An asset-based approach to creating health

In this article...

- The New Economic Foundation's Five Ways to Wellbeing
- A discussion of the theory of health creation
- The nurse’s role in empowering patients to create their own wellbeing

Author

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Abstract


This is the second of two articles introducing ideas associated with asset-based thinking. The first article focused on what nursing itself might learn from asset-based community development (ABCD) approaches. This article focuses on patients and explains theories of how health can be created, which is called “salutogenesis”.

Having a feeling of control of one’s life is crucial to wellbeing. Not being in control can lead to long-term stress, which can directly contribute to cardiovascular illness. Nurses need to develop these ideas by supporting the development of protective factors, including the New Economic Foundation’s Five Ways to Wellbeing and the Young Foundation’s Control, Contact and Confidence.

Nurses are generally taught about health promotion and disease prevention. Rarely do we hear about how health is created, but writers such as Foot (2012) have summarised this and local councils are now building this into their public health leadership role.

Put aside your role as a health professional briefly, and read this article as a person with a family, a community, a job and everything that has made you who you are. In that way, the article will make more sense and, by the end, you may have a few ideas of your own for creating health. Last week’s article suggested that we need to build on nurses’ assets of “heart, head and hand” and do less top-down “fixing” of nursing, which is a deficit-based or glass-half-empty approach. Nurses and nurse leaders need to focus more on listening to colleagues and highlight what is right about nursing, rather than what is wrong. This is an asset-based or glass-half-full approach.

Health creation explained

We have a national health service but it is more like a national sickness service. Sir Harry Burns, the chief medical officer of Scotland, explores this theme in a compelling video (tinyurl.com/YT-Burns-Scotland), which presents the ideas of Antonovsky (1987), a professor of medical sociology who coined the term “salutogenesis” (from the Latin salus – health and genesis – origin).

He had scathing words for the medical profession, which he said was fixated on the causes of disease rather than the mechanisms by which we can create health. Antonovsky said that health is not a “state”, as defined by the World Health Organization (1946), but that people move in and out of feeling well throughout the day or week. This has a lot to do with how they interact with others and the world around them – it is a continuum. By studying women who had been in concentration camps, Antonovsky theorised that health was...
Nursing Practice

Discussion

centrered with how people coped under stress. He identified what he called generalised resistance resources (GRRs), which define whether people have a positive or a negative outcome to managing stress. These GRRs include things like money, social support and ego. An NHS example might be how psychological services use cognitive behavioural therapy as a GRR in terms of changing the ways in which people think and respond to what happens to them.

Think about the people you know. Some come through life’s traumas and build on them, seeming stronger each time – others don’t. The first professor of salutogenesis, Bengt Lindström at the Norwegian University of Science and Technology, referred to a “continuum of life” (Lindström and Eriksson, 2010). He said that life events add to people’s experience and increase their ability to deal with what life throws at them – what doesn’t kill you really does make you stronger. But this is only if you have GRRs; if you don’t, it can lead to pathogenesis (sickness).

The more familiar approach to health promotion is upstream/downstream thinking, where we prevent ill health by mending the fence where people fall into the river instead of pulling the bodies out of the water; an example is helping people to give up smoking. While these interventions are extremely effective and complementary to salutogenesis, Burns advises us instead to consider a “river of life”, which we, as health professionals help people to navigate, helping them to stay on the sunny bank and avoid the rapids. In this way, we create wellbeing rather than prevent illness.

A sense of coherence

Antonovsky (1987) introduced another idea, which he called a sense of coherence. This describes the extent to which we are confident that life can be structured, is predictable and explicable, that we have internal resources to deal with what life throws at us and we see the challenges as something we want to engage with. The sense of coherence has three components:

» Comprehensibility;
» Manageability;
» Meaningfulness.

A sense of coherence enables people to make use of the coping resources available to them. As an example, consider the foster care of young women (an area in which I have considerable experience). By the time teenagers reach their foster homes, they have usually been through significant trauma, which is often something outside of their control. Do they understand it? In most cases, no – they are confused and their youth and emotional level of maturity tends to compound this. Are they able to manage and take meaning from the situation? Usually the reverse – they want to hide away and pretend everything is normal. How does this affect them? Invariably, they have emotional and behavioural problems and this often affects their physical health, too.

Control, contact and confidence

Antonovsky is not the only one to talk about the importance of having control over one’s life. The previous article (Henry, 2013) mentioned the Young Foundation’s three Cs of control, contact and confidence (Hothi et al, 2009) and how these might help improve nurses’ wellbeing. The same is true for communities.

