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'What we've tried, hasn't worked': the politics of assets based public health

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COMMENTARY

'*What we've tried, hasn't worked*': the politics of assets based public health[1]

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> Like you we suffer the relentless erosion of our livelihoods, like you we are afflicted by an unending vandalism wrought upon even the vaguest dream for a future not dictated by those who would keep us precarious. We too are facing a brave new world of austerity, shock economics and class war.
> Solidarity with Classe, student protest of Quebec, University for Strategic Optimism 2012[2]

It is a paradox of recent epidemiology that as material inequalities grow, so the pursuit of non-material explanations for health outcomes proliferates. At one level, a greater recognition of psycho-social factors has deepened the understanding of the societal determinants of health, the links between mental and physical health and the social nature of human need. Too often however, psycho-social factors are abstracted from the material realities of people's lives and function as an alternative to addressing questions of economic power and privilege and their relationship to the distribution of health. The growing influence of salutogenesis and asset-based approaches is one example of this trend. This paper reflects on the theories of public health that lie behind the discourse of assets, together with some of the reasons for, and consequences of, its popularity and influence, notably in Scotland.

Keywords: assets; public health; politics; inequalities; mental health; well-being; Scotland

Introduction

> An asset-based approach is about focusing on the positive capacity of individuals and communities, rather than solely on their needs, deficits and problems. This is linked to the theory of salutogenesis, which highlights the factors that create and support human health, rather than those that cause disease. (NHS Health Scotland 2012, 2)

The emergence of *asset-based approaches* to improving health is generating a level of evangelism not seen since the days when *social capital*, a not unrelated construct, inspired a similar fervour. However, while the research literature on social capital included a very significant level of academic debate (Kawachi, Subramanian, and Almeida Filco 2000; Lynch, David Smith, and Kaplan 2000; Wilkinson 2000; Krieger 2001; Muntaner 2004; McKenzie and Harpham 2006; Baum 2010), there has been little critical analysis of asset-based approaches and their application to public health (Friedli

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2011, 2012a, 2012b). This is surprising, because the language of assets now permeates the literature on health and health inequalities (Harrison et al. 2004; Foot and Hopkins 2010; Foot 2012; Lindstrom and Eriksson 2010; Morgan and Ziglio 2010; McLean and McNeice 2012; Scottish Government and HAPI 2012), and also has a strong presence in UK policy on public sector reform, as well as in wider debates on social protection and public service entitlement (O'Sullivan et al. 2009; Christie 2011; Mair, Zdeb, and Markie 2011; Scottish Government Social Research 2011).

Public health is responsible for understanding and acting upon the 'distribution and causes of population patterns of health, disease and wellbeing' (Krieger 2011, vii). This means paying special attention to how ideas that influence public health policy and practice both explain the fact of health inequalities and account for 'who and what is responsible' (Birn 2009). These questions are always important. They assume a greater urgency at this time of major political debate about the role and responsibilities of the state in relation to health, and in the face of a renewed neo-liberal attack on the existing remnants of market regulation and the *social rights of citizenship* (Beckfield and Krieger 2009, 153). As Beckfield and Krieger have observed: 'Power, after all, is the heart of the matter – and the science of health inequities can no more shy away from this question than can physicists ignore gravity or physicians ignore pain' (Beckfield and Krieger 2009, 170). Constructs like *asset-based approaches* emerge and gain currency in specific social, economic and political contexts and are pressed into service as part of wider ideological conflicts. This paper reflects on the theories of public health that lie behind the discourse of assets, and asks why the assets movement has joined the attack on public sector provision, rather than addressing the health impact of corporate power. It also considers some of the reasons for, and consequences of, its growing popularity and influence, notably in Scotland, where asset approaches enjoy strong support from the chief medical officer (Scottish Government 2010, 2011a, 2011b; McLean 2011; SCDC 2011).

