

Asset-based approaches to health improvement

Introduction

Scotland faces significant demographic changes, large scale real reductions in public sector spending and an intractable gap between the life and health outcomes of the best and the worst off. Against this backdrop, there has been much recent discussion about the need for new approaches to public service delivery.

One specific model which has attracted much attention and enthusiasm, including within Scottish Government circles, is the use of asset-based approaches in the public sector. Specifically, there has been a focus on using asset-based approaches to improving health, led by the Chief Medical Officer.

NHS Health Scotland is keen to contribute to the growing body of knowledge and understanding of this approach. This briefing paper aims to explain what is meant by asset-based approaches and to summarise what is already known about its potential for improving health. Given the current interest in this innovative perspective on public service provision, we hope the briefing will provide a foundation for developing interventions which will enable us to test its potential for contributing to improving health and reducing health inequalities.

Key messages

- Taking an asset-based approach involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits. The approach aims to empower individuals, enabling them to rely less on public services.
- There is a limited evidence base linking actions to strengthen individual and community assets with improved health and wellbeing. Measuring the impact of asset-based approaches on health outcomes is complex, and evidence that the approach can improve health and wellbeing largely comes from case studies at present.
- A wide range of techniques are available to take an asset-based approach, including asset mapping, co-production and various community-led, community engagement and community development methods. While none are as yet of proven health benefit, some show improvements in intermediate outcomes such as increased self-esteem and reduced social isolation.
- The challenge now is to assess the impact and cost-effectiveness of asset-based approaches in Scotland within a robust and sensitive evaluation framework

Evidence for Action

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What is an asset-based approach to health improvement?

Conventional approaches to public health typically seek to identify cause and effect relationships, with interventions then designed to interrupt or modify these. This has been effective in tackling many health problems: for example, preventing infection through immunisation or better sanitation, reducing the effects of second-hand smoke through legislation to ban smoking in public places, and wearing seatbelts to reduce road traffic injuries. However, for many people in Scotland, the cause and effect pathways leading to ill-health are strongly influenced by the adverse social, economic or environmental circumstances in which they live. Unless these underlying “determinants of health” can be addressed, tackling the direct causes may be difficult or impossible. An asset-based approach is therefore one which seeks positively to mobilise the assets, capacities or resources available to individuals and communities which could enable them to gain more control over their lives and circumstances^{1,2}. It is closely linked to the theory of salutogenesis, which highlights the factors that create and support human health rather than those that cause disease.

A recent international review of asset-based approaches¹ grouped relevant assets into three levels:

- **Individual assets** e.g. resilience, commitment to learning, self-esteem, sense of purpose
- **Community assets** e.g. family and friendship networks, social capital, community cohesion, religious tolerance, intergenerational solidarity
- **Organisational or institutional assets** e.g. environmental resources for promoting physical health, employment security and opportunities for volunteering, safe housing, political democracy and participation.

Some authors have made a distinction between assets that are within an individual's or a neighbourhood's control and those that are controlled by outsiders.

Under the umbrella of community development, community engagement and community planning, a range of methods have been developed which aim to identify and mobilise the assets of communities and individuals. Asset mapping - identifying and recording the strengths and contributions of the people and other resources available to a community - is often considered the key first step to enable individuals and communities to recognise what resources may be available to them. How these assets or resources can be used may then contribute to a plan aimed at addressing the problems they have identified. Other specific techniques include co-production, appreciative inquiry, time banking and social prescribing. Co-production – “delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours” - is fully described in a recent discussion paper³. The other methods are described in more detail in a briefing paper from the Glasgow Centre for Population Health⁴.

The approach is ‘person centred’, working with people as active participants rather than passive recipients of health or social care programmes, in ways which are empowering, and could ultimately lead to less reliance on public services^{1,5,6}.

Who is advocating the use of this approach and what steps are being taken to use it in Scotland?

