An assets based approach to health promotion with young people in England

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Abstract

Introduction

The health of young people in England is an area of concern, nationally and internationally. This has prompted a range of strategies and policies to try to address how health may be improved. However, there has not necessarily been agreement as to how this should best be done. There appeared a case for consideration of alternative or additional approaches to health promotion.

Aim

This research aimed to construct an assets based model to shape health promotion practice and policy for young people in England.

Methods

A narrative synthesis was undertaken and highlighted the lack of information regarding which assets might be important for young people's health in England. This programme of research was developed from those initial findings. Quantitative and qualitative methods were employed to gain a more comprehensive understanding than could be gained by individual methods. This mixed methods research involved secondary data analysis of the Health Behaviours in School Aged Children (HBSC) dataset using regression analysis to identify the assets associated with life satisfaction for English youth. Focus groups and interviews were employed to capture the views of young people regarding assets, health and health promotion. Findings were discussed with practitioners to gather their ideas as to the potential of an assets approach. The different research methods were drawn together by the underpinning theoretical frameworks provided by Assets models and the New Social Studies of Childhood.

Results

Two themes emerged from the narrative synthesis providing suggestions for health promotion; the ecological approach acknowledged the range of settings that young people inhabit, whilst the holistic approach recognised the interrelationship between risks and assets.

Critical discussion consolidated the research findings to propose a list of health promoting assets for young people in England; constructive relationships, safety,

positive attributes, independence and opportunity. These findings were brought together into a descriptive model to guide health promotion policy and practice (Figure 1). Constructive relationships appeared as a core asset, providing a foundation from which young people could develop. Having positive attributes was also fundamental to this process, which emphasises the importance of promoting physical and mental health simultaneously. Safety was the third core asset identified through the research strands. There was variation between young people regarding the definition of, and priority assigned to, the additional assets of independence and opportunity.

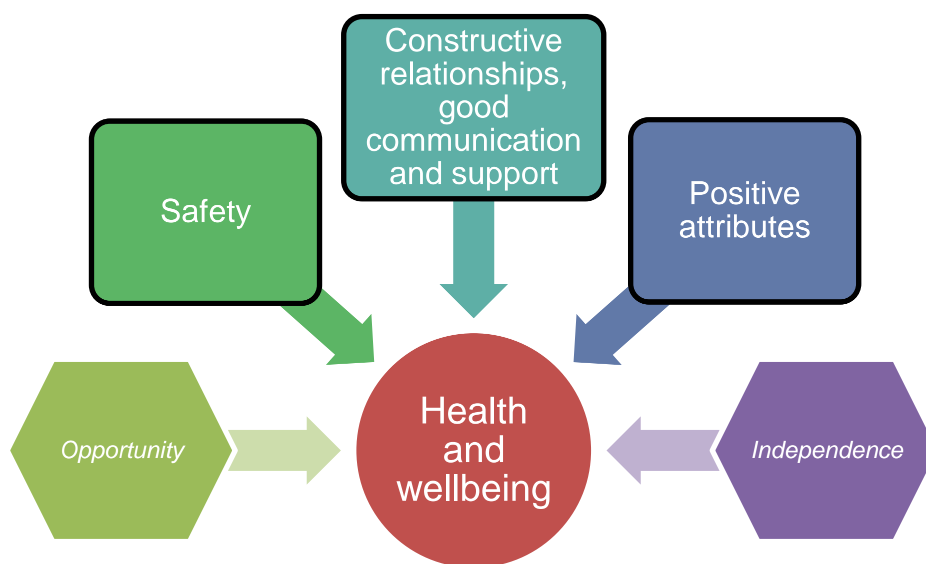

Figure 1: Assets model to shape health promotion with young people

Conclusion

This research contributes to previous work in the field of assets models by providing new insight into the relatively little researched area of assets approaches to health promotion with young people in England. The complex interrelationships between mental health and assets have been highlighted; providing challenge to frameworks that focus on the quantitative accumulation of assets. The inclusion of young people's perspectives provided new depth to previous theoretical models and interpretation of quantitative findings. The variation highlighted within this research raises implications for tackling health inequalities.

This assets based model provides a framework to shape professional practice and policy thus providing the potential to improve young people's health and wellbeing in a sustainable and non-stigmatising way.

Acknowledgements

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Chapter 1: Introduction and summary of chapters

Introduction

Young people's health in England has failed to improve at the same speed as the health of infants and children. Health inequalities are apparent within England and in comparison with other countries. These facts taken together suggested scope to review health improvement policy and consider different approaches to health promotion practice. This research focuses on young people's health in England; suggesting additional or alternative ways that health promotion strategies might be shaped to improve young people's health.

Definitions of what is meant by a young person within this research, the reasons for focusing on England and explanation of the concepts of health and wellbeing are examined below. Statistics to evidence the opening lines of this chapter are provided, demonstrating the stagnation in young people's health improvement and the inequalities that exist. Discussion then turns to health promotion, providing an overview of different approaches. Brief professional motivations are provided for this study with explanations as to my role in relation to the Doctorate in Health Research (DHRes) and Health Behaviours in School Aged Children (HBSC) study group.

The aims and associated objectives of this research are set out. Chapter summaries are provided as an overview of the research process, findings and conclusions.

Defining young people's health and wellbeing in England

The broad definition of young people within this research is 11-19 years old; the aim being to concentrate on the secondary school period. There is some variability between the literature review and fieldwork due to the purely practical cut-offs available. Within the search engines for the literature review used it was possible to specify under 19 years or secondary school aged children. For the fieldwork, the secondary data analysis made use of an existing data set of 11-15 year olds whilst the qualitative work included young people aged 13-18. In terms of understanding the context to health in adolescence, the first two decades of life are included, in line with Developmental Science which recognises the theoretical importance of this

period in terms of establishing the optimal opportunities and circumstances for thriving (Lerner et al., 2011).

The data analysis within this research makes use of the Health Behaviours in School aged Children (HBSC) study dataset; this study is carried out in the UK in England, Wales and Scotland. However, it was decided to focus on the English study for the purpose of this research. England has the largest population of young people of the UK countries. Additionally, there are differences in the provision of health services and public health between England, Wales and Scotland. Implications for practice following from this research are within the context of English public health and service provision.

Whilst there is recognition of the significant value that people place on health it often proves difficult to define succinctly (Tones and Green, 2004). A range of definitions exist and include ideas such as health as self actualisation, as empowerment and as a mirage (unattainable but worth pursuing) (Tones and Tilford, 2001). This range includes quite narrow definitions (free from specific disease) to broader concepts encapsulating function and capacity. The word "health" was derived from a word meaning whole[1]. In the West, the dominant model within health service provision is the bio-medical model which assumes that disease is generated by specific organisms which alter the body's structure or function. This leads to health often being defined as the *absence of disease* (Jones, 1994). Alternatively the social model of health states that people perceive their health as a tool to help them function or carry out normal social roles (Bowling, 1997). The social model of health was encapsulated in the Ottawa Charter for Health Promotion. This Charter was an international agreement signed at the World Health Organisation's first International Conference on Health Promotion in 1986. It proposed a commitment to the promotion of health and wellbeing. Within the Charter health is defined as;

> *"... a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities". (WHO, 1986)*

[1] http://www.etymonline.com/index.php?term=health Accessed 1/9/12

The World Health Organisation's (WHO) definition of health states that health is more than just the absence of disease but considers at its centre the concept of quality of life, positive health and wellbeing (WHO, 2004). Although wellbeing might be seen as a positive aspect of health, it often defies concise definition and has been suggested to be a "*catch-all category*" (page 349, Cameron et al., 2006).

There are concerns with using adult definitions with children as they may have different understandings of the terminology; young people's views of health may not directly correlate with those of adults (Toren, 1993). However, the research on children's and young people's definitions of health and wellbeing is much less developed than adult understandings of wellbeing. There is also little agreement as to which measures to use (Ravens-Sieberer et al., 2008). Young people are likely to place a strong emphasis on their feelings within their definitions of health (National Children's Bureau, 2005) and therefore consider an holistic view of health and wellbeing (Blair et al., 2010). More recent research carried out with young people in focus groups highlighted many aspects of well being, participants identified five themes that supported their wellbeing, with health just being one aspect, the others included: educational achievement, career success, positive relationships, involvement in enjoyable and meaningful activities (McNeil et al., 2012).

Research in 2011 identified a range of domains currently in use to define children and young people's wellbeing including feelings, material wellbeing and housing, for example (Table 1, *page 14*). However, the authors note that there has generally been

> "*neglect of the voices of children and young people in defining what well-being means to them*" (page 10, Hicks et al., 2011).

Although a variety of indicators exist that could be used to define young people's positive health and wellbeing, they may not all be relevant to young people as some of these may be based on adult constructions. As part of the research summarised within the table below (Table 1, *page 14*) a difficulty was noted of identifying indicators that would take into account the many areas that affect young people's wellbeing at different stages of their lives. There may be differences in perception of health for different ages, genders and ethnicities. This resonates with Seedhouse who notes that "*health means different things to different people*" (page 12, , 2001).

Understanding health and wellbeing from a young person's perspective facilitates how this can be promoted and improved.

Organisation	Research	Domains & definitions
British Household Panel survey	Questionnaire included to 11-15 year olds since 1994	How young people feel about their life as a whole plus particular aspects (family, friends, appearance, school work and school).
UNICEF	Child poverty in perspective; an overview of child well-being in rich countries (2007) and (2010)	Material wellbeing, health & safety, education, peer & family relationships, behaviours & risks, Young people's subjective wellbeing.
OECD	Doing better for children (2009)	Material well-being, housing and the environment, education, health, risk behaviours and quality of school life.
Welsh Government	Children and Young People's Well-being Monitor (2008 & 2011)	2008 – Largely objective measures. 2011- age range expanded from 18 to 25 years & to include views from children and young people.
Barnado's	Children in Scotland wellbeing index.	Child poverty, economic participation, education, risk behaviour and physical health.
University of York	Index of child well-being in Europe	Health, subjective well-being, personal relationships; material resources; education; behaviour and risks and housing and the environment.

Table 1: Research on measures of children and young people's health and wellbeing (derived from (Hicks et al., 2011))

Changes in young people's health

Over the past century the health of children and young people has improved dramatically. At the beginning of the 1900s infant mortality was high and life for many children was characterised by periods of infectious diseases and malnutrition. For example, in 1911, 130 out of every 1,000 children born in England and Wales died before their first birthday but by 2010 this had decreased to 4 per 1,000 children (Joloza, 2012). This reduction has been brought about by a range of social and health interventions, such as improvements to sanitation and nutrition, plus the introduction of a wide ranging vaccination program.

Although there have been reductions in mortality and morbidity rates for young people, this now appears to be slowing and patterns are changing. The World Health Organisation reported that despite advances being made in the health and development outcomes of young people since the 1950s (such as reduction in mortality rates), progress during the 21st century has slowed (WHO Executive Board, 2001). For some young people acute and infectious diseases have been replaced with issues such as social, emotional and behavioural difficulties, chronic diseases and lifestyle related health impacting conditions (Wille and Ravens-Sieberer, 2010).

Many countries have seen a change in the age groups most affected by disease. It has been argued that, in the UK, the burden of disease has shifted away from children to adolescence (Hale and Viner, 2012). Whilst there have been improvements in the health of very young children (as measured by a reduction in infant mortality), the health of young people (aged 10-20) has remained fairly static or worsened (as measured by key public health indicators such as obesity and sexual health) (Viner and Barker, 2005). The decrease in age specific mortality since 1960 for those aged under ten is twice that seen in young people aged 15-19 (76% versus 38%) (Payne et al., 2005). Regardless of whether health is measured by mortality, morbidity or health service usage, the picture of young people's health appears less than optimal. After the first year of life, the highest death rates amongst children and young people in the UK are found in 15-19 year olds (Brooks, 2010). When young women reach late adolescence (15-19 years) their GP consultation rate doubles (Hippisley-Cox et al., 2007). After age 11, life satisfaction is seen to decrease, with lower rates being reported in mid to late teens (Currie et al., 2008).

Approximately half of all UK 13-15 year olds do not undertake the recommended one hour of physical activity per day (Department of Health, 2002). Taken together, these statistics suggest that this age group is different; it is not benefitting from the other broader developments impacting on health and/or it is being missed from initiatives.

Why focus on health improvement for young people?

Children and young people make up a large and increasing group within the UK; forming approximately a quarter of the UK population. There has been a gradual increase in the number of teenagers in the UK over the last decade; in 2009 there were approximately 7.6 million young people aged 10-19 years in the UK (page 2, Coleman et al., 2011). It has been suggested that these young people are negotiating an increasingly complex world, faced with unprecedented choice and opportunity but also greater levels of risk (McNeil et al., 2012). Adolescence is a time when young people are establishing their own self identity. This may involve experimentation with a variety of behaviours, challenging authority and authority figures, developing independence from parents and establishing relationships outside the family (Christie and Viner, 2005). Some of the decisions made as young people enter their teens may have immediate as well as long term consequences for their health and wellbeing.

As well as the impact that suboptimal health may have on a young person in their current daily activities, if young people's health needs are not addressed there can be future implications for young people and society in terms of achievement potential and health service usage. Poor health in childhood and adolescence can have a marked effect on educational accomplishment, the attainment of life goals as well as restricting social and emotional development (Currie et al., 2008). It has been proposed that what children become in their adult life is, to a large degree, a product of their experiences in childhood and adolescence (Aldgate et al., 2006). Many of the risk factors for premature mortality and disability from heart disease, cancer, musculoskeletal disorders and mental health problems in adulthood have their roots in childhood and/or adolescence (Stewart-Brown, 2005).

There is the possibility that traditional methods of health education and/or health promotion are not working with some young people. Although many young people have a good understanding as regards healthy lifestyles and are able to identify what would help them live more healthily (National Children's Bureau, 2005), this is not always translated into practice. Clinicians have raised a number of issues that they perceive as specific to adolescent health and health promotion, including the challenging issues in communicating with young people and that adolescents often have different priorities to adults (Payne et al., 2005). This suggests a need to isolate the evidence of what works in promoting health and understand young people’s views of what would help to improve their health.

Inequalities in health behaviours and outcomes exist. Within the UK, differences in young people’s health and wellbeing exist between geographical areas, between age groups and between the genders (Brooks et al., 2009). For example, older girls are less likely to report high life satisfaction or good self-rated health. As the adolescent population is more ethnically diverse than older age groups, inequalities in health due to ethnic differences impact young people disproportionately (Viner and Barker, 2005). Differences between the health and wellbeing of youth in the UK and their peers in other countries have been emphasised in international reports (Currie et al., 2008, UNICEF, 2007, UNICEF, 2010). At the start of this research journey, the UNICEF inequalities report (“Child poverty in perspective”) placed the UK in the bottom third of the rankings for five of the six dimensions reviewed; this includes “subjective well-being” where the UK scored lowest of all countries within the report. By the updated report in 2010 (only three dimensions reported) there had been some improvement in the relative scores for the UK; although still in the bottom third of countries for material wellbeing, the UK was in the middle third for both education and health wellbeing (UNICEF, 2010). Variation in health outcomes between young people in the UK and between themselves and peers in other countries might be due to differing health behaviours, access to services and/or health promotion strategies; it is worthy of investigation to understand how such inequalities might have developed and how areas might have had success in improving health.

How best to improve young people's health: a re-focussing of health promotion?

Health promotion aims to improve health in its broadest, most positive sense. There is a range of differing definitions and interpretations of the concept of health promotion (Scriven and Orme, 1996). The World Health Organisation (WHO) defines health promotion as "*the process of enabling people to exert control over, and to improve their health*" (WHO, 1986). Though it has been argued that health should be viewed as a means to an end rather than the ultimate purpose of health promotion (Tones, 1986). Adolescent health promoting behaviours have been described as those that enhance their lifestyles to achieve, maintain or enhance their "*bio-psycho-social and spiritual aspects of wellness*" (page 360, Wang et al., 2011).

Yet the optimal methods of promoting health with young people are not clear. Health promotion interventions are not always adequately evaluated to provide evidence as to their effectiveness (Health Development Agency, 1997, Bunton et al., 1994), in part this may be due to the limited relevance that the frameworks used within evidence based medicine have within health promotion (South and Tilford, 2000). As health is determined by so many interacting factors, it is likely that effective methods of improving health will need to take account of these interconnections. The determinants of health are illustrated in the diagram below (Figure 2, page 19) and comprise social structures, socioeconomic circumstances, interactions with family, school and community as well as individual characteristics. (Despite its age, this diagram is still widely used to summarise the determinants of health). The environment is important to children in providing safe, friendly and supportive structures for healthy living (National Children's Bureau, 2005). Effective health promotion for children and young people is likely to include an acknowledgement of relevant health determinants.