Definitions of assets

> Asset based approaches are concerned with identifying the protective factors that support health and wellbeing. They offer the potential to enhance both the quality and longevity of life through focusing on the resources that promote the self-esteem and coping abilities of individuals and communities. (McLean 2011, 2)

Asset-based approaches are essentially about recognising and making the most of people's strengths, to 'redress the balance between meeting needs and nurturing the strengths and resources of people and communities' (McLean 2011, 2), with a corresponding shift in focus from the determinants of illness to the determinants of health (salutogenesis). Although assets can include material resources – land, buildings and income (Aradon 2007; Cooke 2010; Scottish Government 2012) – in public health, more typically, the primary focus is on valuing individual and collective psycho-social attributes. These include the familiar roll-call of *self esteem, aspiration, confidence, optimism, sense of coherence (SOC), meaning and purpose*, the so-called *intangible assets* such as knowledge, skills, wisdom and culture, and key features of social capital: *social networks, reciprocity, mutual aid* and *collective efficacy* (O'Leary 2006, 2011; Foot and Hopkins 2010; Lindstrom and Eriksson 2010).

Asset-based approaches draw on positive psychology and the work of Antonovsky on SOC (Antonovsky 1987; Seligman 2003), as well as on traditions of community develop-

ment (McKnight 1995, 2010; O'Leary 2006) and health activism, notably in the disability rights, user/survivor and recovery movements (Duffy 2010a, 2011; Boardman and Friedli in press). Although Antonovsky's analysis acknowledges that psychological attributes are strongly influenced by material and social factors (described as *generalised resistance resources*), it is the concept of *sense of coherence* that dominates in the assets literature.

Based on empirical studies of psychological resilience in the face of profound adversity, Antonovsky argues that the presence or absence of SOC – the belief that life is comprehensible, manageable and meaningful – is fundamental to understanding healthy life outcomes, notwithstanding the experience of trauma. Individuals who experience life as structured, predictable and explicable, who are confident that they have the resources to meet demands and who believe that such demands are challenges worthy of investment and engagement are thus said to be consistently more likely to have positive life outcomes (Antonovsky 1987; Lindstrom and Eriksson 2010). Any correlation between SOC and better health is unsurprising. The marked social gradient in both mental illness (e.g. post natal depression, anxiety and psychosis) and levels of mental well-being (e.g. Warwick–Edinburgh Mental Well-being Scale) suggests that psychological attributes like SOC are strongly linked to social position (McManus et al. 2009). What is more, which attributes attract social value and economic reward is highly ideological: hence, capitalism in crisis prefers *aspiration* to *sufficiency* and *independence* above *solidarity* (Bauman 2007). However, it is not clear that SOC is fixed: one five-year follow-up study found that SOC is not stable, and that the level significantly decreases after a negative life event (Volanen et al. 2007; Volanen 2011). Even a strong SOC decreased during the follow-up period and was no more stable than a mediocre or weak SOC. The author suggests: 'in the light of the present study, it seems that SOC is determined not only by socio-economic factors but also by close and successful social relationships *during both childhood and adulthood*' (Volanen 2011, 3, emphasis added).

Antonovsky's work is part of a broader literature on well-being and resilience, and typifies the growing influence of psychological and cultural explanations for health (for reviews of competing theories see McCartney et al. 2011; Mackenbach 2012). Much of the support for assets approaches is predicated on the view that confidence and self-esteem are determinants of health and other outcomes. Marmot asserts that 'taking an asset-based approach at a local level fosters greater local confidence and self-esteem for people and communities' (Foot 2012, 3) although evidence to this effect is entirely anecdotal. As is widely acknowledged, there is no 'published evidence that use of a broad assets based approach can successfully prevent or reverse the main avoidable causes of ill-health' (NHS Health Scotland 2012, 3; see also MacKinnon, Reid, and Kearns 2006; McLean 2011). What are available are collections of '*case studies*' that in many cases have been retrospectively labelled 'asset based' (McLean and McNeice 2012). As the authors make clear, these examples cannot answer questions about effectiveness one way or the other, although they do illustrate how quickly local projects will adopt a label when it has powerful support. Nevertheless, lack of evidence has not prevented advocates from stating that 'it is justified to be very optimistic about the potential of the asset based approach' (Hills, Carroll, and Desjardins 2010, 97).