The Commission on the Future Delivery of Public Services⁷, published in 2011, emphasises the principles of asset-based approaches in the first three of its nine priorities for action:

- Recognising that effective services must be designed with, and for, people and communities – not delivered ‘top down’ for administrative convenience.
- Maximising scarce resources by utilising all available resources from the public, private and third sectors, individuals, groups and communities.
- Working closely with individuals and communities to understand their needs, maximise talents and resources, support self reliance, and build resilience.

The *Review of Equally Well*⁸ promotes an asset-based approach as a vehicle for tackling the underlying causes of health inequalities: ‘If we are to promote health assets that contribute to a person’s health and wellbeing, a collaborative approach across different public services is required. This includes ensuring the active engagement of service users and the communities they live in. That approach will support and promote people’s sense of coherence and hence their capacity to respond to an environment that is both comprehensible and manageable to them’⁸. As shown in a recent NHS Health Scotland evaluation report, all the Equally Well test sites have incorporated at least some asset-based components in the approaches they have adopted⁹.

This message is reinforced in the Chief Medical Officer’s annual report for 2009⁵ which outlines how an asset-based model could contribute to health improvement. The CMO advocates a greater focus on what creates health (salutogenesis) and can develop a sense of coherence, alongside traditional approaches to preventing illness. Several case studies are provided in the report to illustrate how the approach has had a positive impact on individuals and communities.

An asset-based approach builds on a long history of investment by the Scottish Government and NHS Health Scotland in community-led approaches to health improvement through, for instance, the Community Health Exchange (CHEX) networking intermediary and the Health Issues in the Community capacity building programme. The Scottish Government’s Community-led Supporting and Developing Healthy Communities Task Group led to the capacity building programme ‘Meeting the Shared Challenge’¹⁰, which encourages and supports community-led approaches to health improvement across Scotland. Many of the activities featured in the *Community Empowerment Action Plan*¹¹ may also have a beneficial impact on health and wellbeing.

There is also an important link here to the *Healthcare Quality Strategy for NHS Scotland*¹². One of its three “quality ambitions” is for services to be more “person centred”. This is defined as “mutually beneficial partnerships between patients, their families and those delivering healthcare services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making.”

What tools and techniques are available to apply the approach?

The recently published *Health Assets in a Global Context*¹ provides an excellent account of the use of asset-based approaches internationally. Other examples of their use in community and youth development are available on the websites of the Asset-Based Community Development Institute, Northwestern University, Chicago (www.abcdinstitute.org/); the Search Institute, Minneapolis. (www.search-institute.org/developmental-assets-are-free); and the Beacon Community Regeneration Partnership, Cornwall (www.bcrp.org.uk/content/about-partnership).

The Scottish Community Development Centre provides links to various resources¹³. The guide *Better Together* offers a wide range of methods aimed at building more cohesive communities¹⁴. The Improvement and Development Agency in England, working with local authority partnerships, has produced a guide: *A glass half-full: how an asset approach can improve community health and well-being*².

The Scottish Government, in partnership with the Scottish Centre for Community Development (SCDC) and Long Term Conditions Alliance Scotland, held an event called 'An Assets Alliance Scotland – building our Social Capital' in December 2010. Over 90 people, from across the public, community and voluntary sectors and academia attended to see examples of asset-based approaches in action, and to consider how to take forward an Assets Alliance. Details of 23 'demonstrator projects' are included in the event report¹⁵ and are summarised in a mindmap (Appendix 1).

What is the evidence that asset-based approaches can improve health?

In this section, we summarise the evidence linking asset-based approaches with improved health. This is drawn from a small number of reviews and other key reports and has been grouped into two areas: the methods used to empower individuals and communities; and the evidence for the importance to health of a sense of coherence and resilience.

Community-led and community partnership approaches

Much of the evidence for asset-based approaches is in the form of case studies and anecdotal accounts and has not been published in peer reviewed scientific journals¹. There is a substantial body of studies which have described and evaluated community-led interventions aimed at improving health and which include asset-based elements to a variable degree. Many were considered in a review commissioned by NHS Health Scotland and published in 2006¹⁶. The authors found it difficult to establish a connection between collaboration involving communities and improved health outcomes within those communities. They highlighted the difficulty in attributing change in individual or community health to a particular intervention, possibly because of the influence of broader economic, social and cultural trends, or because the duration of the intervention was too short.

