

Chapter 3: Supporting resilience through asset-based working

In the 2007 Director of Public Health report, "[A call to debate, a call to action](#)"¹, it was noted that our least healthy communities are unlike our healthiest communities in every way. This continues to be the case. Our least healthy communities are more likely to experience long term conditions², more likely to adopt unhealthy behaviours and less likely to have a positive perception of aspects of social capital. The unhealthy behaviours explored included, smoking, being overweight or obese, not meeting the physical activity target, drinking more than the recommended amount of alcohol in a week and not meeting the fruit and vegetable recommendations of 5 a day.

There are five measures in the [Health and Wellbeing Survey](#) (HWB) which are associated with an individual's resilience. These are:-

- Positive perception of control over life
- Social connectedness
- Reciprocity
- Local friendships
- Social support.

The HWB results suggest resilience is lower in our most deprived communities compared to our least deprived communities. For example, those in the most deprived areas are less likely to feel in control over life; most likely to feel isolated from friends and family; less likely to have a positive perception of reciprocity; local friendships and social support.

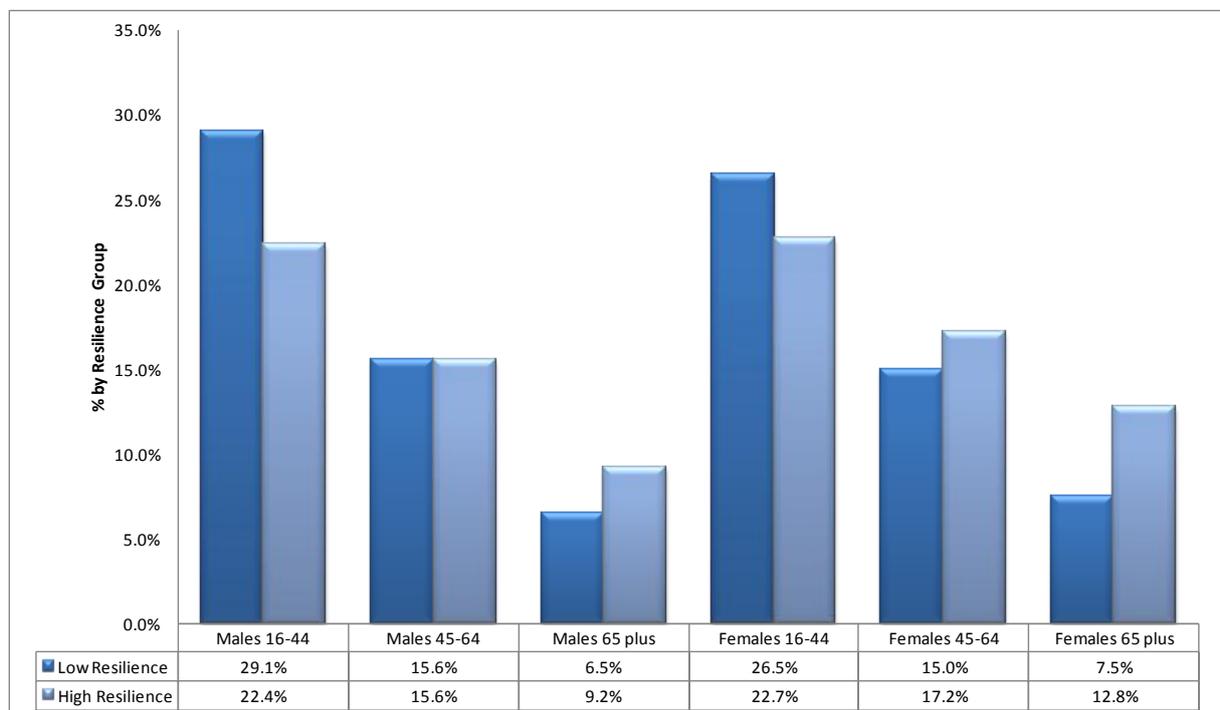
To examine this in more detail, a composite of these five factors was drawn together by creating two groups:-

- The low resilience group (those that had 0 - 3 resilient factors)
- The high resilience group (those that had 4 - 5 resilient factors)

This allowed the exploration of the extent to which resilience was clustered within certain communities. The average number of resilient factors for respondents was 4 (with Glasgow City being a little less at 3.8). Those in the older age groups (particularly over 65 years) were least likely to be in the high resilience group.