Asset approaches reflect and reinforce the view that the psychological attributes of individuals can be extrapolated to explain what is happening to health at a population or systemic level. In other words, an analysis of psycho-social factors can function as an alternative to addressing questions of power and privilege and their relationship to the distribution of health and the political production of social inequalities (Muntaner 2004; Phelan, Link, and Tehranifar 2010; Friedli 2012c). Like the wider well-being

debates (Friedli 2009; ONS 2011; Stoll, Michaelson, and Seaford 2012), asset approaches are strongly associated with a non-materialist position – money does not matter as much as relationships, sense of meaning and belonging, opportunities to contribute and autonomy: *there's a difference between starving and fasting* (Sen 1992).

The importance of the psycho-social domain is also central to critiques of consumerism, materialism and the dominance of marketised solutions to health and social problems (Michaelson et al. 2009). The Stiglitz Report calls for measures of social progress that include non-market activities, sustainability and quality of life, as does the OECD *Global Project on Measuring the Progress of Societies* (ONS 2011; Stiglitz, Sen, and Fitoussi 2009). These critiques come together in calls to value the contribution of those outside the money economy: the *core economy* of friends, family, neighbours and civil society (Cahn 2004). It is notable that the assets literature places a high value on volunteering, for example, and on alternative currencies like Time Banks.

A greater focus on psycho-social factors is part of a wider acknowledgement of the non material dimensions of deprivation, perhaps most famously in Amartya Sen's call for 'the ability to go about without shame' to be recognised as a basic human freedom (Zaveleta 2007). People living in poverty, as well as other vulnerable or excluded groups, consistently describe the pain of being made to feel of no account, which is often experienced as more damaging than material hardship (Nussbaum 2011). From this perspective, inequalities (the lived experience of injustice) greatly exacerbate the stress of coping with material deprivation (Wilkinson and Pickett 2006, 2009). What is at stake is the social, emotional and spiritual impact of poverty and inequality, as well as the belief that 'wellbeing does not depend solely upon economic assets' (Sen 1992).

In their resistance to 'deficit models' and their insistence on recognising and valuing strengths, asset-based approaches also draw on radical traditions in community development: 'They speak to the resistance of deprived communities to being pathologised, criminalised, ostracised; to being described in public health reports in terms of multiple deficits and disorders: 'chaotic, unengaged, and disaffected' (Friedli 2011, 2). These themes are an important element of work on assets-based community development by Kretzmann and McKnight (1993), which argues that by defining communities in terms of deficits, services exploit need and produce clients, whereas communities produce citizens (McKnight 1995, 2010). Strengths based approaches are also central to the recovery and disability rights movements and the principles of respect for people's self determination, choice, control and potential, as well as for support that does not undermine citizenship – themes that find expression in debates about personalisation (Duffy 2010b, 2011).

The social values associated with asset-based approaches – celebration of the power of the human spirit, recognition of people's strengths, resourcefulness and creativity and the empowering nature of collective action – have a long history and are common features of social movements and traditions of struggle for social justice (Freire 1972). From a public health perspective, these values have been given added impetus by growing evidence that social indicators are consistently emerging as more significant to population health than 'health behaviours' (Holt-Lundstadt, Smith, and Layton 2010; Jutte et al. 2010; Hertzman and Siddiqi 2009). The problem with the assets literature is that respect for people's capacity for resistance (generally described as 'resilience') is abstracted from any analysis of social injustice or the causes of inequalities: 'naming who and what are the forces and institutions creating and

perpetuating inequitable conditions in the first place' (Birn 2009). So what emerges is an attempt to reproduce, in poorer communities, psycho-social assets that are in fact tied to material advantage, while leaving power and privilege intact (Bourdieu 1977). The silence about political struggle, and the marked absence of either trades unions or street protests from public health's iteration of asset approaches, precludes any consideration of how SOC, for example, might be forged through the expression of class solidarity. One explanation for this failure by omission is the asset movement's disproportionate focus on the operation of the welfare state, as opposed to the operations of the market. This is evident in their central proposition that public services generate need and produce dependency.

