

Thinking and acting differently

An asset model for Public Health

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Glasgow Centre for Population Health

Seminar series 8

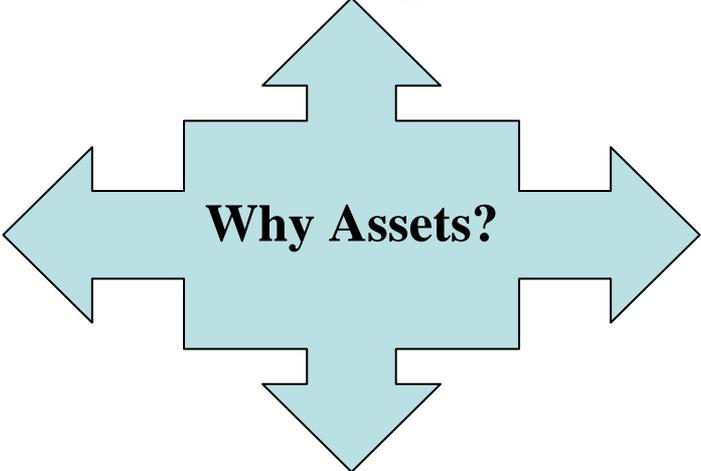
25th January 2012



London



Venice



Why Assets?



Salford

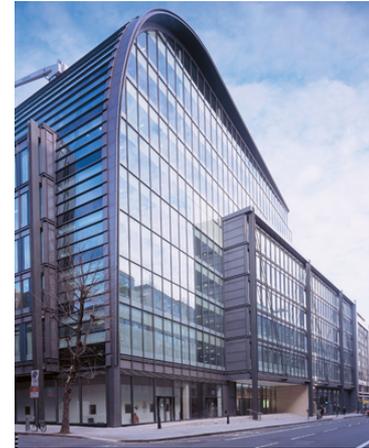


Venta El Gallo Flamenco, Granada, Spain

GranadaMan.com

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.*



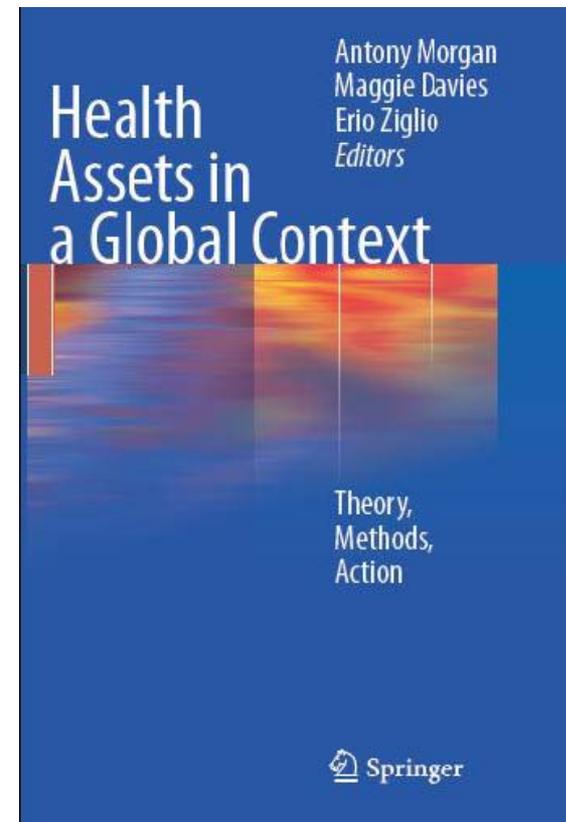
Health Assets in a Global Context

The Article



The screenshot shows the top of a journal article page. The header is a teal gradient with the journal title "Global Health Promotion" in white. Below the header is a navigation bar with buttons for "Home", "OnlineFirst", "All Issues", "Subscribe", "RSS" (with a small icon), and "Email Alerts". The article title "Revitalising the evidence base for public health: an assets model" is displayed in a dark font, followed by the author's name "Antony Morgan" and his affiliation "Karolinska Institute, Stockholm, Sweden, antonyhmfph@tiscali.co.uk". Below this is the name of the second author, "Erio Ziglio", and his affiliation "WHO European Office for Investment for Health and Development, Venice, Italy". The section is titled "Abstract" and begins with the text: "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



Narratives



Positive approaches to health and living

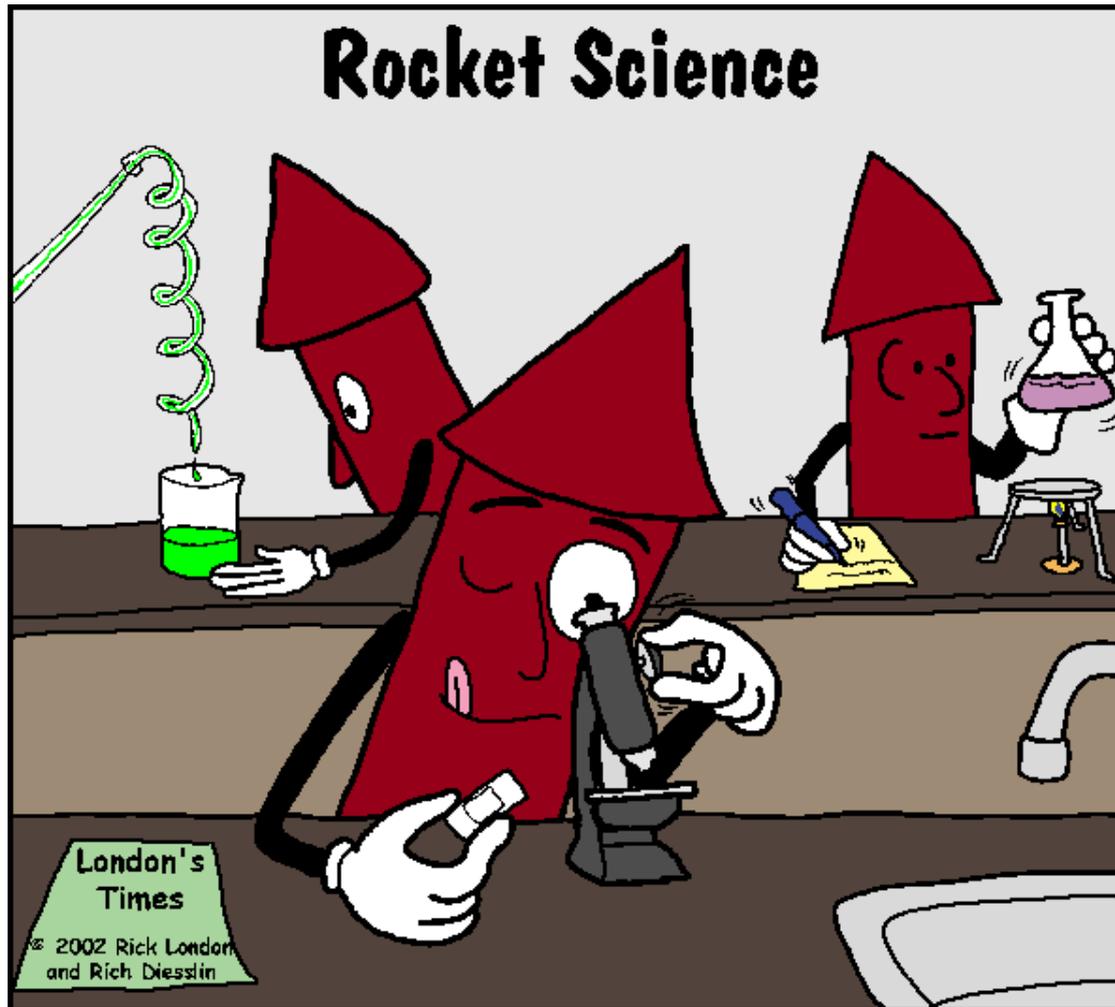
Evidence based public health

Aims of the session

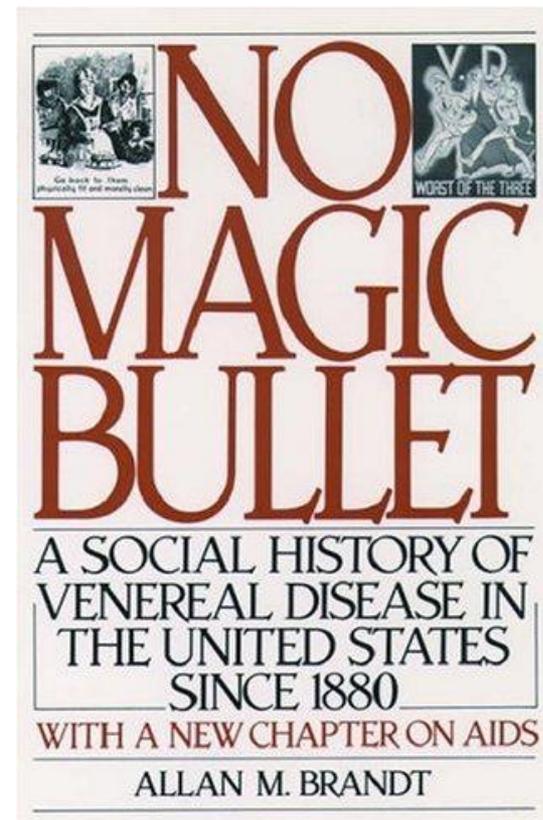
- Rehearse some of my experience of evidence based public health in the context of NICE
- Describe the context and features of the 'Asset Model' and demonstrate how it can contribute to building a better evidence base for the future
- Highlight some of the issues for policy, research and practice - ***to 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!