Figure 3.1: Percentage of respondents with a high number of resilient factors (4 or more) and low number of resilient factors (3 or less) by age group and gender

(Source: Health and Wellbeing Survey (2015))



Glasgow City has the lowest proportion of respondents in the high resilient group and had the highest proportion of respondents in the low resilient group. In contrast, East Dunbartonshire had the highest proportion of respondents in the high resilient group and the lowest proportion of respondents in the low resilient group.

Table 3.1: Percentage of respondents with a high (4 or more) or low (3 or less) number of resilient factors by area

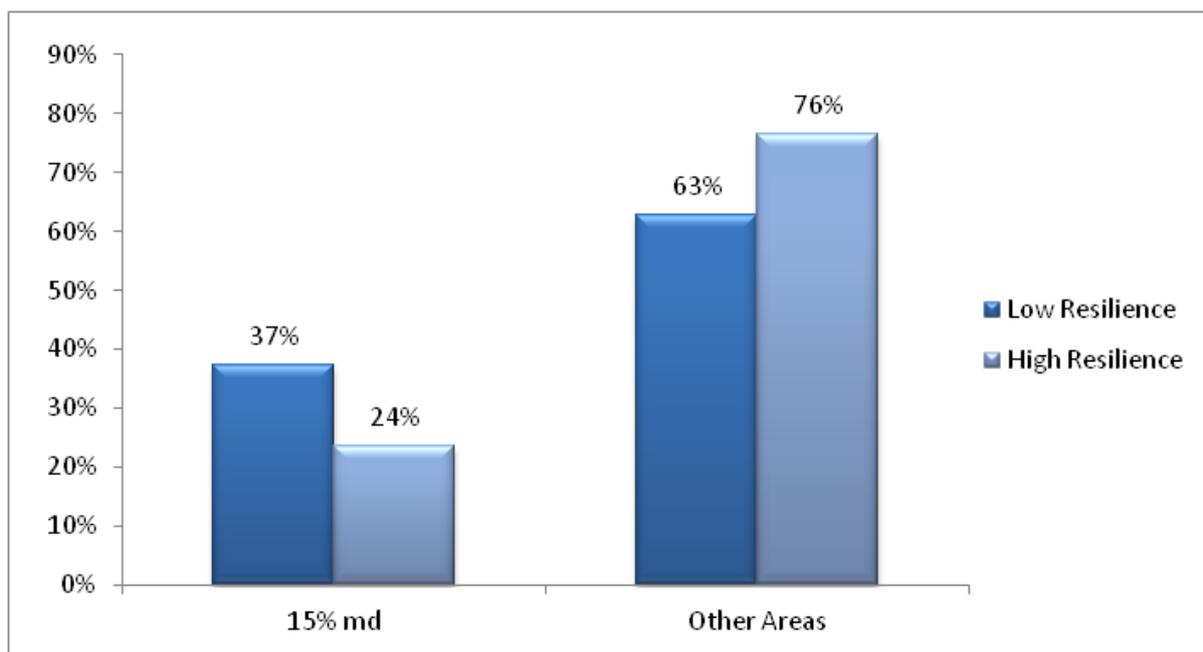
(Source: Health and Wellbeing Survey (2015))

Resilience Group	NHSGGC	East Dunbartonshire	East Renfrewshire	Glasgow City	Inverclyde	Renfrewshire
Low Resilience	29.4%	19.7%	21.2%	34.5%	29.8%	24.5%
High Resilience	70.6%	80.3%	78.8%	65.5%	70.2%	75.5%
Mean	4.0	4.4	4.4	3.8	4.0	4.1
Median	4.0	5.0	5.0	4.0	4.0	4.0

There were fewer respondents in the high resilience group in the most deprived areas.