Rationale for assets based approaches

> With strong support from the Chief Medical Officer, the asset based approach is now being endorsed across Scottish Government and is being promoted for use across all sectors and across the national framework … (NHS Health Scotland 2012, 1)

The rationale for adopting assets-based approaches includes three core principles – (1) focus on the determinants of health (rather than illness); (2) start with what people have (not what they lack); and (3) emphasise the contribution of psycho-social factors to health outcomes. In Scotland, the central arguments are broadly as follows:

- public health approaches to reducing health inequalities have failed – "what we've tried, hasn't worked" (Scottish Government 2010)
- public services are inefficient and unaffordable, requiring a "radical change in design and delivery" (Christie 2011, 26)
- deficit approaches, by focusing on people's needs, rather than their strengths, produce dependency (SCDC 2011)

The persistence and widening of health inequalities in the UK, notwithstanding an ostensibly favourable policy environment under the New Labour government, (Mackenbach 2011; Blakeley and Carter 2011) have been frequently cited to support the case for asset-based approaches. Morgan and Ziglio suggest 'The asset model may help to further explain the persistence of inequities despite the increased efforts by governments internationally to do something about them' (Morgan and Ziglio 2010, 4), a point echoed by Foot, who argues that current approaches to improving health have not made the impact on health inequalities that had been anticipated (2012, 9), and by Scotland's CMO (Scottish Government 2010). This view has a particular resonance in Scotland, where a strong body of research suggests that neither deprivation nor levels of material inequality can fully account for Scotland's poor health. As has been widely commented upon, the rise in mortality in Glasgow since 1980 is greater than in Manchester and Liverpool, the other most deprived cities in the UK and it remains unclear what explains Glasgow's recent excess mortality from drugs, alcohol, suicide and violence, largely among working age adults (McCartney et al. 2011). At the same time, the assertion: 'what we have tried to date, (although well meaning), has not worked' (Scottish Government 2010, 7) raises important questions about what it is, exactly, that public health has tried and in what context.

Assets and inequalities

> Assets approaches invite individuals and communities to take control of managing positive changes to their circumstances by co-producing the interventions by which they can be supported out of poverty. (Scottish Government 2011a, 9)

While it is true that there have been many efforts to address health inequalities, there has been a marked failure to acknowledge that these efforts have occurred in the context of rising material inequalities (Mackenbach 2012) – with income inequalities largely driven by *wage inequalities*. Although these trends occur across Europe, income inequality has risen faster in the UK than in any other OECD country since 1975, overtaking the USA in the 1990s and again in 2000. In the decade up to 2010, income inequalities in the UK widened significantly, driven by a sharp increase in the incomes of the richest (OECD 2011; Cribb, Joyce, and Phillips 2012). The same pattern, although slightly less marked, is evident in Scotland, where income inequality has widened since devolution (McKendrick et al. 2011). This means the sharp inequalities of the Thatcher years – and the problems associated with them – remain, exacerbated by even greater inequalities at the top of the distribution. Although relative poverty (before housing costs) fell slightly during the 1990s and largely continued to fall up to 2009–2010, rates are still well above the 1979 figure of 13.4% of the population living in poverty (Cribb, Joyce, and Phillips 2012).

