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Measuring what matters for young people's health and well-being: an asset approach

By Antony Morgan & Aixa Aleman-Diaz

The notion of 'health assets' has gained ground over the last few years in policy and practice circles as an approach that might help us move forward towards health and well-being goals. The principles of the idea urge us to think positively; to orientate our ideas towards creating the conditions for health rather than having strategies to alleviate problems; and to ensure that individual and community voice is central to health development processes. Many of the ideas and concepts described within the context of a health asset approach are not new. However, there seems to be a moment in time for those currently interested in it to demonstrate the returns on investment that can be achieved by investing in the approach. Morgan and Ziglio (2007) argued for an evidence-based approach to support better take up in mainstream policy-making. This paper aims to summarise where we are now in the context of young people's health and well-being. It rehearses the basic idea; summarises what we already know and what we need to know; and highlights an existing research instrument that can help further develop the evidence base by measuring what matters.

What is the basic idea?

In the context of young people a health asset approach is based on 3 main ideas.

Firstly, programmes aiming to promote health and well-being should take a *salutogenic approach* to their development. Salutogenesis, a term coined by Aaron Antonovsky (1987), provides a means of thinking about what needs to be done to create the conditions for health. At an individual level, this involves understanding the characteristics that help people remain healthy even in times of stress. Morgan (2010) argues that many of these characteristics can be seen as health assets (or protective factors) and that taking a life-course approach (starting in the early years) provides young people with the opportunity to experience and accumulate them. Taking a salutogenic approach also helps to counteract the overemphasis of 'kids as demons'. Demons might seem a bit of an

exaggeration but the media and to some extent policy focus more on young people's risk-taking and anti-social behaviours than on the things they achieve and contribute. This is despite findings from a European study of adolescent health (Currie et al., 2012) that has consistently shown that the majority of young people (aged 11-15) are doing well (measured by self-reports of overall life satisfaction and levels of health). A health asset approach seeks to understand the factors that help them do well, to demonstrate how policies and programmes can be reoriented.

Secondly, *young people's voice* has to be central to the process of understanding how the conditions for health can be created. Professionals who can actively listen to young people and find ways of involving them in programme development are more likely to succeed. Participation in health development processes is particularly important for young people as we cannot assume that an adult view of their world is necessarily accurate or appropriate. Mayall (2002) expresses this as young people being social agents. As such they are active in expressing meaning based on their own social experience, which ensures that the context of the social world they inhabit is taken into account when health programmes are being developed. Active participation allows us to understand young people's existing capabilities and what needs to be further nurtured and developed. A health asset approach utilises 'asset mapping' techniques (McKnight, 1995) to pursue active participation and involves young people visioning their own health and taking responsibility to achieve it.

Thirdly, *developing positive connections* is seen as an active facilitator for achieving health and well-being goals. The health asset approach seeks to connect the individual to communities, and more broadly society, by developing a range of social networks for the common good. The concept of social capital is useful here, as by definition it promotes the development of a range of positive networks for social, economic and health development. Scales (1999) has argued that young people who have networks and resources are more likely to grow up as healthy, caring and productive people. The health asset approach argues that the benefits of participation have to be twofold. The individual benefits are clear, as networks usually provide improved access to information, resources and services. However, in order for participation to be asset based there needs to be benefit for the wider group, whether that be a geographical community or community of interest. In this way, young people are encouraged to develop a value system that involves achieving for themselves and their communities as a whole.

These three ideas link together and can be described as follows: *a health asset approach is a system which creates positive paradigms for building the capacities of young people to be active in their own development and strengthens their ability to connect to a range of networks that facilitate health and well-being gains for themselves and for others.*

Consequently an important question for policy and practice is whether an assets-based approach does actually form the basis of what is measured concerning young people’s health, well-being and development.

What evidence do we have to support long-term investment?

