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Asset-based and strengths-based community initiatives in the UK

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Introduction

There is growing interest in the contribution of asset- and strengths-based activities within social and community development. Asset-based approaches focus on people's and communities' assets (their capacities, resources and networks) as well as their needs. At an individual level, it entails assessments and conversations emphasising personal and community strengths rather than deficits.[1] The aim of this brief article is to overview a number of initiatives across the UK and discuss the challenges in embedding them within local settings. The discussion proceeds as follows. First, an overview of the prevailing policy context within which community development and associated initiatives have emerged. Second, a discussion of the values and aspirations framing such initiatives. Third, the paper review a range of initiatives. Fourth, it examines the future development of such activities.

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The context of local services

The impact of the 2008 financial crisis on UK public sector funding is seen most starkly in local government. Since 2010, Local Government has faced significant fiscal austerity, with local councils in England seeing an average cut to budgets of almost 26%.[2] Those councils in urban areas serving poorer communities have been hardest hit given their reliance on central government grants and limited ability to draw upon additional local sources of revenue. Local Government has wide responsibility for delivering services including those for children (e.g. education, family services and support), adults (e.g. social care, and support for people with

disabilities), culture (e.g. libraries and leisure), housing and planning and development. Analysis supported by the Joseph Rowntree Foundations suggests that cuts in the most deprived local authorities in England have been £220 per head, compared to £40 per head in the least deprived.[3] Council spending on adult social care in England fell by almost 17% between 2009/10 to 2015/16.[4]

Broadly, the response of councils has been three-fold.[5] First, efficiency savings to reduce costs of council services but maintain levels. This includes eliminating management layers, redundancies, and procurement and corporate arrangements that that are more efficient. For example, there are 550 shared services arrangements where councils share the cost of a number of different services (e.g. human resources, IT), providing economies of scale in purchasing and savings for individuals councils who no longer maintain their own complex infrastructures.[6] Councils are also looking to shared senior management arrangements and entering joint-venture relationships

with both public and private sector bodies.[7] Second, retrenchment to reduce the council's role with new models of service delivery (e.g. social enterprises), and citizens undertaking roles previously undertaken by the council, including the upkeep of parks and provision of local library services. For example, many councils have attempted 'transformational projects' involving an increased role of community volunteers and organisations in delivering their library service.[8] [9] The 'Community Right to Challenge' encourages citizens (e.g. within a local community group or

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social enterprise) to bid to take over local services, if they believe they could run them better and innovate.[10] Third, investments which aim to reduce the demand for council services and lessen future costs of intervention. These include a range of preventative support and investment in, for example, children's, youth or older people's services.

Coalition Government measures post-2010 saw reform of national disability benefits, with Employment and Support Allowance replacing Incapacity Benefit, and a points-based Personal Independence Payments. The creation of household benefit caps and 'under-occupancy' penalties, erosion of crisis loans, precarious employment, and burgeoning consumer debt all contribute to increased pressure at the local level. The roll out of Universal Credit, replacing in- and out-of-work benefits will entrench the overload on advice and advocacy services at the local level.[11] The wider social fabric of communities is also under strain, with the social evil of loneliness gaining increased policy attention.[12]

Such developments are against a broader backdrop of population ageing placing increased demands on health and social care services. The 2014 Care Act focused on authorities' duties to undertake needs assessments and to improve people's independence and wellbeing. However, adult social care services face a £1.5 billion funding gap by 2019/20, and £3.5 billion gap by 2024/25 according to the Local Government Association.[13]

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Paradigm shift: community assets and strengths

Given the context of austerity, cuts to spending are perceived as driving public sector reform, rather than reform facilitated by broader transformation. Services with a preventative or developmental role are increasingly under threat, falling prey to a focus on short-term spending and priorities. The Coalition Government – under the banner of the 'Big Society' – emphasised the role of the voluntary sector and civil society groups to fill gaps where the local authority was no longer providing services. However, civil society/community group capacity received less attention and support, as did the increased levels of deprivation in poorer communities that created greater needs for community-based solutions whilst simultaneously eroding capacity within communities.