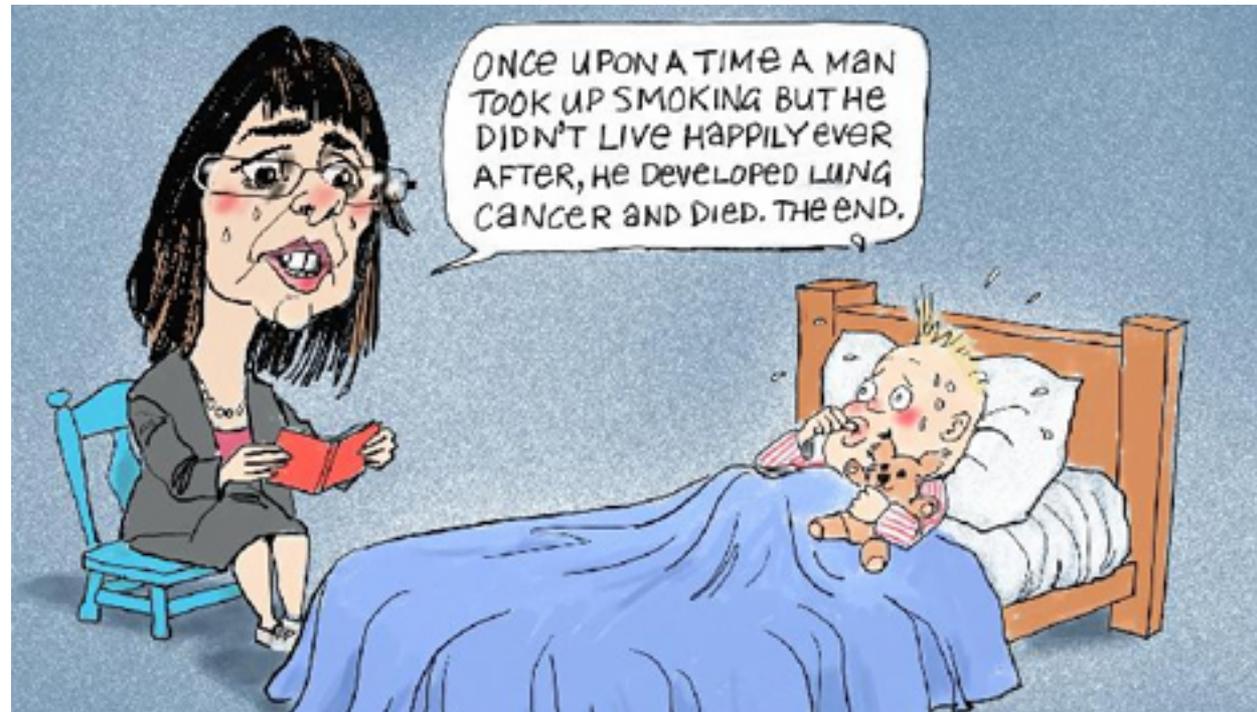


Reinventing wheels (or revitalising old ones?)



- Old concept with new name
- Old wine, new bottles

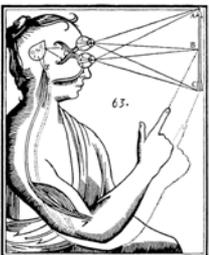
Not just about health its about living



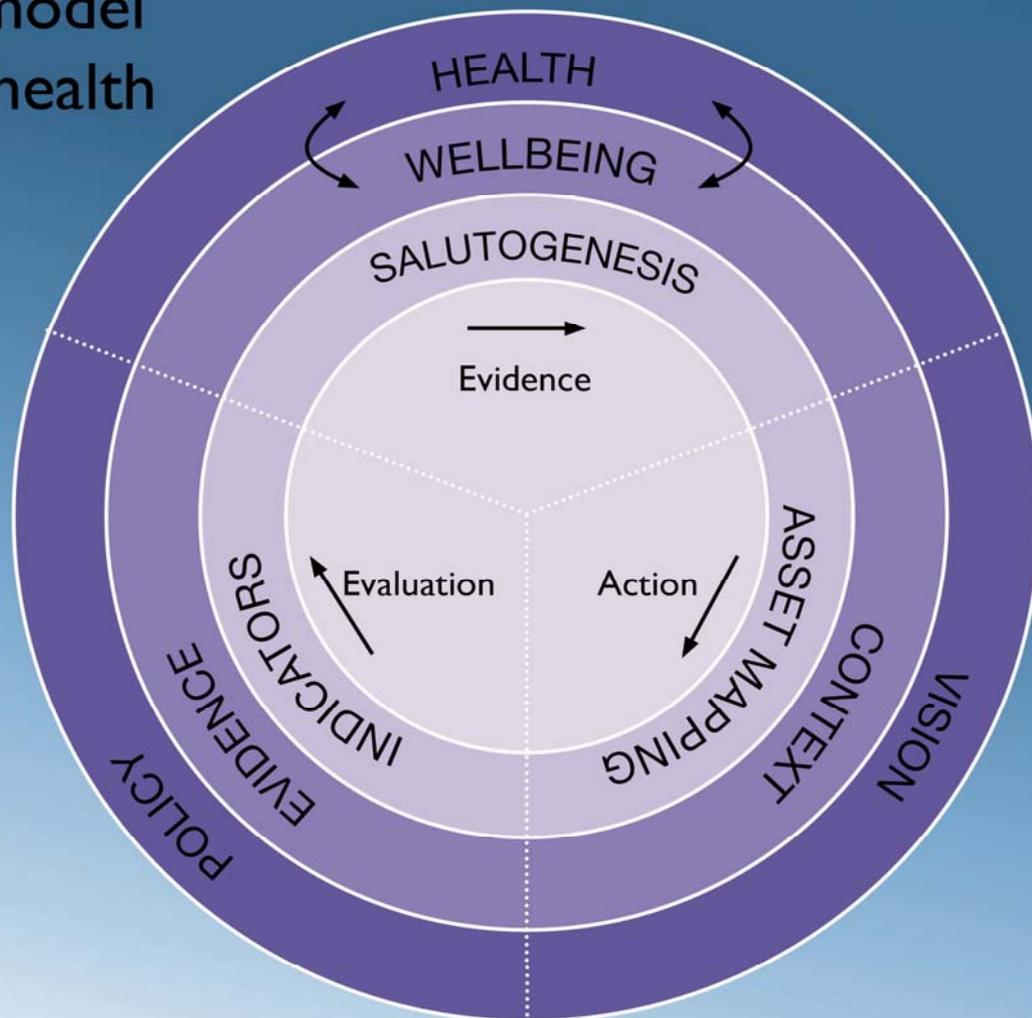
Life is for
LIVING!

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



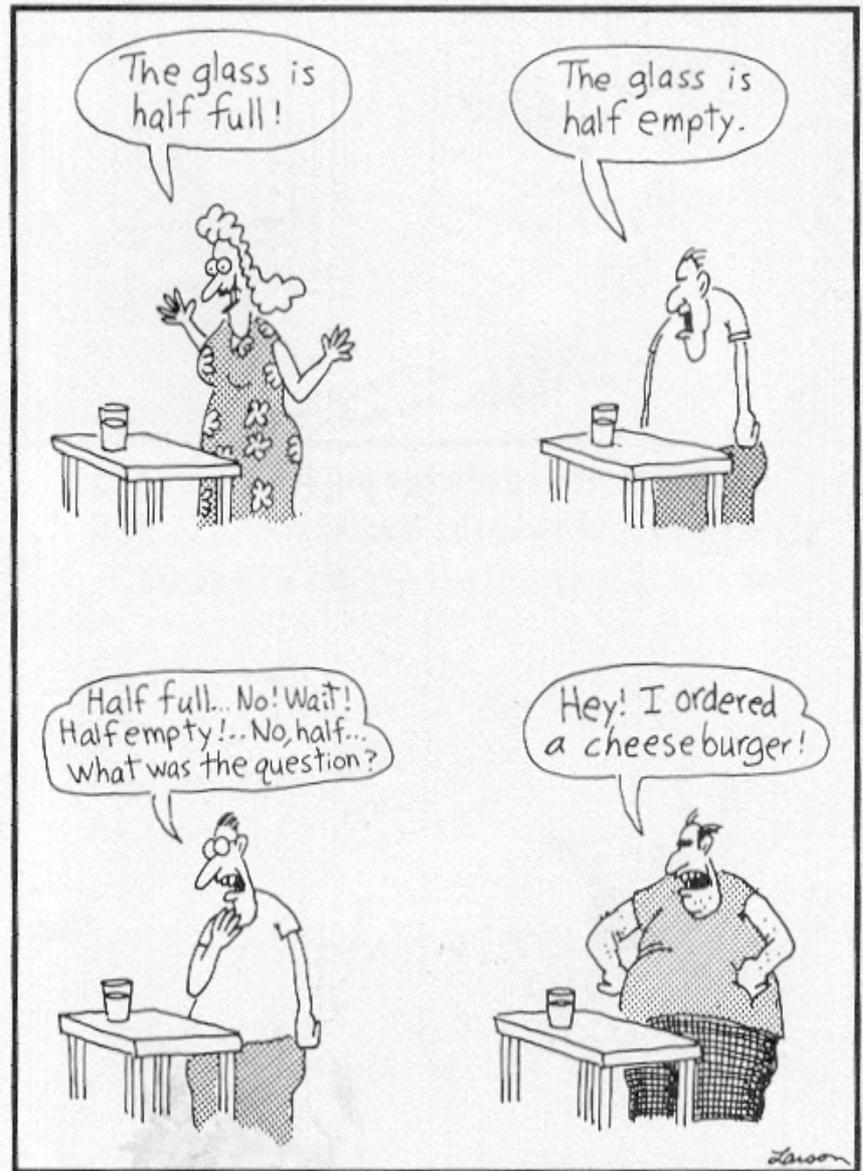
Source,
Morgan, Hernan,
Ziglio, 2011

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 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

