prevent problems from occurring than to treat them when they do occur, however the identified savings may not benefit the council who carries out the preventive work and may not happen in time to have an effect on budgetary concerns.[99]

There are several studies that are currently looking at whether investment in building up both psychosocial and social assets is cost effective.

98 Outcomes Star™ is made available on the basis of Creative Commons License on condition that users do not change the wording or the detailed text. For full copyright information see www.outcomesstar.org.uk/

99 LGID 2009. Valuing Health: developing a business case for health improvement. www.idea.gov.uk/idk/core/page.do?pageId=15246382

# 6. The Health Empowerment Leverage Project

There is widespread recognition of the value of assets such as community networks, social support and reciprocal relationships. However there is little direct evidence of the impact of community development – that is positive action to develop and sustain those capacities and networks – on health and wellbeing outcomes.

HELP[100], was funded in 2010/2011 by the Department of Health to make the business case for the use of community development in health.

Using the Transformative Community Development model in three PCTs (see Chapter three) they established a problem solving partnership, led by the residents and involving health and other agencies such as police, housing providers and the local council. The aim was to develop the confidence of residents and the responsiveness of agencies.

They report that the outcome of the three pilots included improved relations between residents through , for instance, increased volunteering, wider social networks and more co-operation between groups in the community; improved agency provision in relation to issues such as weight management, smoking cessation and sexual health education, and thirdly improved collaboration between residents and agencies leading to the renovation of parks and woodlands and other local improvements.

The final report from HELP[101] sets out their methodology for calculating the business case for community development. The researchers looked at the known impact of community development on selected health conditions and estimated the reduced incidence of those conditions and the consequent savings from such prevention.

Community development is known to impact on some of the underlying causes of conditions such as cardiovascular disease, depression and obesity, as well as such things as A&E attendance. HELP estimated a cautious 5% a year reduction in health service expenditure for three years as a result of the two year investment in community development.

The estimated costs of the community development in an area of 5000 people is approximately £145,000 over two years. The savings were estimated to be approximately £558,714 over three years, a ratio of 1:3.8. Applying this level of savings in the 20% most deprived neighbourhoods would produce savings to the NHS of about £200m a year. There are further savings in public budgets from reduced crime of about £130m a year.

There are also benefits to the health and other services from a more active and self-confident community. Better designed services, more effective prevention, better engagement between commissioners and residents, and – echoing Marmot – improved community capacity can help mitigate health inequalities.

100 http://www.healthempowermentgroup.org.uk

101 Empowering Communities for Health; Business Case and Practice Framework (Health Empowerment Leverage Project. November 2010) http://www.healthempowermentgroup.org.uk/files/project_papers/DH_report_Nov_2011.pdf

# 7. Evidence for the economic benefits of capacity building

The Building Community Capacity for Putting People First project commissioned Professor Martin Knapp of the National Institute for Health Research School for Social Care Research at LSE to show the economic impact of the community capacity-building initiative compared to what would happen in the absence of such an initiative.102 It asked:

- Does investment in building community capacity have the potential to prevent or delay the need for social care?
- Does it have other impacts on individuals and communities that, in turn, will generate cost savings or wider economic benefits?

The research found that each type of initiative studied "generated net economic benefits in quite a short time period. Each of those calculations was conservative in that we only attached monetary value to a subset of the potential benefits [of community capacity building]".

The research concluded that it was not possible in the time available to attach an economic value to a broadly based community development programme, as intended. Such programmes are necessarily complex, multi-faceted and evolve through contestation; evaluation work has focused on process rather than outcomes and been qualitative rather than quantitative. They therefore chose three specific interventions that could be a component of a wider effort to build community capacity, and ones for which they could calculate the costs of the intervention and the potential savings and economic benefits that arise as a result. Their study shows:

- Befriending schemes typically cost about £80 per older person but could save about £35 in the first year alone because of the reduced need for treatment and support for mental health needs. There could well be savings in future years too. Knapp et al state: "If we then also look at quality of life improvements as a result of better mental health – using evidence from some of the Partnerships for Older People Projects (POPPs) pilots – their monetary value would be around £300 per person per year."
- The cost per member of a timebank would average less than £450 per year, but could result in savings and other economic pay-offs of over £1,300 per member. Knapp et al add: "This is a conservative estimate of the net economic benefit, since timebanks can achieve a wider range of impacts than those we have been able to quantify and value."
- 'Community navigators' working with hard-to-reach individuals to provide benefit and debt advice cost just under £300 but the economic benefits from less time lost at work, savings in benefits payments, contribution to productivity and fewer GP visits could amount to £900 per person in the first year. Knapp et al add: "Quality of life improvement as a result of better mental health could be valued in monetary terms […] to add a further sizeable economic benefit."

102 Knapp, Bauer t al. Full study to be published shortly at www.thinklocalactpersonal.org.uk/BCC/EvidenceAndEvaluation

# 8. Cost effectiveness of promoting mental wellbeing

Research[103] commissioned by the All Wales Mental Health Promotion Network explored the economic case for investing in positive mental wellbeing and preventing mental illness. The work to promote mental health included projects to "raise self-esteem, strengthen individuals life and scoping skills and emotional resilience".

The report concluded that investment was worthwhile because positive mental wellbeing contributes to preventing mental illness and leads to better outcomes in physical health, health behaviours, educational performance, employability and earnings, and crime reduction. (See Chapter two for their recommended 'best buys')

Subjective wellbeing increases life expectancy by 7.5 years, provides a similar degree of protection from coronary heart disease to giving up smoking, improves recovery and health outcomes from a range of chronic diseases (for example diabetes) and in young people, significantly influences alcohol, tobacco and cannabis use. It also predicts pro-social behaviour such as participation, civic engagement and volunteering. While the best outcomes are generally associated with the absence of mental illness, the presence of positive mental health brings additional benefits, including for people with mental health problems.

It is also financially beneficial because of the costs associated with mental illness and poor mental wellbeing.

According to new figures prepared for this report, the overall cost of mental health problems in Wales (2007/08) is estimated at £7.2 billion a year. This includes:

- the costs of health and social care provided for people with mental health problems
- the costs of output losses in the Welsh economy that result from the adverse effects of mental health problems on people's ability to work
- a monetary estimate of the less tangible but crucially important human costs of mental health problems, representing their impact on the quality of life.

By way of comparison, the aggregate cost of £7.2 billion is larger than the total amount of public spending in Wales on health and social care for all health conditions combined, which amounted to £6.1 billion in 2007/08.

103 Promoting mental health and preventing mental illness; the economic case for investment in Wales. Friedli & Parsonage (2009) All Wales Mental Health Promotion Network, funded by Wales Assembly Government. www.publicmentalhealth.org/Documents/749/Promoting%20Mental%20Health%20Report%20%28English%29.pdf

# 9. Social return on investment (SROI) – monetising impact

nef's model of SROI is a well established framework and is recognised by HM Treasury. It helps organisations understand and quantify their impact and social value. It applies 'financial values' to social and environmental outcomes that do not have a 'market traded price', such as self-esteem, resilience, meaning and purpose, and supportive relationships. It is therefore of potential interest to asset practitioners, commissioners and decision-makers who want to demonstrate the cost effectiveness of their work, manage their business to maximise social value and take account of the full range of costs and benefits to all stakeholders. While it can be a time-consuming process, it is possible to do it with a light touch, depending on the audience and purpose.

nef and the Community Development Foundation sponsored the Community Catalysts action research project[104] with four local councils who used SROI to evaluate their community development activity; an exercise that has lessons for those evaluating asset-based working. In order to calculate the cost benefit ratio, they first had to analyse the processes by which community development makes an impact.

Using a participative and transparent process, they:

- identified all stakeholders, including differentiating between those community members who deliver the activity, those who participate and those who live in the community but do not get directly involved
- identified the inputs, such as facilitating, enabling and building capacity identified the activities and outputs such as community activities, advocacy and raising awareness
- identified and synthesised the outcomes using the nef 5 Ways to Wellbeing framework
- developed indicators and financial proxies for the outcomes
- established the impact of the change on the outcomes
- calculated the SROI and ratio of cost to benefit.