Over the last decade, strengths- and asset-based approaches have become prominent in the social and community development literature, and are finding their way into service provision and policy frameworks. Roots lie not in attempts to plug gaps and offer short-term, piecemeal solutions, but in longstanding debates about the role of the state and professional roles, and the untapped gifts and skills within communities and neighbourhoods. The welfare state and professional power were seen to render citizens and service users passive within service-settings, and models of personalisation and local and community based activity as potential antidotes.

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Asset-based approaches have become increasingly central in attempts to tackle loneliness through community and neighbourhood initiatives. Indeed, a recent systematic review of the public health consequences of social isolation and loneliness advocated for prevention strategies that utilise an asset-based approach.[14 15] In seeking to address loneliness the Joseph Rowntree Foundation identified low-cost preventative action developed by local government, with neighbourhood-level action and resident involvement as a key 'structural enabler'.[16] Strengths- and asset-based approaches are reflected within policy settings with the 2014 Care Act viewing individuals, their families and their communities as assets.[17 18]

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Asset approaches are co-production activities. Co-production focuses on equal and reciprocal relationships between professionals and service users whereby knowledge, experience and capacities develop sustainable and effective solutions, whilst also re-aligning power relationships. Co-production requires the active input of those who use services, as well as those designing and providing them. Within co-production, we view people as assets, and develop relationship that are reciprocal, involving strong and supportive community and social networks. In some respects, the design and delivery of the welfare state became framed as part of the problem rather than always the solution:

> *The asset approach values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, the glass is half-full rather than half-empty. The more familiar 'deficit' approach focuses on the problems, needs and deficiencies in a*

community. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of expensive services rather than active agents in their own and their families' lives...[19]

Here we overview six initiatives that have developed within the asset and strengths-based paradigm: Local Area Coordination; Shared Lives schemes; community circles; time banks, community navigators and social prescribing.[20][21][22]

Local Area Coordination

A number of English and Welsh Local Authorities, since 2010, have introduced Local Area Coordination, an approach that is strengths- and asset-based.[23] It offers support to all those residing within its local area (typically 10-12,000) regardless of whether an individual is known or not to existing services. It typically works intensively with 50-60 people per Local Area Coordinator but may offer advice and information to many more. Local Area Coordinators support individuals in communities to help them pursue their vision of a 'good life' and shape individual solutions. There is no formal referral mechanism and local residents can contact their Local Area Coordinator directly or be introduced by local agencies or community. Local Area Coordinators seek practical, non-service solutions to issues and problems wherever possible. They help to build supportive relationships and networks; facilitate access to and navigation of services; and provide relevant, and timely,

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information. Moreover, Coordinators draw upon community resources, identify gaps in community opportunities and advance local partnerships.

Local Area Coordination hinges on practitioners getting to know and building positive, trusting relationships with individuals, families and communities, whilst being aware of community resources and their current and future potential. Coordinators seek to 'map' community resources (e.g. individuals, families, communities and services), identify gaps and advance partnerships with local businesses, community, voluntary and third sector organisations.[24] A vocabulary of Local Area Coordination ('introductions'; 'connections'; 'walking alongside'; 'good life'), reflects the emphasis on empowerment, resilience and membership – individuals are citizens and community members and not 'clients' or 'users'.[25] Local Area Coordinator activities include organising drop-ins, lunches and coffee morning to tackle isolation; support for appointments (such as GP appointments); companionship for isolated or vulnerable people; support when navigating social security, housing and health and social care systems; advocacy in multi-agency meetings; signposting to leisure activities; and supporting Community Groups and communities of interest.