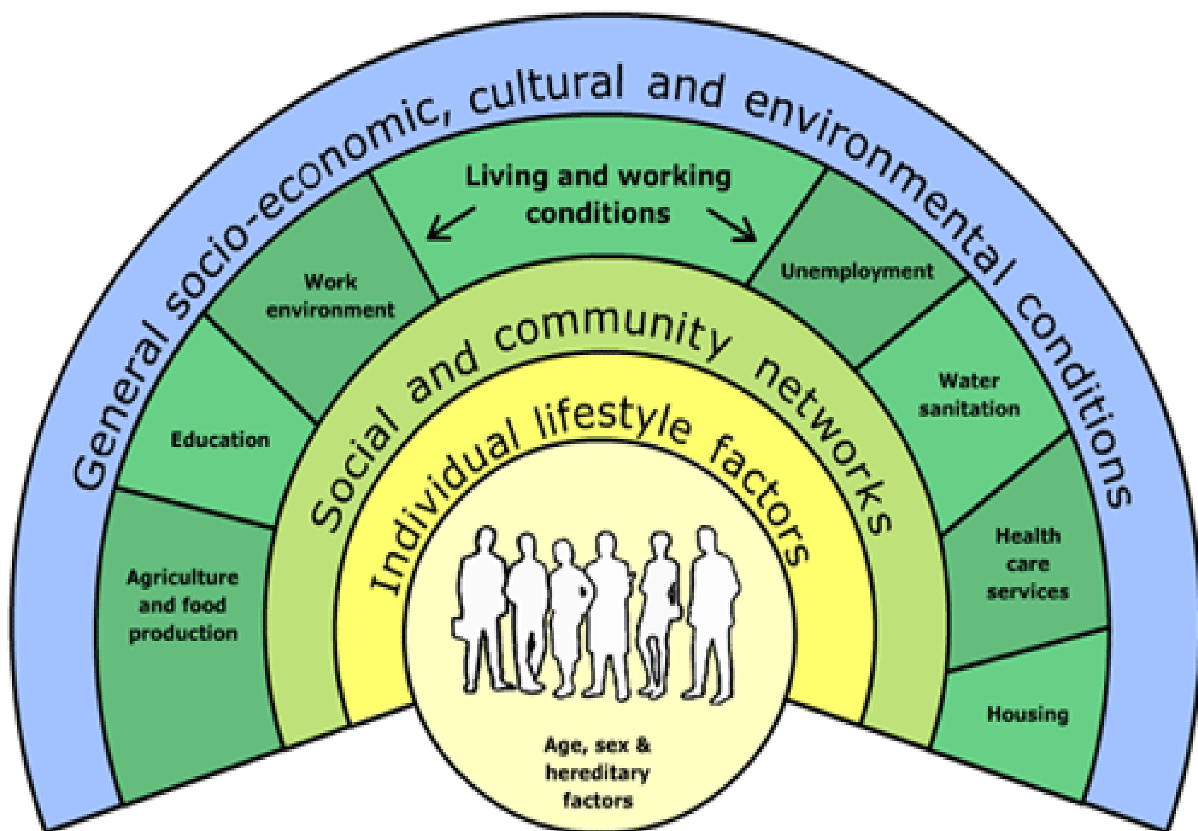

Figure 2: The main determinants of health (Dahlgren and Whitehead, 1991)

Following the discussion above which has highlighted the apparent plateau in young people's health improvement and the health inequalities that exist, it is timely to investigate alternative strategies for health promotion. A comprehensive history of health promotion is beyond the scope of this research; detailed analysis has been given by others (for example, Minkler, 1989, Tones and Green, 2004). Although improvements in health are the goal of any health promotion strategy the method of achievement has varied over time and between practitioners.

Practitioners are likely to be influenced by their training, principles and current politics. Principles of health promotion have been listed to include: empowering, participatory, holistic, intersectoral, equitable and sustainable (Green and South, 2006). It has been suggested that "*preferences for particular strategies and methods are, ultimately, ideologically determined*" (page 2,Tones and Green, 2004). There

have been changes over time, taking account of political pressures and increased understanding. From the relatively narrow focus on individual behaviour change delivered through health education, health promotion became broader, encompassing community action and policy change (Naidoo and Wills, 1998). Policies produced by the Conservative government of the 1990s aimed to reduce health inequalities through encouraging individual behaviour change, whereas the subsequent Labour government targeted the reduction of health inequalities through developing health promoting partnerships between individuals, communities and government (Rifkin et al., 2000). A variety of reasons have been proposed in support of community involvement within health promotion, including, for example, the democratisation of health services and ensuring accountability (South et al., 2005). In the last few decades, health promotion has shifted again; tending towards disease prevention and risk reduction (deficit focussed), with, programmes targeting specific issues for example smoking cessation through individual focussed initiatives. The encouragement of health to become "everybody's business" has resulted in health promotion often becoming an additional part of many individual focussed, patient-practitioner consultations (Gott and O'Brien, 1990) rather than being delivered by health promotion specialists working at the population level.

The impetus to consider alternative methods of promoting health is fired by the limited evidence of the effectiveness of some existing deficit based interventions; there is concern that some initiatives may not work (Catalano et al., 2002) or have unwanted effects, for example the DARE program (Drug Abuse Resistance Education) with its "Just say no" message appeared to have no affect on drug use and reduced participants' self esteem (Duncan et al., 2007, Masterman and Kelly, 2003). There is growing evidence demonstrating that approaches focusing on the building of young people's social and emotional skills can have greater long term impacts than deficit based programmes (McNeil et al., 2012). As well as considering whether the focus of health promotion is the individual or community, there is also an issue as to whether campaigns focus on strength building (assets) or risk reduction (deficits); these concepts are further explored in chapter 3 *(page 36)*.

Professional role and personal involvement

As a consultant in public health, my main area of responsibility has been in children and young people's health. I had noted the improvement in health for infants and younger children but was frustrated that there had not been similar progress in adolescent health. Having spent almost 20 years in the NHS I had noted that the methods of health education and promotion had changed over time, with less participative, community focussed work and more emphasis on individual, didactic approaches. I was keen to discover whether assets models would provide an additional or alternative method to improve the health of young people

I was able to negotiate, as part of my public health training, a placement at the University of Hertfordshire (UH) and this provided me with the opportunity to analyse data from the Health Behaviours in School aged children study (HBSC), culminating in a paper analysing the association of assets with body image (Fenton et al., 2009). Keen to explore more about the potential of assets and positive health I then approached the HBSC team with my research question to gain access to the latest dataset. Due to the clustering nature of the data capture within the HBSC study I was aware that I might need some statistical support at the outset. I approached the UH statistician with my research question and plans for the analysis, he provided some technical support and I interpreted the resultant figures.

This study was conducted as part of the Doctorate in Health Research (DHRes) programme at the University of Hertfordshire. This programme is a professional doctorate which aims to develop students' professional practice through making a contribution to theory, practice and professional knowledge. The programme is delivered within a cohort structure, with several students learning generic research skills alongside each other in terms of the guided learning units, but also providing informal support outside the learning environment. Although the students in my cohort were all working on very different subjects, the moral support they provided was appreciated.

Research aims and objectives

The information within this chapter provides an important rationale for focussing attention on improving the health of young people in England; adolescents represent a large and growing segment of the population and their health does not appear to be improving at the same rate as younger age groups (Viner and Barker, 2005). Choices made during adolescence impact health now and into the future. Variation in health within the UK and between the UK and other countries suggest that there is room for improvement in how health could be promoted. Chapter 2 draws attention to the strategic interest in improving young people's health, whilst acknowledging that there is not necessarily agreement on the best policies to achieve this.

The Marmot review called for government to work with local areas to improve health outcomes by focusing on children and young people, concentrating on illness prevention and developing evidence-based solutions (Marmot, 2010). This research sets out to contribute to a refined understanding of how young people's health can be better promoted in England. A principal driver is to ensure that young people are involved with this research so that their views are captured; young people may have different views of health than adults and unless their views are incorporated within policy and practice, health promotion initiatives may not be effective.

The potential of a more positive approach to health promotion will be investigated by considering assets based models; an assets approach provides a possible additional or alternative method to overcome the stagnation seen in young people's health improvement within the UK. *(*These concepts are explored more fully within chapter 3 and provision of fuller definitions of the terminology provided there*, page 36).*

Aim

The overarching aim of the research is to construct an assets based model to shape health promotion practice and policy for young people in England.

Objectives

- To undertake a critical evaluation of existing assets models
- To identify which assets are associated with young people's health and well being in England
- To gain clarification of young people's perspectives of health and well being; understanding their views on assets and health promotion
- To discuss findings and implications for practice with relevant practitioners

Structure of this thesis

This introductory chapter set out the rationale for the research undertaken i.e. the need to find additional or alternative ways to improve the health of young people in England. This is then followed by a review of policy (chapter 2, *page 27*) and the guiding theoretical frameworks (chapter 3, *page 36*). The following diagram outlines the subsequent chapters, summarising the structure of the research and highlighting how research outcomes were utilised to develop this programme of research (Figure 3).

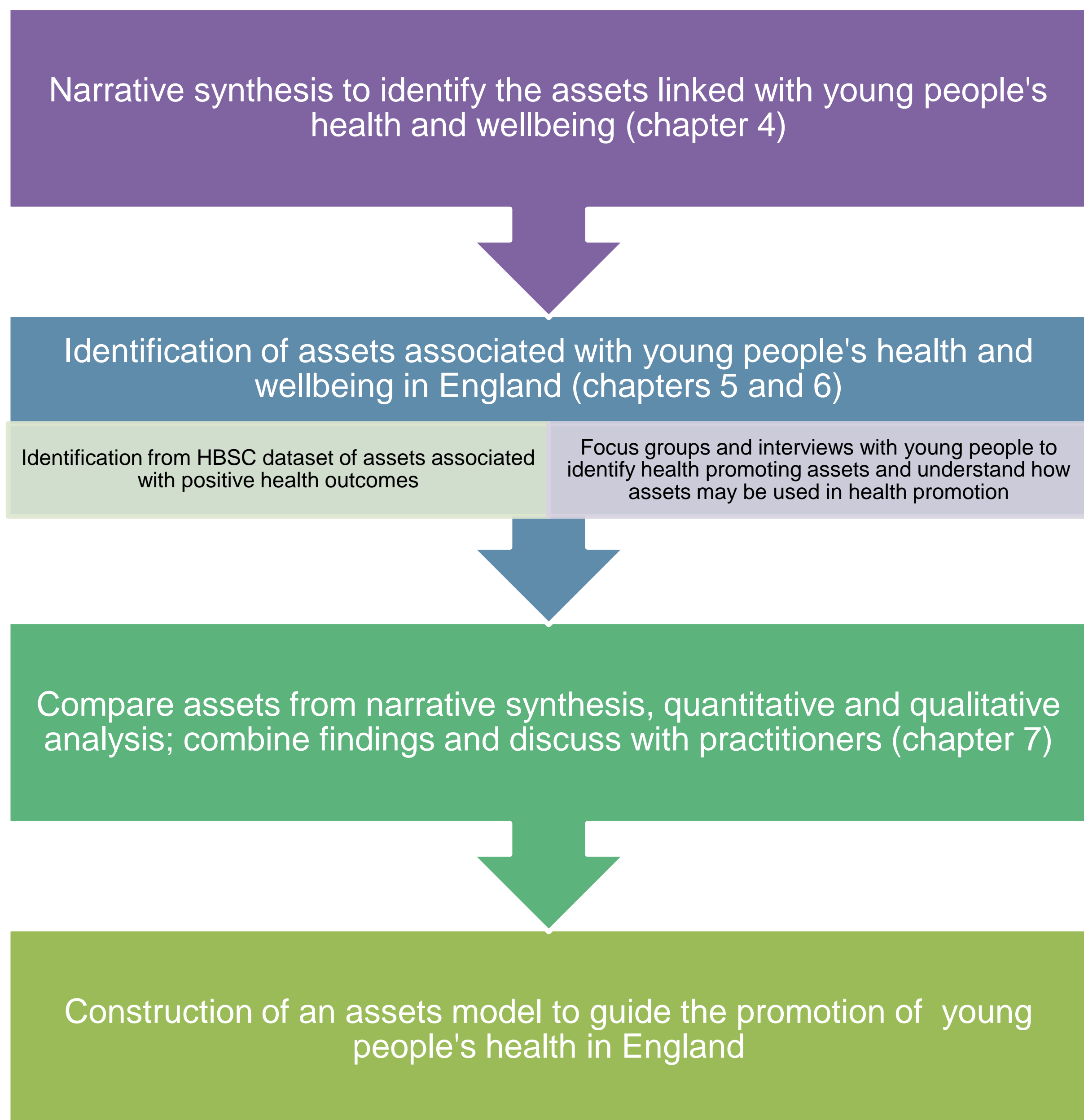

Figure 3: Structure of the thesis

In the next chapter (Chapter 2: Policy review, *page 27*), the policy context to this research is summarised. The governmental interest is explored to suggest reasons as to why there might be continued health inequalities for young people and stagnation in youth health improvement. This chapter proposes a need to investigate different ways of promoting young people's health so that these issues can be addressed.

The main focus of chapter 3 (*page 36*) is a summary of the theoretical concepts underpinning this research. A critical review of the literature is undertaken in relation to positive methods of promoting health. The shared territory between assets models and other concepts such as resilience, social capital and salutogenesis is explored. Definitions of assets and deficits are provided. As well as discussing assets approaches an overview is provided of the New Social Studies of Childhood to highlight why this research sought to include young people's voices and involvement.

In chapter 4 (*page 62*) a narrative synthesis summarises the knowledge and understanding currently available relating to assets models of youth health promotion. The initial plan was to identify existing effective interventions that could be employed in England to improve young people's health. However, due to the limited existent literature on assets based interventions, this was broadened to include theoretical propositions for assets approaches. The findings from the synthesis emphasize the limited knowledge that currently exists concerning the use of assets models to promote young people's health in England. The existing positive health promotion frameworks tend to be mainly founded on theoretical proposition rather than a sound evidence base built from empirical research. These suggest the type of initiatives that theoretically should promote positive health but without evidence from practice. The few that are based on experiential work tend to be found in the US and there is uncertainty that US models will result in the same effects when used in England; some other US interventions have required adaptation before use in the UK (Kipping et al., 2008). A list of potential assets was identified from the literature for consideration in an English context as well as two themes that might influence how health promotion strategies are developed. The lack of English information on assets highlighted the need for this programme of assets based research.

The methodology and methods chapter (chapter 5, *page 88*) provides details of the types of methods used to identify which assets are important to promote the health of young people in England. Justification is provided of why a mixed methods approach was taken. This chapter provides detail on how the empirical work was carried out. In terms of the identification of assets, a quantitative approach was taken to ascertain the most prominent assets associated with positive health for young people in England. This strand of the research employed regression analysis using data from The Health Behaviours in School Aged Children Study (HBSC[2]). The review of policy and literature within chapters two to four identified that young people's involvement appeared lacking and therefore qualitative methods were employed to address this with the aim of gaining an understanding of young people's views. Focus groups and interviews were used to discover which assets might promote health, the processes linking assets to health and to identify which might take priority for health promotion initiatives. Practitioners were also consulted on the potential for an assets approach. Research outcomes were used to develop the research programme. Within the chapter, there is also exploration of issues pertinent to including young people in research, commenting on ethics and confidentiality ("Researching with and for young people", *page 93*).

In chapter 6 (*page 131*) the findings from the quantitative and qualitative analyses are reported. The findings are brought together for discussion in chapter 7 (*page 166*). In this chapter the potential for an assets based approach to health promotion with young people in England is discussed. The assets discovered by this research are compared with the available literature and between the different research strands to identify which are the core assets to promote young people's health. The consolidation of findings resulted in the contribution of a theoretical model to guide health promotion practice and policy. This is discussed with relevant practitioners in terms of its application to practice. Chapter 8 (*page 208*) provides a conclusion to the research, considering the contribution to knowledge that the research has made, proposing implications for policy, the dissemination of findings and suggestions for further research.

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[2] http://www.hbsc.org/ Accessed 30/7/12

Chapter 2: Policy review

Introduction

The introductory chapter summarised the statistics that underscore why young people's health improvement is an area worthy of specific in-depth consideration. Whilst the health of babies and children appear to have improved over the last few decades there is a corresponding plateau in young people's heath. This chapter summarises significant policies that provide some potential explanations for impacts on, and variations in, young people's health. A life course approach is taken in this section acknowledging that young people's health is influenced by a culmination of policies from those focussing on early intervention with infants, those delivered through schools and those directed at teenagers. This chapter demonstrates that government initiatives are often targeted at a single problem, risk factor or group and explores the potential repercussions of this approach.

The UK policy context

> "*Social policy is typically directed at reducing or preventing problems, and not ordinarily to promoting positive outcomes*" (page 839,Porter, 2010).

Since 1974 Health and Education have been managed separately in two distinct government departments. Services for children and young people are often fragmented with limited liaison between the different organisations and staff. The introduction of the use of "Common Assessment Frameworks" (CAF[3]) aimed to amalgamate the information held by school and health staff and yet the focus tends to be on identifying vulnerable children or problems. Although CAF aimed to link up health and education departments, the focus has been on preventing problems from worsening rather than to stop such problems developing.

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[3] https://www.education.gov.uk/publications/standard/EarlyYearseducationandchildcare/Page5/IW91/0709 This is non-statutory guidance, originally published by DfES in 2006. On 1 October 2006, the Children's Workforce Development Council (CWDC) took over responsibility from the Department for Children, Schools and Families (DCSF) (previously DfES) for the implementation of the toolkits and guidance, however, the CWDC closed on 31 March 2012. Its key work and publications have transferred to either the Teaching Agency or the Department for Education.

In 1980, the Inequalities in Health Report advocated tackling the broader determinants of health to reduce the health inequalities gap (Department of Health and Social Security, 1980); one recommendation being that children were given a better start in life. The focus on the provision of a healthy start to reduce the health inequality gap was supported by recommendations set out in the Acheson report, "Independent inquiry into inequalities in health" (Acheson, 1998). This emphasis on starting early and concentrating on prevention was continued by Derek Wanless a few years later (Wanless, 2002). In considering the future of the health service, the Wanless review in 2002 set out to demonstrate that the best health outcomes over the next 20 years would be achieved by the "fully engaged" version, where the public is confident regarding the quality of the health system and levels of public engagement is high. To achieve this for 2020 would require health improvement and engagement with today's seven million young people. Yet despite these policies and strategies, the health of young people in the UK still provides cause for concern; whilst there have been improvements in many child health outcomes, it appears that the impact on adolescent health has not yet been felt. Graham Allen states that one reason for this lack of progress is that:

> "*the provision of successful evidence-based Early Intervention programmes remains persistently patchy and dogged by institutional and financial obstacles*" (page vii, Allen, 2011).