Even though the ideas behind a health asset approach are not new, there does not seem to have been systematic effort to assemble the evidence that can help to make the case for sustained investment. The case needs to be made if the approach is to become central to policy and practice processes rather than a parallel activity by smaller agencies. That is not to say the evidence does not exist, but perhaps it has not been synthesised in a way that fits the principles of evidence-based policy and practice. The Asset Model described in the paper by Morgan and Ziglio (2007) ‘*revitalising the evidence base for public health*’ was put forward as a means of taking a more systematic approach to assembling the knowledge that could promote mainstream activity of the approach. So what types of evidence do we need? The asset model shown in Figure 1 details this in a 3-phased public health approach. The difference is that it uses a salutogenic lens to frame its questions.

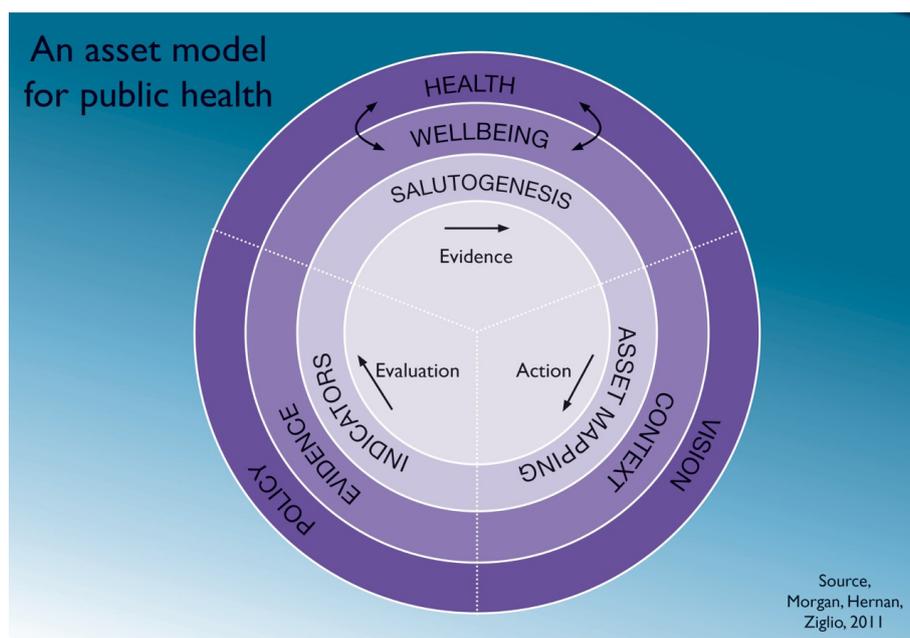


Figure 1.

The first phase aims to identify a vision for health and places salutogenesis (or more precisely its central concept ‘sense of coherence (SOC)’) as an intermediary outcome along the pathway to health and well-being. This is in contrast to the first steps of a public health approach which attempts to quantify the burden of ill health needing to be fixed. SOC can be seen as a first level asset for health and well-being. Those with high levels of sense of coherence are more likely to be able to navigate successfully through stressful life events and challenges (Amirkham and Greaves, 2003). SOC places the asset approach at an advantage as it is measurable. It is fair

to say that most of the evidence on salutogenesis has been carried out in adult populations. Garcia-Moya et al., (2013) however found some evidence to suggest higher levels of SOC are positively associated with a range of positive outcomes in young people (including greater levels of subjective well-being).

This phase also seeks to identify the factors or the precursors to an individual's ability to develop a sense of coherence. These factors or characteristics can be seen as second level health assets. They are comparable to the risk factors identified in a pathogenic approach to public health as those things that need to be addressed to alleviate the burden of ill health. Much work has already been done to improve our knowledge in this area. A notable example is the work of the Search Institute (www.search-institute.org) which has identified 40 development assets that are seen to be fundamental to positive youth development. These development assets include: family dynamics, support from community adults, school effectiveness, peer influence, values development, and a range of specific skills and competences required for young people to thrive.

Two notable gaps in the evidence exist. Firstly, Garcia-Moya and Morgan (article submitted) argue that more effort needs to be placed on finding a better understanding of the mechanisms underpinning links between SOC and well-being. Secondly, whilst much knowledge has been accrued on the associations between different assets and health (and its related outcomes), less has been done to understand how different assets link together to explain SOC and its longer term outcomes.