Local Area Coordination seeks a range of outcomes. For individuals and families it aims to improve health and well-being, developing confidence, choice and control. At the community level, it seeks stronger and better-resourced communities. At the

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system level, it targets prevention, building social capital, increased range of support and services, and consolidated partnerships and joint working between across services, statutory and third sector organisations.[26] [27]

Shared Lives schemes

Shared lives schemes is a model of community-based support for a group, including those with learning disabilities and mental health problems, which matches their needs with an approved carer. Around 70% of those who receive support are individuals with learning disabilities, and around 20% of support is to those aged over 65 years of age.[28] Also called adult placements, it supports people aged 18+ and, for some, 16+ when they meet eligibility for adult services. The carer shares their family and community life with the individual, and provides care and support that may involve co-residence, or being a regular visitor. Such schemes are an alternative to traditional, residential, provision such as care homes.[29] SharedLivesPlus is the UK-wide network of regulated schemes that match trained and approved Shared Lives carers with those who need their support.[30] It is a national network of services, administered through councils at a local level. The scheme is embedded in the local neighbourhood, addressing a range of practical issues and emotional issues at the local level. There are 132 Shared Lives schemes operating in England, with numbers supported in long-term arrangements (6,420), short breaks (2,960) and day support (2,230).[31] Findings from one study of services

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for older people highlighted Shared Lives' ability to deliver good outcomes, particularly for measure of overall quality of life.[32]

Community circles

Community Circles seek to prevent and alleviate needs by drawing on community assets, and engaging people and communities in co-producing sustainable support. A Community Circle consists of two or more people together around someone who wants a little help in order to change something in their life.[33] That change can be anything – from getting out of their home more, to starting a new hobby, working through major life changes, or beginning to exercise more. The circle then works towards making this change happen drawing on the support of a volunteer Community Circles Facilitator. Members meet every few weeks with the person supported and the facilitator role is to ensure conversations lead to actions. Many Community Circles focus on older people, those with dementia, disabled people, children and young people, although they are suitable for anyone who might want to make a change in their life. Community Circles aim to improve wellbeing, health and ensure people are more connected.[34]

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Time banks

Time banks use time as a unit of local exchange and which allow people to come together and help each other. As a community-based volunteering initiative they are underpinned by the belief that *everyone* has something to contribute. Participants

make 'deposits' of their time in the bank by providing help or support, and are able to make a withdrawal when they require something themselves. Everyone's time is valued equally, irrespective of the skill they bring. The time bank coordinates recruitment, matches offers with needs, and helps people to identify what they can offer and records offers and exchanges.[35]

Timebanking is less formal than volunteering, and reciprocal in seeking to involve those who may be most marginalised. For example, someone may need help with hospital after care, gardening, getting to the shops, practising a new language, community events or simply someone to talk with. Timebanking is a tool for generating community capacity:

> *By earning and by banking time credits people ensure that any support that they may need will be available when they need it. The time based community currency that circulates sets in motion a chain reaction that forms bonds between strangers and brings people together in unforeseen and unpredictable alliances. There is an inbuilt multiplier effect as one act of kindness generates others and so on. This is real social capital in action.*[36]

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The first UK time banking project was established in 1998 in rural Gloucestershire. Timebanking UK is umbrella organisation for the promotion, implementation and development of Timebanking in the UK.[37] There are around 41,000 people and 5,500 organisations involved in timebanking activities. Benefits include those of wellbeing

and tackling particular problems, reducing isolation and supporting those with long-term health conditions, fostering support networks and building social capital. As well as engaging those potentially marginalised, being preventative, it treats people not as passive service recipients but is transformative in seeing them as *co-producers* of their own wellbeing.

Community navigators

Community Navigators support people to explore opportunities in their local areas and to consider how they might develop networks and activities. In some models targeting those with mental health, participants have up to 10 meetings with their Community Navigator over a six-month period. The support involves reviewing and mapping each person's existing social network, and developing an action plan to increase connectedness (including awareness of available activities and support and resources to access these). Group meetings are an opportunity to meet co-participants, and share information and experiences.

Community Navigator service have also been developed in some schemes to help older people access local services and activities that improve their health, wellbeing and independence, providing links to the community and voluntary sector. Community Navigator for example may signpost older people to Home Safety Check, Benefit Entitlement Check, Luncheon Club and Befriending Schemes. The Community Navigator also supports community group activities to build capacity.