Confidence case study: Lostock Community Partnership

About six years ago, the Lostock clinic stood close to Manchester’s Trafford Centre. Built during the Second World War, it had developed severe structural defects. The primary care group (as it was) decided to close the clinic and build the Delamere Centre, about a mile and a half away. The Lostock part of the community had not properly consulted and had concerns for the very old and young because there was no suitable bus service to the

![FIG 1. MOVING FROM A DEFICIT APPROACH TO AN ASSET APPROACH](https://example.com/fig1.png)

<table>
<thead>
<tr>
<th>Where we are now – the deficit approach</th>
<th>Where an asset-based way of thinking takes us</th>
<th>Example of asset-based approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start with deficiencies and needs in the community</td>
<td>Start with the assets in the community</td>
<td>Some health and wellbeing boards now include assets as well as needs in joint strategic needs assessments</td>
</tr>
<tr>
<td>Respond to problems</td>
<td>Identify opportunities and strengths</td>
<td>Self-help groups, such as Al Anon (for families of alcoholics) offer a support model that builds on others’ strengths, rather than dwelling on problems</td>
</tr>
<tr>
<td>Provide services to users</td>
<td>Invest in people as citizens</td>
<td>Connecting Communities is one of a number of asset-based community development (ABCD) approaches, which builds resident-led partnerships. It offers a comprehensive training and support programme. Residents are always seen as the solution and never the problem See <a href="http://www.healthcomplexity.net">www.healthcomplexity.net</a></td>
</tr>
<tr>
<td>Emphasise the role of agencies</td>
<td>Emphasise the role of civil society</td>
<td></td>
</tr>
<tr>
<td>Focus on individuals</td>
<td>Focus on communities/neighbourhoods and the common good</td>
<td></td>
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<tr>
<td>Treat people as passive and done to</td>
<td>Help people to take control of their lives</td>
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<tr>
<td>See people as clients and consumers receiving services</td>
<td>See people as citizens and co-producers with something to offer</td>
<td>Many health professionals dealing with long-term conditions now view their patients as assets who are experts in their own health and learn from them what works best</td>
</tr>
<tr>
<td>“Fix” people</td>
<td>Support people to develop their potential</td>
<td>Lostock residents were coached until they actively formed alliances with local health workers</td>
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<tr>
<td>Implement programmes as the answer</td>
<td>See people as the answer</td>
<td>NHS Institute online resource Experienced-based Design (tinyurl.com/NSI-Experience-based-design) is a patient-led approach to service redesign</td>
</tr>
</tbody>
</table>

Source: based on Foot (2010)
Delamere Centre so these vulnerable people had to walk or get a taxi.

The residents felt no control over what had happened but, over the next few years, through a resident-led partnership called Lostock Community Partnership, they began a dialogue with the NHS, the police, the council, local schools and others, and began to work together as equal partners. They became stronger and more resilient.

Lostock Clinic, in the meantime, fell into disrepair, becoming a huge eyesore and a target for vandalism. To Lostock residents, this was adding insult to injury. Feeling empowered, the residents of Lostock Partnership went together to the primary care trust’s public board meeting where the latest paper on the future of the clinic was being discussed; they were allowed to speak and, for the first time, the residents described their hurt and loss directly to decision makers. The decision was made that day to sell the clinic site. This gave the residents a sense of confidence in their achievement.

About two years later, the new Lostock clinic opened. Using their new confidence, the residents had developed a relationship with the community pharmacist and a nearby GP surgery that needed more space to become a teaching practice. They made an appointment with the director of commissioning and persuaded him to sell the Lostock clinic site to the pharmacist and GP, who raised their own finance to build a new surgery and pharmacy.

Five ways to wellbeing

Another, perhaps better-known wellbeing approach is the New Economic Foundation’s Five Ways to Wellbeing (2008), which is a set of evidence-based actions to improve wellbeing (Box 1).

The concepts can be seen in action at CALLplus, a Manchester charity (www.canceraid.co.uk), where volunteers support people with life-limiting illness by offering a listening ear, trips out, drop-ins, transport to clinic appointments, respite and practical support at home such as shopping. From in-depth interviews with clients, it can be demonstrated that volunteers address many aspects of the Five Ways to Wellbeing. By connecting with people, they offer a listening ear, which for many is a relief because clients often say that their families do not know how to talk to them when they are given a diagnosis of a life-limiting illness. The drop-ins and volunteer transport help to prevent isolation and depression.

As people begin to make friends (often for life), they become more active. For some, this means going to CALLplus events and, for others, it means a return to hobbies or fundraising. Many report that their focus shifts from being introspective to being outward-looking. Over time, clients learn how to listen and support others, with many who have recovered from illness volunteering with CALLplus. Through giving back, they experience a tremendous sense of wellbeing.

The biology of stress

Imagine a community where the streets are lined with graffiti and fly-tipped rubbish. Residents complain of public spitting, urination and defecation, never mind the ubiquitous dog fouling. Parking is a nightmare, the traffic lights are out of sync and people worry about the drug dealing. The average life expectancy is 66. Living in such a place leads inevitably to chronic stress.

Stress mobilises cortisol, which in turn mobilises fat, which then lodges in the carotid artery walls (Barnett et al, 1997).

The above description is the reality in some disadvantaged communities in the UK. How can we create health in such a place? We can start by giving residents (who are the experts in their own community) some control, contact and confidence. One way that this can be achieved is by putting in place an equal partnership between the residents and the agencies that support them.

What else can nurses do to create health?

This article has discussed examples of how health is created. It is time for you to voice your ideas. Nurses are an enormous asset and you all know what will work in your own area of practice. Discuss with colleagues and use the nursingtimes.net discussion boards to share ideas on:

- How can we/do we enhance our partnership work with residents/patients by giving them greater control, contact and confidence?
- How can we/do we help them to make their lives more comprehensible, manageable and meaningful?
- How can we/do we reduce chronic stress in our communities?
- How can we/do we build five ways to wellbeing into our own and our patients’ lives? NT

References