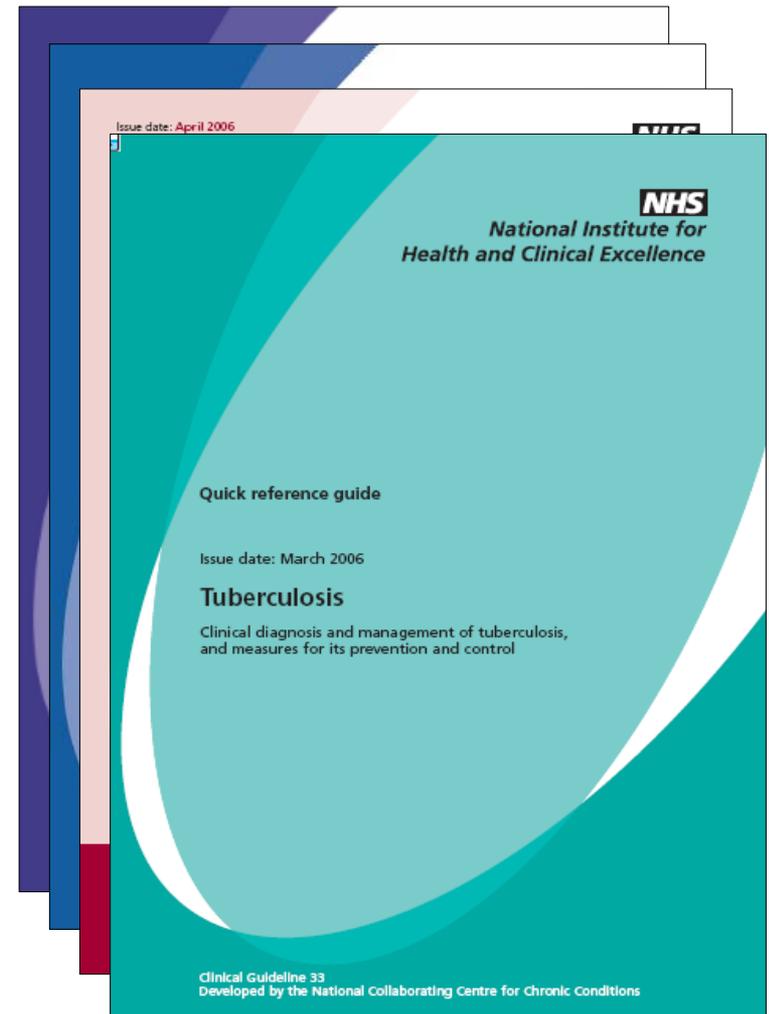
Summarising..

- Its about helping us to ***understand and manage the worlds we live it*** - and that may even involve
- Its ***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*

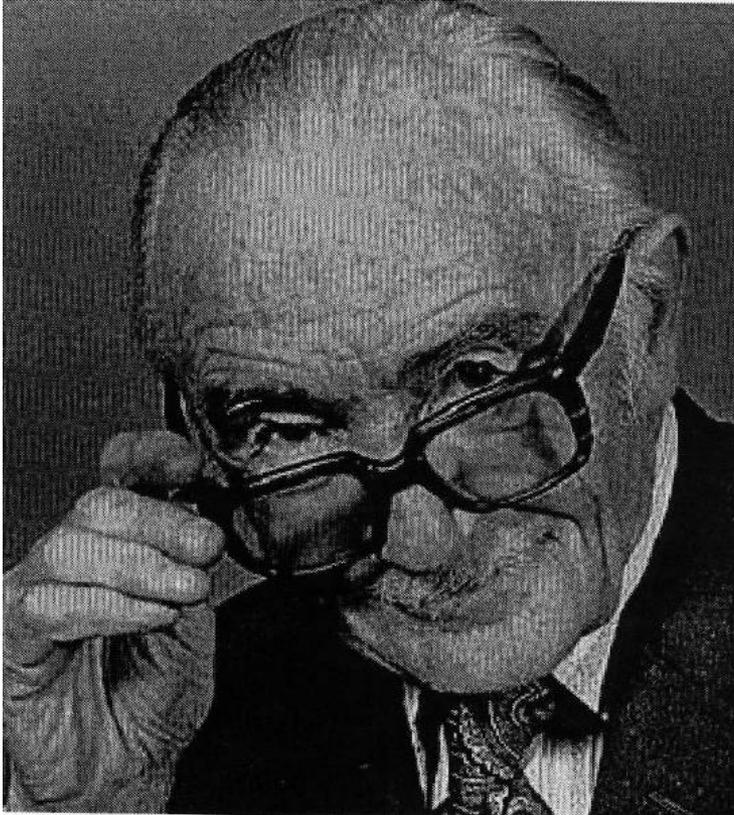
We produce guidance in three areas

- **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'*

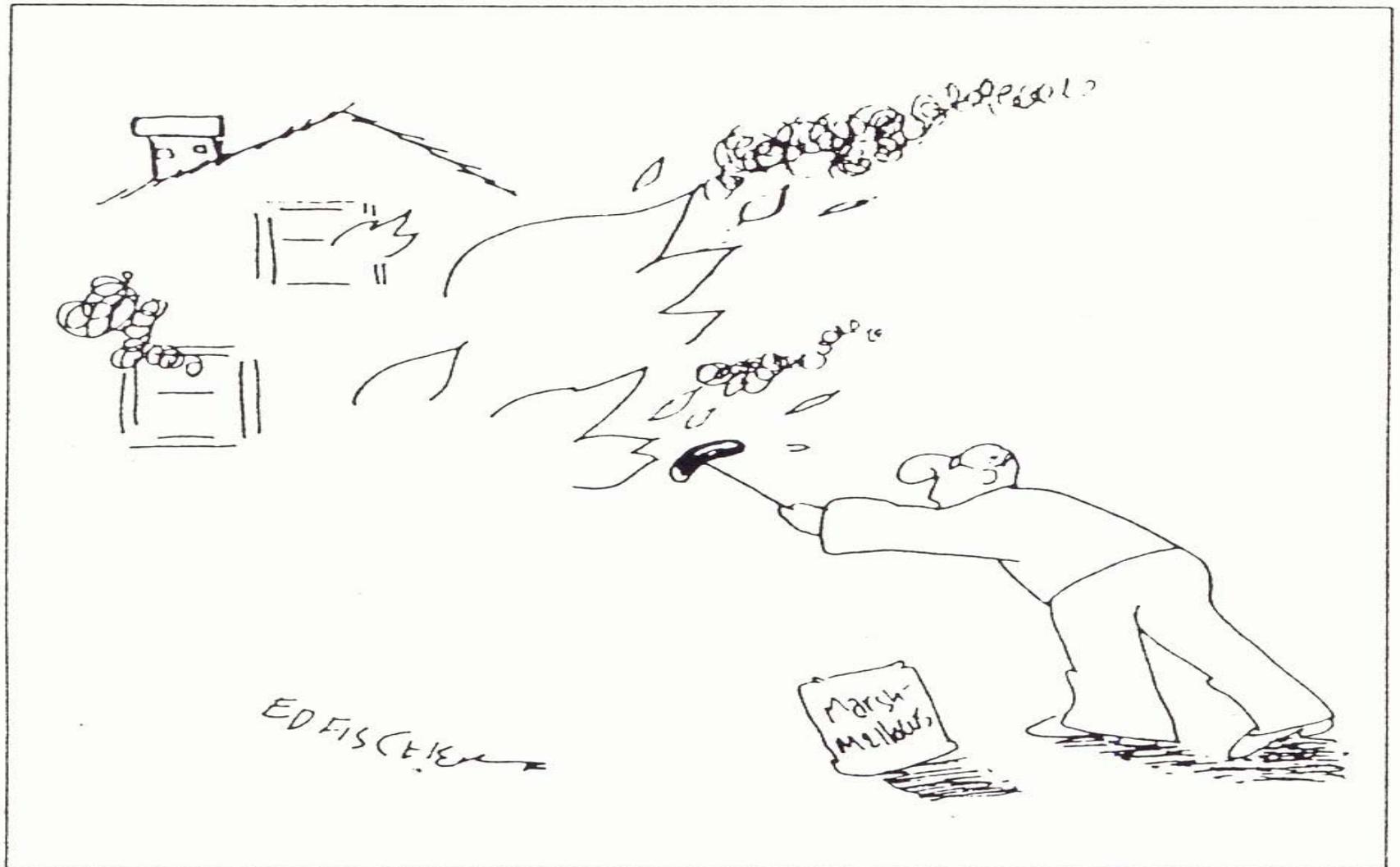
- In the real world there are both strengths and needs

So where is most practice focused?

Where is most policy focused?



Make the Most of Bad Situations



Resourceful but not an asset!!

mac

WWW.DAILYMAIL.CO.UK/MAC



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

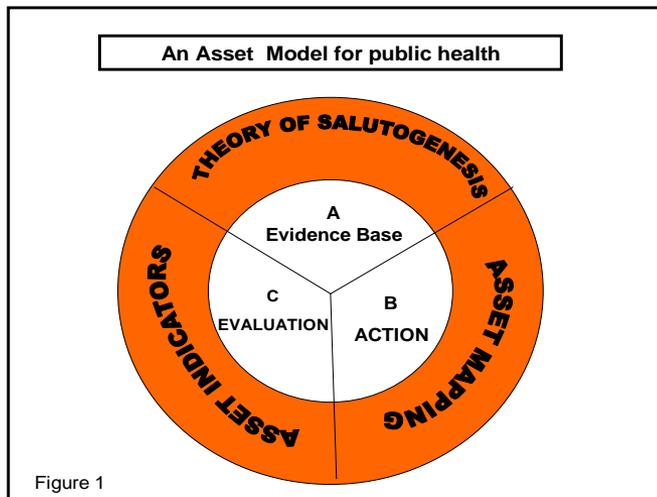
Risk factors:

- 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.



