Thinking and acting differently
An asset model for Public Health

Antony Morgan, Associate Director, Centre for Public Health Excellence, NICE

Glasgow Centre for Population Health
Seminar series 8
25th January 2012
What is NICE?

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.
Revitalising the evidence base for public health: an assets model

Antony Morgan

Karolinska Institute, Stockholm, Sweden, antony@mphil.tiscali.co.uk

Erlo Ziglio

WHO European Office for Investment for Health and Development, Venice, Italy

Abstract

Historically, approaches to the promotion of population health have been based on a deficit model. That is, they tend to focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on hospital and welfare services. These deficit models are important and necessary to

The Book

Health Assets in a Global Context

Antony Morgan
Maggie Davies
Erlo Ziglio
Editors

Theory, Methods, Action

Springer
Narratives

Evidence based public health

Positive approaches to health and living
Aims of the session

• Rehearse some of my experience of evidence based public health in the context of NICE

• Describe the context and features of the ‘Asset Model’ and demonstrate how it can contribute to building a better evidence base for the future

• Highlight some of the issues for policy, research and practice - to think and act differently
A few caveats before we start…
It’s not rocket science!!
But there is no magic bullet!
Been round the block a few times?

Been there done that!
Reinventing wheels (or revitalising old ones?)

• Old concept with new name

• Old wine, new bottles
Not just about health its about living

Life is for **LIVING!**

Once upon a time a man took up smoking but he didn't live happily ever after, he developed lung cancer and died. The end.
Doing and knowing (Daniel James Shigo, 2011 – vocal coach and opera singer)

• Doing and knowing. Are they the same thing?

• Not if you are learning to ride a bike. You can sit down with a book and study the parts of a bicycle, but this knowledge won't help you go around the block. In the end, you will have to get on the thing, find your balance and your legs

• Research can be like panning for gold: you go through a lot of dirt before you find a nugget that can be useful, even revelatory

• The kid on the bike just wants to feel the thrill of movement, of being alive, and going downhill at breakneck speed. Whatever you do: don't 'know' so much that you forget how to ride with the wind in your hair
An asset model for public health

Source, Morgan, Hernan, Ziglio, 2011
Health Assets – a definition for the Asset Model

‘An health asset can be defined as any factor which maximises the opportunities for individuals, local communities and populations to attain and maintain health and wellbeing’.

There are assets for ‘knowing’ and assets for ‘doing’

Morgan and Hernan, 2011 (adapted from Morgan and Ziglio, 2007)
The glass is half full!
The glass is half empty.

Half full... No! Wait! Half empty... No half... what was the question?

Hey! I ordered a cheeseburger!

The four basic personality types
Summarising…

• It is about *thinking differently* - refocusing our questions to the ‘glass half full’

• It is **about identifying those protective factors that keep us well** so that they can help offset the risks that inevitably people will face in their lives.

• It’s about re-energising community based programmes to activate solutions for health and wellbeing through recognition of individuals and organisations
Summarising..

- It's about helping us to understand and manage the worlds we live in - and that may even involve

- It's not a new concept aiming to instigate multi-disciplinary territorial wars but it is a framework for bringing existing concepts and ideas together in a systematic way
Evidence Based Public Health...experience and challenges
We produce guidance in three areas

- **Public health** – guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector

- **Health technologies** – guidance on the use of new and existing medicines, treatments and procedures within the NHS

- **Clinical practice** – guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.
Arrogant, illogical and totally out of touch, NICE must be scrapped... it's killing too many people
Archie Cochrane’s Principles (1979)

- The best care available to all - universalism
- The need for a means to determine what was best - empirical
- The importance of rooting out harmful or useless practice - compassion
- The necessity of ascertaining costs and benefits - accountability
Core principles of all NICE guidance

- Comprehensive evidence base
- Expert input
- Patient and carer involvement
- Independent advisory committees
- Genuine consultation
- Regular review
- Open and transparent process
The legacy of Cochrane – 30 years and about 15

• The Cochrane and Campbell Collaborations

• The importance of the systematic review and meta analysis

• The importance of making evidence based decisions

• The importance of dealing with health inequalities
How systematic reviews have disappointed

- Not paying enough attention to the right questions – too much on the ‘what’ questions and not enough on the ‘how’

- Trying to cover too much ground – broad questions – broad answers

And the most cynical…..

