ASSET-BASED APPROACHES IN GLOUCESTERSHIRE – A SUMMARY OF CURRENT RESEARCH

An overview of the evidence for the impact of asset-based approaches on health and wellbeing, drawing on national and international research.

The second part of this report will follow in February 2016 and will consist of original research into the effects of these approaches in Gloucestershire specifically.

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Contents

EXECUTIVE SUMMARY

- This report provides a summary of current research on the impacts of asset-based approaches on health and wellbeing. to follow in February 2016 will be a piece of original research applying this research in looking at the impacts in Gloucestershire specifically.

- Asset-based approaches are now a prominent feature of international and national policy, particularly in the fields of community development and health. Public and voluntary sector organisations are adopting asset-based approaches as a way of meeting the dual challenges of rising demand and increasing financial pressure on the public sector and in designing more 'people-centred' services.

- A key element of asset-based approaches is the emphasis on connecting people and increasing 'social connectedness'. Social isolation and loneliness have been shown to be as significant predictors of poor health as obesity, smoking and moderate alcohol abuse. Similarly, increased social connections have been shown to have a significant positive effect on survival rates. This body of research presents a strong case for the positive impact of asset-based approaches.

- Another key element of asset-based approaches is the belief that long-lasting change can only happen if individuals and communities are given the space and opportunities to use their assets for mutual benefit. Traditional 'deficit models' of public service, it is argued, often prevent this, focusing instead on 'passive service delivery'. This focus on encouraging individuals and communities to drive change and action broadly aligns with the concepts of 'social capital' and 'community capital'. There is now significant evidence that both of these concepts have a significant relationship on a wide range of aspects of health and wellbeing.

- This report suggests that a model using these linked concepts of 'social connectedness', 'social capital' and 'community capital' is the best way to understand the varied evidence base for asset-based approaches. There is compelling evidence that for each of these concepts there is potential for a significant impact on health and wellbeing and that asset-based approaches are one way that these impacts can be achieved.

- Despite this compelling evidence, there remains some debate about whether social capital and social connections *cause* good health or are partially the result of it, and further long-term research is needed to clarify this relationships. There also remain concerns that asset-based approaches do not address the underlying structural issues that cause health inequalities and social issues and so must remain only one solution rather than a 'fix-all'.

SECTION 1 - INTRODUCTION

I. Introduction

Across the public sector, financial pressure and rising demand are the new norm. There is a growing consensus that in order for all public bodies to meet this challenge, there are fundamentals of the public sector in the UK that need to be re-assessed and challenged. A cluster of ideas that could loosely be termed 'asset-based approaches' form a central plank of this agenda. These approaches are based on a critique of what has been termed the 'deficit model' of public service, challenging the model of social welfare that has largely defined public services in the UK since 1942, when Beveridge identified the five 'Giant Evils' of society to be tackled.

This 'deficit model' understands communities and individuals primarily through the problems they face, for example, their unemployment, ill health, poverty or crime. As such, the role of traditional public services is one of attempting to solve and prevent these problems - to improve people's lives through fixing their problems. In contrast, the asset-based model argues that people should be understood primarily through their existing strengths, capacities, skills and resources, and that these should form the basis for improving their lives. From this understanding, the role of the state becomes not fixing problems, but supporting people and communities to build the capability to improve their own lives.

There is now a general agreement on the importance of asset-based approaches to the future of the public sector, with endorsement at a national and international level. The development of asset-based approaches to health have been recommended in the recent NHS Five Year Forward Plan and, with the support of the Chief Medical Officer, form a central part of health policy in Scotland. Their growing adoption by local authorities and the wider public sector have been further encouraged through high-profile national reports such as the LGA's *"Glass Half Full",* Nesta's *'People Powered Health'* campaign and the RSA's *'Connected Communities'* project. [1] In Gloucestershire itself, there has been a growing movement in support of asset-based approaches, with the development of a cross public sector 'Enabling Active Communities' strategy, the Barnwood Trust's 'You're Welcome' community building project, and investment by the Police, health services and local authorities into community building roles.

However, among the public, professionals and academics there is often a healthy skepticism about the supporting evidence for an 'asset-based approach' and the desire for a clearer picture of its impact and implementation, especially in comparison to more traditional approaches.

There has been an explosion of research in this area over the last few decades, and perhaps most of all it is the sheer range of topics this research covers that makes a summary of the evidence for asset-based approaches difficult. This report is an attempt to summarise this

[1] NHS England, *Five Year Forward View*, 2014; Foot & Hopkins,, *A Glass Half Full*, 2010; *Health in Scotland: Annual report of the CMO*, 2009.

evidence base as the foundation for original research into the impact of asset-based approaches in Gloucestershire, to follow February 2016.

Section 1 of this report provides a brief overview of asset-based methodologies and the development of asset-based approaches in the key areas of community development and in health.

Section 2 of this report provides a summary of current research and debate, with a focus on the impact of asset-based approaches on. In the context of this report, 'wellbeing' is taken to cover what Hubbert refers to as 'the combination of feeling good and functioning well', socially, physically and mentally.[2] A model for understanding the impact of asset-based approaches is suggested using the three inter-linked concepts of social connectedness, social capital and community capital.