The Asset model may draw on:

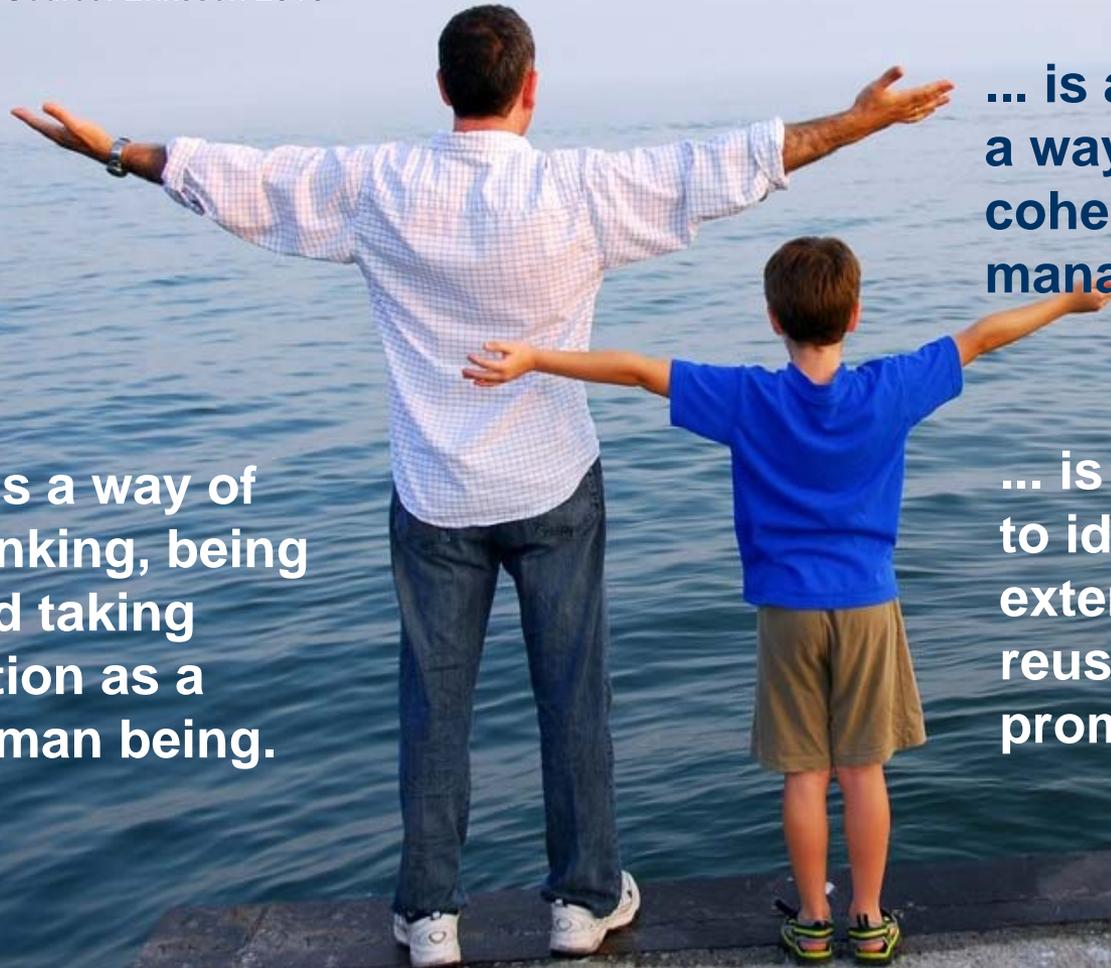
- **Salutogenesis** (Antonovsky, 1979)
- Self-efficacy (Bandura (1977) & Lennings, 1994)
- Satisfaction with life (Diener et al., 1985)
- Dispositional optimism (Scheier, Carver & Bridges, 1994)
- Resourcefulness (Rosenbaum, 1990)
- Constructive thinking (Epstein, 1992)
- Emotional intelligence (Goleman, 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