The second phase of the asset model aims to put into action what we know to be effective in promoting health and well-being, or in the context of the health asset approach – a process for working with individuals and local communities to attain their vision and goals for health and related goals. If phase one has provided us with the evidence that highlights those factors that significantly impact or are most important to our phenomenon of interest (sense of coherence as an intermediary indicator of health and well-being), then phase 2 aims to translate them into a set of strategies that brings them to reality. In general, little or no attempt has been made to evaluate the efforts of work that is specifically labelled as asset based. There is review level evidence however to suggest that participatory approaches to health add value to programmes when considered in its broadest sense. For example, Attree et al (2011) found some evidence of the positive benefits (improved physical and psychological health) of being involved as reported by participations. Milton et al. (2013) found evidence of positive impacts on housing, crime, social capital and community empowerment. Most recently, O'Mara et al. (2013) concluded that whilst there is 'solid' evidence that community interventions have a positive impact on health behaviours and other health-related outcomes, there is insufficient evidence to demonstrate the long-term benefits. More particularly, they report that it is difficult to determine whether one particular model of engagement is more effective than others. Whilst there were some studies included in this review that

related specifically to young people, it is fair to say that evidence-based work to demonstrate the impact of a health asset approach remains to be carried out (or at least assembled and published).

Phase three of the model highlights the importance of monitoring and evaluation as a specific means of understanding whether what we do is worthwhile and to improve our knowledge about what and why things work. This phase specifically aims to address the gaps in research evidence that could substantiate an asset approach. It has 2 distinct features. It takes note of Potvin’s (2005) observation that innovations in public health are rarely accompanied by the relevant theory that informs and transforms practice. The Asset Model uses 2 ideas that have the potential to be developed as theories for use in asset-based work. They are salutogenesis and social capital. These were used as exemplars to illustrate how the pathways to health and well-being could be articulated. However, Eriksson and Lindstrom (2010) highlighted a wider range of concepts that could be used as part of the health asset approach (see figure 2). The second feature important to phase 3 is that it defines evaluation in its broadest sense being inclusive of a wide range of quantitative, qualitative and narrative methods. Similar to the need for form to follow function, a health asset approach to evaluation specifies that methods of research should follow the question (or the vision) being asked.

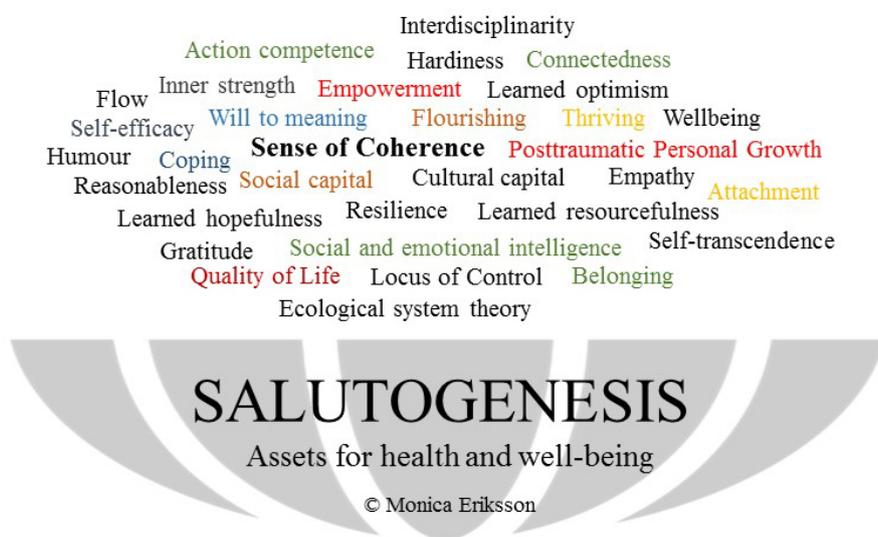


Figure 2. Source: Eriksson and Lindstrom (2010)

Effective monitoring and evaluation efforts rely on our ability to measure the phenomenon we are interested in. Asset-based work is no different to traditional deficit models in this regard. Improving the evidence base for the health asset approach with respect to young people has been given a head start with the Health Behaviour in School-aged children (HBSC), a cross-national collaborative study done in partnership with the World Health Organisation (WHO) for more than 30 years. It is currently carried in in 44 countries in Europe and North America (www.hbsc.org)

What can the WHO Health Behaviour in School-Aged Children offer our ability to monitor and evaluate?