- Too much journal impact factor and not enough population health impact factor
Key questions

• What is effective? And how?

• What is ineffective? And what should we disinvest in?

• What is harmful or dangerous?

• What is cost effective? What is the business case for public health and which interventions give the best return on investment – in the very short, short and long term
Finding, collating and synthesising evidence

• Broad spectrum of possibilities,

• Quality of the research, not privileging types of or hierarchies of evidence

• Constructing a more coherent evidence base through methodological diversity

• Start with the decision that is needing to be made rather than what the evidence can tell you!
CPHE: colloquial evidence

CPHE methods, 2009 (Source Lomas 2005 & Davies 2005)
A limited evidence base ....

• Evidence about what works to reduce inequalities very limited

• Rich in description, weak on solution.

• More on what is effective but little on how things can be done to improve things
And why?

- Gaps in the initial formulation of primary research studies.
- Gap between evidence and practice
- Failure to distinguish between determinants of health and determinants of health inequalities
- *Much more focus on deficit /risk factor model than asset based/ resources model*
Assets and deficits

• Much of the evidence base available to address inequalities is based on a deficit (pathogenic) model of health.

• **Deficit models** focus on identifying problems and needs of populations requiring professional resources, resulting in high levels of dependence on hospital and welfare services (risk factors and disease).

In contrast:

• **Asset models** tend to accentuate positive ability, capability and capacity to identify problems and activate solutions, which promote the self esteem of individuals and communities leading to less reliance on professional services.
In reality, both are important - need to redress the balance between the more dominant ‘deficit model’ and the less well known (and understood) ‘assets model’
• In the real world there are both strengths and needs

So where is most practice focused?

Where is most policy focused?
Make the Most of Bad Situations
Resourceful but not an asset!!
Health Assets – a definition for the Asset Model

‘An health asset can be defined as any factor which maximises the opportunities for individuals, local communities and populations to attain and maintain health and wellbeing’.

There are assets for ‘knowing’ and assets for ‘doing’

Morgan and Hernan, 2011 (adapted from Morgan and Ziglio, 2007)
### Assets
- What makes us strong?
- What factors make us more resilient (more able to cope in times of stress)?
- What opens us to more fully experience life?
- What do asset rich workplaces and communities look like and how can they support ‘health’ development?

### Deficits
Risk factors:
- Fitness
- Body Fat
- Cholesterol
- Smoking
- Excess alcohol and other drugs
The Asset Model: revitalising the evidence base for public health: phase 1

Assets for knowing:
- the first phase of the model identifies the need for a better evidence base for understanding which are the essential assets for health and wellbeing maximisation; but importantly to know how these assets can operate together to produce the essential ingredients for success.

Figure 1: An Asset Model for public health
The Asset model may draw on:

- **Salutogenesis** (Antonovsky, 1979)
- Self-efficacy (Bandura (1977) & Lennings, 1994)
- Satisfaction with life (Diener et al., 1985)
- Dispositional optimism (Scheier, Carver & Bridges, 1994)
- Resourcefulness (Rosenbaum, 1990)
- Constructive thinking (Epstein, 1992)
- Emotional intelligence (Goleman, 1995)
- Coping (Amirkhan, 1990)
- **Social capital** (Kawachi, 1997, Putnam, 2000; Morgan, 2004)
- Social support (Procidano & Heller, 1983)
- Reality orientation (Jackson & Jeffers, 1989)
- Self actualization (Knapp, 1976)
- Hope (Snyder, et al. 1991)
- Spiritual well-being (Ellison & Smith, 1991); Hungelmann et al. 1996; Vella-Brodrick & Allen, 1995)
- **Resilience** (Barnard, 1994); Beardslee, 1989; Grotberg, 1997; and Rutter, 1984
Majoring on salutogenesis (Antonovsky, 1979, 1987)

- Derivation of Greek and Latin
  - Latin: salus = health; Greek: genesis = source
  - In combination = Sources of health

- Salutogenesis focuses attention on *health generation* as compared to a pathogenesis focus on disease generation

- What causes *some to prosper*, and others to fail or become ill in similar situations?