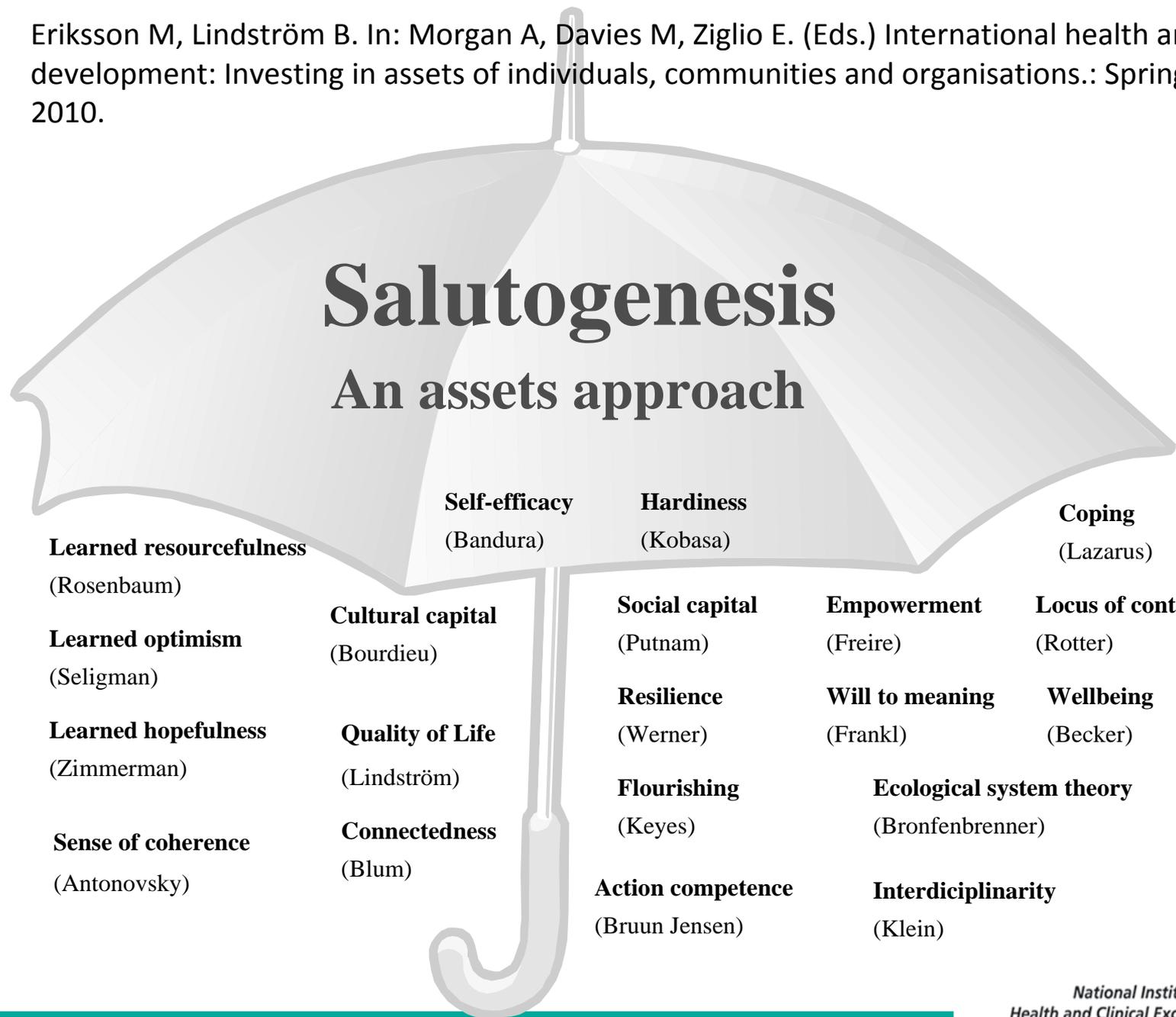


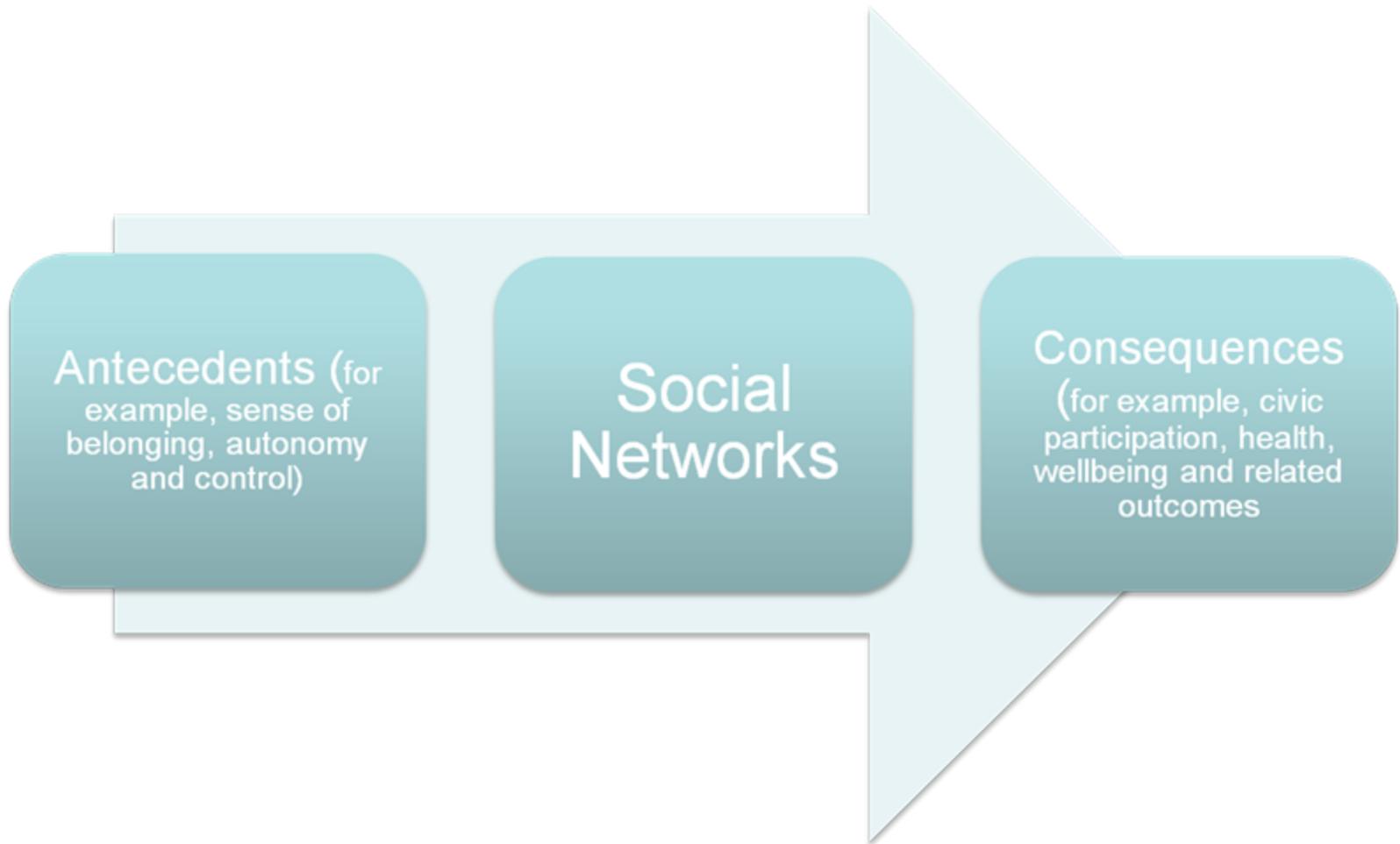
... is a way of thinking, being and taking action as a human being.

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

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

Eriksson M, Lindström B. In: Morgan A, Davies M, Ziglio E. (Eds.) International health and development: Investing in assets of individuals, communities and organisations.: Springer; 2010.





Defining social capital (Coleman, Bourdieu or Putnam)

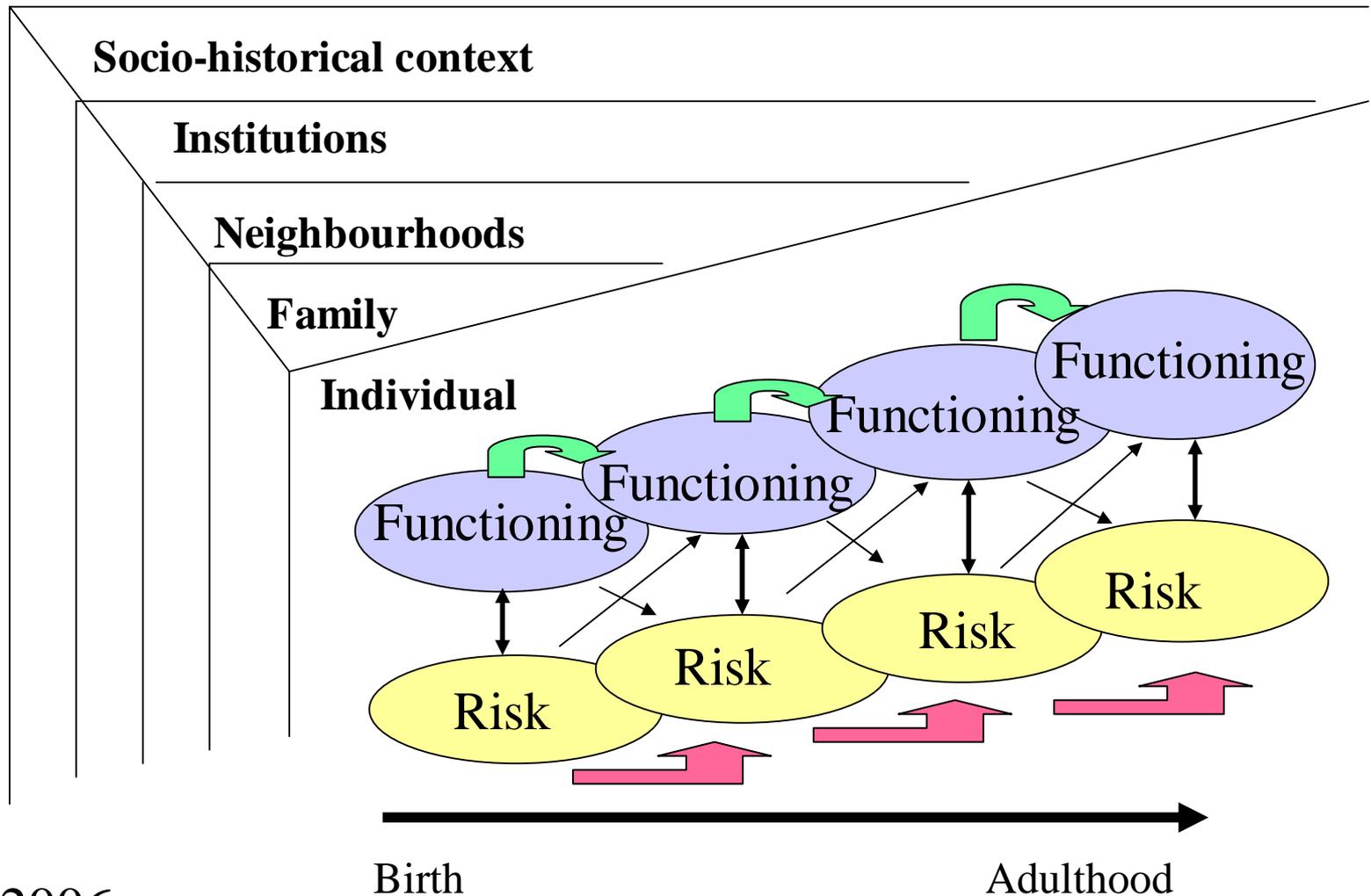
...their common thread relates to the importance of positive social networks of different types, shapes and sizes in bringing about social and economic and health development between different groups, hierarchies and societies

What is Resilience?

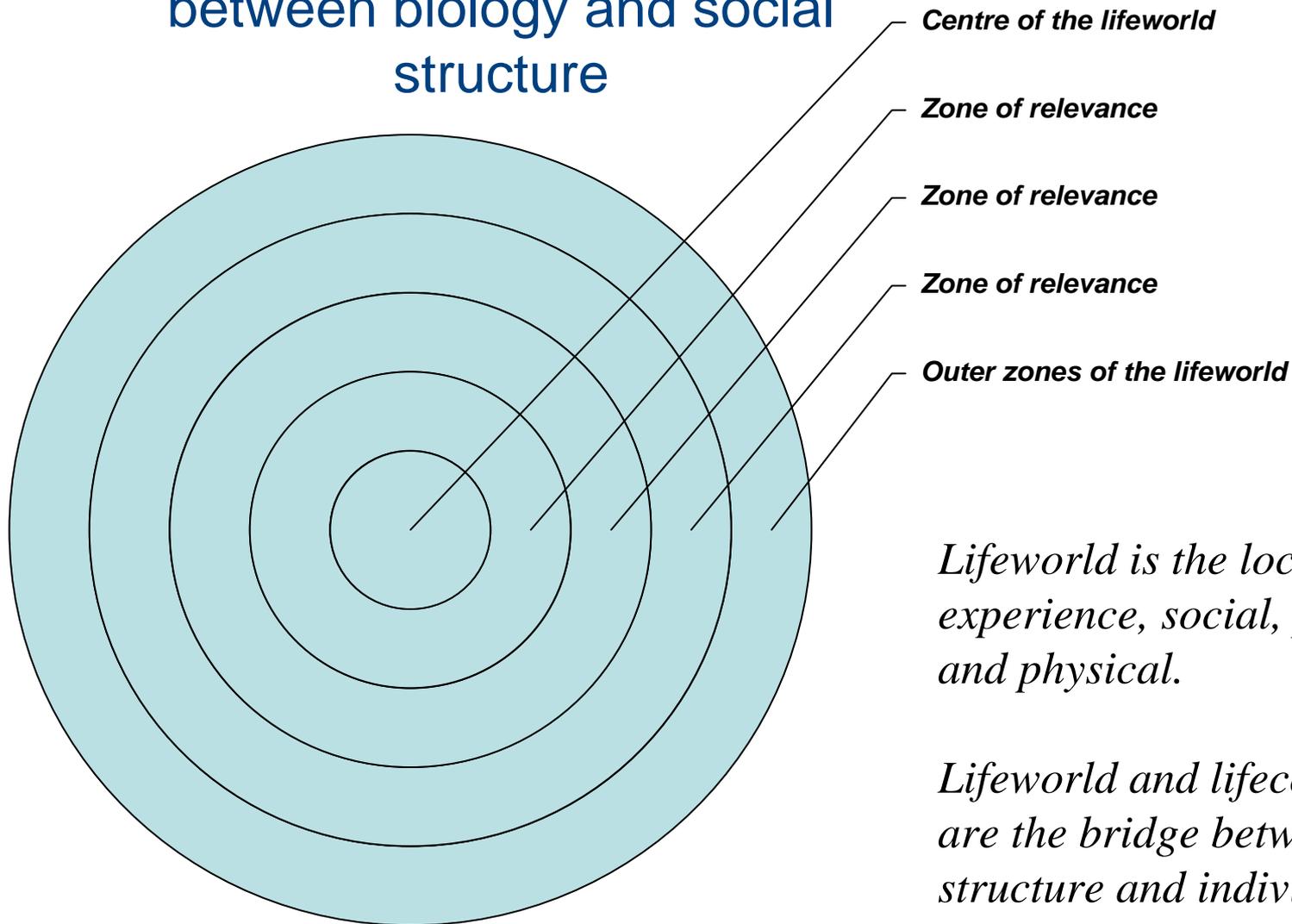
- A chance event
- A personality characteristic
- A dynamic, ongoing process involving a set of interactions between individual, social context, and opportunities