Figure 3.2: Low and high resilience groups by deprivation

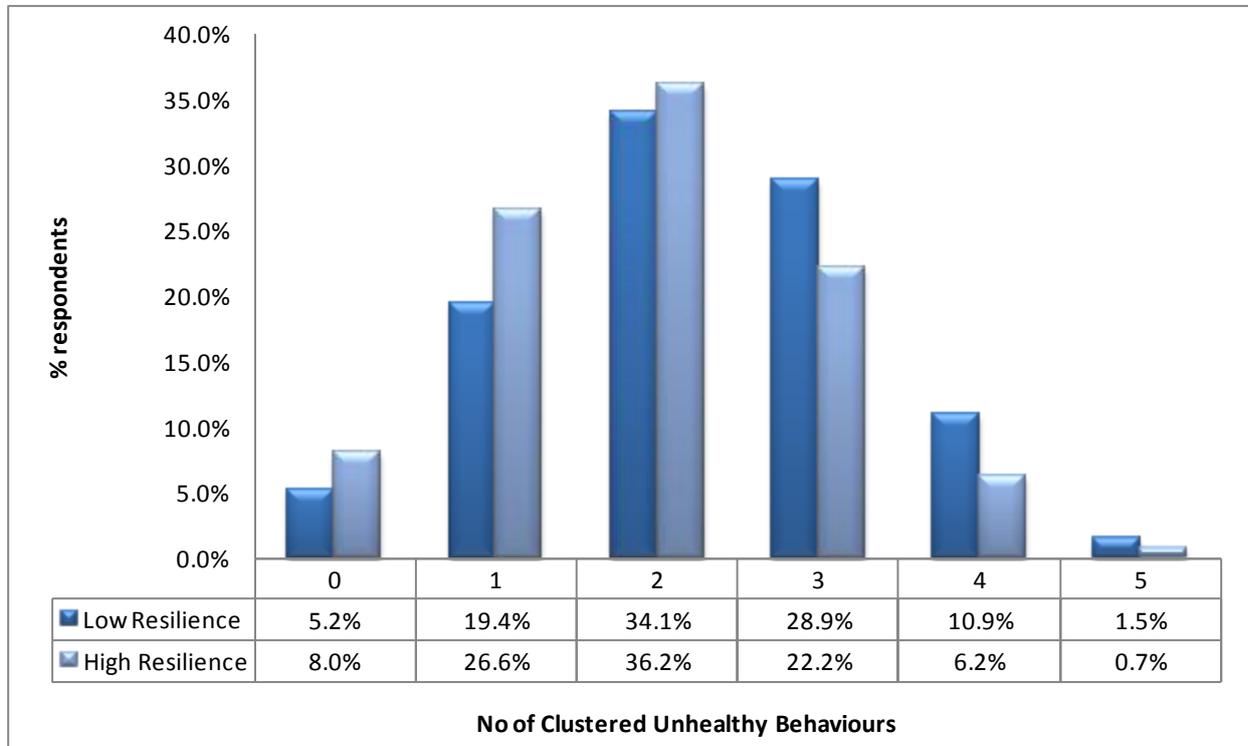
(Source: Health and Wellbeing Survey (2015))



The high resilience group was associated with fewer unhealthy behaviours, a more positive perception of quality of life (93% of those in the high resilience group also had a positive perception of quality of life) and a positive view of mental and emotional wellbeing (91% of those in the high resilience group also had a positive view of mental health).

Figure 3.3: Number of unhealthy behaviours by low and high resilience groups

(Source: Health and Wellbeing Survey (2015))



A new way of working

“History suggests that the achievement of better prospects for disadvantaged communities and fairer outcomes within Scotland as a whole will not be achieved through continuing with established approaches. Innovation, sustained commitment and more person-centred ways of working will be needed”.³

One alternative way of responding to the challenge of health inequalities is to use asset-based approaches. An assets approach is a set of values and principles and a way of thinking about the world (Foot and Hopkins 2010)⁴. These aim “to nurture, sustain, protect and build the health assets in every individual, family and community in order to improve people’s life chances and enhance positive health and wellbeing”.⁵ To do this requires a shift in the professional’s role, away from solving

problems to supporting people to recognise and mobilise the assets and resources they have. Practitioners working in an asset-based way take a different starting point; they ask ‘What makes you healthy?’ rather than ‘What makes you ill?’ Communities and individuals often labelled deprived are often rich in relationships, resourcefulness and social and personal assets⁶. Asset-based approaches are about recognising and making the most of people’s strengths. There is a shift in focus from defining people in terms of what they don’t have (their needs) to what they do have (their assets).