He suggests that public funding be used more effectively and other sources of finance sought from charitable and private organisations. The case is made for investment now to reduce the financial impact of underachievement for the future.

The 2010 report by the Audit commission states that Children's health has been an increasing priority for governments over the preceding ten years. However, even after substantial investment in health improvement programs, some indicators have worsened, for example dental health and obesity (Audit Commission, 2010). The "Every Child Matters" (ECM) agenda[4] established five key outcomes for children and young people aged 0-19 years; the first was "Being Healthy" (Department of Education & Skills, 2004). These outcomes were woven into policy across

[4] ECM has been archived since the coalition government took office in 2010.

government departments and embedded within the strategies of all organisations involved with children, for example, hospitals, Primary Care Trusts, schools, police forces and voluntary groups. It is troubling that, with this level of political interest and range of strategies, there are still poor health outcomes for some UK young people. One critique of ECM has suggested that it is the focus on "symptoms" of ill health, such as teenage conceptions, that has distracted those tasked with delivering, from addressing the broader underpinning issues (Hoyle, 2008). One of the issues highlighted by the Audit Commission was the continued health inequalities gap between children from rich and poor families (Audit Commission, 2010); without addressing these material inequalities it is likely that poor health outcomes will continue into adolescence.

The previous government acknowledged that something needed to be done to improve young people's health and a multitude of strategies and polices were produced which set out to influence children and young people's health. The Children's Plan set as one of its goals for 2020 to "*enhance children and young people's wellbeing*" (Summary, page 19, Department for Children Schools and Families, 2007). The Children's Fund, the Connexions Programme and the Youth Inclusion Programme, all aimed to target and assess "problem youth", smooth their transition to adulthood and prevent future problem behaviours (France, 2004). However, it could be argued that these programmes, strategies and policies still left notable gaps; several of these are discussed below to provide examples within recent UK policy. Although on the surface these documents provide strategies to improve young people's health, they continue to draw attention to the problems with youth and their behaviours.

The Healthy Child Programme **"***sets out the good practice framework for prevention and early intervention services for children and young people ... and recommends how health, education and other partners working together across a range of settings can significantly enhance a child's or young person's life chances***"** (page 10, Department of Health and Department for Children Schools and Families, 2009). In the first chapter of the strategy for 5-19 year olds it is stated that lifestyles and habits picked up through childhood and adolescence influence a person's later health; the document highlights in particular the risks associated with obesity, alcohol

consumption and sexually transmitted infections. It talks of the risks to individuals of adopting behaviours which "*store up problems*" for their adult health (page 11, Department of Health and Department for Children Schools and Families, 2009). As well as reducing negative outcomes, such as poor management of chronic conditions, incidence of infectious diseases and bullying, it also aims for improvement in broader health and wellbeing outcomes such as higher life satisfaction and participation in positive activities. Although the programme has great potential to improve outcomes, the focus remains one of early intervention to avert trouble, stop problems taking hold or becoming intractable rather than looking to the positive and indicating what can be done to support the creation of health. Unfortunately, many of the ideas mentioned within the programme have since either been downgraded, for example "You're Welcome[5]" or been dropped completely, for example, "ContactPoint[6]". Within the Healthy Child Programme there appears less prominence placed on the benefits to young people now of being healthy, though one example is given by Health Promoting Schools which emphasises how poor nutrition in childhood may affect adult health but also stresses the benefits on learning and development from good nutrition for children now (Dixey et al., 1999). The "Healthy Schools" initiative in England was re-launched in 2011 with new materials made available to schools[7]; however, support from government waivers, during 2012 the initiative was seen as less of a priority, but has recently been reinstated with another re-launch planned for April 2013.

The Aiming High ten year strategy celebrates successes such as participation and attainment in learning but agrees that there is more to do (HM Treasury and DfCSF, 2007). One example includes the disparity in education achievement between young people from affluent and deprived backgrounds; amongst disadvantaged young people there are relatively high levels of poor mental health, increasing levels of obesity, rising incidence of sexually transmitted infections and higher levels of "high risk behaviours" (which are listed as substance misuse, early sexual intercourse and underage alcohol consumption). The failings or risks identified are very much at the

[5] These are quality criteria to assess how "young person friendly" services are. The DH website states that from March 2011, the "You're welcome" process is locally led
[6] This was going to be an online database which stored information on children up to their 18th birthday to facilitate sharing of information amongst all practitioners that worked with children
[7] http://www.education.gov.uk/schools/pupilsupport/pastoralcare/health/a0075278/healthy-schools Accessed 2/11/12

level of the individual, they also tend to be quite visible, such as drug and alcohol use or teenage pregnancy. Methods of improving health and narrowing differences in health inequalities are listed as including encouraging a positive approach to young people across society, increasing participation in positive activities and empowering young people to have more influence over the services provided for them. Examples are provided of initiatives to promote positive community activities such as the Bradford Youth Development Partnership (page 19, HM Treasury and DfCSF, 2007). Whilst focus is on trying to fix the visible problems, targets and indicators are set around "risky" behaviours which often results in reactive, short lived and targeted programs rather than longer term interventions to understand and influence the wider determinants of such social and health issues. The focus in publications produced for "Youth and Adolescence" since the coalition government came to power in 2010 has included educational attainment, teenage pregnancy and drug use; the Department of Education's website tellingly lists positive activities as 5th on the list of categories for young people's policy following NEET (young people "not in education, employment or training"), alcohol and substance misuse, teenage pregnancy and youth crime.[8]

The Children's Plan mentioned the Youth Taskforce as a way of introducing change. This taskforce's Action Plan concentrated on targeting those young people seen as problematic;

> *"A significant minority of young people can get into trouble with alcohol or illegal drugs, persistent truancy, or other unacceptable or anti-social behaviour – causing serious problems in their neighbourhoods. The Youth Taskforce will concentrate on this group of young people"* (Foreword, page 1, Department for Children Schools and Families, 2008).

However, there was notably little focus on how to improve these young people's lives but rather talk of "tough enforcement", support for overcoming problems and prevention of behaviours becoming entrenched. Out of the 18 actions discussed, only three could be seen as positive development; one talked of capital funding to improve youth facilities, another of increasing young people's participation in positive

[8] https://www.education.gov.uk/publications/standard/Youthandadolescence/Page1 Accessed 2/11/2012

activities and another promoted interaction between young people and other sections of society. The DfCSF became part of the Department for Education in 2010 with the change of government; many of the ECM associated programmes were archived at this time.

"Positive for youth" was the coalition government's first statement on young people, bringing together all of the Government's policies for the age group 13-19 (HM Government, 2011). Although the document sets out how the Government's policy aims to support all families and improve outcomes for young people there is still a focus on the most disadvantaged young people, for example, one of the most high profile initiatives launched by the Prime Minister in 2011, was the Troubled Families programme[9] which aims to target 120,000 families, to improve school attendance, reduce antisocial behaviour, reduce parental worklessness and ultimately reduce costs to the public sector.

Many of the national policies and strategies mentioned above have similarities; one of the most striking is the emphasis on prevention of problem behaviours. The continued negative attention through targeting "risk groups" or "risk behaviours" has an effect on young people and their communities. (A summary of issues regarding how children and young people are viewed is given later*, "*Children in UK society*", page 52)*. The previous Government acknowledged that they might have added to the current negative perception of youth;

> "*rather than presenting a positive vision for youth development, national priorities and local services have been organised and targeted around avoiding and addressing problems such as crime, substance abuse, or teenage pregnancy*" (pages 4-5, HM Treasury and DfCSF, 2007).

There was also recognition in The Children's Plan that "*too often we focus on the problems of a few young people*" (Summary, page 16, Department for Children Schools and Families, 2007). This could be seen as a cyclical relationship, whereby targeting such behaviours stress their prevalence and cause more awareness in society. In light of political and social pressure to tackle such visible problems as crime and teenage pregnancy; promoting positive development or issues such as

[9] https://www.gov.uk/government/policies/helping-troubled-families-turn-their-lives-around Accessed 4/2/13

self esteem may be seen as too ephemeral. It is also difficult to quantify success due to lack of validated positive outcome measures.

In planning initiatives, government makes a choice between universal interventions affecting all in society and those targeted at individuals; this could be seen as indicating where responsibility for any problems lie. Whilst the concept of youth is promoted positively in the media (for example the idea of "anti ageing"), young people themselves are often portrayed negatively; for example, 98% of young people believe that the media depicts them as anti social (YouthNet and the British Youth Council, 2006). Initiatives to promote community safety might, for example, include improved street lighting (as a universal resource that all benefit from) or targeting young people to stop them loitering in public places which both stigmatises young people and generates negative connotations associated with their behaviours. Strategies and policies that build on the strengths of young people would counteract this negative imagery.

Policy developments have often focussed extensively on young people's future self, such as Educational Maintenance Allowances[10] or the New Deal for Young People[11] (Jones and Bell, 2000). Similarly, many of the interventions aimed at tackling social exclusion also concentrate on children as "future workers", with interventions being seen as an investment in the future workforce (Evans and Pinnock, 2007) focusing on improved educational outcomes and subsequent increased chances of employability (Williams, 2004). Such policies appear to place less value on young people's current wellbeing. However, there are signs that this might be changing; the Children's Plan stated: "*children and young people need to enjoy their childhood as well as grow up prepared for adult life*" (page 5, Department for Children Schools and Families, 2007). "Positive for youth" has also included extensive participation of, and consultation with, young people to ensure policy reflects what is important to young people now (HM Government, 2011). The New Social Studies of Childhood

[10] Educational Maintenance Allowances supported young people from poorer backgrounds to stay on post 16 to study; introduced by the Labour government it was withdrawn from use in England in 2010, though is still available to young people from Wales, Scotland and Northern Ireland. Post 16 study is now mandatory in England with bursaries available to support some young people https://www.gov.uk/education-maintenance-allowance-ema Accessed 4/2/13

[11] The Jobcentre Plus New Deal for young people (aged 18-24) aimed to help young people find and keep jobs; this scheme was replaced in 2009 by the Flexible New Deal programme and then withdrawn in 2010 to be replaced by "The Work programme" in 2011 http://www.dwp.gov.uk/policy/welfare-reform/the-work-programme/ Accessed 4/2/13

conceptualise the child as a member of a specific generation with current needs, rather than considering the child as requiring development into a future healthy adult (James et al., 1998). The impact of the New Social Studies of Childhood will be discussed later in this research (Chapter 3*, page 52*). Overall, however, a balance needs to be achieved between considering what young people require to support their current health needs and determining what is needed for their future growth and development.

Concluding comments for this chapter

The apparent stagnation in young people's health improvement was described in chapter 1 and evidence provided of the inequalities in health that exist. This has occurred despite the substantial interest and investment by government since the turn of the century. This second chapter has reviewed policy from the last couple of decades to suggest reasons as to why this might be the case, exploring issues and challenges from the recent political context which might inhibit improvement in young people's health and wellbeing. Much governmental youth policy has been directed at tackling those behaviours that put young people at risk of non-achievement or future health problems; there appears less emphasis on the benefits to young people now of being healthy. It has been suggested that:

> "*public policy is regularly blind to adolescents, except on occasions when their actions make adults uneasy*" (page 781, Benson et al., 2004).

This seems to be borne out in UK policy where interventions often appear to be directed at individuals or "problem" groups and although well-meaning this has not improved the health of young people universally. The focus on trying to fix visible problems has resulted in short lived, targeted initiatives, rather than longer term interventions that aim to influence the wider determinants of health or tackle inequalities. Whilst the targeting of initiatives may have unwanted outcomes, such as disengagement and stigmatisation, it has also been suggested that it is an ineffective method of reducing health inequalities. Within "Fair Society, Healthy Lives" there was recognition that focusing solely on the most disadvantaged would not reduce health inequalities sufficiently, but rather a universal approach should be taken, with a scale and intensity proportionate to the level of disadvantage; this was termed proportionate universalism (Marmot, 2010). The findings from the review of policy

suggested that additional or alternative approaches to improve the health and wellbeing of young people should be considered.

Chapter 3: Review of key theoretical concepts

Introduction

There appears a deficit focus prevalent in much of current youth policy. The findings from the policy review influenced the theoretical perspectives chosen to guide this research. The first part of the chapter explores a more positive approach to health improvement. This first section summarises the main aspects of asset and deficit approaches; critically exploring their advantages and disadvantages. Focus then moves to the New Social Studies of Childhood outlining aspects of working with young people, the potential benefits this brings to young people themselves, research and policy. Whilst the influence that these concepts have on the shaping of this research is discussed within this chapter, a wider examination of methodology occurs in chapter 5 *(page 88*).

Theoretical perspectives: asset models

Assets models may be relatively new in terms of terminology but bring together many existent positive approaches to health (Preface, pages ix-x, Morgan et al., 2010). Four of the models and frameworks which are most relevant to this study are examined below.

Terminology and definitions

There is no current consensus in the construct "developmental assets"; however, many researchers tend to group assets into those that appear linked to the individual and then those based in the broader community (Wang et al., 2011); sometimes termed internal or external assets (Search Institute, 1997, 2006). The focus below is on aspects relevant to young people; for example assets that help promote young people's health, support development or that protect youth as they gain independence.

Assets

Health promoting assets may be thought of as protective factors; promoting health, offsetting risk or adding value to a life where the negatives cannot be deleted or reduced. Assets have been identified as providing adolescents with a level of resilience that may help them both cope with, and buffer them from, negative influences (Benard, 1991). As well as protecting against negative outcomes, assets may also be thought of as promoting health (Fisher, 2011). Assets may include such factors as a supportive family, a network of friends, community cohesion, safety, opportunities to volunteer, employment, pleasant environment, secure housing and self esteem (Search Institute, 1997, 2006, Kawachi, 2010).

Deficits

Deficits may be seen as risks or risky behaviours which impact negatively on health. A deficit approach focuses on reducing risk or risky behaviours in order to improve health. For example, smoking is acknowledged as the main risk factor for lung cancer and the health promotion initiatives around reducing cases of lung cancer therefore focus on smoking cessation. Deficits may be specific, such as smoking, or broader, for example, a lack of engagement with services.

Key aspects of deficits and assets approaches

Deficits approach

A deficit approach to health promotion defines an individual or community by those things it is lacking, indicating their deficiencies and problems. These models have a role in identifying levels of need and priority within communities. This has been useful in highlighting where investment or intervention was needed. However it has been argued that taking this approach relies on waiting for people to “fail” before implementing an intervention (Edwards et al., 2007).

A deficit approach often starts by analysing data to identify target groups to receive an intervention. However, the continued attention given to need has been demonstrated to create communities that decrease their sense of self reliance and instead take on the role of clients (Kretzman and McKnight, 1993). There also starts an expectation that they will require specialist services or help to access existing services. The community may feel:

"*disempowered and dependent; people can become passive recipients... rather than active agents*" (page 6, I&DeA, 2010).

Unfortunately, labelling often becomes self-perpetuating – young people are labelled as problems to be fixed, specific interventions are targeted toward them which increases their view of themselves as needy or requiring "special measures" and this disempowers them further, which may lead to disengagement with, or distrust of, health and social care agencies.

There is a concern that the defining of risk and/or labelling of groups of young people "at risk" is dependent on, and determined by, the dominant culture (Howard et al., 1999). There is an ethical and moral issue as to who defines what is normative behaviour and therefore what is risk. The groups of young people and sometimes their families identified as being "at risk" are often required to change their behaviours to fit the prevailing culture (Goodlad and Keating, 1990). The idea of whether public health is seen as "nanny state" intervention or rather "stewardship" shaping individual choices within a health improvement framework has been debated (Jochelson, 2005).

There is disquiet amongst health and educational professionals in relation to the potential stigmatizing effects of labelling communities as disadvantaged or needy. This is enforced through the continued targeting of "problem" groups. Some positive youth development work, although taking a different stance from traditional deficits based public health, often still identifies risk groups to work with (Wiggins et al., 2009). As risk behaviours or risk factors often co-exist, similar groups may be targeted by several initiatives or organisations; the "silo effect" of considering problems as isolated and unrelated has been criticised (Hamilton, 2006).

The implementation of a multitude of deficit interventions also raises issues of sustainability. There has been a call to public health to stop focussing on single issue approaches (Catalano et al., 2002) and instead develop practice that focuses on common protective factors (Viner and Barker, 2005). In part this is due to a better understanding of the common antecedents that many risk behaviours share (Hale and Viner, 2012).

There is a risk that young people may become resistant to health messages if they are always construed as telling them not to do something; this may in part be due to the idea of deprivation of an individual's freedom to choose their behaviours (Wang et al., 2011). A reaction to this may be that messages are ignored or reacted against; outcomes may result that oppose health professionals' intention (Whitehead and Russell, 2004). Acknowledging young people's need for independence and control is one step towards building more effective health promotion initiatives.

Assets approach

Whilst deficit models tend to view individuals and communities in negative terms, assets models provide a counter balance, accentuating the positive and identifying capability and capacity at the level of the individual, organisation, community, or population (Morgan and Ziglio, 2007). An assets approach starts by reflecting on what is working well within a group or community so that this can be built on. This may be by asking questions such as:

- "*What makes us strong?*
- *What makes us healthy?*
- *What factors make us more able to cope in times of stress?*
- *What makes this a good place to be?*
- *What does the community do to improve health?*"

  (page 8, I&DeA, 2010)

Asset approaches link with concepts such as resilience, social capital and salutogenesis. Assets models provide potential to challenge health inequalities through strengthening existing community networks and building on local experience. As such, the assets approach is not a new way of thinking but rather a new way of managing thinking, bringing together previous concepts in an overarching model; this idea is illustrated in the figure below (Figure 4*, page 40*). The diagram captures how many similar theories are linked by assets approaches[12]. Three of these concepts (Sense of Coherence, resilience and social capital) are discussed later in this chapter; their commonalities and theoretical underpinnings are explored in more detail.