» Bartley et al, Chapter 6 – Resilience as a asset for healthy development

A Developmental-Contextual Model of Resilience



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



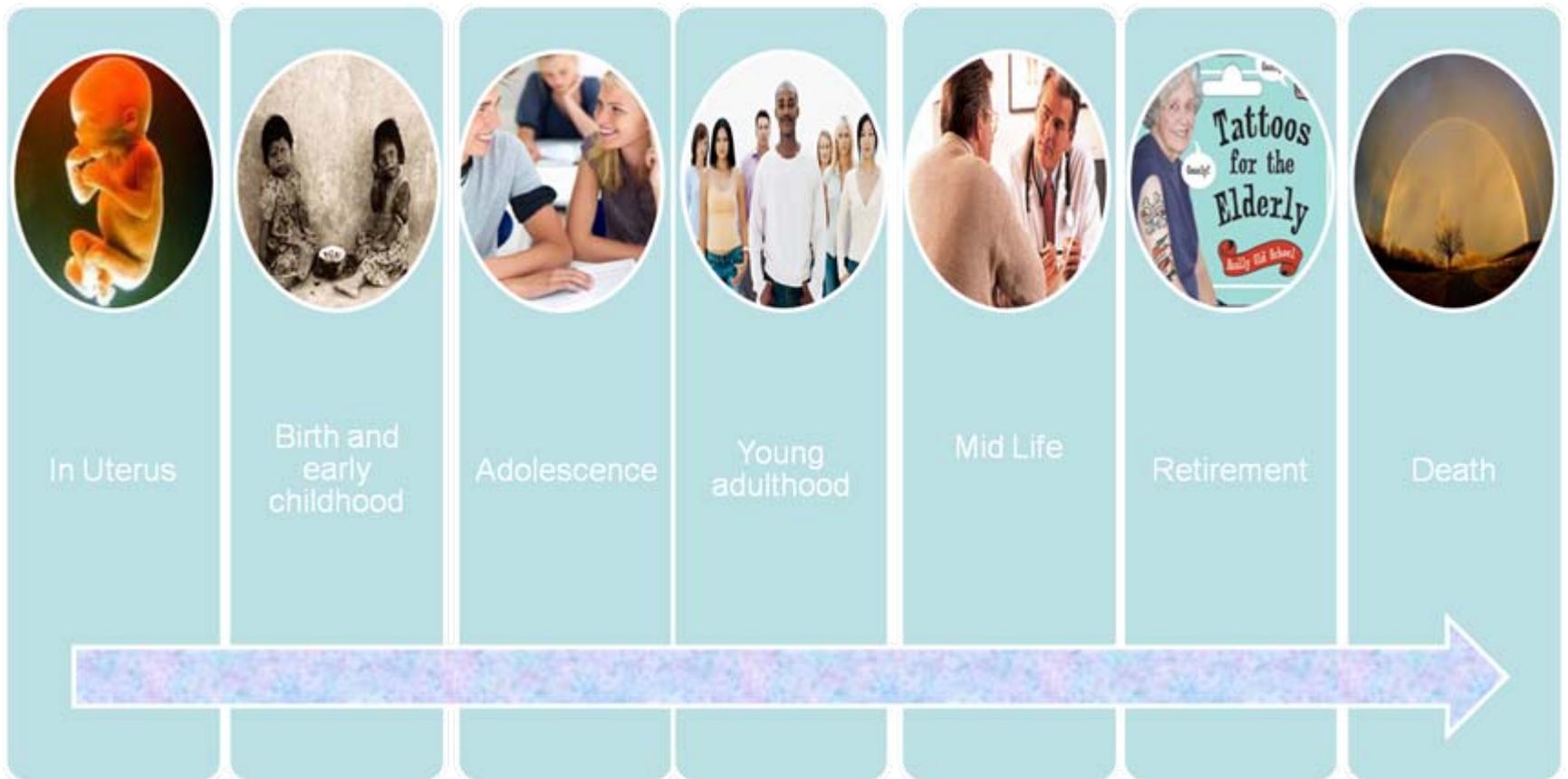
Lifeworld is the locus of experience, social, psychological and physical.

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.

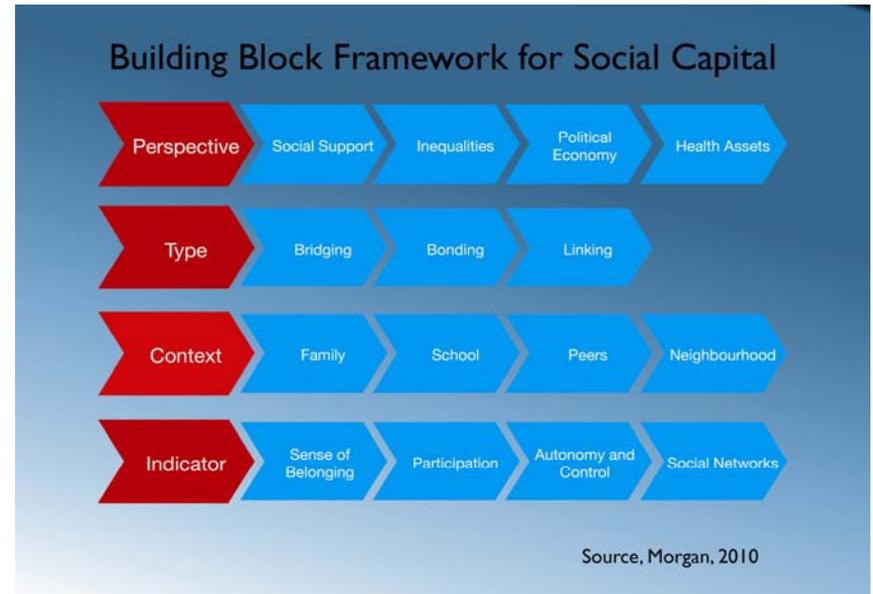




A constellation of assets across the life course

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

Good Education

Decent Housing

High Standards of Living

Access to health promoting physical environments

Key development assets

Young People's Well Being

Positive Health Promoting Behaviour

Low levels of substance misuse

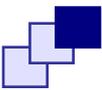
Increased healthy eating and physical activity

Safer sexual health

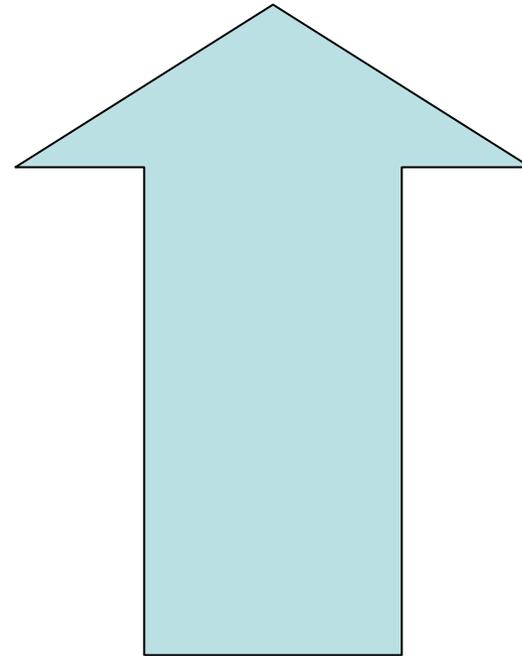
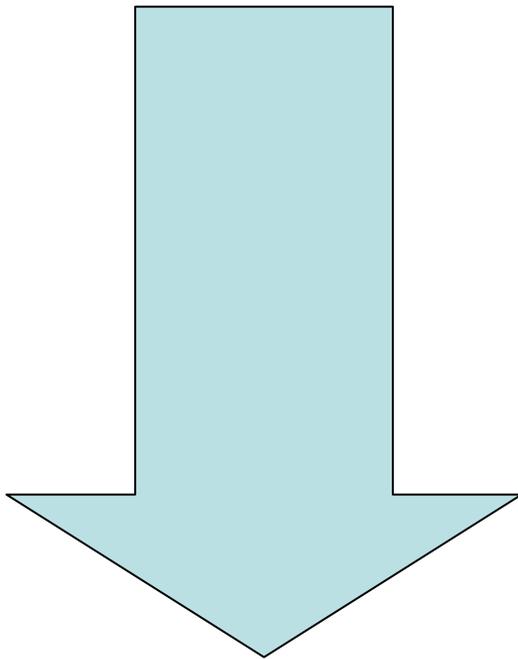
Low incidence of bullying

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

Increasing age – less opportunity for mental well being to effect +ve health promoting behaviour