Their headline findings were:

"For each £1 invested by a local authority in community development activities and by the volunteers' time input to deliver activities, £2.16 of social and economic value is created. And for every £1 that a local authority invests in a community development worker, £6 of value is contributed by community members in volunteering time."

104 Catalysts for Community Action and Investment: a social return on investment analysis of community development work based on a common outcomes framework. (nef October 2010) www.cdf.org.uk/web/guest/publication?id=362954

### Social Value

Social value is the collective gain to the community from commissioning/procurement over and above the direct purchase of goods and services. For instance, a contractor can be required to employ local people, take on local apprentices, or use local suppliers, all of which contribute to a healthy local economy . A mental health service that employs local people with mental health problems will improve their wellbeing as well as deliver the commissioned service. It is a way of valuing the financial and other benefits that accrue to other partners, for example from investing in prevention or acting to improve social networks. A Social Value Toolkit has been developed for NHS North West to help commissioners make use of this approach[105].

The Public Services (Social Value) Bill 2011 which is currently going through Parliament (January 2012) will require all councils to "give greater consideration to economic, social or environmental wellbeing during the pre-procurement stage" of any commissioning exercise.

**The economic value of volunteers – an important local asset**

According to the National Council for Voluntary Organisations (NCVO) 2011 Almanac, 24 per cent of people volunteer formally through groups and organisations at least once a month, and 29 per cent volunteer informally to give unpaid help to family and friends at least once a month. This is a significant resource locally.

105 www.northwest.nhs.uk/document_uploads/Social%20Value%20Project/1%20%20Summary_web.pdf

# Appendix one:

## The Toronto framework for mapping community capacity

This Appendix quotes in full from three of the five elements of the framework for mapping and measuring community capacity.[95] The measures in the right hand column refer to information available in Canadian context and UK practitioners will have to explore what is available locally.

### 3. The talents and skills of individuals who live in the community and which contribute to their ability to effect change

| **Talents and skills of residents – examples** | |
|---|---|
| Organising | Organising events<br>Facilitate meetings |
| Hospitality | Live harmoniously with neighbours<br>Make people feel welcome |
| Human relations | Work together productively<br>Link to many networks |
| Technical | Cooks, caterers, hairdressers, musicians, singers, electricians, for example |
| Professional and academic | Teachers, doctors and engineers often with credentials not recognised in Canada<br>Children who have gone to college and university |

### 4. Indicators of overall community capacity – linked to the ability of the community to include and deal with the conflicting interests and work together for the common good

| **Indicators of overall community capacity** | **Possible measures of capacity** |
|---|---|
| The community is welcoming and supportive to the whole diversity of community | • Information about events is available in various languages of the community<br>• Community events include all age groups and display the food and music of many different groups |
| Residents have positive perceptions of their community | • A range of residents report feeling proud to live in the community<br>• Residents report feeling comfortable to have outsiders visit their community |
| Residents celebrate together | • Residents celebrate together |
| People actively participate in the social, political and economic life of the community | • Residents report they are involved in political action<br>• Banks and other businesses located in or near the community contribute meaningfully to community life |
| People come together around community issues and work together towards a common purpose or joint project in balanced and proactive ways | • Opposing or different points of view are present at community meetings<br>• A range of groups are present at community meetings<br>• Many people share leadership and other responsibilities |
| Community members have a sense of control and sense of ownership in relation to planning and implementing local programmes and activities | • Residents sit on boards of directors of local agencies and organisations<br>• Residents are involved in programme design and implementation in local agencies and organisations |