It is difficult to predict future income inequality trends because much of the impact of cuts in welfare benefits is still to come (Cribb, Joyce, and Phillips 2012), but income inequality in the UK is well above the OECD average – the Gini co-efficient is currently close to its highest point since 1961 (OECD 2011). This is not accidental but has been driven by neo-liberal policy (Scambler 2007). Since the mid 1980s, UK transfers and taxes have become less redistributive, benefits have become less redistributive, benefit amounts are declining, eligibility is more restrictive and more people are working at low-wage jobs: Britain has one of the highest proportions of low-paid workers in the developed world and the share of low-paid work in the British labour market has grown steadily over the past three decades. (OECD 2011; Cribb, Joyce, and Phillips 2012; Pennycook and Whittaker 2012). Britain also has some of the lowest social mobility in the developed world, with earnings in the UK more likely to reflect those of our fathers than in any other country (Crawford and Machin 2011). Against a background of the growing gap between rich and poor, growing wage inequality, a decline in the living standards of low- and middle-income households that long predates the current recession and increasing levels of insecurity and precariousness for households below median income (Hirsch, Plunkett, and Beckhelling 2011; Pennycook and Whittaker 2012; Whittaker and Bailey 2012), it is not difficult to identify plausible reasons why inequalities in health have also increased.

Of course, income inequality is not the only driver of health and other inequalities, but the silence of the assets movement on the impact of major economic shifts on people's lives is a serious shortcoming. The focus on welfare obscures what is happening in the market. For example, the failure to analyse the *health impact* of the following trends:

- sharp inequalities in the distribution of the benefits from previous periods of economic growth
- growing *wage* inequality
- the shift from wages to profits

- falls in real earnings
- the rise in commodity prices
- the rise in women's employment, which has helped to sustain household incomes for low- and middle-income households, (while income from men's employment fell significantly)
- reduced opportunities for organised resistance to poor pay and working conditions (Cribb, Joyce, and Phillips 2012; Pennycook and Whittaker 2012; Whittaker and Bailey 2012).

In the case of Scotland, for all the talk of a culture of dependency, 'labour supply is outstripping demand as there are currently more people than jobs. There are more people with qualifications than there are jobs that demand those qualifications for entry' (Scottish Government Social Research 2011, 58). Other factors implicated in increasing or reinforcing health inequalities include the rise in spatial inequalities – gentrification, the disproportionate impact of motor vehicle traffic on the poorest communities, the psycho-social effects of geographical segregation and the privatisation of public space (Smith 2002; Minton 2009; Dorling 2010; Slater in press).

The relative contribution of psycho-social vs. material factors to health inequalities is a long-standing and ongoing debate. The Commission on the social seterminants of health has argued that health inequalities are a symptom, an outcome, and of inequalities in power, money and resources (CSDH 2008; Solar and Irwin 2011). These structural and material inequalities result in unequal exposure, by social position, to a range of health risks and health advantages. An important emerging literature has also called for a greater focus on political analysis – going beyond social processes and the biological impact of status hierarchies to consider underlying political and economic systems. In other words, inequalities are not accidental (Beckfield and Krieger 2009; Collins and McCartney 2011; Krieger 2011). Central to these accounts is an acknowledgement of class power, vested and competing interests and their expression in struggles around employment, pay, income, social protection and housing, or what Birn describes as *societal determinants*: how health is shaped by the political and economic interests of those with power and privilege (Birn 2009). These issues are completely absent from assets discourse: perhaps because encouraging communities to reflect on 'inner and innate resources' and 'starting from what they have, rather than what they lack' tends to preclude questions about the distribution of wealth and the production of poverty, in Scotland and elsewhere. Nevertheless, thinking about political determinants raises questions about why the primary focus of asset approaches is on public services, rather than on corporate power and the health consequences of the UK's especially unfettered free market (MacKay 2011).

Attacks on state provision

Assets based approaches are being used both to highlight the failings of the public sector and to reinforce the view that the way in which poor people make use of welfare benefits (income and services) is morally flawed (Friedli 2011).

> Our three social frameworks (Equally Well, Achieving our Potential and the Early Years Framework) promote an assets, rather than a deficits, approach, to tackling poverty and inequality. This means building the capacity of individuals, families and communities to manage better in the longer term, 'moving from welfare to wellbeing and from dependency to self determination'. (Scottish Government 2011b, 7)

There are two main strands: firstly, the argument that public services have focussed on deficits 'the problems, needs and deficiencies within communities' (McLean 2011, 5) and secondly, that this focus has engendered 'a culture of dependency that stimulates demand' (Scottish Government 2010; SCDC 2011, 2).