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Social prescribing

Social prescribing (or community referral) links people with health, social or practical needs to a range of local, non-medical support in the community, including voluntary and community groups. Typically, it is organised by community development workers with local knowledge based within primary health care settings, enabling GPs, nurses and other health and care professionals[38] to refer people. Examples of social prescriptions include opportunities for arts and hobbies, physical activities and exercise, learning, volunteering, cookery, befriending and self-help, as well as support in navigating social security benefits, education and debt problem.[39] Social prescribing has related names including link worker, community connector, health trainer and even community navigator. There is a continuum from simple signposting for activities to more intensive and sometimes longer-term individual support.[40]

Social prescribing and community-based support is part of the NHS Long Term Plan's commitment to personalised care within the health and care system that builds on individuals' strengths and needs. The Plan, published in January 2019, has a commitment to increasing access to social prescribing for the whole population,[41] funding 1,000 new social prescribing link workers by 2020/21, with significantly more after that, leading to at least 900,000 people referred to social prescribing by 2023/24.

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The role is now part of the framework for General Practitioner contract reform, aiming to better embed these link workers within the primary health care.[42]

Social prescribing claims to work for a wide range of people, including those with long-term conditions, those needing support with their mental health, those lonely or isolated, and those who have complex social needs. There is some limited evidence that social prescribing schemes may also lead to a reduction in the use of NHS services and general practice attendance rates.[43] However, a more robust and systematic evidence base is yet to emerge.[44] [45]

Looking forward and next steps

Having reviewed a number of emerging approaches and initiatives, clear differences exist with, for example, some hosted within Local Authorities (Local Area Coordination), others within healthcare (social prescribing), and some remaining outside local authority and health service settings (Community Circles). Despite these funding and institutional differences, there is a shared vision to harness community capacity, engage in co-production, and challenge traditional service models and professional power.

A recurring criticism of asset-based work however is that downplays the structural context of inequality and disadvantage, including health disparities, life chances and access to power and resources.[46] [47] The emphasis on social capital, some argue,

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serves as a thin apology for the neoliberal project and displacing government responsibility.[48] Emphasising individual agency does not account for those experiencing significant poor health or disability, and who are inherently reliant for care and support.

In defence, adherents see effective assets- and strengths-based approaches working hand-in-hand with investment in services and addressing structural causes of disadvantage to service delivery and community building.[49] Asset approaches do not displace a growing need for care and urgent societal debate about its funding and responsibility. Neither do asset-based initiatives wish-away growing social inequalities and disadvantage. More positively, asset-based approaches are part of a broader conversation about how a contemporary welfare state and social support aligns with prevailing values and expectations. It is also evident that specific initiatives may also be transformational, for particular groups, in particular settings, in a myriad of ways.

Clearly, challenges of asset-based initiatives include the most appropriate scale and the most effective host, and whether becoming part of contracting arrangements and core welfare state provision compromises transformational potential. There is complexity in evaluating asset-based work and initiatives that develop 'at the speed of trust'.[50] The effectiveness of both social prescribing and Local Area Coordination draws on small scale and qualitative studies, with no control group and a reliance on

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self-reported outcomes. The focus on progress (and process) rather than outcomes may serve to hamper future investment within local authority and health care settings.[51] There is as yet more limited community-level evidence, including how activities help build social capital. A greater emphasis on capacity building and the consolidation of partnerships and relationship with other services, communities and third sector organisations will take time to emerge and capture.[52] Wider transformation will also involve structural and cultural shifts in community and service settings, not precluding service reconfiguration and investment in services.

Asset-based initiatives cannot perform all the heavy lifting required in rebuilding and consolidating community. There however promising signs in how initiatives contribute to tackling loneliness, build positive visions of the future, shape non-services solutions and help navigate complex service-worlds. Such initiatives cohere around local knowledge and connections, giving greater voice to marginalised individuals and communities with the potential to improve well-being and community resilience.

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