## 5. Indicators of the facilitators or barriers to community capacity, both within the community itself and from external organisations and regulations

| Proposed indicators of the facilitators or barriers to community capacity | Possible measures of facilitators or barriers |
|---|---|
| Inside facilitators / barriers<br>• Residents support one another/are isolated from each other<br>• People are recognised for their community involvement or volunteering /people don't feel thanked for their contribution to the communities<br>• Residents, agencies, organisations, businesses and politicians are well linked and work together / work on their own in an uncoordinated fashion<br>• Agencies play an enabling role in the community/agencies display alienating characteristics<br>• Agencies have stable long-term relationships with the community/ agencies have short time frames, programme funding is only for one year, or previous history or success is ignored<br>• Mechanisms that facilitate community participation exist/do not exist<br><br>Outside facilitators/ barriers<br>• Non-residents have a positive image of the community/ have a negative image of the community<br>• Government and private sector policies specifically decrease the challenges of daily living in the community or neighbourhood/ specifically increase the challenges of daily living in the community or neighbourhood<br>• Convenient access to high quality and appropriate green space, services, amenities and programmes designed and developed according to community desires/ access is very difficult or does not exist<br>• Residents are employed working a reasonable number of hours, in good working conditions and earning a living wage/ residents are chronically unemployed, underemployed or working in two or more jobs | • Residents report that neighbours are friendly, welcoming, respectful, caring and willing to help one another<br>• Residents report they do not know their neighbours<br>• The community holds celebrations to honour volunteers<br>• All sectors report and are observed to have good relations with one another<br>• Residents report that community workers are empowering, support the community-defined direction, and elevate the communities' voice<br>• Agency staff do not know the community<br>• Programmes offered are not relevant<br><br>• Appropriate community space is available<br>• Child care appropriate to the community is provided during community meetings<br>• Meetings are not well run<br>• Not enough information or notice about meetings<br>• Events, time or space feel unsafe or is not accessible<br>• Bus drivers and police for example have positive or neutral attitudes towards residents of the community<br>• The extent to which reporting about the community in the media is negative<br>• Policies exist around a timely and appropriate response to property maintenance issues in public housing and are enforced<br>• Day-care subsidy rules mean people cannot work part time and get childcare<br>• User fees for municipal services like libraries and recreation services<br>• One neighbourhood is the 'dumping ground' for most of the municipality's community services for mentally ill, drug detoxification, parole halfway houses, young offenders, for example<br>• Schools, libraries, public transit, grocery stores, recreation facilities and parks are easy to get to<br>• Green space that is available is not suitable for the needs and interests of the community |

# Appendix two:

## Further reading on connected policy areas

### 1. Healthy communities

The Local Government Improvement & Development / Department of Health Healthy Community team published a series of useful publications, still available at www.idea.gov.uk/health

- 'Valuing health; developing a business case for health improvement' (2009)
- 'The social determinants of health and the role of local government' (2010)
- 'The role of local government in promoting wellbeing' (2010)
- 'A glass half-full' (2010)
- 'Joint Strategic Needs Assessment: A springboard for action' (2011)
- 'Peeling the Onion (LGG and CfPS 2011)

### 2. Community capacity, adult social care and personalisation

Adult care is a very closely linked field of policy and practice, not least as it moves closer to public health under the auspices of the health and wellbeing board and the refreshed JSNA. The Building Community Capacity project, originally part of the Putting People First programme but now part of the Think Local, Act Personal Partnership, has supported and collated many local examples of work being done by councils with their public sector, third sector and community partners to build social capital, as part of the jigsaw of resources that people draw on including personal and family strengths and professional services. It has also commissioned work on evidence and evaluation. There is a wide range of current materials available on the website www.thinklocalactpersonal.org.uk/BCC

### 3. Health Scotland

the Scottish Government has adopted a salutogenic or assets approach to heath and wellbeing, and tackling health inequalities. .

The Annual Report of the Chief Medical Officer for Scotland 2009 'Health in Scotland 2009: Time for Change' (Scottish Government, 2010) *(http://www.scotland.gov.uk/Publications/2010/11/12104010/0)*

Glasgow Centre for Public Health Briefing Paper 9 Concepts Series. Asset based approaches for health improvement: redressing the balance (October 2011) *(http://www.gcph.co.uk/work_programmes/new_asset_based_approaches_to_health_improvement)*

The Assets Alliance Scotland (Scottish Government, Scottish Centre for Community Development (SCDC) and Long Term Conditions Alliance Scotland) *(http://www.scotland.gov.uk/Topics/Built-Environment/regeneration/engage/empowerment/newsletter/December10/News/AssetsAllianceScotland)*

## 4. Health assets in a global context

eds Antony Morgan, Maggie Davis, Erio Ziglio (2010) Springer. This book has inspired and underpinned many of the debates and ideas that are contained in this publication. For those that want to delve deeper, it is essential reading.