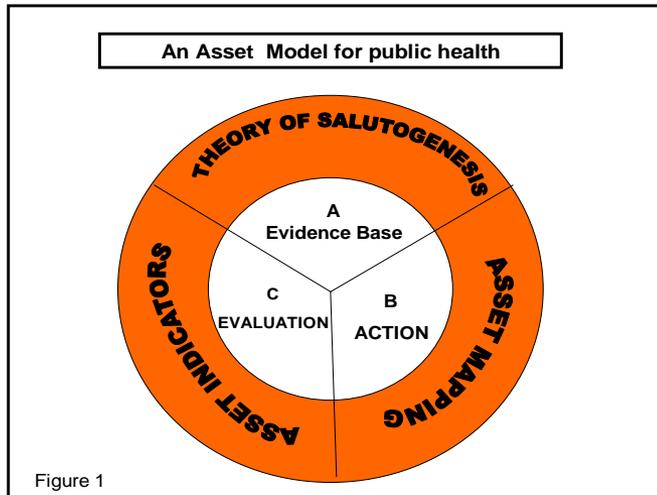
Reducing Risks and Increasing Assets



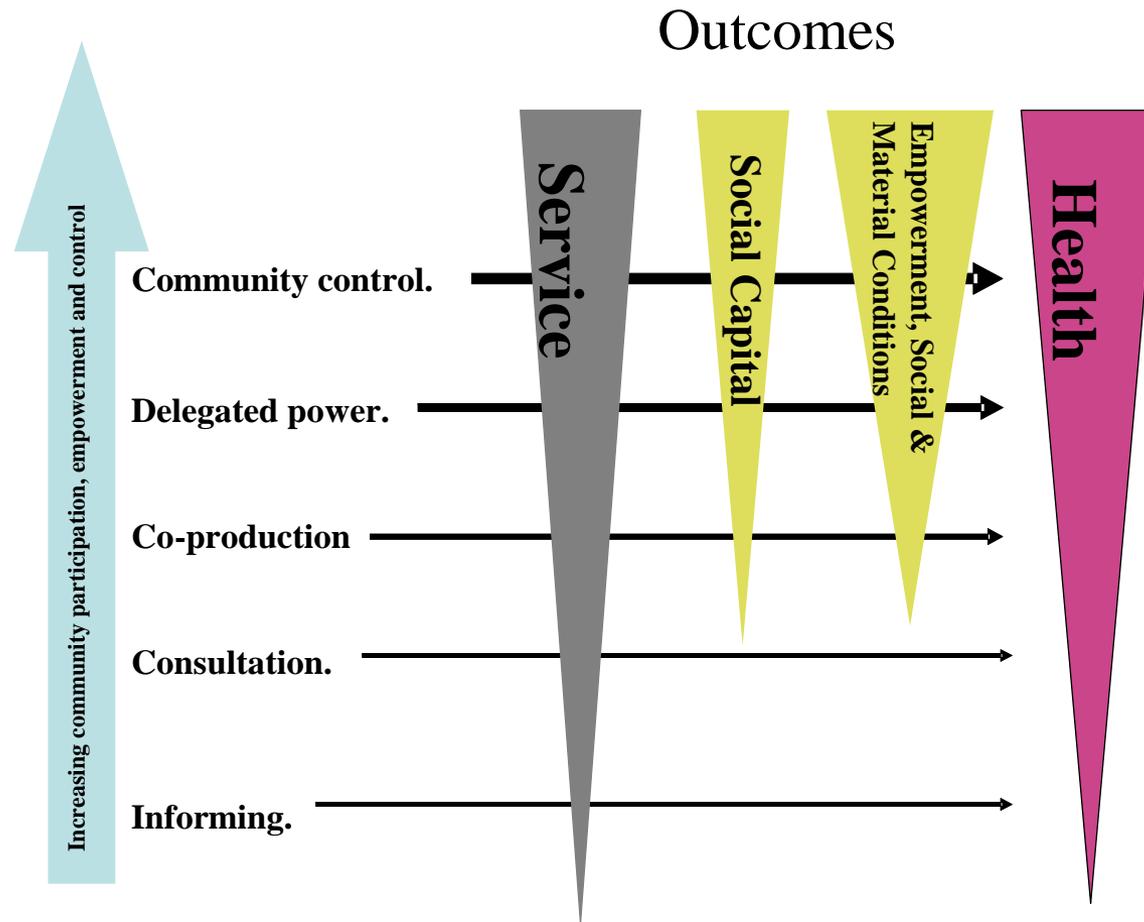
The Asset Model: revitalising the evidence base for public health: phase 2

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.



Pathways from community engagement to health improvement



Source: Popay 2010

Asset mapping

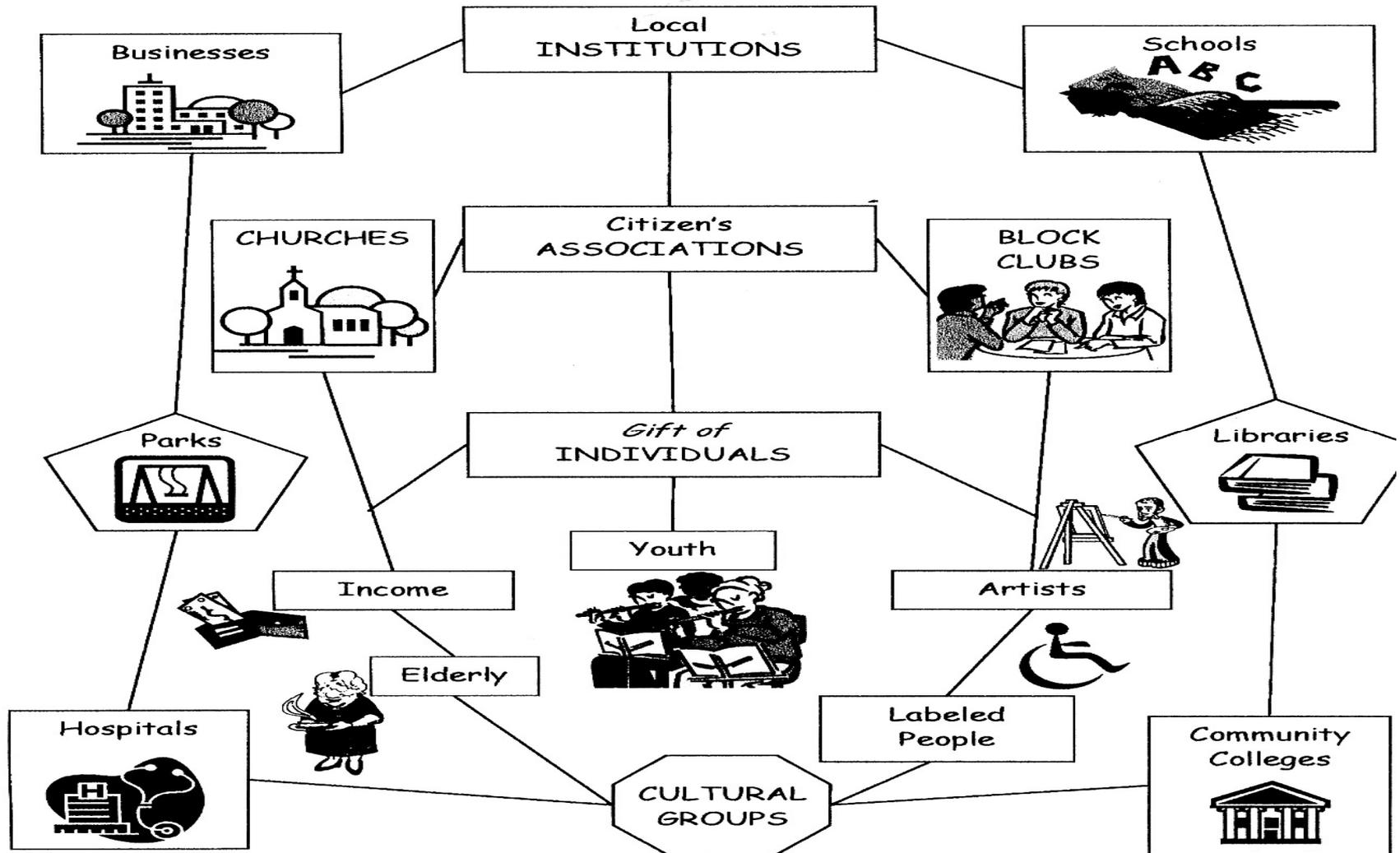
- Professionals tend to define communities by their deficiencies and needs
- Asset mapping:
 - ***Makes us learn to ask*** what communities have to offer
 - It makes explicit the ***knowledge, skills and capacities that already exist***
 - Helps to make best use of ***individual skills , physical and 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