HBSC is a survey carried out through self-administered questionnaires given to 11-, 13- and 15-year-old children in schools in each of the participating countries. Samples are representative of the populations in those age groups and include a mean sample size of about 1,500 children per age group. The 2013/14 questionnaire included responses from 219,810 students; to date, the survey has been completed by over 1 million young people in Europe and North America. Its reach, for example within the European region, makes it an attractive vehicle for identifying specific indicators related to the assets model and getting participating country buy-in to the benefits of moving away from deficits measurement and into quantifying the positive aspects of health.

In general, the HBSC study seeks to understand the health and health behaviour of adolescents by exploring the social, environmental and psychological influences on health and well-being. Since its inception, HBSC formulated the perspective that adolescent health is shaped and constrained by factors stemming from the social spheres of family, peers, school, and the wider economic conditions in which they are growing up (Aarø et al., 1986). An important area of interest within the survey describes the social relations of young people, to understand how aspects of the relational interactions between adolescents and their family, peers, and others shape their everyday life and circumstances and influence adolescents' health and well-being. Specifically, the HBSC study aims to explore the concept of social competence and its connections with young people's ability to develop social networks and their subsequent effect on health inequalities in adolescence. This is being used as a way of measuring young people's ability to engage in a range of individual and community networks, which are hypothesised to promote good health and a sense of well-being. As such, the HBSC embodies the asset model which suggests that contextual aspects of young people's lives, such as factors related to family, school and community, serve as a protective function against health risk behaviours. In this vein, the study has developed questions to demonstrate the importance of these wider influences on health, and helped to map the patterns of health and health behaviour in adolescents' social context. For example, items relating to family, peers, and school are part of the core questionnaire that is used by all participating countries. While in its latest iteration, the study also included an optional package on participation that was used by 8 countries in their national survey which consisted of 6 items measuring participation in decision-making in class and at the school level. Participation is seen as an enabler of student decision-making and input on matters concerning their own lives. This is an important aspect of their community engagement and belonging which can have important effects on their health. In the past, the survey has also included questions on club participation and neighbourhood social capital (Zambon et al., 2010; Boyce et al., 2008; Morgan and Haglund, 2008). These are a few examples of how the HBSC protocols explore the importance of young

people's social networks in acquiring and sustaining good health.

The HBSC study has been instrumental in increasing available data on adolescents; the breadth of its topics and cross-national nature offer a snapshot into the factors that contribute to young people's well-being in different country contexts and internationally. As such, we recognise that the questions and issues that make up the scientific base of the study set the tone for the adolescent health research agenda in Europe, and its approach can help reconceptualise the way we think about health in young people. HBSC reports (for example Kuntsche et al. (2015); Inchley et al., 2016) which target policy-makers and practitioners, have also highlighted family, peers and socio-economic circumstances as key contexts related to the health and health-related behaviour of young people. These reports represent critical vehicles for showcasing and promoting the measurement and use of positive indicators in assessing the health status of children and young people. As such, we posit that HBSC can be a catalyst in debates about measuring what matters not only in terms of the data that it produces but also given the range and depth of knowledge it generates.

HBSC's well-developed theoretical base, which values adolescent capabilities, provides a viable alternative to the often limited theoretical underpinnings that comparable studies have. Therefore, it is critical that the asset model continue to be an important part of the study in the future, to enable tangible measurements that complement and work more equally in tandem with traditional ways of measuring health and its determinants.

Authors

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