## 5. Asset based community development

If you want to know more about ABCD: www.abcdinstitute.org/ - the originators of asset working at Northwestern University, USA. - the site for the growing European network *(http://coady.stfx.ca/work/abcd/ - the Coady Institute has published and researched asset based working extensively.)*

In the UK, organisations are exploring the use of asset principles in different contexts, for instance

Appreciating Assets. (2011) O'Leary, Burkett & Braithwaite (IACD & Carnegie UK Trust) *(www.carnegieuktrust.org.uk/publications/all-publications?search=appreciating%20assets&year=2011)*

The report covers both tangible assets such as buildings and land as well as intangible assets such as self-esteem. It showcases work in rural communities in UK, Ireland and internationally.

The sustainable livelihoods handbook: an asset approach to poverty. (Oxfam and Church Action on Poverty 2009) There are several local projects working on poverty in the UK using an assets approach; the shared approach provides an opportunity for place-based collaboration between those working on wellbeing and those working on poverty. They work with an assets pentangle as the framework of analysis. *(www.oxfam.org.uk/resources/ukpoverty/in-depth-livelihoods.html)*

The toolkit has lots of ideas for working with individuals and groups to gain a deeper understanding of the situation and to think about solutions. *(www.oxfam.org.uk/resources/ukpoverty/downloads/Sustainable%20Livelihoods%20Handbook2.pdf)*

## 6. Evaluation

These three evaluation resources are particularly relevant to asset working:

**Jamie A A Gamble (2008) Developmental Evaluation. J W McConnell Family Foundation.**

Developmental Evaluation is an approach "adapted to the emergent uncertainties of social innovation in complex environments". Gable's publication gives concrete guidance on implementing the ideas explored in Getting to Maybe ( Michael Quinn Patton (2006) Getting to Maybe: How the world is changed. Toronto. Random House Canada) *(www.mcconnellfoundation.ca/assets/Media%20Library/Publications/A%20Developmental%20Evaluation%20Primer%20-%20EN.pdf.)*

**W K Kelloggs Foundation & ABCD Institute (2005) Discovering Community Power**

Discovering Community Power is one of the ABCD Institute Workbooks, funded by the Kelloggs Foundation, to help funders, project proposers and communities self-assess the assets of individuals, organisations and communities and show how they are connected to the proposed project. *(www.wkkf.org/knowledge-center/resources/2005/09/Discovering-Community-Power-A-Guide-To-Mobilizing-Local-Assets-And-Your-Organizations-Capacity.aspx)*

**W K Kelloggs Foundation Evaluation Handbook (2004)**

The handbook is written for project directors and evaluation teams to achieve a better balance between showing that programmes work and improving how they work. It supports an asset-based approach to working in the community.

'A glass half-full' referred to Developmental Evaluation. It also referred to the Kelloggs Logic Model Development Guide (2004) as a method for planning how an asset project can also be used to evaluate how the project has progressed and evolved. *(www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx)*

# 7. Linked Resources

**Antony Morgan, Maggie Davis, Erio Ziglio eds (2010) Health Assets in a Global Context. Springer**. This book has inspired and underpinned many of the debates and ideas that are contained in this publication. For those that want to delve deeper, it is essential reading.

**Mulhern C & Emanuel J (2011) Working with Possibility: Appreciative Inquiry in the North West** (NWTWC 2011)
A report from AI practitioners on a project for NW Together We Can.
*(www.nwtwc.org.uk/uploads/NWTWC-appreciative-Inquiry.pdf)*

**O'Leary, Burkett & Braithwaite (2011) Appreciating Assets. IACD & Carnegie UK Trust**.
The report covers both tangible assets such as buildings and land as well as intangible assets such as self-esteem. It showcases work in the UK, Ireland and internationally. *(www.carnegieuktrust.org.uk/getattachment/aedb15fb-a64a-4d71-a2d6-e8e6e865319b/Appreciating-Assets.aspx)*

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# Notes

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