- It helps to *identify the key sources of health*

- It helps to identify the factors that keep individuals from moving towards the disease end of the health and illness spectrum?
Sense of Coherence

Source: Eriksson 2010

... is a global life orientation – a way of viewing life as coherent, structured, manageable and meaningful.

... is a way of thinking, being and taking action as a human being.

... is a confidence to be able to identify internal and external resources, use and reuse them in a health promoting manner.
Salutogenesis
An assets approach

Learned resourcefulness
(Bandura)
Hardiness
(Kobasa)
Coping
(Lazarus)

Learned optimism
(Seligman)
Social capital
(Putnam)
Empowerment
(Freire)
Locus of control
(Rotter)

Learned hopefulness
(Zimmerman)
Resilience
(Werner)
Will to meaning
(Frankl)

Sense of coherence
(Blum)
Quality of Life
(Lindström)
Flourishing
(Keyes)
Wellbeing
(Becker)

Cultural capital
(Bourdieu)
Flourishing
(Bruun Jensen)
Ecological system theory
(Bronfenbrenner)

Connectedness
(Blum)
Interdiciplinarity
(Klein)

Defining social capital (Coleman, Bourdieu or Putnam)

...their common thread relates to the importance of positive social networks of different types, shapes and sizes in bringing about social and economic and health development between different groups, hierarchies and societies.
What is Resilience?

- A chance event
- A personality characteristic
- A dynamic, ongoing process involving a set of interactions between individual, social context, and opportunities

» Bartley et al, Chapter 6 – Resilience as a asset for healthy development
A Developmental-Contextual Model of Resilience

Schoon, 2006
Kelly, Chapter 3 – the link between biology and social structure

Lifeworld is the locus of experience, social, psychological and physical.

Lifeworld and lifecourse together are the bridge between social structure and individual biology
Lifeworld actions

• technical skills to control local environments,

• relationship building within communities,

• creating environments in which a sense of coherence can flourish

• creating a meaningful account, a narrative, about why things are the way they are and how they might be changed.
A constellation of assets across the life course
The multi-component challenge of complex concepts

Unravelling the components

Laying the pieces out systematically
‘The misery of youth: Teenagers depressed and fearful as drink, drugs and crime take their toll’
July 2008, Daily Mail
Happy not sad!

• Most children are satisfied with their lives, perceive their health to be good and do not regularly suffer from health complaints

Source: Health Behaviour in School Aged Children, 2008
Assets versus deficits

• The more we provide young people with opportunities to experience and accumulate the positive effects of protective factors (health assets), the more likely they are to achieve and sustain health and wellbeing in later life

Morgan, 2010
40 Development Assets for Young People’s Health and Development (Scales, 2001)

Internal -
• **Support** (family relationships, caring school and neighbourhood)
• **Empowerment** (community values youth, young people seen as resources)
• **Constructive use of time** (participation in clubs and associations)

External -
• **Commitment to learning** (achievement motivation)
• **Positive values** (caring and responsible to others)
• **Social competencies** (cultural competence, peaceful conflict resolution)
• **Positive identity** (self esteem)
Supporting Macro Environment

Key development assets

Young People’s Well Being

Positive Health Promoting Behaviour

- Low levels of substance misuse
- Increased healthy eating and physical activity
- Safer sexual health
- Low incidence of bullying

Increasing personal socio-economic circumstances – chances for increasing well being

Increasing age – less opportunity for mental well being to effect +ve health promoting behaviour
Reducing Risks and Increasing Assets
The Asset Model: revitalising the evidence base for public health: phase 2

**Assets for doing**: the second phase of the model focuses on the need to develop programmes and initiatives which follow the principles of assets based working and that support the effective implementation of such programmes. In this instance, ‘assets for doing’ will identify a set of key assets from phase 1 that help to set out what needs to be achieved and will in addition identify how the assets of organisations and institutions can be employed in order to activate solutions to issues that are to be addressed.
NICE Guidance on Effective Community Engagement