Common factors of assets-based approaches include:-

- Starting with the assets and resources in a community
- Seeing people as the answer
- Supporting people to develop their potential
- Identifying opportunities and strengths
- Investing in people as active participants
- Focusing on communities, neighbourhoods and the common good
- Seeing people as having something valuable to contribute
- Helping people take control of their lives

Asset-based approaches are not an alternative to good public services, but challenge public services to work more collaboratively to transform their relationship with communities and those with poor health. Crucially, asset-based approaches are not about overlooking structural and material issues or asking vulnerable people to think positively despite their circumstances³. Addressing poverty, deprivation and inequality must continue to be the focus of concerted effort as key social determinants of health and wellbeing.

Assets in action in NHS Greater Glasgow and Clyde (NHSGGC)

There are a number of examples where asset-based working has been used in NHSGGC to benefit communities and individuals⁷. Three of these are described here.

Glasgow Community Planning Partnership has agreed a ten year focus on nine neighbourhoods. These nine neighbourhoods are characterised by persistent poverty and inequalities. This targeted approach, called Thriving Places, has begun to help to refocus broader programmes of health improvement work by:-

- Exploring and analysing current ways of working and linkages
- Identifying and trying out different ways of working
- Making new connections
- Responding more directly to local need

Initially three Thriving Places are pioneering work, Ruchill/Possilpark, Parkhead/Dalmarnock, and Greater Gorbals. In these areas, local groups have been established which involve a range of stakeholders (including local people) as well as a political lead. Activities and processes vary in each area but have included: asset mapping; reviewing previous consultation work; literature reviews; community conversations; local events; and small scale community budgeting initiatives. The areas have in common a distributed leadership model whereby workers from partner agencies in the statutory and non statutory sectors link back to host organisations. In this way, it is anticipated resources and assets will be shifted to meet local needs more appropriately.

The Thriving Places city infrastructure has learning at its heart. Continuing professional development for Thriving Places groups has been implemented through learning programmes including “Whole Community Transformation and Asset Based Community Development”. Support from What Works Scotland⁸ will ensure learning from the programme is enhanced while the Single Outcome Agreement for the city now includes measures in relation to the Thriving Places.

Thriving Places aims to lead to a step change in the reduction of persistent poverty on a community wide basis.

A second example of asset-based working aims to enhance the experience of children by offering an intensive orchestral programme. Big Noise Govanhill was established in 2013 as an expansion of the Sistema Scotland project. Big Noise aims to deliver a music programme of the highest quality and ambition to children from pre-school to school leaving age. The programme is a long term, no fee, intensive programme tailored to individual need with proactive promotion to families with low uptake and complex needs. Participation in the Big Noise is believed to achieve social benefits including greater confidence, discipline, teamwork, pride and aspiration in the participants, their families and the wider community. Big Noise is an example of assets in action as it builds positive skills within participants whilst investing in the early years and sustaining the investment through to young adulthood. In doing so, it is hoped that some of the negative consequences associated with living in areas of deprivation can be overcome.

A multi-component evaluation of Big Noise has yielded the following early findings:-

- Strong relationships throughout the programme have been vital in securing the social and emotional development of participants by providing a safe and positive environment
- Short term outcomes for participants include improved: school attendance; creativity; adaptability; problem solving; decision making; team work; collaboration; co-operation; self discipline and control
- The programme is a protective environment from what might be stressful home circumstances and provides a diversion from negative health behaviours whilst developing positive life skills and musical accomplishment
- These benefits are achieved by a staff team that are approachable, caring and consistent in the support, encouragement and rewards offered to children particularly during times of challenge and disruption to family life
- Cost benefit analysis for those social gains and losses that could be monetarised predicts that Big Noise will deliver more social benefits than the resources used to deliver the programme

The third example is the Family Nurse Partnership (FNP). FNP is an evidence based programme for first time mums aged 19 and under. It is an intensive, structured home visiting programme which is delivered by specially trained nurses to pregnant women through to their child's second birthday.