Section 3 of this report provides an overview of the original research to follow in February 2016 that will draw on this evidence review.

II. Asset-Based Community Development.

Asset-Based Community Development (ABCD), developed in America by John McKnight and John Kretzmann in the early 1990s, is founded on the belief that the traditional deficit model of working with communities is counter-productive. It argues that the traditional emphasis of public organizations and agencies on the weaknesses within communities and on 'fixing' their problems has led inevitably to 'dependency' on external agencies, creating 'client communities' or 'environments of service' rather than self-supporting communities.[3] To McKnight and Kretzmann, the traditional model of service delivery provides no opportunity for individuals and communities to develop their own capacities and so prevents the development of more resilient, engaged and self-supporting communities. ABCD is founded on the belief that: 'every single person has capacities, abilities and gifts… and living a good life depends on whether those capacities can be used'.[4] By placing the use and development of these capacities, or assets, as the basis for community development Kretzmann and McKnight argue that a relationship of dependency is avoided and, furthermore, that these strengths, often missed by a deficit-based approach, can form the basis for sustainable, long-term change. In other words: 'communities are never built from the top down, or from outside in'. [5]

Kretzmann and McKnight divide their concept of "assets" within a community into five groups as the basis for their approach:

The **individuals** of a community and their respective strengths and abilities

The informal **associations** within a community, such as peer groups or clubs

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[2] Huppert, *Psychological wellbeing: evidence regarding its causes and consequences,* 2009.
[3] Kretzmannn & McKnight, *Building Communities from the Inside Out,* 1993.
[4] Kretzmann & McKnight, *Building the Bridge from Client to Citizen*, 1998.
[5] Rans & Green, *Hidden Treasures: Building Community Connections,* 2005 ; Kretzmann & McKnight, 1993.

The **institutions**, whether public, private or charitable working within a community

The **physical assets**, such as land, buildings and finances available to that community

The **connections** and relationships that exist between individuals in a community

The first step in ABCD is identifying and 'mapping' these assets alongside the community. The work of 'community building' is then to help build relationships between individuals to connect people's assets and support them in using them to improve their lives and those of their community. As Kretzmann and McKnight write: the key is 'to locate all of the available local assets, to connect them with one another in ways that multiply their power and effectiveness, and to harness those local institutions that are not yet available for local development'.[6]

Underpinning this approach is the concept of 'community capacity', the 'ability of communities to solve their collective problems and improve or maintain their wellbeing'.[7] Kretzmann and McKnight's argument is based on the belief that intervention by external agencies largely *decreases* community capacity through fostering dependency, whilst encouraging communities to utilise their assets *increase* community capacity. [8]

III. Asset-based Approaches to Health

Outside of community development, health is the area where asset-based approaches have had their greatest impact. Following a similar approach to ABCD, asset-based approaches for health reject a wholly deficit-focused model as the basis for health care. Traditionally, it is argued, health services have focused on identifying health problems and designing interventions to alleviate them, leading to an inevitable focus on ill-health and deficiencies. As Rotegard writes: 'the primary emphasis of problem orientated care is on professional observations and interventions on behalf of the individual with little focus on enhancing the individual's strengths and capabilities'.[9] This results, it is argued, in dependency on service delivery as people become passive recipients of care.[10]

In contrast, asset-based approaches to health aim to identify and build the protective factors that support health and wellbeing, the 'health assets' of individuals or communities. A health asset in this context refers to: 'any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and wellbeing' and act as 'protective and promoting factors to buffer against life's stresses'.[11] Asset-based approaches to health are often based on the idea that many of the key determinants of health lie within the social context of people's lives and, as such, the health assets identified often extend beyond

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[6] Kretzmann & McKnight, 1993.
[7] Chaskin, *Building Community Capacity: a definitional framework,* 2001.
[8] Kretzmann & McKnight, 1998.
[9] Rotegard et al, *Health Assets: A Concept Analysis,* 2010.
[10] Foot & Hopkins, 2010.
[11] Morgan and Ziglio, *Revitalizing the evidence base for public health: An assets model,* 2007

those considered in traditional health interventions and can include, education, employment, social networks, level of community organisation and relationships with external agencies.

As with ABCD, asset-based approaches to health often focus on encouraging not just individuals but communities to become more active agents. One of the key protective factors of health is seen to be an engaged and connected community that is not just a passive recipient of care, but able to advocate for itself and its members. As Professor Marmot writes in his influential review of 2010, displaying the considerable influence of asset-based approaches: 'effective local delivery [of health services] requires effective participatory decision-making at local levels. This can only happen by empowering individuals and local communities'.[12]

IV. Criticisms of Asset-based approaches

Despite the general acceptance of the importance of asset-based approaches, there are a number of criticisms levelled at them at a theoretical level. Perhaps the most persuasive is that while adopting an asset-based approach may have benefits for individuals and communities, it does little to address the structural economic, social and political inequalities that underlie social problems and may be the root cause of problems within a community. A focus so wholly on assets, it is argued, can easily leave the root causes of unequal distribution of assets among individuals and communities unaddressed. [13]

Similarly, some have seen the opposition to external intervention by the state and other agencies as placing too much responsibility on individuals and communities for social problems that they may not have caused, or may be unable to affect. Critics of asset-based approaches often see it as an approach that shifts the responsibility for tackling social problems from the state to individuals, with the most sceptical critics, especially those in the USA, seeing it as a convenient 'smokescreen' for the retraction of essential public services, rather than a radical new direction that benefits communities.