In a review of 34 studies of interventions involving community partnerships, ten found some evidence of health benefits potentially attributable to the interventions¹⁷. These were mainly multi-stranded community-wide interventions addressing a particular issue such as high infant mortality rates, alcohol-related road traffic accidents or teenage pregnancies. Two of the larger and more methodologically sound studies found no or small reductions in tobacco use or alcohol and drug use respectively.

In a systematic review of interventions aimed at reducing health inequalities, including those involving community support and participation, Arblaster and colleagues¹⁸ identified a number of factors which they considered contributed to successful outcomes. These included: intensive approaches; multi-faceted interventions; face-to-face interventions; training for those delivering the interventions; and support materials. Incorporating all or even some of these components in anything but small-scale interventions would be particularly challenging in the current economic environment.

The National Institute for Health and Clinical Excellence (NICE) reviewed the evidence for community engagement to improve health¹⁹ and recommended actions in relation to the prerequisites, infrastructure, approaches and evaluation of community engagement, whilst highlighting barriers to engagement and gaps in economic evidence. In the next two years, NICE will be updating this guidance with new evidence on aspects such as volunteering.

The evidence for the mental health impacts of interventions relating to individual and community assets was reviewed by NHS Health Scotland to inform the development of Scotland's mental health improvement outcomes framework²⁰. Small to moderate improvements in mental health outcomes such as self-esteem and social isolation have been reported following interventions in a variety of settings including schools, workplaces and community services.

We have been unable to find any published evidence that asset-based approaches have prevented or reversed the main avoidable causes of ill-health and early death in contemporary Scotland: smoking, excess alcohol and calories, and the misuse of drugs. Thus, while there is evidence that asset-based approaches can improve perceived individual and community wellbeing, an important challenge is to identify how they can help to reduce these profoundly unhealthy behaviours. This underlines the need for closer collaboration between researchers, practitioners and policy makers to explore how to make the most of asset-based approaches.

Sense of coherence and resilience

“Sense of coherence” (SOC) is a core concept in the theory of salutogenesis, which has informed thinking about asset-based approaches to public health²¹. SOC can be defined as the skills and confidence to manage the demands of life. The SOC scale consists of three components. A person with a well developed SOC when faced with stressful a situation will:

- be motivated to cope (meaningfulness)
- believe that she/he has the capacity to understand the challenges of everyday life (comprehensibility)
- believe that resources to cope are available (manageability).

Evidence that a sense of coherence is strongly related to perceived health comes from a review of studies using the scale in 32 countries²¹. The review cites studies showing significant correlations between higher SOC and physical measurements such as lower blood pressure, a reduced incidence of heart disease and reduced all-cause mortality. Although the SOC scale has not been widely used in Scotland, the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS) includes components similar to those of the SOC scale, asking respondents questions about how confident they feel now, how well they are dealing with problems and how optimistic they are about the future²². WEMWBS forms a

part of the Scottish Mental Health Indicators²³ developed by NHS Health Scotland and has been recently incorporated into the annual Scottish Health Survey. The national mental health improvement outcome framework²⁰, published by NHS Health Scotland in 2010, identifies “sustaining inner resources” as an important intermediate outcome. This embraces ideas such as meaning, purpose, optimism, hope and resilience. Consequently, by using WEMWBS and the outcomes framework, Scotland now has the tools both to measure individual and community mental health and wellbeing and to focus efforts on improving it.

Current understanding of resilience is largely based on studies of children who went on to ‘live well, work well and love well’ despite being brought up in conditions of severe adversity¹. ‘Assets’ such as competence, coping skills and self-efficacy and ‘resources’ such as parental support and adult mentoring have been identified as important contributors to resilience¹. However, this has not yet been translated into interventions which have been able reliably to enhance young people’s assets and resources with beneficial outcomes, such as avoidance of addiction or violent behaviour.