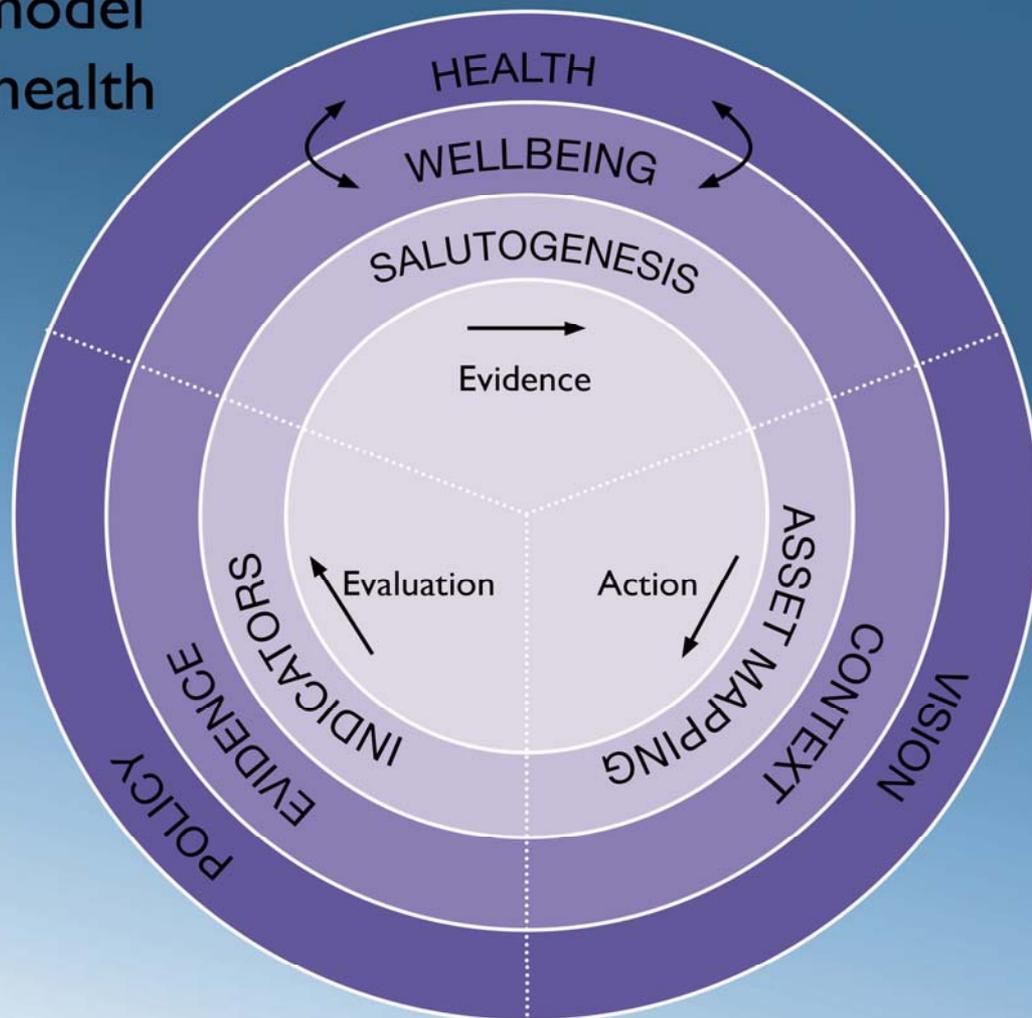


Source: Hopkins, 2010

Mobilizing Assets

- Create a Vision
- Connect the Assets for Productive Purposes

An asset model for public health



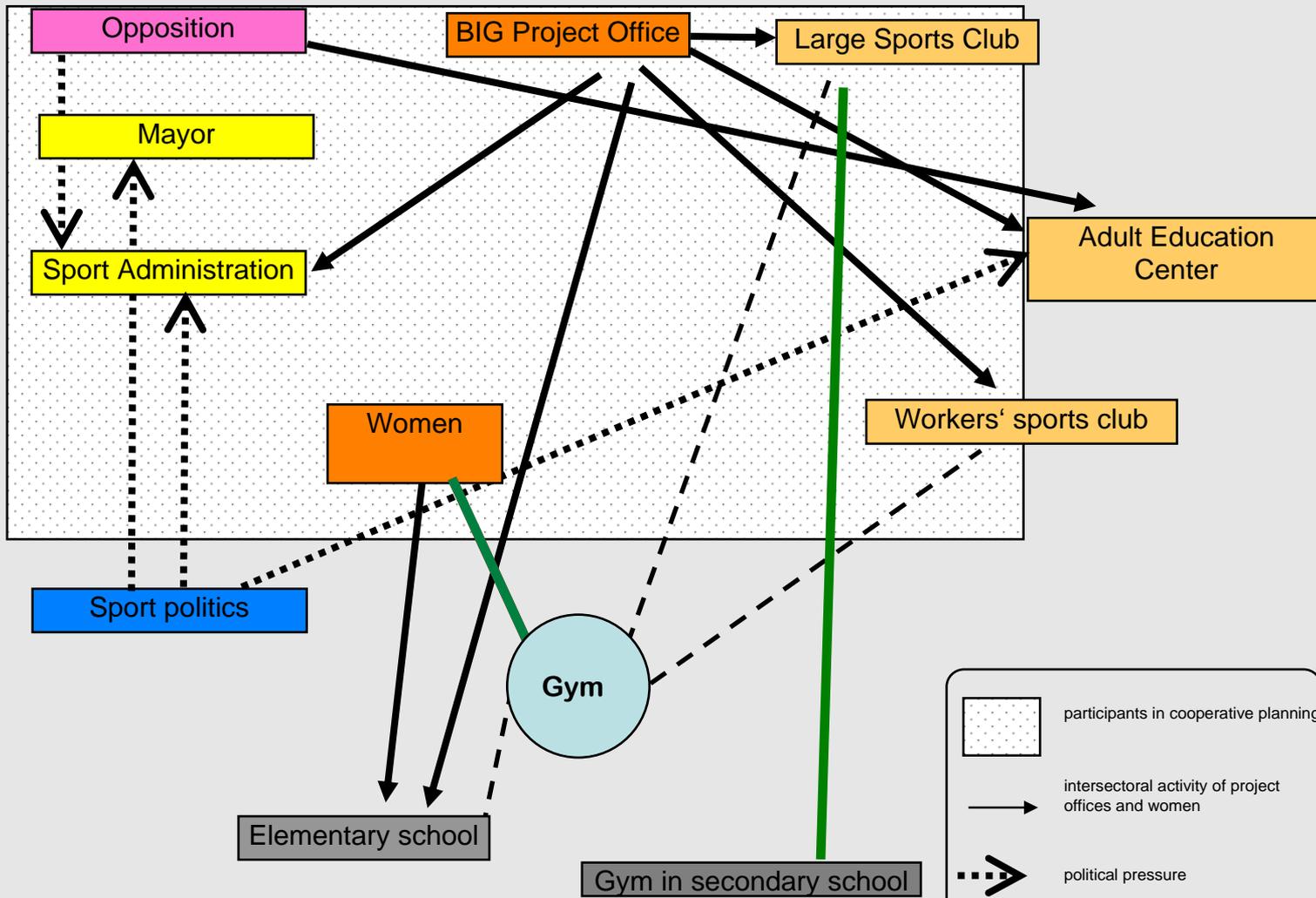
Source,
Morgan, Hernan,
Ziglio, 2011

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**



focus groups

cooperative planning

participatory Implementation

participatory Evaluation

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:

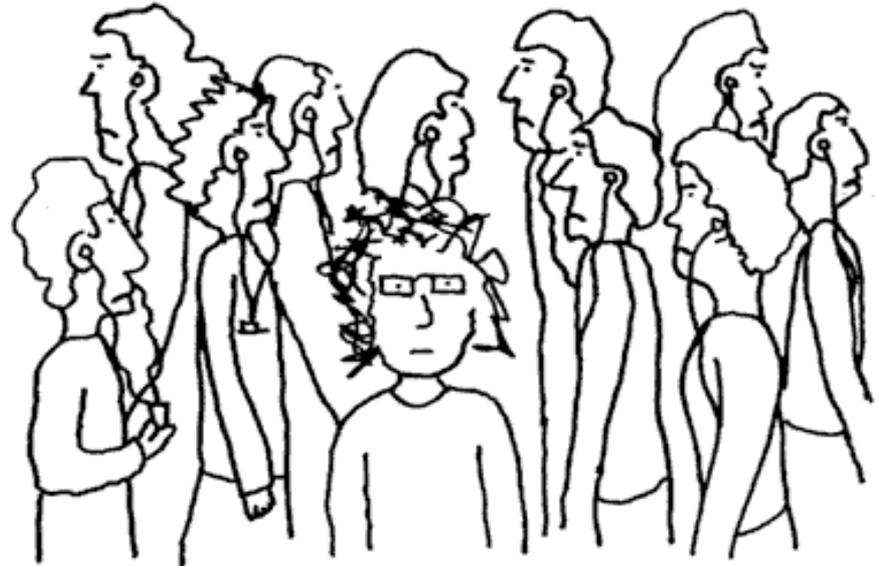


One in seven is Grumpy.

THE COMMUNITY WORKER

CartoonChurch.com

*'There is too much interference from **'them'**and we need more money*



I LIKE TO GO OUT INTO THE
COMMUNITY AND MINGLE
WITH THE PEOPLE

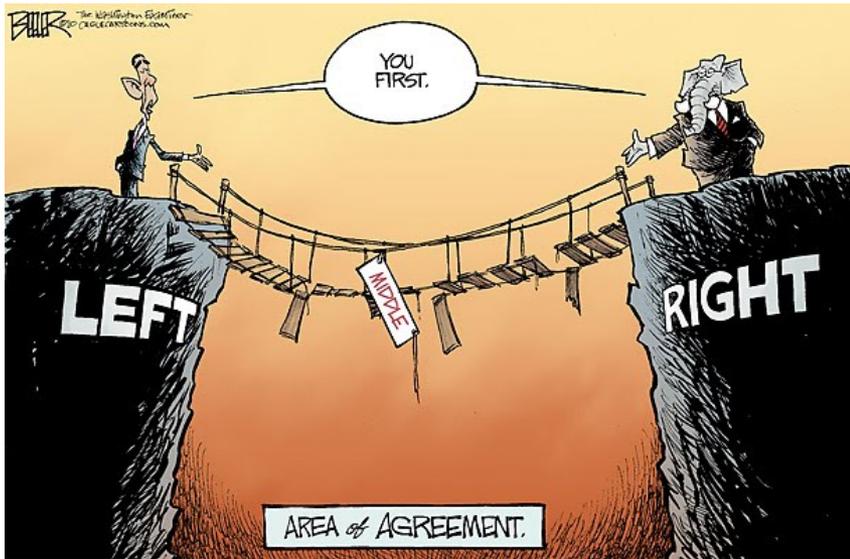
THE POLICY MAKER

‘Count it, show me that it works and do it very quickly’



© fran@francartoons.com

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