In the UK this argument has had less impact, as the adoption of asset-based approaches has been gradual, often building around existing services rather than replacing them entirely. As an example of the approach often pursued: 'The adoption of asset based approaches will not on their own tackle health inequalities and should therefore be… one component in a multi-faceted approach to accentuating positive capability and encouraging the participation of individuals and communities in the health development process'.[14]

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[12] Marmot et al, *Fair Society, Health Lives: The Marmot Review,* 2010, p.15.
[13] Emejulu, "What's the matter with ABCD?", 2015.
[14] McLean, *Asset Based Approaches for health improvement*, 2011, p.12.

SECTION 2 - SUMMARY OF EVIDENCE

I. A model for understanding the evidence base for asset-based approaches

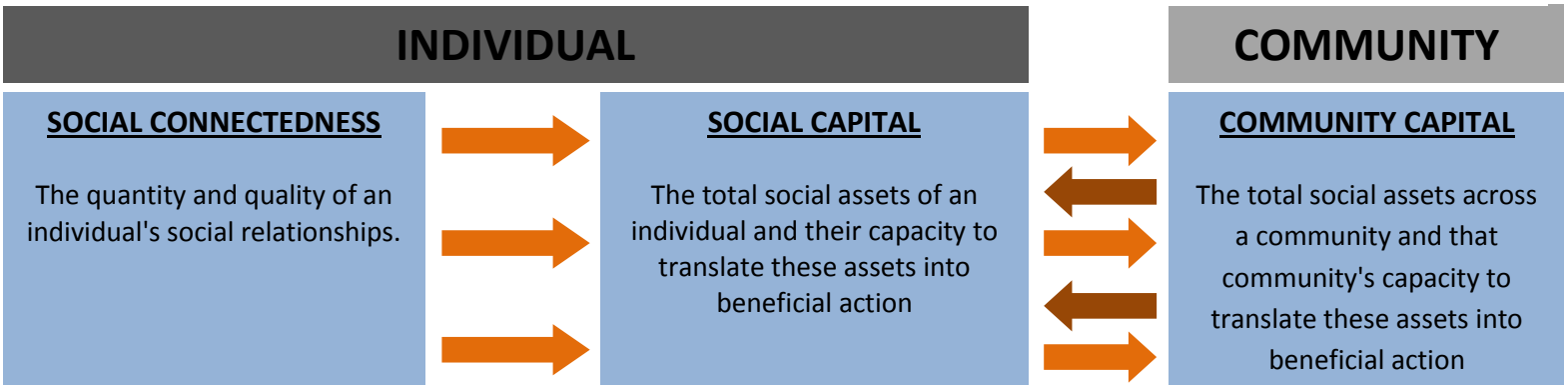
The vast range and complexity of activities that could be classed under the label of 'asset-based approaches' makes a general summary of the evidence base a difficult task. There are however a number of elements that are central to all asset-based approaches and around which much research is clustered. As we have seen, once assets are identified, all asset-based approaches emphasise first of all the forming of social contacts, and second of all the encouragement of individuals and communities to use their assets for mutual benefit:

These key concepts broadly align with three interlinked areas of research that have seen significant growth in the last decade:

1) **social connectedness** - the level of social connection of an individual, whether measured for quantity or quality
2) **social capital** - the social assets available to an individual that can facilitate positive change or action
3) **community capital** - the total social assets available to a community that can facilitate positive change or action

For each of these areas, it is possible to review the evidence base for their links and impacts on wellbeing and health, and thus suggest the potential impacts of adopting asset-based approaches. The interlinked nature of these concepts also broadly matches the methodology of asset-based approaches (see fig. 1.1 below): as assets are identified, social connections are built (**social connectedness**). Through these connections, the opportunity and capacity for individuals to make positive changes in their life increase (**social capital**). Once enough individuals are connected and engaged, the potential for communities to create positive change also increases(**community capital**). The following sections provide a summary of the research exploring the relationships between these key concepts and health and wellbeing

Fig. 1.1 Relationship between social connectedness, social capital and community capital



Through increasing their level of social connection (their 'social connectedness'), people increase their capacity to draw on social assets for positive change (their 'social capital').

The more individuals with high social capital connected in a community, the greater that community's capacity to use these assets to create positive change ('community capital'). This in turn increases the range of social assets available to members of that community further increasing their 'social capital').