In terms of community assets, there is some evidence that disadvantaged communities which are more cohesive are more likely to maintain health^{24,25}. It has thus been suggested that community capacity building is a necessary condition for developing and maintaining effective health improvement interventions¹. However, a review of the evidence shows many barriers to effective involvement of the public and a lack of impact of these processes on health outcomes¹⁹. It should also be recognised how particularly challenging it can be to mobilise assets amongst the most vulnerable groups, whose personal assets and those of the communities they live in are typically the least, and especially during a recession.

Why is evaluation essential?

Measuring the impact of complex community interventions on health and social outcomes is not straight-forward. Concepts like participation, community cohesion and social capital are difficult to define or measure and interventions will inevitably be influenced by a host of other factors affecting the lives of individuals or the wider community. Evaluating asset-based approaches is, therefore, challenging, particularly when attempting to assess whether or not a given intervention has had a beneficial effect on the health of the individuals or communities it has involved. However, it is only by conducting careful evaluations that the contribution of asset-based approaches can be measured, judged and learned from. Such evaluations are costly and should only be undertaken if the interventions they focus on are of sufficient clarity, scale and intensity that they offer a reasonable prospect of producing measurable change. An evaluation framework should include:

- A clear logic model setting out the perceived links between inputs (assets, resources etc.) and outcomes, and the theoretical mechanisms whereby the intervention will result in beneficial change.
- Agreed definitions and measures of the processes and outcomes of the intervention, whether aimed at individuals, groups, communities or larger populations.
- A robust evaluation design including sufficient numbers of participating individuals or communities and sufficient duration of the intervention to be able to confirm or exclude a useful effect; before and after measurements or comparisons with control groups; and measurement of costs.

- An analysis of stakeholder perspectives, particularly of participants, other local community members and relevant service providers.

Conclusions

This briefing has shown that asset-based approaches may have the potential to address Scotland's continuing health problems in innovative ways which could complement more traditional methods for improving population health. However, the published evidence on the impact of these approaches on health is currently very limited. The challenge now is to assess their impact and cost-effectiveness in Scotland within a robust and sensitive evaluation framework.

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References

- 1 Morgan A, Davies M, Ziglio E. Health assets in a global context: theory, Methods, Action: Investing in assets of individuals, communities and organizations. London: Springer; 2010.
- 2 Foot J, Hopkins T. A glass half-full: how an asset approach can improve community health and well-being. London: Improvement and Development Agency; 2010. www.idea.gov.uk/idk/aio/18410498 (14/10/11)
- 3 Boyle D, Coote A, Sherwood C, Slay J. Co-production: right here, right now. London: NESTA; 2010. www.nesta.org.uk/library/documents/coproduction_right_here_right_now.pdf (14/10/11)
- 4 Glasgow Centre for Population Health. Assets based approaches for health improvement: redressing the balance. Glasgow Centre for Population Health 2011. www.gcph.co.uk/assets/0000/2627/GCPH_Briefing_Paper_C59web.pdf (14/10/11)
- 5 Chief Medical Officer of Scotland. Health in Scotland 2009: Time for Change. Edinburgh: Scottish Government; 2010. www.scotland.gov.uk/Publications/2010/11/12104010/0 (14/10/11)
- 6 Crawford F. Doing it differently – an asset based approach to wellbeing. Edinburgh: NHS Health Scotland; 2005. www.healthscotland.com/documents/1035.aspx (14/10/11)
- 7 Christie C. Commission on the Future Delivery of Public Services. Edinburgh: Scottish Government; 2011. www.scotland.gov.uk/About/publicservicescommission (14/10/11)
- 8 Scottish Government. Equally Well Review 2010: Report by the Ministerial Task Force on implementing Equally Well, the Early Years Framework and Achieving Our Potential. Edinburgh: Scottish Government; 2010. www.scotland.gov.uk/Publications/2010/06/22170625/0 (14/10/11)
- 9 Fyfe A, MacMillan K, McGregor T, Hewitt E, Callaghan M. Equally Well Test Sites: Evaluation. NHS Health Scotland, 2011 www.healthscotland.com/understanding/evaluation/programme/EquallyWellEvaluation.aspx (14/10/11)
- 10 Hashagen S, Taylor P. Continuing to meet the challenge: A report on 'Meeting the Shared Challenge' – a national initiative to encourage and embed community-led health. Glasgow: Scottish Community Development Centre; 2010. www.scdc.org.uk/media/resources/what-we-do/mtsc/Continuing%20to%20Meet%20the%20Challenge.pdf
- 11 Scottish Government. Scottish Community Empowerment Action Plan – Celebrating Success: Inspiring Change. Edinburgh: Scottish Government; 2009. www.scotland.gov.uk/Publications/2009/03/20155113/0 (14/10/11)
- 12 The Scottish Government. The Healthcare Quality Strategy for NHS Scotland. Edinburgh: Scottish Government; 2010. www.scotland.gov.uk/Publications/2010/05/10102307/0 (14/10/11)
- 13 Scottish Community Development Centre www.scdc.org.uk/ (14/10/11)
- 14 Lawrence A. Better Together: A guide for people in the health service on how you can help to build more cohesive communities. Institute of Community Cohesion; 2008. www.resources.cohesioninstitute.org.uk/Publications/Documents/Document/Default.aspx?recordId=5 (14/10/11)