> Implicit in this discourse are beliefs dating back to the Poor Laws, namely that social protection results in moral and spiritual decline and that take up of welfare is driven not by market failure, but by certain character traits – dependency and coping style. (Friedli 2011, 11)

The move from 'welfare to well-being' also signals that assets based approaches are part of efforts to reduce 'unaffordable demand', to achieve public spending cuts and to promote a DIY response to loss of services and loss of benefits: 'a focus on positive ability, capability and capacity leading to less reliance on professional services and reductions in the demand for scarce resources' (McLean 2011, 9). As the Scottish Government notes in its child poverty strategy, 'We believe that sustainable improvements in people's life chances are most likely to be achieved by identifying and supporting the development of their own capabilities to manage their way out of poverty' (Scottish Government 2011a, 9). In this way, not only is poverty seen as an individual misfortune, (rather than the systemic outcome of a particular economic model), but the debate about public services and the public sector is framed in terms that stigmatise need – dependency as moral failing, not as a fact of the human condition or even a reminder of what it *means* to be human. The recurring leitmotif of the dependent poor also serves to disguise the nature and extent of state benefits enjoyed by the rich: fiscal and economic policies that support the privileges of wealth: land, property, inheritance and capital gains. For example, the tax exemption on private education enjoyed by the 7% of children in the UK who go on to become 70% of high court judges, one third of MPs, 50% of FTSE 100 Chief Executives and 50% of medical consultants (Guardian Datablog 2012). The point is, of course, that both rich and poor depend on the prevailing economic system, but with rather different consequences – for health and other outcomes.

The extent to which the public sector is implicated, as the assets literature suggests, in the failure to reduce health and other inequalities, raises important issues. There is now growing evidence that health services influence public health and that public health systems are under-acknowledged as a determinant of health (Rasanathan, Villar Montesinos, and Matheson 2011; Solar and Irwin 2011). At the same time, to attribute health inequalities largely to the shortcomings of the public sector serves to minimise the importance of the market and the highly differential impact of wider global economic trends. When problems are framed in terms of the 'deficit approach' of professionals and a 'culture of dependency' among the poor, hard questions about corporate power are avoided and the neo-liberal attack on the values of collective responsibility, pooled risk and universal services goes unchallenged. Blaming the public sector – the public services that are both picking up the pieces and picking up the tab – provides ideological support for the retreat of state provision and let unregulated free market capitalism off the hook. It also appears to be unsupported by the evidence. OECD figures show that public services reduce inequalities in the UK more than almost anywhere else, and this impact increased over the 2000s (OECD 2011). Against all the odds, public services have improved their impact on reducing inequalities. While there is always a case for improving services, it is not a 'radical change in

the design and delivery of public services' (Christie 2011, 26) that is required so much as a radical change in economic and fiscal policies that in Scotland, as elsewhere, 'sanction gross inequalities and obscene greed' (Rio de Janeiro Declaration 2011).

Conclusions

> Asset models tend to accentuate positive capability within individuals and support them to identify problems and activate their own solutions to problems … they focus on promoting health generating resources that promote the self esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services. (Scottish Government 2010, 7)

The radical agenda that perhaps originally inspired commitment to asset based approaches still needs addressing. This includes the relationship between public sector professionals and the communities they serve, the democratic deficit and abandonment of areas of deprivation by both the market and the state, steep income hierarchies within the NHS and the social, material and emotional distance between those who design public health interventions and those who experience them. International comparative studies suggest that *status* (the respect we receive from others), *control* (influence over the things that affect our lives) and affiliation (sense of belonging) are universal determinants of wellbeing (Kenny and Kenny 2006; Samman 2007). Public health needs to pay more attention to the factors that injure these needs and the health impact of injuries to these needs, undermining what Sen has called the *freedom to live a valued life* (Nussbaum 2011). But in these efforts to address the missing dimensions of poverty and deprivation (Samman 2007), the *distribution* of economic assets is still of fundamental importance. There is a link between living conditions and dignity. The idea of justice is paramount (Nussbaum 2011).