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[12] http://www.salutogenesis.hv.se/eng/Related_concepts.8.html
Accessed 10/2/13. Diagram included with agreement from Monica Eriksson, received by email

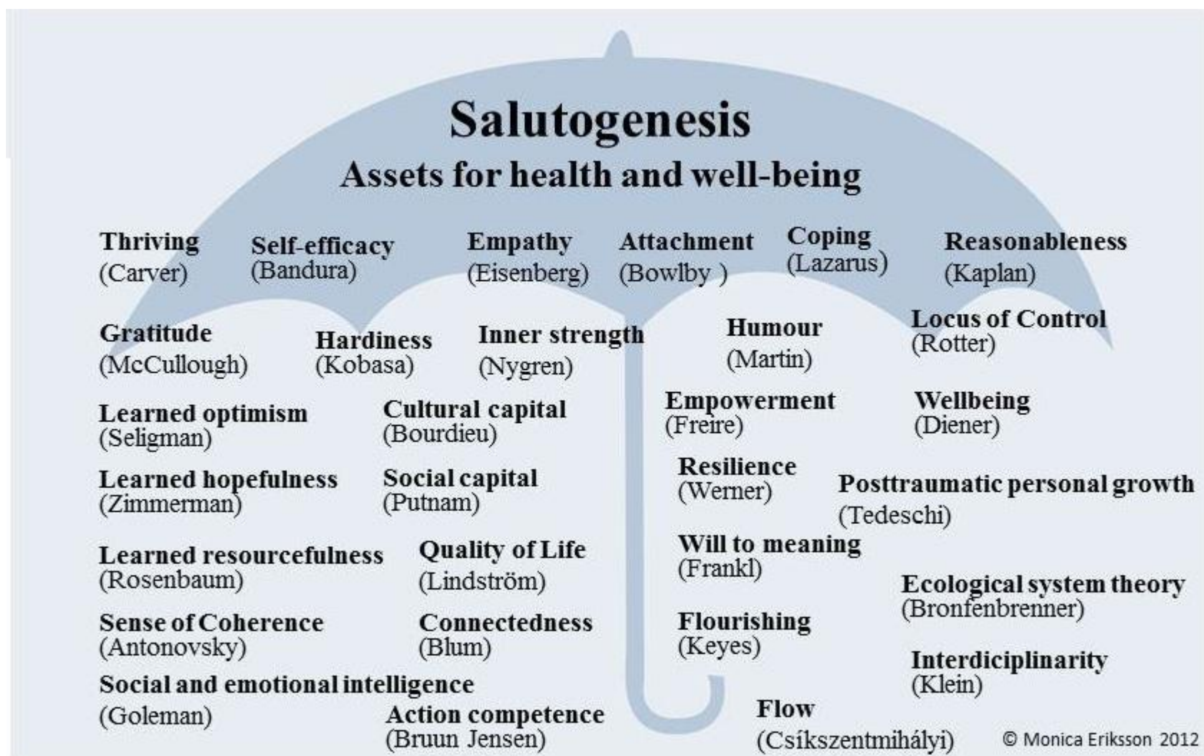


Figure 4: Assets approaches

Relationships between assets and deficits

An assets approach is more than just a flipside of a deficits model. Most individuals and their communities will have both assets and deficits; the two are not proposed as being mutually exclusive.

Rutter argued that to understand resilience one needed to understand the processes and mechanisms that produce resilience. Otherwise it was merely a case of semantics, with protective factors simply being the antonyms of risk factors (Rutter, 1990). Early work that looked at which factors could protect young people from negative outcomes (Resnick, 2000) has been progressed to look at which factors may actively promote health or wellbeing. Salutogenesis also considers the processes involved in improving health as well as which assets are associated with positive health and wellbeing (Antonovsky, 1979).

Morgan (2006) suggests that an assets based approach adds value to the deficits approach in three ways:

1. The population becomes seen as a co-producer of health rather than a consumer of scarce resources
2. The ability of individuals and communities to achieve their health development potential is strengthened
3. The process of community development is likely to also impact social and economic aims

Further advantages are highlighted in the introduction to the Improvement and Development Agency's report "A glass half full"; it is stated that an assets approach:

> "... *has the potential to change the way practitioners engage with individuals and the way planners design places and services. It is an opportunity for real dialogue between local people and practitioners on the basis of each having something to offer*" (page 4, I&DeA, 2010).

An assets approach therefore suggests a different way of working with individuals and their communities.

To better understand assets models the theoretical underpinnings and historical development of assets based approaches will be explored.

Theoretical underpinnings of the assets based approach

An assets approach is not new. It builds on related concepts that have aimed to understand how health is created or promoted. The frameworks in existence can be summarised by grouping them into those that focus on "internal assets", "external assets" or a mixture of both; the discussion below starts by considering those focussing on mainly "external", then "internal" and moving on to those models which incorporate both. The following frameworks and theories are those which appear most often in the assets literature:

- Social capital – external
- Resilience – mainly internal
- The Search Institute's developmental assets framework – internal and external
- Salutogenesis – bringing internal and external assets together to promote health

In the following section, these theories and frameworks will be critically examined, with consideration given to history and existing literature. The links between these related concepts and assets models are investigated, with shared ground and any gaps indicated.

Social capital: mainly external assets

Although the term "social capital" is relatively modern, the idea can be traced back to both classical sociology and economics (Hawe and Shiell, 2000). Social capital refers to the "*features of social organization such as networks, norms and trust, that facilitate coordination and cooperation for mutual benefit*" (page 66, Putnam, 1995). A person's health and wellbeing is affected not only by the social and community context in which they live but the relationships and social networks that exist within those settings (Campbell, 1999). Social capital highlights the two-way benefits between an individual and a supportive community and has clear links with the concepts of resilience and salutogenesis.

Empirical studies have linked social capital and health at four different levels; macro-social, meso, micro, individual (Kawachi, 2010). At the macro level, it has been argued that those societies with the most equal distribution of incomes, tend to be more cohesive and healthier (Wilkinson, 2005). The meso level considers the impact of settings such as neighbourhoods, schools and workplaces on health. Social networks, friendship circles and the role of family are included at the micro level. Social participation, volunteering and perceptions of trust are considered at the individual level.

There are issues in terms of measurement, whether social capital should be measured at macro level (for example, social structures or environment quality) or at the micro level (via, for example, attitudes or behaviours). Within the research literature, social capital is often considered at a geographical level defined by administrative boundaries rather than bearing a close relation to the communities or networks that people live within (Popay, 2000). The heterogeneity in measurement approaches to assess social capital has been noted in a systematic review of the social capital literature (Kawachi, 2010). Although it might be difficult to promote or alter social capital, being able to measure it and determine where it is low might help

with implementing targeted health promotion activities for young people deemed “at risk”. (Boyce et al., 2008).

There are connections between social capital and other assets approaches, for example, social capital may be thought of as an asset as it acts as a potential resource for society. There are alignments between aspects of social capital and some of the Search Institute’s developmental assets (Morgan, 2010). Social capital could also be seen as an example of an aggregated salutary factor and, as such, links with salutogenesis (Kawachi et al., 1997, Lomas, 1998). Antonovsky’s view of population based health promotion interventions echo the wider determinants of health model by considering the settings that could improve health (Antonovsky, 1987). It has been argued that health promoting interventions should target the social and cultural conditions that influence health and wellbeing (Frohlich and Potvin, 1999, Corin, 1994). This reflects the WHO’s settings based approach for health promotion programmes; for example, “Healthy Schools” and “Healthy Cities”.

Although the social capital literature has expanded over the last decade, there remain gaps in current understanding. Whilst some studies have looked at young people’s health in relation to neighbourhood social capital, for example, linking the building of social cohesion with improved health and wellbeing outcomes for young people (Edwards and Bromfield, 2010), the measurement of social capital is usually at an adult level (Kawachi et al., 1997, Khawaja et al., 2006, Drukker et al., 2003). Associations have been identified between low social cohesion and dropping out of school (Coleman, 1990), high levels of social capital and high behavioural and development scores (Runyan et al., 1998) but some have criticised this as a reductionist view of child wellbeing, with the use of such measures not fully describing child health (Blair et al., 2010). Some of the measurement issues related to young people and social capital are being addressed; for example, recent work has demonstrated a link between social capital and health and wellbeing, with both assessed through young people’s self report (Brooks et al., 2012).

Further research is needed in terms of application to practice (Morgan and Haglund, 2009). Social capital is thought to develop very slowly in communities and cannot be manufactured, although it may be possible to accelerate its development (Boyce et al., 2008), particularly through urban design (Sauter and Huettenmoser, 2008).

There appears a lack of social capital research directly targeted at interventions for young people.

Resilience: mainly internal assets

Dissatisfaction with the deficits model within education gave rise to research in the 1950s into more positive approaches (Howard et al., 1999). Concerns with a deficits model within education included issues such as failure to "resolve" problem children (West and Farrington, 1973), lowering of teachers' expectations for labelled children (Soodak and Podell, 1994) and normative labelling (Goodlad and Keating, 1990). Deficit approaches did not seem to be working and an alternative method was needed that would help work with individual and systems' strengths. This links closely with the psychiatric research into invulnerability and resilience (for example, Garmezy, 1985, Werner and Smith, 1988). As a concept, resilience dates back to the 1970s with research into specific populations of children following shortly after (Dryden et al., 1998). Both educational and psychological research highlighted that, although "bad" experiences often had "bad" effects on health, there was evidence that this was not the case universally; there were those who survived not just unscathed but often flourishing.

Research therefore turned to identify the factors and processes that would act protectively. Rutter describes protective factors as:

> "...*influences that modify, ameliorate, or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome*" (page 600, 1985).

The concept of adversity or environmental hazard may include socioeconomic disadvantage, poor living situation, genetic or biological risk factors amongst others. The factors that were identified through the resilience research highlighted the importance of the process and the interactions that occurred rather than just "obtaining" some type of asset.

The idea of resilience in the face of adversity is primarily thought to be due, not to some sort of personality attribute, but rather to a "*dynamic process of positive adaptation*" (page 22, Schoon and Bynner, 2003). The process may be captured by considering an individual's ability to adapt, or their success (through educational

achievement, for example) or by measuring certain protective factors. A protective factor is not necessarily due to a positive experience; going through something that was difficult or stressful may provide the individual with coping mechanisms that could be used to mitigate future problematic situations. Stress or bad experiences are therefore not automatically to be avoided but rather encountered in a way and at a time that allows self confidence to grow through dealing with the experience and coming out the other side unscathed (Selye, 1956). Being able to deal with and manage difficult situations can increase confidence;

> "*the more time an individual has spent in a capability producing environment, the greater the resilience they are able to carry forward to meet the next challenge*" (page 105, Bartley et al., 2010).

This suggests that one should not seek to eliminate all risks from young people's lives but instead ensure that they are provided with the resources and support to handle and negotiate such circumstances (Coleman and Hagell, 2007, Compas, 2004). It is identifying which protective factors are needed and how young people can make use of these that is important in understanding the process of resilience.

In 1979, when little evidence existed regarding protective factors, Rutter suggested that explanations would probably include

> *"the patterning of stresses, individual differences caused by both constitutional and experiential factors, compensating experiences outside the home, the development of self esteem, the scope and range of available opportunities, an appropriate degree of structure and control, the availability of personal bonds and intimate relationships, and the acquisition of coping skills"* (page 70, Rutter, 1979).

Rutter believes that subsequent research has broadly confirmed this list (Rutter, 1985). Protective factors have been identified at individual level, within characteristics of family and also within the wider social context (Schoon and Bynner, 2003). However, to understand the processes which occur, a comprehensive assessment of resources at each level would be needed, alongside consideration of the impacts of intervening at the three different levels, individually or addressing more than one level at a time. It is felt that the long term processes

through which factors impact on development and how the effects accumulate over time are less well understood (Schoon and Bynner, 2003). Rutter calls for systematic testing of the "*longitudinal chains*" within protective processes (page 606 1985). Understanding how a protective factor works, the timing and setting needed, would be important in relation to any health improvement initiatives that aimed to manipulate such factors.

The resilience literature has suggested important information in terms of the protective factors or assets that are integral to positive health for young people. However, most resilience research appears to have been based on young people deemed to be at risk. There may be issues as to the generalisability of protective mechanisms or factors that may work universally for all young people rather than solely those "at risk". Other potential issues regarding the resilience literature includes the considerable cross study variation in the definitions of resilience used, different emphasis on risk and protective factors, and different outcomes considered which may cause difficulties in comparing findings (Fergus and Zimmerman, 2005, Olsson et al., 2003). In terms of further research there are concerns regarding the development of a measurement instrument which could assess a range of protective mechanisms that operate in multiple domains. Such an instrument would need to be sufficiently sensitive to pick up differences in individual's developmental levels and the interactions which occur between individuals and their domains. There is also a lack of clarity as to how risk and protective processes work together (Olsson et al., 2003). These measurement and definition issues are also present in other assets approaches. A recent review of resilience measurement scales, for example, concluded that there is "...*no current gold standard*" and yet a reliable and valid measure is needed to evaluate interventions and policies (page 1, Windle et al., 2011).

The Search Institute's 40 developmental assets: internal and external

In reviewing the literature on assets models and health promotion, the Search Institute has made a significant contribution to the field. (The Search Institute is based in Minneapolis in the US). The idea of developing an assets model came from the view that it is better to concentrate on the positives that a society want for their youth rather than continuing to emphasise the risk behaviours one wanted to avoid. This resulted in a list of 40 developmental assets (see the summary table, Table 2*,*

page 59). This model has links to the “Positive Youth Development” (PYD) movement in the US (Lerner et al., 2005) which acknowledges the disadvantages of focussing on prevention and is summed up by the often quoted “*problem free is not fully prepared*” (Pittman et al., 2002).

The list of 40 developmental assets was decided upon following a range of workshops and discussions with secondary school aged young people, parents and policy makers. Since 1989, The Search Institute has conducted numerous studies of several hundred thousand school students across the US using a survey entitled “Search Institute Profiles of Student Life: Attitudes and Behaviors”. This tool measures 40 developmental assets, eight indicators of thriving behaviours and risk behaviours such as young people’s use of alcohol, tobacco, and marijuana. Schools or communities pay to use the survey and have results turned into a report which identifies strengths and areas for development. The reliability of the survey questions in measuring assets has been described as “*generally adequate but in some cases could be better*” (page 116, Scales, 1999).

The framework is not without its critics (Howard et al., 1999, Price and Drake, 1999). One of the criticisms of developing a checklist of “developmental assets” is that it creates a view that any person, irrespective of where they are from socially or geographically, can succeed if only they obtain all these things. It is very much at the level of the individual, which has been a criticism of deficits approaches. The method of counting assets parallels with the deficits approach that it is supposed to offer an alternative to, in that it looks to identify which assets are missing. It also detracts from the wider importance of building supportive communities, families and schools. It highlights the current need for simple quick fix solutions, targeted interventions rather than looking at longer term, sustainable systems. It could be argued that this is the flipside Rutter (1990) argued against. Additionally, the thriving and risk behaviours included could be viewed as normative and adult-centric; many young people will undertake such “risk” behaviours as part of their growing up.

Salutogenesis: internal and external assets

Salutogenesis emphasises those factors that contribute to universal health and well-being. The term salutogenesis was coined by the sociologist Antonovsky as meaning "*the origins of health*" (Antonovsky, 1979). Aaron Antonovsky (1923-1994) was a professor of medical sociology at the department of Sociology of Health at the Faculty of Health Sciences at the Ben-Gurion University in Israel. Antonovsky used the narratives of the survivors of the Holocaust to develop a theory concerning how people were able to maintain good health despite having gone through the horrors of concentration camps.

Conventionally, health research has considered stress and stressors (risk factors) as negative events in people's lives. However, Antonovsky stated that disease and stress occur regularly in people's lives and therefore should be seen as part of life's natural state (Lindstrom and Eriksson, 2010, Antonovsky, 1979). It is not so much the level of stress that someone is exposed to that has the greatest impact on their health, but the ability to resolve tensions and therefore prevent their transformation into stress (Antonovsky, 1990). Antonovsky explained that people have access to resources which help them make sense of the world; he called these Generalised Resistance Resources (GRR) (Antonovsky, 1987). These may refer to internal motivators or external possibilities for practising skills. Examples of GRRs range from material factors such as money to psychosocial factors such as self esteem or commitment (Lindstrom and Eriksson, 2006). It has been argued that it is not the quantity or quality of resources available but the ability of the individual to make use of them which is important (Lindstrom and Eriksson, 2005). The capability to make use of GRRs differs between people and Antonovsky termed this ability the Sense of Coherence (SOC).

Antonovsky (page 19, 1987) defined the Sense of Coherence (SOC) as:

> "*A global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that:*
>
> *1. The stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable;*

2. *The resources are available to one to meet the demands posed by these stimuli; and*

3. *These demands are challenges worthy of investment and engagement*".