- 15 Scottish Community Development Centre. Assets Alliance Scotland event report. Glasgow: Scottish Community Development Centre; 2011.
www.scdc.org.uk/media/resources/assets-alliance/Assets%20Alliance%20Scotland%20Event%202013%20Dec%202010_Reportpdf.pdf (14/10/11)
- 16 Mackinnon J, Reid M, Kearns A. Communities and health improvement: A review of evidence and approaches. Edinburgh: NHS Health Scotland; 2006.
www.healthscotland.com/uploads/documents/2876-Communities%20and%20Health%20Improvement.pdf (14/10/11)
- 17 Roussos ST, Fawcett SB. A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health* 2000;21:369–402.
www.ncbi.nlm.nih.gov/pubmed/10884958 (14/10/11)
- 18 Arblaster L, Lambert M, Entwistle V, et al. A systematic review of the effectiveness of health service interventions aimed at reducing inequalities in health. *Journal of Health Services Policy and Research* 1996;(1):93–103. www.ncbi.nlm.nih.gov/pubmed/10180855 (14/10/11)
- 19 NICE. Public Health Guidance: Community Engagement to Improve Health. London: National Institute for Clinical Excellence; 2008.
www.nice.org.uk/nicemedia/pdf/PH009Guidance.pdf (14/10/11)
- 20 NHS Health Scotland. Outcomes Framework for Mental Health Improvement in Scotland. Edinburgh: NHS Health Scotland; 2010.
www.healthscotland.com/uploads/documents/13716-Outcomes%20Framework%20for%20MHI%20September%202010.pdf (14/10/11)
- 21 Eriksson M . Lindstrom B. Antonovsky's sense of coherence scale and the relation with health: a systematic review. *Journal of Epidemiology and Community Health* 2006;60:376–81. <http://jech.bmj.com/content/60/5/376.abstract> (14/10/11)
- 22 Warwick and Edinburgh University. The Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). Edinburgh: NHS Health Scotland, University of Warwick and University of Edinburgh; 2011. www.healthscotland.com/understanding/population/Measuring-positive-mental-health.aspx (14/10/11)
- 23 NHS Health Scotland. Adult Mental Health Indicators.
www.healthscotland.com/understanding/population/mental-health-indicators-index.aspx (14/10/11)
- 24 Kawachi I, Kennedy BP, Lochner K, Prothrow-Stith D. Social capital, income inequality, and mortality. *Am J Public Health* 1997 Sep 1;87(9):1491–8
www.ncbi.nlm.nih.gov/pubmed/9314802 (14/10/11)
- 25 Holt-Lunstad J, Smith T B, Layton J B. Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Med* 2010;7(7).
www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000316 (14/10/11)

Appendix 1: Mindmap of Assets Alliance Scotland demonstrator projects