II. Social Connectedness

Social Connectedness is a broad term that refers to the social relationships an individual has, whether measured in quantity or quality. The impact of people's social relationships on their health has become a prominent feature in UK and global public policy, with the high-profile National Campaign to End Loneliness receiving recognition and support from the Prime Minister and other senior political figures. This commitment has also received legislative backing, with the Care Act giving councils the legal responsibility to tackle social isolation and loneliness. Gloucestershire is one of a number of councils working to implement this locally by mapping levels of social isolation and loneliness. Internationally, a recent commission led by Nicolas Sarkozy tasked to identify the limits of current indicators of economic and social progress concluded that social connections and relationships should be a key measure of quality of life globally.[15]

This policy shift is largely a result of the rapid growth of published studies exploring the effects of both high and low levels of social connection. Asset-based approaches place these social relationships at the heart of their philosophy and understanding their impact can form a key base of evidence for their use in policy. While there is general agreement that social connectedness can have a significant impact on health and quality of life, this impact is often complex, hard to explain and non-uniform

The Impact of Social Connectedness on Health and Wellbeing

The importance of social connections to health is not a new discovery. Since a 1988 review of five large-scale studies concluded that there was a significant link between social relationships and mortality, the role of social relationships in health has been largely accepted.[16] Robert Putnam, one of the foremost writers on community and social connection, felt confident enough in 2000 to write that: 'in none is the importance of social connectedness so well-established as the case of health and wellbeing'.[17] Despite this, the background to this field of research has been a growth in the evidence suggesting that the level of social connection in post-industrial societies is actively decreasing as a result of a range of factors, from reduced intergenerational living, greater social mobility to delayed marriage and dual-career families.[18]

Major recent studies have highlighted the relationship between levels and quality of social contact and a wide range health outcomes, including mortality itself. A meta-analysis of 148 studies in 2010 found that for those with 'stronger' and more frequent social contacts, there was a 50% increased likelihood of long-term survival versus those with 'weaker' or fewer relationships. The research concluded that lack of social contact was as an equivalent risk

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[15] Stiglitz et al, *Report by the Commission on the Measurement of Economic Performance and Social Progress,* 2009.
[16] House, Landis and Umberson, *Social Relationships and Health,* 1988.
[17] Putnam, 2000.
[18] See: McPherson & Smith-Lovin, *Social Isolation in America, 2006;* Putnam, R.D., *Bowling Alone: the Collapse and revival of American community,* 2000.

factor to smoking 15 cigarettes a day or moderate alcohol abuse. [19] Perhaps more surprisingly, the meta-analysis showed lack of social contact actually exceeded both physical activity and obesity as a reliable predictor of mortality. A further study from 2014 following 2,101 adults supported these claims, finding lack of desired social contact to have almost twice the impact of obesity in predicting premature death.[20] There is now convincing evidence for a significant relationship between social connectedness and a wide-range of health outcomes, including: accidents, suicides, strokes, infectious disease, neo-plastic and cardiovascular disease, heart disease, self-reported mental health, and even all-cause mortality. [21]

Despite this, it is more difficult to find evidence that the relationship between social connection and health is a causal one.[22] For example, it is not hard to see how ill-health might negatively affect one's level of social connection or one's ability to make new social connections. A number of studies have attempted to control for this through a variety of means, with largely promising, through often complex, results. An important study looking specifically at the UK retired population found that once initial health status had been controlled for, there was a large variance in the effect of social connection. For those with *poor health* at retirement, social connection had a large effect in maintaining health. For those with already *good health*, social connection had little additional effect on health or wellbeing. However, the study also found that 'life-time shocks' such as widowhood or bereavement had a greatly reduced negative impact on health for those with more social connections, whatever the initial quality of health at retirement.[23]

This study aligns with one theory put forward to explain the reasons for the effect of social connections on health, that of the 'stress buffering effect'. This suggests that social relationships provide the resources to help moderate negative effects on health, whether through purely social support or the resources relationships can bring. [24] A further theory, the 'main effects model' suggests that social relationships themselves might actively encourage healthy behaviours through encouraging 'conformity to social norms'. A 30 year longitudinal study of obesity found that an individual was 57% more likely to become obese if close social contacts become obese, and that 'unhealthy behaviours' could 'spread' through a network of social contacts. [25] While this research shows a negative element to social connectedness, the reverse also holds true: social contacts play a central role in forming our perception of 'healthy behaviours' and are potentially a powerful tool for positive health change. There is strong evidence that smoking, alcohol and obesity interventions are far more effective when they help shift an individual's social connections to include more 'role models of healthy behaviour', for

[19] Holt-Lunstad, Smith and Layton, *Social Relationships and mortality risk,* 2010.
[20] Caccioppo, *Rewarding Social Connections Promote Successful Aging, 2014.*
[21] See: Smith, *Social Connectedness and Retirement,* 2010.
[22] For a discussion of the debate about causality see: Durlauf, *On the Empirics of Social Capital,* 2002
[23] Smith, 2010.
[24] Holt-Lunstad, Smith and Layton, 2010.
[25] Christakis & Fowler, *The Spread of Obesity in a Large Social Network over 32 Years,* 2007.

example through connecting people with local sports or support groups.[26] Research conducted by the RSA found that this can hold true even for those with the most complex needs, suggesting that increasing social contact was one of the key elements of positive recovery from addiction.[27]

Thus, the potential health and wellbeing effects of social connectedness are two-fold: on the hand there is the positive impact on mental and physical wellbeing for the individual and on the other is the potential for relationships to support happy and healthy lifestyle choices across a a social network or community. This is not to say, however, that the importance of social connection to health is unproblematic. The process through which social contacts affect health are still poorly understood, and some academics argue that measures of poverty or social status are still far more effective in understanding ill health.[28] Similarly, due to the sheer range of possible outcomes, those interventions specifically aiming to increase social contact in communities often have difficulties in addressing specific issues such as health inequalities. For example, a recent RSA project aiming to encourage social contact found that those with significant barriers, such as long-term disabilities, were the least likely to report an improvement in wellbeing as a result.[29] As such equally important to exploring the potential of social connectedness, is the task of making sure that its limits are understood.