The SOC enables someone to comprehend, manage and find meaning in the world; the higher the SOC the better the person's ability to manage life and sustain or improve their health (Antonovsky, 1987). The development of the SOC is influenced by factors such as the impact of generational experiences on families and individuals (for example, wars and economic depressions), the influence of society on the individual and the way a child is raised. Antonovsky believed that SOC developed over the first three decades of life and continues at a fairly steady state for the rest of an individual's life, though some life experiences may weaken or strengthen the SOC (Antonovsky and Sagy, 1986). Any interventions to improve an individual's SOC would therefore need to take place before levels have been "set". Although others have shown that SOC tends to increase with age over the lifespan (Eriksson, 2007).

The SOC scale provides a quantitative approach to measuring this concept. The scale contains 29 items, which measure three protective factors (comprehensibility, manageability and meaningfulness). The scale was developed following interviews with individuals who had experienced severe trauma (Lindstrom and Eriksson, 2006), and, as such, links to the research on resilience, learning from those who had survived or achieved despite severe life events (Konttinen et al., 2008). However, this raises questions as to how generalisable findings from such groups of individuals are. Many researchers have compared the SOC with other measures of physical and psychological health (Flannery and Flannery, 1990, Midanik et al., 1992, Larsson and Kallenberg, 1996, Kivimaki et al., 2000, Surtees et al., 2003). Overall there seems to be a stronger and more direct relationship between SOC and mental health than with physical health. This is likely to be because managing stress and stressors is closely linked to being able to understand and manage emotions (Eriksson and Lindstrom, 2006, Eriksson and Lindstrom, 2008). It has also been proposed that SOC is not a distinct construct, but rather simply an inverse mirror of depressive symptoms (Henje Blom et al., 2010).

The salutogenic model concentrates on the assets and protective factors which may contribute to coping, resilience and positive health; it seeks to understand how people become, and remain, healthy. As such it is concerned with positive health promotion rather than risk or disease prevention. It has been suggested that, whilst resilience research provides information in relation to protective factors, research concerning salutogenesis considers how such knowledge can be used to promote health (Eriksson and Lindstrom, 2010). It has been argued that salutogenesis could provide the theoretical basis for health assets (Morgan and Ziglio, 2007).

As public health addresses the health needs at population level, there is an argument that health promotion should also be targeted at this level rather than at individuals. Antonovsky (1987) argued that one should look at the salutary factors that promote health rather than looking at identifying and preventing disease or risk specific factors. He stated that salutogenesis was a useful paradigm for health promotion, as it focuses on "*moving people in the direction of the health end of a healthy/dis-ease continuum*[13]" (page 14, Antonovsky, 1996). Such a model has potential for everyone, not just those at risk from certain environments, behaviours or diseases.

Some have criticised the SOC scale as ambiguous (Geyer, 1997). Although a children's Sense of Coherence Scale is available in English (aimed for use with children aged 5-10 years), using the adult SOC with older children may be problematic due to interpretation issues[14]. It is also measured at the level of the individual rather than gathering information on the community. However it does offer potential. There is a large body of evidence linking SOC with health, yet more needs to be done to explore use with children and young people.

Tabular summary of asset based conceptual frameworks

There is some common ground between these frameworks and concepts: these are summarised overleaf (Figure 5). One of the unifying threads is the idea of understanding the processes at work.

[13] Antonovsky viewed health as a continuum with "ease" being total health and dis-ease the complete lack of health; conceptually salutogenesis meant the movement towards total health ANTONOVSKY, A. (1987) *Unravelling the mystery of health,* San Francisco, Jossey-Bass.
[14] Supervision discussion 16th October 2009: Fiona Brooks & Antony Morgan

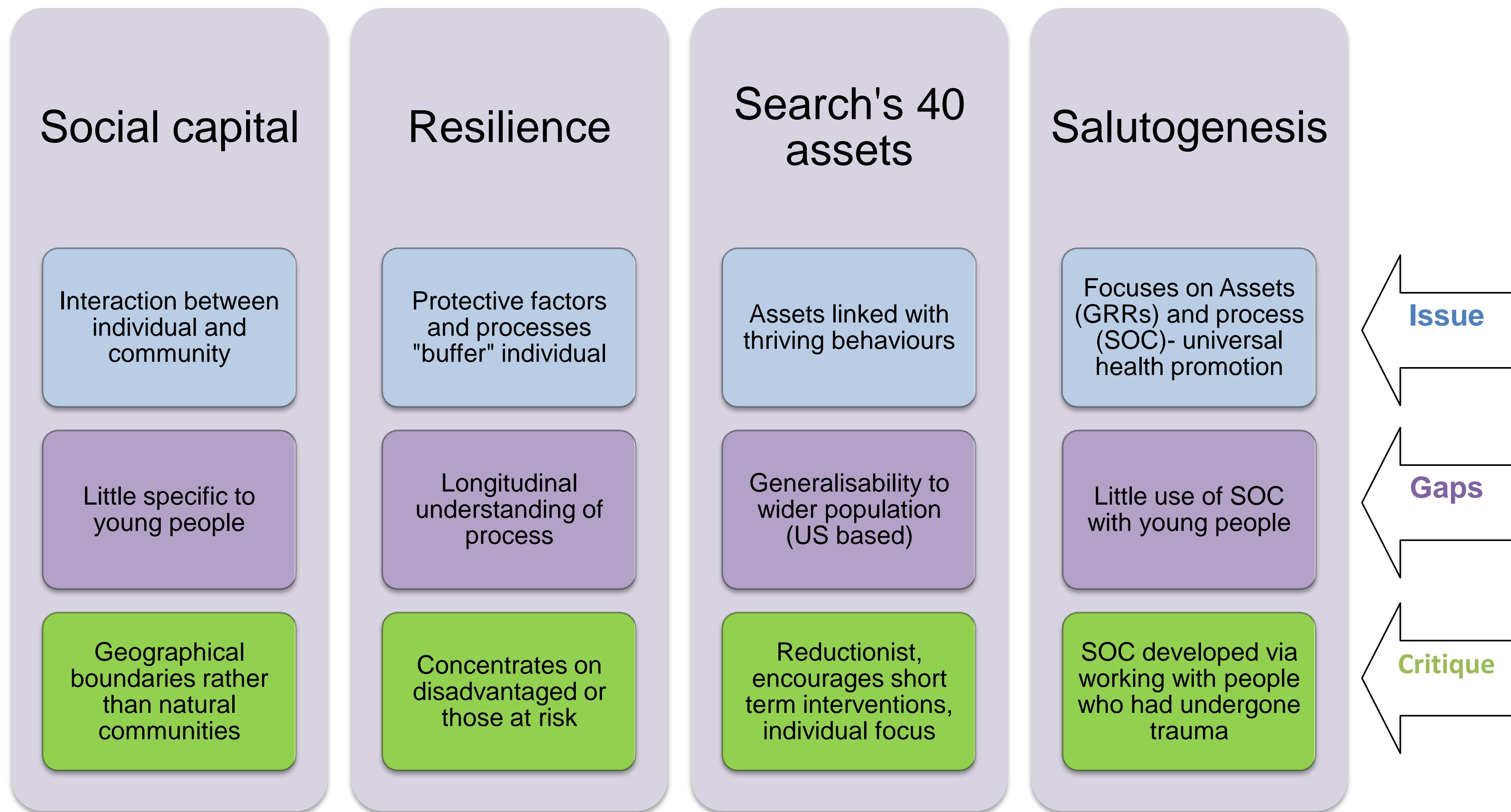


Figure 5: Diagram summarising conceptual frameworks

Theoretical perspectives: the New Social Studies of Childhood

The need for young person specific research was highlighted in the discussion of different assets approaches above. Including young people within research, ensures that their views, definitions and priorities are captured. Any policy and practice then based on this research increases its relevance to young people and thereby facilitates more effective engagement with health promotion initiatives. The policy review in chapter 2 drew attention to a concentration within strategies on the improvement in young people's future health or achievement rather than consideration of what is needed now.

The following section considers the position of children in UK society and their social agency (defined below, *page 53*); this provides the background to a need for a conceptual framework that brings children and young people to the fore. This need was met by the New Social Studies of Childhood. The section then explores issues of researching with children and young people.

Children in UK society

"*It is often said that the UK is not a child-centred society*" (page 88, Blair et al., 2010). This is evidenced through the low priority that UK society gives to parenting, for example, the levels of welfare provision and access to subsidised childcare tends to encourage shorter parental leave than in many other European countries (Boje and Ejrnaes, 2009). The lack of welcome given to young people in restaurants or shopping centres (Beunderman et al., 2007) provides further proof of a predominant negative societal view. This is corroborated by the type of stories portrayed in the news. A recent example has been the use of "mosquito" anti loitering devices[15] that emit a noise that can only be heard by people aged under 25; its aim being to stop young people congregating.

Media and policy makers alike seem to readily accept and, almost promote, the negative positioning of young people in the UK; for example, *Time* magazine on 7th April 2008 ran the headline on its front cover:

> "*Unhappy, Unloved and Out of Control: An epidemic of violence, crime and drunkenness has made Britain scared of its young*".

[15] http://www.compoundsecurity.co.uk/security-equipment/mosquito-device Accessed 21/11/11.

The story behind this headline suggested many of the failings of young people in British society (Mayer, 2008). Unfortunately stories within the media often influence people's views of societal groups. As part of the "Place Survey" (Department for Communities and Local Government, 2009) undertaken by local authorities across the country "teenagers" are proposed as a group which may be perceived as contributing to anti social behaviour[16]. No other age group or section of society is singled out in such a way; one cannot imagine residents being asked to state whether other groups, such as particular ethnic communities, contribute to anti social behaviour. Unfortunately it is these negative findings and stories that tend to be reported and therefore might have a stronger influence on majority view.

Children and social agency

An important discussion in sociological theory considers the relationships between individuals and the social structure they inhabit; how structures might limit the ability of individuals to act autonomously (Abercrombie et al., 1994). Being able to exercise free will and behave independently is termed "agency". This concept is important in terms of children and young people as there might be disagreement between their own views of their agency and what parents, guardians and other carers believe is appropriate.

Children in western society sometimes occupy a position whereby they can almost be seen as work activities, for example for parents to care for or for teachers to teach. This concept of child as a work activity was further developed by the sociologist, Lareau, who coined the term "concerted cultivation" for some styles of parenting (Lareau, 2003). Children and their parents are valued and praised for meeting developmental milestones and when children behave in desired ways. The parent or carer has an important role in identifying potential for problems before they arise and promoting the health of the child; during such early years children are dependent on these caregivers to keep them healthy.

As children grow up, they become more independent, their individual agency increases and they take on more responsibility for their self maintenance (Piaget et

[16] National Indicator 17: NI 17 is a composite indicator based on perceptions of different anti-social behaviours (noisy neighbours or loud parties; teenagers hanging around the streets; rubbish or litter lying around; vandalism, graffiti and other deliberate damage to property or vehicles; people using or dealing drugs; people being drunk or rowdy in public places; abandoned or burnt out cars. http://www.communities.gov.uk/publications/corporate/statistics/placesurvey2008 Accessed 20/5/12

al., 1995, Harter, 1990). It has been suggested that, although this is a natural part of adolescence, in part, it might be influenced for adult benefit.

> "*Both at home and at school, children are asked to regulate their bodies and manage their emotions, in the interests not of self-care but of adult agendas and timetables*" (page 111, Mayall, 1996).

However, as young people become more liable for their own health and wellbeing, they are influenced by a range of implicit and/or explicit health messages from a variety of sources. Adult role models help:

> "*transmit important environmental cues to youth concerning expected norms of behaviour within the community*" (page 168, Kawachi, 2010).

But as young people mix more with peers, the values and behaviours that are deemed appropriate or expected may change; there may be conflict between conservative or traditional societal norms and the "celebrity" values that have become more prevalent in the last couple of decades (Henderson, 1992). The health behaviours that children and young people adopt and exhibit will be shaped by these different pressures; the challenge is in balancing these differing needs and suggestions to achieve healthy outcomes.

As young people become more autonomous, tensions can arise as care givers may doubt young people's ability to take on these new independent roles safely. Young people report that they feel subordinated to adults, often unable to make their own decisions; for example, young people may want more freedom and yet be denied this by parents (Morrow and Mayall, 2010). These tensions may be influenced by points highlighted earlier, where negative portrayals in the media affect expectations of young people. Young people want to be judged by what they can accomplish and be given the opportunity to achieve. In a presentation given at the conference "Health in schools: participation and partnerships" a group of young people requested:

> "*Let us show you how much we can do, instead of focusing on how bad we are, or what we can't do*" (Conference proceedings, Institute of Education, 2008).

Including young people in the development of activities that improve their health ensures that their independence is acknowledged. Positive models of health promotion build on young people's strengths and this might help re-orient views and policy away from the negative; it has been suggested that by taking an assets approach society's positive expectations of young people are emphasised (Murphey et al., 2004).

Researching children and young people

Over the last few decades, social scientists' perspectives on researching children and childhood have evolved. There has been a movement from seeing children as "human becomings" who are important primarily as future adults to human beings in their own right (Lee, 2001). This recognises the child as an independent individual rather than someone who needs to be socialised into the world of adults (as was proposed by Parsons (1956)); though others have argued against such a dichotomised view, suggesting that children can be both dependent and independent, competent and vulnerable (Lee, 2001). The types of research methods chosen have changed over time to ensure that young people are more central to the process.

It has been noted that:

> "*the history of the study of childhood in the social sciences has been marked not by an absence of interest in children... but by their silence*" (page 7, Prout and James, 1997).

In recognition of this, more recent research has included more participatory methods to capture the experiences of children and young people; such methods are thought to provide a more accurate representation of the lives and views of children and young people. Young people's involvement as active participants within research aims to redress the power imbalance within society, ensuring that policies and strategies result from research which has captured their views.

> "*taking account of children's perspectives.... is in favour of the upgrading of childhood as social status, taking account of respect for children as moral agents*" (page 2, Mayall, 2002).

There has been a marked movement from the child as an object of study to the research subject.

Prout and James (1997) suggested a new paradigm for studying childhood, made up of six key features:

1. Childhood is a social construction rather than a universal feature and will be a product of time and context
2. Childhood cannot be separated from other variables in society, for example, gender and ethnicity
3. Children's social interactions, relationships and cultures should be studied in their own right and remain independent of the adult perspective
4. Children should be actively involved in decisions that may impact upon their lives
5. Ethnography can be a valuable research approach for the study of childhood
6. A new paradigm of childhood necessitates the reconstruction of childhood in society

It has been noted that, unless young people's views are actively sought, policies and interventions may be developed based on adult interpretations and perspectives (Dryden et al., 1998). To include young people as social actors in their own right within health policy requires that their voices are heard within the research that informs such policy (Christensen and James, 2000). Young people are likely to have their own ideas as to what constitutes healthy behaviour and their own priorities for health maintenance. These may be different from adult beliefs, perspectives and priorities (Brooks and Magnusson, 2006, Wills et al., 2008).

The academic shift to encourage young people to participate actively in research has been supported by government policy during the early 2000s. For example, one of the key issues proposed within "Every Child Matters" is that children and young people should be able to "*make a positive contribution*" (page 4, Department of Education & Skills, 2004). Governmental endorsement is provided of research that includes young people:

> "*... we must ensure that our policies and practices are developed through the eyes of being a young person growing up in England today*". (Anne Milton, foreword to the HBSC England Report, Brooks et al., 2011).

Participation is also a right enshrined in Article 12 of the UN Convention on the Rights of the Child (UNCRC), which states that children have the right to express their views and have them taken into account in all matters that affect their lives.

It is important that participation is not the end of the process. It has been suggested that the involvement of young people in research should lead to their views being listened to and acted upon (Wills et al., 2008). The level of participation within my research is discussed within the methodology chapter *(*chapter 5*, "*Researching with and for young people*", page 93).* Young people's views are reported in the findings (chapter 6*, page 131*), then discussed in terms of implications for practice (chapter 7*, page 166*) and policy (chapter 8*, page 208*).

Concluding comments for this chapter

This chapter has highlighted some of the potential issues with deficit approaches, for example, being problem focussed, non-sustainable, stigmatising and sometimes causing disengagement. A more positive approach to promoting health is a possible alternative or additional way of addressing the poor health outcomes identified in chapter 1 and lack of progress from policies discussed in chapter 2. In this chapter a number of asset based models have been reviewed, similarities and differences have been explored. However, it is recognised that some "positive youth development" programmes have been seen to have different effects in different settings and may result in unwanted outcomes (page 118, Wiggins et al., 2009, Philiber et al., 2001). It is therefore important when identifying assets and associated models for health promotion that there is clarity as to what has potential to work for young people in England.

A common finding amongst much of recent governmental policy and some of the concepts discussed above was a shared view of young people as adult "becomings"; the emphasis being on intervention to promote later health rather than focussing on initiatives that will provide improved health now. The premise of accepting that a young person has current needs, is central to the New Social Studies of Childhood (James et al., 1998). Understanding how young people view their own health and

wellbeing becomes a vital task, if effective and contemporaneous health promotion strategies are to be developed. Acknowledging, and working with, young people's emerging independence is also important if policy and strategy are to be made more relevant and therefore more effective at improving health.

Through reviewing some of the leading asset models, the importance of Salutogenesis as a theoretical focus was clarified. For example, it includes the importance of promoting health universally; focussing on all young people rather than those "at risk" or disadvantaged. The narrative synthesis in the next chapter takes Salutogenesis as a focus and explores what is known about the use of assets in promoting the health of young people.