The programme aims are:-

1. To improve maternal health and pregnancy outcomes
2. To improve child health and development
3. To improve parents' economic self-sufficiency

There are currently two teams in NHSGGC, the first team covering Glasgow City, East Dunbartonshire and West Dunbartonshire has just begun graduation of clients into health visiting services and are about to re-start recruitment. The second team covers Renfrewshire, Inverclyde and East Renfrewshire and has just finished recruiting women to the programme.

Based on theories of attachment, self efficacy and human ecology the programme, through a therapeutic relationship between a nurse and a client, utilises the intrinsic motivation of the mums with an aim of improving outcomes for both the mother and the child. Within the programme there are other factors that interplay to make FNP different, for example the use of motivational interviewing approach, working in a strength-based way, the content of the programme and the tools like Dyadic Assessment of Naturalistic Child/Caregiver Experience (DANCE) and Partners in Parenting Education (PIPE). The programme is further strengthened by the model of supervision used and the frequency of supervision which is in a parallel process of the programme. Feedback from the FNP programme gave the following example to demonstrate how clients can benefit from the approach.

Box 3.1: An example of how clients may benefit from FNP approach

One of the recent clients benefitted greatly from this approach. When we first met her there was a general expectation from professionals that she would be unable to parent her child. This mum was very young and lived in a Children's Unit due to her own very poor experience of being parented. Despite many attempts to engage her with services, particularly education, this had failed. She had significant risk taking behaviours that put not only herself at risk but would also be a risk to her baby. The FNP programme allowed the nurse to work in a strength based way that was solution focussed and sought to build mums self efficacy through understanding of what she had achieved and transferring those skills to new challenges. It also promoted a deep understanding of what children need to develop and grow safely and to their full potential. This did not mean ignoring the risk but instead working holistically on all aspects of the clients' life alongside inter-agency partners.

As a result of working in this way with the mum she has blossomed into a child centred, loving mum that currently meets all of her child's needs. As a result her child is thriving, growing and developing well within normal limits and is secure in her relationship with her mum. Additionally not only has the mum been able to achieve this, her child has never been subject to child protection procedures apart from pre birth, has never been on the child protection register and has never been Looked after and / or accommodated⁹.

For details of community level examples of assets-based approaches in Greater Glasgow and Clyde, see *Assets in Action: Illustrating asset-based approaches for health improvement*¹⁰.

What need to be done to embed asset-based approaches in NHSGGC?

At present, asset-based working within health and care services is occurring within specialised services for specific target groups. The potential exists for wider adoption of this way of working, for example, in how we organise our services. Much of this depends on recognising the value and contribution that people and communities have something to offer; it requires fostering of good relationships at personal and professional levels. Furthermore, there is a need to increase awareness of this way of working across the organisation at all levels and its potential for improved health and wellbeing outcomes, alongside and complementary to, existing good public services, and established interventions to improve health and wellbeing.

Asset-based approaches are neither a no-cost nor a money saving option. Investment in the development of people and communities requires long term-commitment and finance. The culture of performance monitoring and target setting should be redefined; it must be conducive to new ways of working which are responsive to local need and circumstances. This way of working is community-led and open-ended with less certain outcomes which will take longer to emerge.

Summary points

- Our unhealthiest communities are unlike our healthiest communities in every way
- Low resilience is associated with younger age (16-44 years) and deprivation
- Asset-based working aim to nurture, sustain, protect and build the health assets in every individual, family and community in order to improve people's life chances and enhance positive health and wellbeing
- Asset-based working is not an alternative to good public service, but challenges public services to work more collaboratively to transform their relationship with communities and those with poor health
- Examples of asset-based working in NHSGGC include the Thriving Places initiative, Big Noise and the Family Nurse Partnership
- Evaluation of asset-based approaches has yielded positive findings regarding the impact of this way of working with some of our most vulnerable individuals and communities

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