Asset-based community development and asset-based approaches take social connections as the fundamental element of their approach, with social connections the 'currency of building strong community'.[30] As seen in Section 1, the building of relationships across a community is seen to be the key activity of community building. With the now significant evidence for the link between social connection and physical and mental health and wellbeing, it is this element of the approach that has perhaps the most convincing evidence base. For all the more political motivations of ABCD and related approaches, the focus on building social connection within a community has the potential for a significant positive effect across a wide range of outcomes. However, ABCD and other approaches do not just aim to increase social connectedness for its own sake, but to create a community of individuals and assets that can mobilize itself for positive change. As such, the concept of 'social connectedness' is not sufficient to explore their potential impact. What is needed is a concept that includes this element of 'intentional action' and the broad terms of 'social capital' and 'community capital' are such concepts.

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[26] Wing & Jeffrey, *Social Support for Weight Loss and Maintenance,* 1999*;* Malchodl et al, *Effects of peer counselling on smoking cessation,* 2003*;* McKnight & McPherson*, Peer Intervention Training for High School Alcohol Safety Eduction,*1986*;* Wechsler et al, *Adverse Impact of Heavy Episodic Drinkers on Others,* 1995.
[27] Daddow & Broome, *Whole Person Recovery: A user-centred systems approach to problem drug use,* 2010.
[28] Ottman, Dickson & Wright, *Social Connectedness and Health: A Literature Review,* 2006.
[29] Parsfield et al, *Community Capital: The Value of Connected Communities,* 2015.
[30] Rans & Green, 2005

III. Social Capital

'Social capital' is a controversial term that is still hotly debated by academics and researchers. Indeed, economist Ben Fine describes it as 'a totally chaotic, ambiguous, and general category that can be used as a notional umbrella term for almost any purpose'.[31] This is however, also its greatest strength; as a concept it promises to bundle the elements of a 'successful community' into a single package, and the difficulty of representing this in a single clear definition has led it to be used in a range of different contexts.[32] The common thread between all these uses, however, is that at its most basic, social capital is a short hand for the social assets of individuals that can facilitate positive change or action. *Social connectedness* is a measure of the quantity or quality of social contact, but *social capital* is a measure of the capacity to transform those social relationships into beneficial action.

Robert Putnam, the most influential writer on social capital, defined it as 'the features of social organization such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit'.[33] However, Putnam's focus on formal associations as the main expression of 'social capital' has been largely replaced by a greater emphasis on looser social networks and the shared 'values' and networks that enable people to work together. This broadening is reflected in the questions used by the UK's Office for National Statistics to 'measure' social capital covering: levels of community trust, membership of groups (either informal or otherwise) and level of social contact. The adoption of social capital into UK public policy is part of a similar shift globally, with the WHO and the UN both arguing that the development of social capital should be a key objective of all governments.[34]

The Relationship between Social Capital and Health and Wellbeing

With the growing prominence of asset-based approaches and their focus on encouraging individual and community action, a significant body of evidence about the health and wellbeing impacts of 'social capital' is now available. In terms of impacts on health, this research has largely looked at the role social capital can play in protecting and maintaining the health and wellbeing of individual and there is a general consensus that social capital has statistically significant, positive relationships with a wide range of mental and physical health issues.[35]. A systematic literature review by the Glasgow Centre for Population Health, looking at children and adolescents specifically, found that around half of international peer-reviewed studies found a positive relationship between social capital and a wide range of health and wellbeing outcomes, from measures of mental health, to levels of physical activity, to poor health behaviours such as smoking or alcohol abuse (see Fig.2.1 for a full summary of results) .[36] In a

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[31] Halpern , *Social Capital*, 2005, p13. For a full summary of the critiques of 'social capital' see: Fine, *Theories of Social Capital*, 2010.

[32] For overview of development of 'social capital' as a concept see: McPherson et al, *The Role and Impact of Social Capital,* 2013, p.2.

[33] Putnam, 2000.

[34] Rocco & Suhrcke, *Is Social Capital Good for Health?,* 2012

[35] McLean, J., 2011, p.6 ff.

[36] For full list of studies see: McPherson et al, *The Role and Impact of Social Capital,* 2013, p.38.

major study using data from the British Household Panel Survey, a research team from Bath University also found a positive association between the ONS's measures of social capital and a variety of measures of general mental and physical health and wellbeing.[37]

Fig 2.1 Summary of systematic literature review of relationship between social capital and health and wellbeing in children and adolescents, reproduced from: McPherson et al, *The Role and Impact of Social Capital,* 2013.