Table 2: Summary of concepts

	Developmental Assets		**Resilience**	**Social Capital**	**Salutogenesis**	
Main authors & contributors	The Search Institute		Rutter, Garmezy, Werner and Smith	Kawachi, Putnam	Antonovsky	
Key references	(Scales and Leffert, 2004)		(Werner, 1984, Garmezy, 1985, Rutter, 1984)	(Putnam, 1995)	(Antonovsky, 1987)	
Main protective factors	20 External assets	**Support** (Family support, Positive family communication, Other adult relationships, Caring neighbourhood, Caring school climate, Parent involvement in schooling) **Empowerment** (Community values youth, Youth as resources, Service to others, Safety) **Boundaries and Expectations** (Family boundaries, School boundaries, Neighbourhood boundaries, Adult role models, Positive peer influence, High expectations) **Constructive use of time** (Creative activities, Youth programs, Religious community, Time at home)	**Self efficacy** **Social competence** (problem solving skills, adaptability) **Autonomy** **Positive relationships** **Sense of purpose and future** (aspiration, sense of usefulness, required helpfulness)	Social relations Formal and informal social networks Group membership Trust Reciprocity Civic engagement Communication Volunteerism	Generalised Resistance Resources (GRRs) Sense of Coherence	Biological, material and psychosocial factors (for example, money, knowledge, experience, self-esteem, social support, intelligence) Being able to use GRRs so that lives appear consistent, structured & understandable: **Comprehensibility** **Manageability** **Meaningfulness**

	Developmental Assets		Resilience	Social Capital	Salutogenesis	
	20 Internal assets	**Commitment to learning** (Achievement motivation, School engagement, Homework, Bonding to school, Reading for pleasure) **Positive values** (Caring, Equality and social justice, Integrity, Honesty, Responsibility, Restraint) **Social competencies** (Planning and decision making, Interpersonal competence, Cultural competence, Resistance skills, Peaceful conflict resolution) **Positive identity** (Personal power, Self esteem, Sense of purpose, Positive view of personal future)				
Main outcomes	Thriving behaviours (includes school educational success and risk avoidance)		Wellbeing despite engagement with, and exposure to, risk	Various outcomes include: lower crime rates, social inclusion, participation, health, economic achievement etc.	Sense of Coherence, as measured by a scale, predicts positive health outcomes	

	Developmental Assets	Resilience	Social Capital	Salutogenesis
Evidence in support of concept	40 assets included in model chosen through a mix of evidence, theory and expert endorsement. Mostly cross sectional surveys linking high numbers of assets with thriving behaviours.	UK based research evidences that some children thrive despite their circumstance, "against the odds" (Rutter, 1985).	Links between socio-economic status and health (Whitehead, 1988), group membership and social trust (Kawachi et al., 1997), close knit relationships and lower heart disease (Lasker et al., 1994)	Systematic review of over 400 publications which found that SOC scale was reliable, valid and cross culturally applicable instrument to measure positive health (Eriksson and Lindstrom, 2006).
Gaps in knowledge	Tested within US but by self selection of schools, these were not necessarily representative of the whole US population. It was noted that there was overrepresentation of Caucasian youth within the studies, schools tended to be from smaller conurbations and the students included tended to have parents with higher than average formal education (Scales and Leffert, 2004). It has been suggested that the included assets are very specific to the values and aspirations of a particular social group (Howard et al., 1999)	Based on children and young people "at risk" or exposed to traumatic events and therefore possibly not universally applicable	Problems defining it clearly and therefore problems measuring it. Social capital tends to be owned by the group rather than the individual. However, it tends to be measured by aggregating individual survey responses. Much of the research has been carried out in the US. "*The concept has tended to be exported wholesale to the UK which ignores the cultural context of its conceptualisation*" (National Statistics, 2001)	Limited research of SOC scale with children and young people (Eriksson and Lindstrom, 2006)
		Few intervention studies to prove that health is improved by increasing assets, resilience factors/processes, SOC or social capital. Limited involvement of Children and Young People in some areas for example SOC & social capital.		

Chapter 4: Narrative synthesis: the assets and processes associated with the promotion of young people's health

Positive models of health promotion have been suggested as a possible additional or alternative approach to address the stagnation in young people's health improvement. However, to change the orientation of health promotion or policy, some level of evidence is required to support this.

In this chapter, the aims and objectives of the narrative synthesis are set out. These reflect the theoretical frameworks reviewed in chapter 3 (*page 36*); assets models and the New Social Studies of Childhood. Information is supplied to explain how the method of synthesis was chosen to bring the findings together. The relevance of the assets identified through the narrative synthesis is discussed in relation to English young people and the justification for this programme of research is demonstrated.

Aim

The aim of this narrative synthesis was to identify and understand the main assets and/or processes that promote the health of young people.

Objectives

- To gain an understanding of young people's perspectives of health promotion
- To identify the different environments and settings in which health can be promoted
- To clarify measurement issues – how are assets captured? How is an improvement in health measured? When is the best time to intervene?

Methods

As with other parts of the research process, the methods of a literature review are determined by the question to be answered. Although an initial driver was to identify interventions that had been demonstrated to work and to consider whether these could be used with young people in England, this was broadened due to the limited evidence available on effective initiatives. This widening of the search subsequently identified "views papers" regarding assets approaches and provided information from those experts working both practically and theoretically in this field.

This review aimed to identify the assets associated with positive health as well as understanding how such assets work. There was an acknowledgement that, as this was likely to involve the use of quantitative research to identify assets and qualitative research to better understand the processes involved, a method of incorporating a range of research into the review was required. It has also been argued that due to the complex nature of health promotion, evaluation should incorporate both quantitative and qualitative components (Peersman et al., 1999); a range of methodologies within asset health promotion research were likely. There are a variety of methods available to synthesise findings from qualitative and quantitative studies; these are discussed below to clarify the choice of using narrative synthesis.

Evidence synthesis: combining the findings from literature reviews

> *"Evidence synthesis embodies the idea... of making a new whole out of the parts: individual studies or pieces of evidence are somehow combined to produce a coherent whole, in the form of an argument, theory or conclusions"* (page 15, Pope et al., 2007).

There are a variety of ways to combine findings so that conclusions can be drawn from the whole body of research. The main methods dealing with a mixture of quantitative and qualitative studies include:

- **Narrative synthesis** – this includes some integration of findings alongside the interpretation of themes
- **Realistic synthesis** – this is strongly interpretive, aiming to develop new theory from the existing body of evidence
- Separate analysis of quantitative and qualitative studies, but findings brought together (**Evidence for Policy and Practice Information (EPPI) method**) –

this is ideal if there are two parts to the question that suit different study methods

These types of synthesis rely on thematic analysis to review evidence, looking at the prominent themes. They share similarities in their systematic selection and review of evidence but what differentiates them is their way of summarising or bringing together the findings.

There has been considerable debate as to whether different research methods can be combined and whether the findings from such research can be brought together satisfactorily (Pope et al., 2007, Dixon-Woods et al., 2005). There has been discussion in the literature concerning "*deconstructing the divide*" and "*dispelling the misconceptions*" between quantitative and qualitative research (page 265, Harden and Thomas, 2005). These authors propose that there are many similarities in terms of underlying views of the researchers, types of data collection or analysis and one should not be distracted by the labelling of the research as quantitative or qualitative. They go on to say that, once research papers are broken down into their component parts, most are formed of mixed methods. It has also been suggested that beneath all the varying views and constructions, there will be an underlying idea or concept that remains the same (Hammersley, 1992b). This research has been driven by a wish to identify a better way of promoting health with young people and acknowledges that there are both quantitative and qualitative components to this.

It has been debated as to whether qualitative studies should be "quantified" or quantitative "qualitised" and which type of study should take priority (Dixon-Woods et al., 2005). If there is a range of types of study, it has been suggested that a broadly narrative approach is the favoured option as data do not have to be altered from their initial studies (Pope et al., 2007).

> "...*the approach stops short of the formal integration or re-interpretation of different evidence sources, aiming rather to juxtapose findings from multiple sources and highlight key messages from a body of literature*" (page 95, Pope et al., 2007).

Narrative synthesis was therefore chosen as a method of "*bringing together evidence in a way that tells a convincing story*" (page 4, Popay et al., 2006); this

allowed the findings to speak for themselves without altering them to fit a qualitative or quantitative framework or prioritising one research method over another.

Search strategy

Due to the variety of types of paper to be included, the search strategy was based on P-I-C-O (population, intervention, control, outcome) (Sackett et al., 1997) but with flexibility to include a range of health promoting initiatives that might not have been trialled as interventions; control groups were therefore irrelevant for some types of papers.

Types of studies

Quantitative and qualitative studies were included as were "non-research", theoretical papers.

Types of participants

Studies applicable to the general youth population (under 19 years) were included, whereas those targeted at specific populations or limited to "high risk" groups were excluded.

Types of interventions and initiatives

Papers dealing with general positive health promotion were included, whilst those talking of preventing specific illness (for example, sexually transmitted infections) were excluded; asset* and salutogen* were included as search terms to capture these positive approaches.

Types of outcome measures

The primary outcome was an improvement in health and/or wellbeing.

Search methods for identification of studies

As advocated by a number of authors, computerised database searches were undertaken (Fink, 1998, Playle, 2000, Hek et al., 2000). The initial search was undertaken in December 2009 and then re-run in March 2012 (strategy MESH terms included in Appendix 1). The following free text terms were used to search PubMed[17], PsycINFO, the Cochrane Library, Google scholar, Assia, Cinahl Plus and ISI Web of knowledge:

Health promotion, young people, youth, adolescen*, teen*, asset*, salutogen*

An outcome term was not specified in the search as an initial review of papers had identified the wide range of outcome terms used (for example, life satisfaction, wellbeing, physical activity improvement etc.) This approach has been supported by recent research which notes that previous studies were only able to provide limited information on assets and health promotion because they were too specific as regards the health promoting behaviour or outcome (Wang et al., 2011). By allowing the computerised search to identify a variety of outcomes, the initially returned papers were then hand sifted to detect those relevant to this research.

The search terms were tailored for each database, register or engine as summarised in Table 3 (*page 70*). The table also summarises any restrictions placed on each search; due to financial restraints only literature published in the English language was included (Meade and Richardson, 1997). All the papers' reference lists were then hand searched to identify any further papers that met the inclusion criteria. This has been highlighted as a useful method of picking up a range of further information (Greenhalgh and Peacock, 2005).

Quality assessment

Papers were assessed for quality and this was dependent on the type of study undertaken. There is an abundance of frameworks to guide quality assurance of papers (Dixon-Woods et al., 2004). Quality assessment criteria for both quantitative and qualitative reviews have been suggested elsewhere in the literature (Harden et al., 2009, Mays and Pope, 2000). However, others have suggested that strict adherence to inclusion frameworks to appraise quality may not always be better than

[17] This includes Medline.

subjective judgement, though the use of structured instruments tend to make reviewers more explicit about their reasoning (Dixon-Woods et al., 2007). The framework below (Figure 6) was used to guide the assessment of which papers should be included in this review.

- How credible are the findings?
- How has knowledge been extended?
- How well does the evaluation address its original aims and purpose?
- How well is the scope for drawing wider inferences explained?
- How clear is the basis of evaluative appraisal?
- How defensible is the research design?
- How well defended is the sample selection?
- How well are inclusion and exclusion criteria described?
- How well was data collection carried out?
- How well has analysis been explained?
- How well has diversity of perspective been explored?
- How well has the richness of data been conveyed?
- How clear is the route from data to conclusions?
- How clear are the assumptions and theoretical perspectives?
- Has the study been carried out ethically?
- Has the research process been adequately documented?

Figure 6: Quality appraisal framework (Spencer et al., 2003)

Limitations

With any review of the literature there is the potential limitation that it has not captured all the available knowledge on this subject. This synthesis was limited to papers published in the English language. By searching reference lists, it was hoped that further research published as reports or within books would be identified. It is therefore limited to findings that have been published; there may be additional contributory knowledge or grey material that is not in the public domain.

One aim of undertaking a narrative synthesis, rather than a statistical meta-analysis, was to include all types of papers. The search terms were kept broad to identify as wide a range of study types as possible. However, the majority of papers detected by the search strategy were based on data from cross sectional studies or questionnaires (Donnon and Hammond, 2007, DuBois et al., 2002, Lindberg and Swanberg, 2006, Marsh et al., 2007, Morgan and Haglund, 2009, Murphey et al.,

2004, Smith and Barker, 2008, Vieno et al., 2007, Youngblade et al., 2007, Fenton et al., 2009). There was a lack of data from intervention studies or longitudinal research. One of the main limitations of surveys or cross sectional studies is their inability to identify causation or clarify the direction of effect. It was hoped that the review would identify findings from qualitative studies that would incorporate young people's experiences and perspectives into the synthesis, but from the papers currently available this area remains to be further developed. This provides further impetus to undertake research with young people, to explore with them ideas of process and causation as well as ensuring that their views are heard and acknowledged.

Selection of papers

The following diagram (Figure 7*, page 69*) summarises the stages of the review. Chapter 3 (*page 36*) provided the justification of using salutogenesis as a focus; it appeared to provide an umbrella concept capturing many other asset type approaches to universal, positive health promotion.

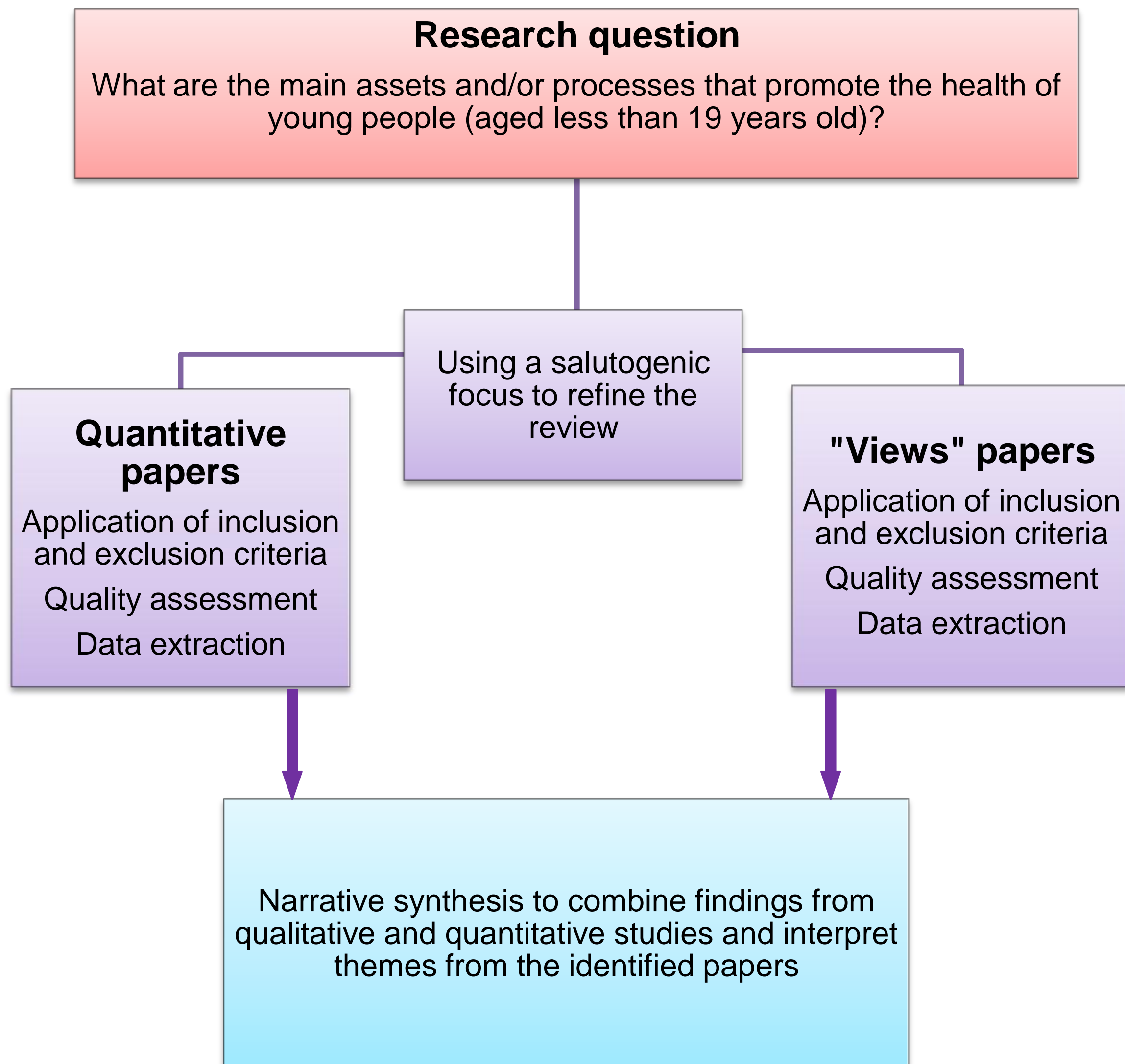


Figure 7: Stages of the narrative synthesis

Results of the narrative synthesis

The methods used to find the literature that met the pre-specified inclusion criteria have been detailed above. Initial searches based on the search terms (*page 65*) yielded a large number of potential papers (for example, in 2012 this was 2357 titles from the PubMed search). Within some search engines it was difficult to add limits and so sifting was necessary to identify those that appeared to meet the search strategy criteria. Based on information within the title and abstract many of these were then excluded from full review as they did not meet these criteria, for example, many papers were limited to particular groups (for example, a specific ethnic group or gender). Full papers were then obtained and reviewed, checking against the search criteria and quality framework (*page 67*), any duplicates were removed. This final selection were then included within the narrative synthesis.

Table 3 summarises how many papers were identified from each source for review (following the initial sift and discard) and the number that were then included within the synthesis.