‘What community engagement approaches and methods are effective and cost effective in improving health and reducing health inequalities’
Pathways from community engagement to health improvement

- Community control
- Delegated power
- Co-production
- Consultation
- Informing

Outcomes:
- Service
- Social Capital
- Empowerment, Social & Material Conditions

Source: Popay 2010
Asset mapping

• Professionals tend to define communities by their deficiencies and needs

• Asset mapping:
  – *Makes us learn to ask* what communities have to offer
  – It makes explicit the *knowledge, skills and capacities that already exist*
  – Helps to make best use of *individual skills, physical and organisational resources* within the community
  – It helps *to build trust* between professionals and the local community

Source: McKnight, 1995
Types of Community Assets

- Individuals
- Associations
- Institutions
- Physical Infrastructure and Space
- Local Economy
- Local Culture
Neighbourhood assets map

Source: Hopkins, 2010
Mobilizing Assets

• Create a Vision

• Connect the Assets for Productive Purposes
Phase 3: Evaluation
Phase 3: Evaluation and Indicators
No magic bullet however it focuses on ..

- Multi-method approaches to evaluation
- Matching research design to research question
- More emphasis on the effectiveness of implementation (understanding not just what works but how things work in different contexts)
- Participatory approaches to evaluation
- Narrative synthesis to bring different types of research together
- Different indicators (‘protective factors’) to reflect more realistically the intermediate outcomes along the pathway to health
- **Evidence from case studies and stories**
Participation Intersectoral Cooperation Policy Advocacy

- BIG Project Office
- Large Sports Club
- Adult Education Center
- Workers' sports club
- Gym
- Elementary school
- Gym in secondary school

Key:
- Green arrows: participants in cooperative planning
- Green lines: intersectoral activity of project offices and women
- Black arrows: political pressure
- Black dotted lines: access to facilities

WHAT NEXT FOR ASSETS?
Opportunities

• Many of the assets acting as protective factors cut across risk behaviours?

• Many of them lie within the social context of young people’s lives and have the opportunities to contribute to reductions in health inequities

• Not rocket science but does need a different mindset
Other challenges ....

• What is the economic case for investing in asset based approaches.

• What are the returns on investment for policy makers?

• How can the asset model - help decision makers make better decisions for maximising health and minimising cost?
Moving the knowledge base on ……

• Are some assets (protective factors) more important than others?

• What are the cumulative effects of multiple assets on young people's mental well being?

• How do different social and cultural contexts impact on the benefits of these assets?

‘Redressing the balance between asset and deficit models for research’
Key Features of the Asset Model

• Focuses on **positive health promoting and protecting factors** for the creation of health.

• Emphasis on a **life course approach** to understanding the most important key assets at each life stage.

• Passionate about the need to **involve people in all** aspects of health development process.

• Recognises that many of the key assets for creating health lie within the **social context of people’s lives and therefore links to** health inequality agenda.

• Helps to reconstruct existing knowledge in such a way as to help policy and practice to promote positive approaches to health.
Bridging the policy research practice gap
Challenges for:

• Policy - how to stimulate those working in decision making positions to **think differently** about how they devise, monitor and evaluate health programmes which aim to promote wellbeing and to reduce health inequities.

• Practice - The **prerequisites** for effective asset based practice and how best to **evaluate** it

• Research - The **types of research questions** that will support the development of a more systematic evidence base on asset approaches to health and wellbeing
THE RESEARCHER

‘Well that is conceptually flawed – anyway the sample size isn’t big enough – and we need more research’

Academics are like dwarves:

One in seven is Grumpy.
'There is too much interference from ‘them’ …and we need more money.
THE POLICY MAKER

‘Count it, show me that it works and do it very quickly’.
A Bridge to Far?

Ideally at a societal level we can strive for a better balance between preserving the rights and liberties of individuals to pursue their own life and goals and the need to foster the values that provides in individuals with a sense of duty and obligation to communities.

Society and values

Can bridging and bonding social capital coexist together?
Positive Lives, Positive Futures
Contact details

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

Contact: antony.morgan@nice.org.uk