	Mental Health: (depression, anxiety, stress)		Health Promoting behaviours: (nutrition, physical activity, body image and weight status, dental health)		Health Risk Behaviours: (tobacco, alcohol, drug, sexual health)		General health and wellbeing	
Total investigated associations	173		48		165		61	
Positive	84	48.6%	27	56.3%	68	41.2%	35	57.4%
Inconclusive	30	17.3%	4	8.3%	37	22.4%	7	11.5%
Negative	6	3.5%	2	4.2%	6	3.6%	2	3.3%
None	51	29.5%	15	32.3%	54	32.7%	17	27.9%

However, as with social connectedness, due to the nature of the subject there is often a great degree of uncertainty about whether social capital can cause good health or is merely a result of it. A number of studies have attempted to solve this problem by controlling for different factors. A recent study that controlled for 'community level heterogeneity', i.e. differences of culture, socio-economic class, education or religion, in Eastern Europe found a comparable positive effect.[38] The two most critical in-depth studies of the causal relationship between social capital and health, were unable to reject the possibility of a causal link between the two.[39]

IV. Community Capital and Health and Wellbeing

Social capital is often referred to as something possessed by an individual, but in reality is something created only in interactions and relationships with others. It is thus possible to talk of two broad types of social capital; individual social capital, the social assets of a single individual, and community social capital, the totality of social assets created by individuals within that community. It is this second concept that is often referred to as 'community capacity' or 'community capital'. As Chaskin has defined it: 'community capacity is the interaction of human, organizational and social capital existing within a given community that

[37] Sessions, Yu and Wall, *Social Capital and Health,* 2011.
[38] D'Hombres et al, 2010.
[39] Folland, *Does 'community social capital' contribute to population health?,* 2007 ; D'Hombres et al, *Does Social Capital Determine Health?,* 2010.

can be leveraged to solve collective problems or improve and maintain the wellbeing of a given community'.[40]

The relationship between community capital and health has been much researched, the most famous and striking example being that of Rosetto, a town in eastern Pennsylvania. Rosetto, settled by Italian immigrants from a single home-town in 1882, displayed a remarkable level of ethnic and social homogeneity, and was defined as a community by its cohesive family relationships, strong religious communities and emphasis on community social life. Studied extensively from 1935-1985, Rosetto displayed a remarkable mortality rate for heart attacks that was significantly lower when compared to neighbouring communities that lacked the same levels of social cohesion, even when controlling for other factors: the so called 'Rosetto effect'.[41] In the final decades Rosetto was studied, this cohesive community life began to fragment, as a new generation adopted the 'Americanized' ways of modern society slowly cutting many of the close ties of community of the previous generation. Researchers predicted a consequent reduction in the 'Rosetto Effect' and were proved correct as a sharp rise in the mortality rate for heart attacks brought Rosetto in line with its neighbours. While only a single study of a particular situation, the story of Rosetto suggests the potential impact of a cohesive and connected community on the health of its inhabitants.

A major recent international study for the World Health Organisation has further explored this relationship between 'community social capital' and individual health. In a similar manner to the ONS in the UK, the study used a survey of level of social trust as a proxy indicator for individual social capital to compare against levels of self-reported health and wellbeing across 14 European countries.

As can be seen in Fig. 2.2 below, the positive relationship discussed above is once more replicated. More importantly, this study also examined the relationship between *individual* social capital and *community* social capital. Community social capital, here defined as an average score across a given population, once controlled for, had no impact beyond that of individual social capital on health or wellbeing. In other words, living in a connected and resourceful community does you no good if you are not yourself connected within that community. However, community capital did have a significant effect in enhancing the benefits of individual social capital; in other words, if you are part of a 'connected' community, the greater your connections within that community, the greater the effects on your health and wellbeing.

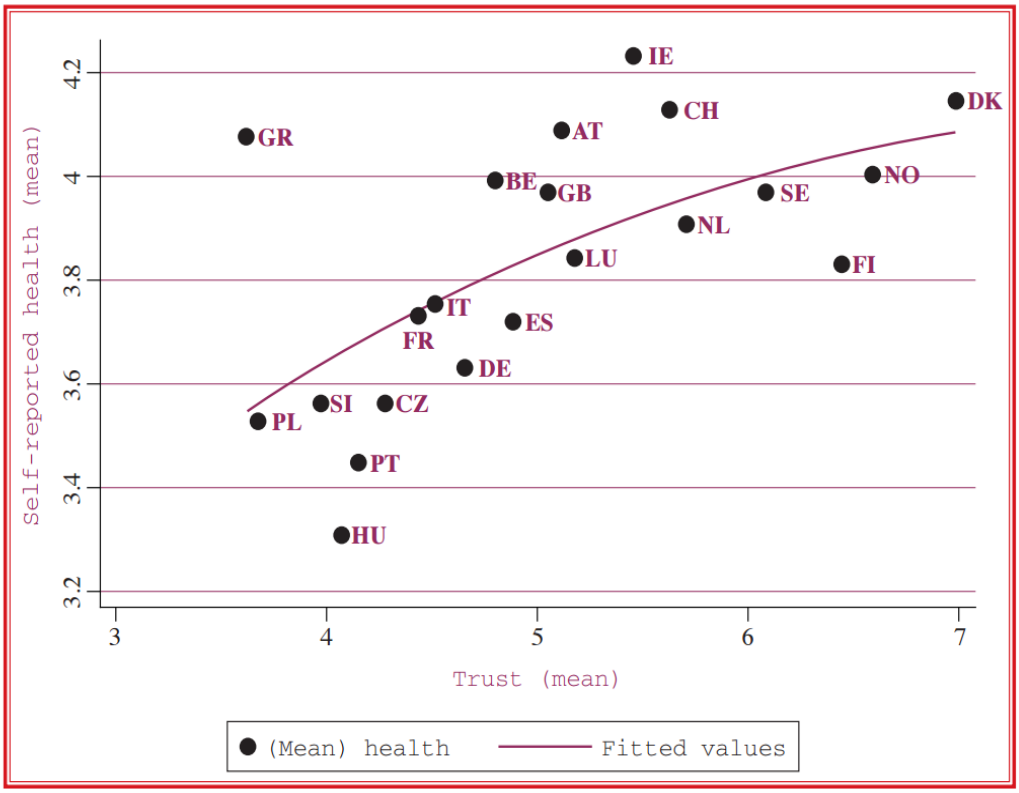
What this study suggested is that one major benefit of asset-based approaches is their focus on forming individual relationships and increasing social capital across a community. By focusing on developing the social capital of individuals there is potentially health and wellbeing benefits