Table 3: Results of the reviews

Date	Database or search engine	Terms	Limits	Papers identified through search terms and after initial sift.	Papers meeting inclusion criteria (duplicates removed)
16/12/09	PubMed	Health promotion, Young people, Youth, Adolescen*, Teen*, Asset*, Salutogen*,	Humans English	51	7
9/3/12			Under 19 years	71	9
16/12/09	Psychinfo [18]	Salutogen* Health Promotion	Humans English	20	0

[18] Not available to re-run search via UH in 2012

Date	Database or search engine	Terms	Limits	Papers identified through search terms and after initial sift.	Papers meeting inclusion criteria (duplicates removed)
16/12/09	The Cochrane Library	Health promotion	reviews	31	0
19/3/12				24	0
16/12/09	Google scholar	Health promotion Salutogen* Asset*	Non-adult Biology, life sciences & environmental science Medicine, pharmacology & veterinary science Social sciences, arts & humanities	72	2
19/3/12				34	0
21/12/09	Assia[18]	"Health promotion" salutogen*		20	1
21/12/09	Cinahl Plus	"Health promotion", Asset*, Salutogen*	English Peer reviewed	10	0
19/3/12				2	0
21/12/09	ISI Web of knowledge	Health promotion, young people, youth, adolescen*, teen*, asset*, salutogen*	English	40	2
19/3/12				5	0
10/1/10	Searching reference lists of selected papers				5
2/6/12					0

Characteristics of the identified research papers

The term asset is used throughout this research to capture those concepts which appear predictive of positive outcomes. Within the literature, however, a variety of terms were used including: protective factors, strengths, resources, health-enhancing factors, competencies, Sense of Coherence, developmental assets, developmental strengths, resiliency factors and behavioural assets. In some papers terms were used interchangeably.

In 2009, seventeen papers were included for full review and synthesis (Appendix 2). These included a control trial (one paper), quantitative analysis of survey data (9 papers), discussion papers (4 papers) and evidence reviews (3 papers). One of the quantitative papers also analysed findings from participant interviews. The discussion papers and evidence reviews drew on other published papers, expert opinion and theory to propose health promoting methods and frameworks. This confirmed an observation noted elsewhere that much research does not fit neatly into the categories of “qualitative” or “quantitative” (Harden and Thomas, 2005). The majority of papers were from the US (9 papers), but there were also papers from Poland, England, Canada, Sweden and Italy.

On re-running the search in 2012, the academic interest in assets had increased substantially. Nine further papers were included for full review and synthesis (Appendix 2); these papers included quantitative analysis of data (2), discussion papers (6) and a qualitative analysis of interviews (1). Some of these papers had already been identified during the research period through talking with others with an interest in assets, attending conferences and reading journals. However, many of the issues mentioned above remained the same; the majority of the literature was US (8) and there were no intervention studies undertaken. The main difference over time was that the latter papers seemed more interested in understanding the contexts and processes, rather than simply identifying assets.

Although only a small number of papers were included in the narrative synthesis, the papers identified represent research that spans decades; for example the Search Institute has been involved in research with children and young people for over fifty years [19]. The Institute also builds on work developed by others, for example

[19] http://www.search-institute.org/research-and-publications Accessed 3/6/12

Bronfenbrenner's research into the ecology of human development and Jessor's research into the social-cultural influences on adolescent behaviour (Benson, 2002). The 40 developmental assets have evolved through research with hundreds of thousands of young people across over 1500 communities. Other included papers drew on a wealth of other research into models and approaches, for example, "Creating the conditions linked to positive youth development" (Granger, 2002), "What do Adolescents need for Healthy Development?" (Roth and Brooks-Gunn, 2000) and "Inspiring Healthy Adolescent Choices" (Duncan et al., 2007) which, between them, drew on over 20 large scale bodies of research.

Synthesis of themes identified

The papers identified through the search criteria took different approaches to consider how health could be promoted, from analysis of survey data to intervention study, from theoretical discussion to evidence review. The findings from these varied approaches were brought together by using narrative synthesis. Papers were not ranked or weighted.

The aim of this narrative synthesis was to identify the main assets and processes that promote the health of young people. For many of the quantitative papers, it was a relatively simple task to identify those assets that were statistically associated with positive health outcomes. However, by taking all the papers together and considering the issues that were discussed and proposed, other ideas emerged. Some of these were also noted as possible assets. However, some of the proposals regarding causation or the asset-health process prompted ideas for approaches to health promotion. As ideas were identified, common threads were acknowledged and these were grouped to form themes. The two key themes that emerged were given the terms:

- "Holistic approach" to health promotion (consideration of the interplay between risk and protective factors)
- "Ecological approach" to health promotion (consideration of the different contexts in which young people live).

Through understanding the assets associated with young people's health and how these might be manipulated, there is the possibility of aiding theory development in this area.

Detail on the assets and themes identified

In this next section, a summary of the papers is tabulated (Table 4) and then discussed. Table 4 lists the papers included within the narrative synthesis categorising by asset and theme. The papers are further classified by how these assets or themes were identified, for example through expert discussion or quantitative analysis. A more detailed table provides further information on the setting for each piece of research, the type of study, the main outcomes, findings and themes (Appendix 2).

Table 4: Comparison of findings from studies of positive health promotion

Assets and themes	**Reference**	
	Quantitative papers	**"Views" papers**
Assets		
Constructive social relationships	(Lindberg and Swanberg, 2006, Youngblade et al., 2007, Morgan and Haglund, 2009, DuBois et al., 2002, Marsh et al., 2007, Fenton et al., 2009)	(Roth and Brooks-Gunn, 2000, Scales, 1999, Granger, 2002, Weissberg and O'Brien, 2004, Lindstrom, 1992, Duncan et al., 2007, Benson, 2002, Ward and Zabriskie, 2011, Mainella et al., 2011, Garst et al., 2011, Caldwell and Witt, 2011, Kia-Keating et al., 2011)
Safety	(Youngblade et al., 2007, Morgan and Haglund, 2009)	(Granger, 2002, Duncan et al., 2007, Roth and Brooks-Gunn, 2000, Benson, 2002, Mainella et al., 2011, Garst et al., 2011, Kia-Keating et al., 2011)
Health maintenance behaviours	(Lindberg and Swanberg, 2006, Youngblade et al., 2007, Morgan and Haglund, 2009, Bronikowski and Bronikowska, 2009, Smith and Barker, 2008)	(Duncan et al., 2007, Ward and Zabriskie, 2011, Mainella et al., 2011)

Assets and themes	**Reference**	
	Quantitative papers	**"Views" papers**
Assets		
Autonomy/ independence	(Smith and Barker, 2008, Morgan and Haglund, 2009, Bronikowski and Bronikowska, 2009, Urban et al., 2010)	(Caldwell and Witt, 2011, Mainella et al., 2011, Granger, 2002, Duncan et al., 2007, Benson, 2002, Gestsdottir et al., 2011, Dawes and Larson, 2011, Kia-Keating et al., 2011)
Positive attributes – positive sense of self	(Donnon and Hammond, 2007, Youngblade et al., 2007, Smith and Barker, 2008, Vieno et al., 2007, Bronikowski and Bronikowska, 2009, Fenton et al., 2009)	(Benson, 2002, Scales, 1999, Roth and Brooks-Gunn, 2000, Granger, 2002, Lindstrom, 1992, Garst et al., 2011, Caldwell and Witt, 2011, Dawes and Larson, 2011, Kia-Keating et al., 2011)
Themes		
Holistic approach – interplay of risk and protective factors	(Smith and Barker, 2008, Donnon and Hammond, 2007, Youngblade et al., 2007, Murphey et al., 2004)	(Roth and Brooks-Gunn, 2000, Scales, 1999, Duncan et al., 2007, Garst et al., 2011, Kia-Keating et al., 2011)
Ecological approach- the context of health creation and health promotion	(Smith and Barker, 2008, Lindberg and Swanberg, 2006, Youngblade et al., 2007, DuBois et al., 2002, Marsh et al., 2007, Donnon and Hammond, 2007, Vieno et al., 2007, Morgan and Haglund, 2009, Urban et al., 2010)	(Scales, 1999, Benson, 2002, Granger, 2002, Roth and Brooks-Gunn, 2000, Weissberg and O'Brien, 2004, Ward and Zabriskie, 2011, Mainella et al., 2011, Garst et al., 2011, Gestsdottir et al., 2011, Caldwell and Witt, 2011, Kia-Keating et al., 2011)

Assets

The aim of the narrative synthesis was to identify the main assets and processes that promote the health of young people. Below, each asset is taken in turn; the evidence stated, issues regarding any gaps in the knowledge are raised and limitations are discussed. Not all papers used the term "asset" when discussing the following concepts, within some research they were identified as protective factors, strengths or resources.

Constructive social relationships

Healthy outcomes were associated with a mixture of interpersonal relationships. The variables used to capture such relationships differed and included a range of people such as family members, peers, school members or those in the community. In terms of how relationships were measured, a variety of terms were used; for example, communication, engagement, support or involvement. Associations between health and family were found for measures, such as; closeness, contact with separated parents (Lindstrom, 1992), connection (Roth and Brooks-Gunn, 2000), relationships (Duncan et al., 2007, Ward and Zabriskie, 2011), communication (Fenton et al., 2009, Lindstrom, 1992) and engagement, including having dinner together (Youngblade et al., 2007, Ward and Zabriskie, 2011) or "doing things together" (Morgan and Haglund, 2009, Ward and Zabriskie, 2011). Issues of measurement and definition will be discussed later (Measurement issues*, page 84*).

Getting along with teachers and classmates was also associated with positive health (Lindberg and Swanberg, 2006, Duncan et al., 2007, Fenton et al., 2009, Kia-Keating et al., 2011) as were relationships with friends (Duncan et al., 2007, Caldwell and Witt, 2011) and staff working with youth (Garst et al., 2011, Caldwell and Witt, 2011). Associations between health and community were measured via such variables as neighbourhood involvement, relationships with co-workers (Morgan and Haglund, 2009, Duncan et al., 2007), social connectedness (Granger, 2002), social support and neighbourhood cohesion (Marsh et al., 2007, Garst et al., 2011) as well as broad asset collectives, such as "support and empowerment" (Benson, 2002, Scales, 1999).

The types of relationships linked with positive health varied across the research reviewed. There was not overriding support for each context. For example, in one paper, although relations with teachers/school and peers appeared associated with wellbeing, parental relations were not statistically significantly associated (Lindberg and Swanberg, 2006) though one Italian study suggested that parental support may well encourage school engagement (Vieno et al., 2007). Others looked at the role of "significant adults", but found little evidence to support their role in improving young people's health in the short term (DuBois et al., 2002). Elsewhere, social capital (as measured by family/school sense of belonging, autonomy and social networking) was found to have a stronger role in promoting health than the influence of family (Morgan and Haglund, 2009). The importance of relationships and support appear to vary between studies and participants, which emphasises the importance of providing health promoting opportunities in a variety of settings so that there is the possibility of compensation should individuals have lower levels of support elsewhere.

Suggestions of how constructive relationships could be built to improve health were made within the literature. The establishment and development of healthy relationships was identified as a teachable core competency by the Collaborative for Academic, Social and Emotional Learning (CASEL) (Weissberg and O'Brien, 2004). Additionally the opportunities provided by play and other leisure activities to develop social relationships was highlighted (Mainella et al., 2011). Assets may be promoted formally through teaching or encouraged to develop more informally though social interaction; both emphasise the importance of the health enhancing role of settings.

Safety

Safety is a broad heading encompassing both physical and emotional safety. School and neighbourhood safety was associated with greater social competence in one study (Youngblade et al., 2007) whilst other papers found an association between sense of belonging to school and wellbeing (Morgan and Haglund, 2009, Kia-Keating et al., 2011). If parents feel an area is safe they are more likely to let their children play outside, which brings a range of physical and emotional benefits (Mainella et al., 2011). In terms of trying to define emotional safety, the researchers proposed concepts such as living with limits, rules, boundaries or expectations (Duncan et al., 2007, Roth and Brooks-Gunn, 2000, Benson, 2002, Youngblade et al., 2007, Kia-

Keating et al., 2011, Garst et al., 2011). Stability and sense of belonging within a family was linked with youth satisfaction (Ward and Zabriskie, 2011).

Health maintenance behaviours

A range of specific healthy behaviours were associated with healthy or thriving outcomes such as: eating habits (Lindberg and Swanberg, 2006, Morgan and Haglund, 2009, Duncan et al., 2007), physical activity and play (Bronikowski and Bronikowska, 2009, Duncan et al., 2007, Mainella et al., 2011, Ward and Zabriskie, 2011), having a bedtime, exercising regularly and using a seat belt consistently (Smith and Barker, 2008). Healthy behaviours have been linked with comprehending meaning (Lindstrom, 1992, Bronikowski and Bronikowska, 2009, Granger, 2002, Dawes and Larson, 2011) and holding positive perceptions (Fenton et al., 2009). Parents who modelled healthy behaviours believed their children had greater levels of social competence and engagement with health promoting behaviours (Youngblade et al., 2007).

Autonomy/independence

Autonomy and independence were linked with positive health through a variety of measures. This included active decision making (Duncan et al., 2007, Caldwell and Witt, 2011, Dawes and Larson, 2011, Morgan and Haglund, 2009), taking responsibility for planning activities (Bronikowski and Bronikowska, 2009) and making a commitment to learning (Benson, 2002, Granger, 2002, Dawes and Larson, 2011). The importance of opportunity for unstructured leisure time was linked to promoting independent thinking and decision making (Mainella et al., 2011).

Being motivated to achieve was also identified in the literature (Smith and Barker, 2008, Caldwell and Witt, 2011, Dawes and Larson, 2011); this links with the concept of self regulation, an ability to "*formulate, pursue and attain goals... that are beneficial to both self and context*" (page 62, Gestsdottir et al., 2011). Self regulation has been proposed as a fundamental facet of positive development (Gestsdottir et al., 2011, Kia-Keating et al., 2011, Urban et al., 2010). The ability to use spare time constructively was highlighted as health promoting (Benson, 2002, Caldwell and Witt, 2011). The facility to act autonomously, identify opportunities and pursue these to meet goals could be considered internal assets.

Positive attributes – positive sense of self

Studies list positive characteristics linked with healthy outcomes such as being caring or compassionate, having integrity (Scales, 1999), values (Smith and Barker, 2008), moral commitment (Roth and Brooks-Gunn, 2000) and hope (Kia-Keating et al., 2011).

A range of positive attributes link to the concept of self regulation mentioned in the preceding section above. Attributes such as self efficacy, confidence, self esteem or a positive sense of self have been identified as resources that promote successful adaptation throughout adolescence (Caldwell and Witt, 2011, Smith and Barker, 2008, Vieno et al., 2007, Roth and Brooks-Gunn, 2000, Kia-Keating et al., 2011, Benson, 2002, Granger, 2002, Scales, 1999, Garst et al., 2011, Youngblade et al., 2007). There are similarities between such attributes and the concept of being socially competent (Benson, 2002).

Themes to guide health promotion

As well as identifying assets, the narrative synthesis aimed to understand the processes linking assets with the creation of health (salutogenesis). The underlying objectives were to consider young people's perspectives of health promotion and identify the settings that were most important for promoting their health. Two themes were identified through the narrative synthesis; "holistic" included how assets and risks might be tackled together and "ecological" incorporated the different contexts in which assets might be promoted or created.

Holistic approach to health promotion – interplay of risk and protective factors

> "... *a holistic and comprehensive approach to optimising adolescent development requires an understanding of factors related to both reducing problem behaviour and increasing positive competent youth behaviours*"
>
> (page S48,Youngblade et al., 2007)

Although many researchers were keen to develop the potential of an assets approach, they appreciated that risk and protective factors may be linked. The Search Institute have identified that those young people with the highest number of assets demonstrate more thriving behaviours and fewer risk behaviours (Benson, 2002, Scales, 1999). The importance of simultaneous consideration of reduction of risk behaviours and increase in positive behaviours was stressed (Youngblade et al.,

2007). Findings from cross sectional study analysis highlighted this interplay between behaviours, risks and assets; those students reporting possession of the highest number of assets were less likely to report engaging in health compromising behaviour and more likely to report health enhancing behaviours (Murphey et al., 2004, Smith and Barker, 2008, Donnon and Hammond, 2007). Therefore, rather than concentrating simply on disease and risk prevention, one study suggested that healthcare settings should undertake dual risk and strength assessments as part of their young people's health screens (Duncan et al., 2007).

Risk is not necessarily to be avoided at all costs, there are likely to be levels that are safe and desirable for healthy growth. Some authors suggested that risk taking was important for youth development; for example, through challenge courses or wilderness trips (Garst et al., 2011) and the emotional risks involved in staging entertainment events (Caldwell and Witt, 2011). The types of risks discussed varied in terms of their potential to impact emotional or physical health, but were likely to induce increases in adrenaline. It was proposed that risk avoidance was not enough and that one should actively promote strengths building, which would have the added bonus of also helping to reduce risk behaviours (Kia-Keating et al., 2011). For example, youth development programs should stress skill and competency development rather than avoidance of specific problem behaviours (Roth and Brooks-Gunn, 2000). Another paper suggested that, by promoting protective factors, young people become more resilient, reducing engagement in at risk activities and correspondingly increasing more prosocial or constructive behaviours (Donnon and Hammond, 2007). Although these papers described a potential relationship between risk and protective factors and their effects on health behaviours, there was no obvious deconstruction of this interaction. It was not clear how the factors worked together, compensated for each other or how the outcomes may be interrelated.