The assets literature includes a wide range of case studies describing what communities have achieved, in the face of considerable adversity, through focusing on assets and adopting strengths based, glass half full approaches (Foot and Hopkins 2010; Morgan and Ziglio 2010; SCDC 2011; Foot 2012; McLean and McNeice 2012). The emotional impact of stories of transformation like the widely cited Beacon and Old Hill estate in Cornwall is powerful (Durie, Wyatt, and Stuteley undated; Friedli 2011). A reminder, where that is needed, that materially deprived communities are rich in relationships, resourcefulness and creativity. That coming together to change things for the better is inspiring and empowering. Many such projects provide an urgently needed sanctuary, a refuge from grim circumstances and respite from class disadvantage. But, it is the responsibility of public health to distinguish between providing 'escape for some', while leaving the system that produces the need for escape intact, and providing leadership on addressing the determinants of health.[3] As John McKnight, founding father of asset-based community development recently observed:

> We must emphasise again that the local economic capacity for choice and sustenance is the threshold policy issue. For we have economically abandoned far too many communities and left at sea those citizens who have remained. It is these fellow citizens and their economic dilemma that is the first policy issue of the twenty-first century. (McKnight 2010, 76)

As has been noted, asset-based approaches also draw on the language of recovery, which traditionally adopted a strengths-based lexicon as a form of resistance to the imposition of psychiatric labels and diagnostic categories (Campbell 2005). By contrast, the asset movement employs psychological constructs that validate a very specific and narrow range of attributes: *self efficacy, aspiration, confidence, optimism, positive thinking, agency, self reliance, resilience*. These characteristics are frequently described in terms of mental 'well-being', and are used to explain 'health behaviours' and to reinforce behaviourist approaches. The discourse of assets makes no acknowledgement of the contested nature of what constitutes mental health and mental illness, or the relationship between multiple expressions of alienation, despair and self harm, and experiences of oppression and exploitation (Survivors' History Group).[4] While public health rallies to the cry that 'focusing on the positive is a public health intervention in its own right' (Stewart-Brown cited in Foot 2012), complex questions are avoided; for example, questions about the social gradient in mental illness and in recovery from mental illness (Lorant et al. 2003; Hauck and Rice 2004; McManus et al. 2009) and about the wider structural factors that influence individual mental illness journeys: individual and collective experiences of pain, anger and demoralisation. Instead, therapies that aim to change how people think are enthusiastically commissioned: it is more important to be positive than to have an accurate perception of reality. Symptoms are reclassified as causes: 'something within the spirit of individuals living within deprived communities that needs healed' (SCDC 2011, 3).

Perhaps, the major problem with public health's uncritical adoption of asset-based approaches is that it fails to distinguish between a *radical* critique of welfare, one that is firmly linked to an analysis of neo-liberal economics and the *neo-liberal attack* on welfare, which by contrast, supports the further de-regulation of markets and withdrawal of the social rights of citizens. If the strength of the assets movement is that it has generated discussion about re-dressing the balance of power between the public sector, public services and local communities, its fatal weakness has been the failure to question the balance of power between public services, communities and corporate interests. As such, asset-based approaches sound the drum beat for the retreat of statutory, state provision of both public services and public health.

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Notes

1. Early versions of this paper were presented at the *Poverty Alliance Understanding Poverty Seminar Series: Community Assets and Poverty* (http://www.youtube.com/watch?v=dHC-SiZkjJk) and the Socialist Health Association Health Inequality in Scotland and England (http://www.sochealth.co.uk/events/inequality/) and appear in the Scottish Anti Poverty Review Winter 2011/12.
2. http://universityforstrategicoptimism.wordpress.com/2012/06/10/london-plan-c-support-night-for-classe-quebec/.
3. Margaret Carlin personal communication.
4. The Survivors' History Group *Pageant of Survivor History* http://studymore.org.uk/mpu.htm.

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