[40] Chaskin, *Defining Community Capacity,* 1999, p.4.
[41] Egolf et al, *The Rosetto Effect: A 50-year Comparison of Mortality Rates,* 1992.

not just for the individual, but also for the wider community through an increase in community capital. In turn, research suggests that community capital can reinforce and increase the health benefits of social capital for the individual.

Perhaps the study's most interesting conclusion however is that through the concept of community capital, place and community are central to encouraging health and wellbeing. A public health intervention that improved the social capital of a large number of individuals in one community would have an enhanced effect through the reinforcing effect of *community* social capital. A public health intervention that improved the social capital of the same number of individuals located in *different* communities would not produce this same enhancement. This effect is potentially further strengthened by the impact of social networks on encouraging 'healthy behaviours' as discussed previously.

Fig. 2.2 Health and Trust in 21 European Countries, 2002 (reproduced from Rocco and Suhrcke, 2012)



Note: AT = Austria; BE = Belgium; CH = Switzerland; CZ = the Czech Republic; DE = Germany; DK= Denmark; ES = Spain; FI = Finland; FR = France; GB = the United Kingdom; GR = Greece; HU =Hungary; IE = Ireland; IT = Italy; LU = Luxembourg; NL = the Netherlands; NO = Norway; PL = Poland;PT = Portugal; SE = Sweden; SI = Slovenia.

V. Conclusion - the evidence for the impact of Asset-based approaches on Health and Wellbeing

The above summary of current research, while not exhaustive, gives a broad picture of the current evidence in support of asset-based approaches. There is a general consensus and convincing evidence that social connectednesss, social capital and community capital all have the potential for significant impacts on health and wellbeing. These impacts are however wide-ranging and often unpredictable or non-uniform. A handful of promising studies suggest the relationship between these concepts and health is in part a causal one, but the lack of longitudinal data and long-term studies prevents a conclusive answer currently being drawn.

Despite this, asset-based approaches do present a compelling approach that promises to realise these potential benefits to wellbeing. The prominence given to individual relationships and forging links across communities will inevitably increase the social connectedness of individuals. Similarly, the focus on encouraging people to drive change and action gives the opportunity for the building of social capital, or the capacity to use their social resources for benefit. The belief of both ABCD and asset-based health approaches that communities must also be able to drive change and action themselves further provides the opportunity for the building of community capital. Community capital can in turn enhance and reinforce the health benefits of social capital and social connectedness. As we have seen, these three approaches have the potential for significant impacts on health and wellbeing. A further advantage of ABCD lies in it's place-based nature. Current research suggests this has the potential to multiply any health and wellbeing benefits throughout the social networks in a community.

However, despite the growing evidence in support of this approach, there are still a number of unanswered questions. As the RSA comments, adopting asset-based approaches requires a fundamental shift of control from public sector professionals to individual citizens, 'that will take the certainty out of delivery and raise very real concerns about safeguarding and risk', perhaps a challenge worth meeting but one that will need to be considered carefully.[42] The outcomes realised for individuals and communities are also often unpredictable, resisting being strictly directed or commissioned. If asset-based approaches are to be adopted at any scale across the public sector, a new approach to commissioning, evaluating and monitoring will be required that can adapt to the unpredictable nature of community and one willing to accept an increased level of risk and uncertainty. However, if this challenge is met, current research suggests the benefits could be significant with the potential to help people and communities increase their social, physical and mental wellbeing in a way traditional interventions often fail to do so.

[42] Conway, *Combating Loneliness and Connecting Communities,* 2015.

APPENDIX I: OVERVIEW OF RESEARCH TO FOLLOW

The second half of this report is to follow, and will provide a summary of original research into community groups in Gloucester and their impact on the lives of communities and individuals. This research is currently being undertaken and will be completed during February 2016. This research will seek to apply this national and international research to a Gloucestershire context to not only explore whether the impacts suggested by the research are being realized locally, but to also provide local case studies of the potential benefits of, or barriers to, implementing asset-based approaches to aid commissioners and policy-makers.

As discussed, one of the potential advantages of an ABCD approach is its place-based nature and as such this research has mainly been focused on the area of Kingsway within Gloucester. A community builder has been in place in Kingsway for almost a year employing an asset-based approach to help connect people within Kingsway and support the development of community groups and other community action and initiatives. Four major community groups been established through this work, whether through the direct involvement of the community builder or more indirect support, and it is these four groups that the research will focus on. The following is a brief summary of each of the groups and their reason for inclusion in the research.

I. Kingsway & Quedgeley Men's Shed

*"Having a **healthy body and a healthy mind** can be based on many factors including **feeling good about yourself**, being productive and valuable to your community, connecting to friends and **maintaining an active body and an active mind**. Becoming a member of a **Kingsway and Quedgeley Men's Shed** gives a Man that safe and busy environment where he can find many of these things in an atmosphere of **old-fashioned mateship**, and, importantly, there's no pressure. Men can just come and have a yarn and a chat if that is all they're looking for!"*

Founded in May 2015 by the community builder and a number of interested residents, the group now has a regular attendance of between 10-20 local men of a range of ages. A number of projects have been undertaken by the group including: the building of furniture and work-benches, as well as the construction and putting up of hand-made bird boxes around the community. Currently based in Quedgeley Village Hall, with the support of the community builder and funding from the Police and Crime Commissioner, the group is now arranging for the use of land and the purchase of a port-a-cabin to provide dedicated wood-working and social space.

The Men's Shed is one of a few groups aimed specifically at men in the Quedgeley and Kingsway area, providing a social group, the chance to develop new skills and the potential for projects to benefit the community.

Research focus**:** Work with members of the Men's Shed will focus on the impact of the social focus of the group, as well as the opportunities for developing new skills, working as a team and undertaking community projects. The Men's Shed is an especially interesting group from a public health perspective as older men are typically a 'hard-to-reach- group for many health interventions.[43]

II. Kingsway Runners

"The community running club for members of Kingsway and the surrounding area - all abilities welcome"

Initially set up with the support of the community builder and interested residents, the group is now run by volunteers and members of the community. The group meets every Monday with a range of group runs and coaching for all levels from beginners to more experienced runners. The group is free to join and take part in and has a large number of attendees with beginner groups reaching 30-40 individuals and around 150 regular attendees total. The group also holds social events and other activities such as the printing of club hoodies.

Research focus: Interviews with members of Kingsway Runners will focus on first of all the impact of the group on physical and mental wellbeing, and second of all the impact of the social and community aspects of the group. As discussed in Section 2, self-directed social relationships can be powerful motivators for improving health and wellbeing, and this will be explored in Kingsway.

III. Kingsway Cycling

"A friendly local community cycling club for all ages and abilities"

Set up after a number of residents expressed a wish for a cycling group, the community builder supported the founding members to establish the group. With three different level groups riding every Sunday, the group has a regular attendance of between 10-15 cyclists and regular online and face-to-face social events.

Research focus: Interviews with members of Kingsway Cycling will focus on the impact on physical and mental wellbeing. The impact on social relationships will also be considered as the group has a lively social side with weekly meet-ups at a local pub and online discussion group. Cycling arguably has a higher barrier of entry to running due to the cost of the required kit and so provides an interesting example of the potential benefits of more 'niche' community groups.

[43] Pringle, *Researching Physical Activity and the Health of Hard to Reach Men, 2011.*

IV. Kingsway Parkrun

"Chat to other like-minded folk over a cup of tea or coffee and become a part of this running community phenomenon that is parkrun - please come and join us!"

Set up and ran by local volunteers initially with the support of the community builder, Park Run in Kingsway now sees around 100-175 people attending each Saturday morning, as well as a team of between around 10 - 20 volunteers. The event emphasises the fun and social aspect of running, encouraging people new to running, those with prams, dogs or small children and even those who prefer just to walk the course. After each event, attendees are encouraged to stay for tea and coffee to meet other members of the community. The group currently has plans to seek funding to make the course more accessible for those with disabilities, as well as to make the course a more permanent part of the park.

Research focus: Interviews with attendees of Park Run in Kingsway will focus on the impact on their physical health, and due to the emphasise of the event on those new to running, will focus on those new to physical activity and impact of social relationships on wellbeing. The emphasis on a community aspect to the event will also be explored. Interviews with the organisers and volunteers of Park Run will focus on the impact setting up and running the group has had, especially in terms of their ability to change things for the better for their community.

V. Research Methodology

Due to the nature of the subject, the methodology will be mainly qualitative using one-to-one interviews with community members and workshops with small groups. The aim of this research will be to evaluate the impact of asset-based approaches on 'wellbeing' in its broad sense for individuals and community in Gloucester, and, informed by the current evidence base, the two key focuses of the research will be:

1) **The effect of community involvement on 'wellbeing** - this will cover a wide range of factors for physical, mental, emotional and social wellbeing and health
2) **The effect of community involvement on 'social capital' and 'community capital'** - this will cover the skills, relationships, abilities and resources that people and communities can bring to bear to improve their lives

The four groups chosen as part of the study cover a wide range of age ranges, activities and purposes to give a broad picture of the potential impact of asset-based approaches. Interviews are being undertaken with volunteers from each of these groups as well a suggested list of participants drawn up with the community builder to cover a range of demographics, outcomes and experiences. These interviews will be supported by surveys to capture wider responses from the community.

All participants will be informed fully of the purpose of the research as well as how their interviews may be used. The final report will be fully anonymous and no personal or contact details of individuals will be given.

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