Ecological approach- the different settings for the asset-health process (the multiple contexts of health promotion)

The external environments of young people were discussed as offering a range of opportunities for health promotion. Many papers looked at the effects of parents/home life, teacher/school, peers and neighbourhood/community on positive health outcomes (Roth and Brooks-Gunn, 2000, Youngblade et al., 2007, Marsh et al., 2007, Granger, 2002, Smith and Barker, 2008, Vieno et al., 2007, Ward and

Zabriskie, 2011, Kia-Keating et al., 2011). The "Caring School Community (CSC)[20]" introduced interventions to promote cross age group working, family involvement at school and whole-school community building activities – this strengthening of links was seen to improve prosocial behaviour (Weissberg and O'Brien, 2004). Such findings link to the theoretical background of youth development which acknowledges "*a child's embeddedness within a complex pattern of social institutions*" (page 124, Benson, 2002). As well as appreciating the roles of various organisations, the environment has also been cited as an arena for health promotion. The positive impact of interaction with nature was identified, with suggestions that such opportunities reduced stress and anxiety (Garst et al., 2011, Mainella et al., 2011). Such evidence highlights the range of different opportunities to promote assets and improve health.

Discussion of findings

Within this section findings from the narrative synthesis are discussed in light of the review's aims and objectives (*page 62*). Limitations of the literature reviewed are first explored with proposals as to how these areas can be developed.

Areas for further development

The review and narrative synthesis identified a list of assets associated with positive health and wellbeing amongst young people. However, the majority of assets came from US based papers which tallies with a systematic review that found few UK based trials in health promotion and public health interventions (Harden et al., 2009) It is not clear whether the assets identified from the US studies are generalisable to the UK population, given differences in religious and social attitudes between the two countries. The lack of UK data emphasises the need for research into the key assets important for the health and development of young people in England.

The review also aimed to clarify the processes at work to promote young people's health. The deficiency of intervention and longitudinal studies meant that it was not possible to ascertain how assets could be manipulated to promote, create or sustain health. Experimental studies would be useful to identify the dynamic relationship between assets and risk factors; how they impact both promoting and more problematic behaviours. The lack of longitudinal studies also meant that the optimal

[20] CSC is a program which helps elementary schools become caring communities through a range of activities.

timings for asset based health promotion could not be established; no studies were identified that could illustrate how quickly an impact on health could be demonstrated following acquisition or development of an asset. This has implications for policy and practice, as it is not clear when would be the best times to intervene to promote health. Other research acknowledges this; for example, it has not been clarified how Sense of Coherence (SOC) develops (Marsh et al., 2007) over time or why the number of assets decrease between the younger and older year groups (Benson, 2002, Scales, 1999).

Further research is required to understand prioritisation within the range of assets. Although a distinction was drawn between internal assets (i.e. specific to the individual) and external assets (outside the individual's control, for example, school or neighbourhood level) there did not appear to be a difference in priority given to one over the other (Donnon and Hammond, 2007, Scales, 1999, Smith and Barker, 2008). Positive outcomes seemed to be associated with having a mixture of internal and external assets. It could be suggested that an internal asset such as self regulation or autonomy facilitates young people seeking out opportunities for development within the multiple contexts that they inhabit (Urban et al., 2010, Gestsdottir et al., 2011). There may be some core internal assets which provide young people with the ability to make the most of other assets to promote their health; however it is not clear from existent literature what these might be.

The role of young people within health promotion

Underneath the main aim there were three objectives to this review and synthesis, the first being to gain an understanding of young people's perspectives of health promotion. From the research papers reviewed it is unclear whether young people were involved in the development of the questionnaires used to measure their health and wellbeing. Although, by using broad search terms, it was hoped that this information would be identified, possibly an additional, separate question was needed.

Quite often outcomes appeared normative; for example, what adults might feel are healthy behaviours; doing well at school, wearing a safety helmet or seat belt (Benson, 2002, Donnon and Hammond, 2007, Scales, 1999, Smith and Barker, 2008). The success of the Promoting Alternative Thinking Strategies (PATHS)

programme, which was designed to develop emotional awareness and peer relationships, was measured by how well children follow rules and stay on task (Weissberg and O'Brien, 2004). In this study, as in several others, there appeared little attention paid to positive health, wellbeing or happiness. Often the emphasis was placed on academic achievement, or the necessary assets to become a responsible adult rather than consideration of a young person's current wellbeing.

Young people may have a different understanding of health and wellbeing as compared with adults. Amongst all the papers examined, there was just one study in which young people (12 year olds) were asked to include their own definitions of wellbeing and they responded by including suggestions such as being comfortable, having fun, being glad or happy, feeling well, being healthy, eating healthy food, being physically active and sleeping well (Lindberg and Swanberg, 2006). Being able to capture young people's views and terminology to use within health promotion strategies is likely to improve the effectiveness and relevance of such strategies.

The context of health promotion

The second objective was to understand which settings for health promotion were important to young people. The multiple contexts and significant individuals that affect a young person's positive health were identified in the synthesis captured by the "ecological" theme. Granger highlights the importance of moving away from producing a list of factors needed by an individual; he states:

> *"Although it is possible to conceptualize strengths and assets as existing primarily in the person, theory suggests that they are meaningfully manifest only in the transaction between the person and the environment" (page 153, , 2002).*

To improve the effectiveness of health improvement interventions it therefore appears likely that one should bear in mind the many contexts in which young people live and consider how they negotiate within these arenas when addressing the promotion of assets.

A settings approach within health promotion moves the focus from individuals to the organisation with which the young person interacts; creating conditions that are supportive of health and wellbeing (Tones and Green, 2004). The idea of promoting

healthy places is already seen within such initiatives as “Healthy Schools” and health promoting hospitals. However taking this further leads to the value placed on actively connecting with the community (Hawe and Shiell, 2000) which links with consideration of young people as active social agents, shaping the world around them (the New Social Studies of Childhood (James and James, 2004, Mayall, 2002)) and stresses both the importance of participation and having a community prepared to encourage and support such participation. The concept of self regulation, mentioned above within the “autonomy” asset (“Assets”, *page 76*), determines how well an individual can make the most of the assets available to them in the different contexts in which they live (Gestsdottir et al., 2011, Urban et al., 2010). Direct research with young people provided a chance to increase understanding of the opportunities and supports required by them to promote their health.

Within the selected literature, a range of activities that might promote young people’s health was discussed with a fairly dichotomized split between the structured and less structured. There were arguments for the benefits of organised initiatives (Roth and Brooks-Gunn, 2000, Weissberg and O'Brien, 2004, Caldwell and Witt, 2011, Urban et al., 2010) and others who were more in favour of unstructured activities (Mainella et al., 2011, Garst et al., 2011). In some discussion, unstructured time was seen as a potential risk to health (Benson, 2002). The types of activities though to be beneficial or risky to health, may be labelled as such form an adult perspective; this again highlights the importance of young people’s involvement in furthering understanding.

Measurement issues

The final objective was to discover more about the measurement of assets and improvements in health outcomes. The terminology used with assets can be fairly abstract making accurate measurement difficult (Wang et al., 2011). This may cause difficulty in making true comparisons across studies; for example, is a broad concept such as “communication” measuring the same asset, study to study? There was also an issue grouping assets for example; there were similar constructs linked with independence and positive attributes (for example, self regulation and self efficacy). Positive attributes also appeared associated with autonomy and health maintenance behaviours. The narrative synthesis did not resolve this objective but indicated a level of awareness amongst existing research which requires further investigation.

Chapter conclusions

This narrative synthesis aimed to identify the main assets and processes associated with young people's positive health. Although the initial hope was to discover effective interventions to improve health there were few empirical studies located. The range of the search was broadened to include opinion and views based papers in order to capture as much information as possible on potential health promoting assets. The narrative synthesis has included a range of papers which have incorporated expert opinions built over decades of research, based on work with hundreds of thousands of young people. The papers identified through the search criteria took different approaches to consider how health could be promoted, from analysis of survey data to intervention study, from theoretical discussion to evidence review. The findings from these varied approaches were brought together by using narrative synthesis. The use of narrative synthesis was adopted as a pragmatic response to make the most of the existent research and knowledge.

Not all the papers incorporated within the synthesis used the term "asset" and so may have been missed if broad search terms had not been used; this supports the use of salutogenesis as an umbrella term to incorporate the many asset-type approaches. The synthesis has identified a list of assets that appear to be associated with positive health amongst young people; constructive social relationships, safety, health maintenance behaviours, autonomy/ independence, positive attributes/ sense of self (Table 4*, page 74*). Constructive relationships included family members, peers, school members and the community with suggested processes including the use of play and leisure activities to develop social relationships. Physical and emotional safety were linked with health and measured by capturing information on "living with rules and boundaries" and sense of belonging. The literature proposed that feeling safe in a neighbourhood helps develop social competency. Healthy eating, physical activity, play and regular bedtimes were identified as important health maintenance behaviours that promote health for young people. Autonomy was associated with positive health through the idea of unstructured leisure time and development of independence; measured through active decision making and taking responsibility. A range of positive attributes were identified through the synthesis including concepts such as: integrity, values, moral commitment, hope, self efficacy and confidence. The holding of

positive attributes appeared linked with both autonomy and the practice of health maintenance behaviours; for example, a healthy level of self regulation aids the setting, pursuit and attainment of goals.

The two themes identified through the synthesis were a consideration of the interplay between risk and protective factors (indicating the importance of a holistic approach to health promotion) and the multiple settings that impact health (advocating an ecological approach to health promotion). Within the holistic theme some papers proposed that taking risks did not always result in poor outcomes; there was a close relationship between risks and assets which was not entirely understood (an increase in assets might decrease the likelihood of risk behaviour through better negotiation, similarly navigation of some risks might increase assets and/or improved outcomes). The papers that described the ecological theme identified the multiple contexts young people inhabit which included home, schools and community; there was variation as to which settings might be most important for health promotion.

The narrative synthesis met its aim of identifying assets associated with young people's health, as well as offering some ideas as to how health can effectively be promoted (for example alongside risk reduction and within the multiple contexts in which young people live). However, the synthesis ascertained that there is currently a lack of UK based research on assets approaches to health promotion with young people (only 2 papers used English data). Although the review identified research from the US, there is uncertainty as to whether these assets will have the same relevance to young people in England. This highlights the need for asset based research focussing on young people's health and wellbeing promotion in England, building on the assets and themes identified.

The types of studies identified in the synthesis suggested associations between assets and positive health but the processes leading from one to the other are still unclear (in part this was due to the lack of published intervention studies). Clarification regarding the measurement of assets and the asset health promoting process remain unresolved. Other objectives included gaining an understanding of young people's views of health promotion. Young people's voices appeared missing from most of the research; many assets and outcomes appeared adult-centric. This justified the need for qualitative fieldwork with young people to capture their views on

the subject of effective health promotion initiatives (for example, probing the debate regarding unstructured and structured activities), to identify definitions of assets in their own terminology and to gain young people's perspectives on the asset health process. Such direct research provided opportunity to identify a sense of priority amongst assets and health promoting settings, ascertaining which are the most important for young people.

Chapter 5: Methodology and methods; the choice of mixed methods

Introduction

The narrative synthesis identified a list of assets associated with health for young people; however, it was not clear whether these would be relevant to English youth due to the lack of UK based research. This chapter sets out to explain the methods chosen to identify the assets associated with young people's health in an English context with reference to the underlying theoretical perspectives.

The narrative synthesis had identified that there was no predominant methodology in assets research. A quantitative approach appeared the best option to identify associations between assets and young people's health, whilst adding depth to these findings and exploring the processes involved leant itself more to qualitative methods. Some of the assets identified within the narrative synthesis appeared adult-centric; without understanding their relevance to young people it might prove difficult to encourage engagement with health promotion initiatives. A mixed methods approach was chosen as a pragmatic solution to answer the research question as comprehensively as possible.

The first part of this chapter provides justification for the choice of methods whilst the more practical aspects of how the research was carried out are discussed in the second half of the chapter. Issues of researching with young people, including ethics and confidentiality, are explored.

Choice of methods

Each branch of research is based on a set of paradigms or theoretical perspectives; a particular way of looking at the world. The practical research methods employed depend on the question to be answered and the epistemological stance of the researcher (Bowling, 1997). Our understanding of how knowledge is created (our epistemological position) can be considered as a spectrum including subjective idealism, objective idealism, critical realism, scientific realism and naive realism (Barnett-Page and Thomas, 2009). The researcher's philosophical stance will be shaped by how strongly the researcher believes there is one true version of reality to

be discovered (or rather, whether they believe that there are an infinite number, that everything is subjective). Critical realism is somewhere in the midst of the spectrum, acknowledging that different research participants may have different views, but by combining research findings a shared reality or truth will be approximated (Danermark et al., 2001). In terms of a review of evidence, a positivist is likely to err towards a statistical meta analysis. However, my view was that whilst one single answer could be captured through combining statistical papers, this might be at the expense of losing detail and perspective available through "views" papers. This research takes a pragmatic perspective, making the most of incomplete information, collecting it together and drawing out the combined messages.

The narrative synthesis identified a range of different methods employed in existing assets' research; there was not one dominant methodology. Assets are multifaceted factors; as discussed in chapter 3 (*page 36*), the quantification and measurement of them is difficult due to their qualitative elements.

> *"In order to capture these complex phenomenon and their causal effects on outcomes of interest, there needs to be an approach that integrates both data collection tools and analytical strategies to consider how particular health assets are internally structured, externally related to a set of interacting contextual factors, and finally, causally connected to positive health outcomes"* (page 85, Hills et al., 2010).

A mixed methods approach was adopted for this research. Such an approach has been described as "... *an attempt to get the best of all the available options*" (page 45, David and Sutton, 2004). A methodology was needed which could incorporate the qualitative and quantitative components of assets models research.

Creswell suggests that when different methods need to be brought together, it is useful to take a theoretical lens as the overarching perspective to the research (2003). The methods chosen to answer the research question were brought together by the underpinning theoretical frameworks of assets approaches and the New Social Studies of Childhood. This use of frameworks to guide this research resonates with Dillow who describes their use: "*to cradle my thinking rather than ... as a structural straightjacket*" (page 148, Dillow, 2009). These perspectives bring the strands together to form one research programme.

Mixed methods

Definition, aims and benefits of mixed methods

Although current terminology may refer to this type of research as mixed, multiple or combined methods, within this research the phrase "mixed methods" will be used. There are various definitions of mixed methods (for example, see Table 1 in Johnson et al., 2007). In its most general sense, mixed methods means the:

> *"deliberate use of more than one method, theoretical framework, and/or paradigm to overcome the technical and political limitations of a single strategy"* (page 18, Greene and McClintock, 1991).

By using both quantitative and qualitative methods a greater insight is afforded of health assets than either method could provide by itself. This ability to achieve a more comprehensive perspective and improve accuracy of findings is supported in the methodology literature (Tashakkori and Teddlie, 2003, Coyle and Williams, 2000, Lingard et al., 2008).

The narrative synthesis identified the limitations of current knowledge and a mixed methods approach offered the potential to address these as fully as possible. This makes use of an advantage highlighted in the following definition which states that mixed methods research is "...*an intellectual and practical synthesis based on qualitative and quantitative research"* and that this method will often *"provide the most informative, complete, balanced, and useful research results*" (page 129, Johnson et al., 2007). Quantitative analysis, by its very nature, cannot come up with qualitative reasons. Differences between health outcomes can be identified, plotted and measured but not fully explained. Whilst qualitative analysis may provide in depth explanations on a topic it is unlikely to result in findings that can be generalised to a large population. By utilising quantitative and qualitative methods, the aim was to provide a more detailed answer to this research question.

Mixed methods research is informed by the postmodernist belief that there are multiple, diverse ways of understanding the world. "... *each method yields a different slice of reality*..." (page 246, Denzin, 1989). A mixed methods approach takes into account the need for interaction between theory and evidence. Findings from the

narrative synthesis, quantitative and qualitative analysis were taken and used to build on, clarify and refine each other. Wright Mills argues:

> *"that any systematic attempt to understand involves some kind of alternation between (empirical) intake and (theoretical) assimilation, that concepts and ideas ought to guide factual investigation, and that detailed investigations ought to be used to check up on and re-shape ideas"* (page 74, Wright Mills, 1967).

The iterative ongoing process of testing ideas against findings is a benefit of this method of working.

Although there is some knowledge as to which assets may be linked to health, there is little knowledge within the UK context or an understanding of the processes behind **how** such assets affect health. Qualitative techniques have an advantage over quantitative methods in situations where pre existing knowledge is minimal and there is a need for exploration (Bowling, 1997) or interpretation (Tonkiss, 2004b). The use of qualitative techniques within this research provided opportunity to add meaning to quantitative findings and generate more in depth discoveries through close working with participants. Qualitative methods have been suggested as a way to understand the paradoxes that quantitative data reveal (Graham, 1990). When methods are mixed, they may obtain a more accurate and comprehensive perspective of participants' experiences (Tashakkori and Teddlie, 2003, Coyle and Williams, 2000).

> *"By coupling the power of the general with the insight of the particular, such research illuminates people's lives and the larger contexts in which they are embedded"* (page 440, McLafferty, 1995).

It has also been suggested that, through emphasizing public participation, mixed methods can serve a transformative purpose through airing voices and views to policy makers (Stewart et al., 2008). This facility to include young people's perspectives links with the underlying theoretical framework of the New Social Studies of Childhood.

The debate between qualitative and quantitative research proponents appears to be lessening whilst the interest in the potential in mixed methods approaches is growing. There are those who believe that there has been an overemphasis on

differences between approaches, with less attention paid to the shared ground between methods (Spicer, 2004, Hammersley, 1992a). Others have gone farther still, suggesting that it is impossible to undertake research thoroughly without using a collection of methods.

> *"Qualitative and quantitative data are indivisible. It is not possible to count something until there is first a definition of what is to be counted – therefore the issue must be understood qualitatively. Questions cannot be framed for surveys without knowing what words and concepts will be understood by community members, including children. Statistics can only be correctly interpreted through an understanding of the context in which they have been generated".* (page 14, International Labour Organisation, 2002)

There appears a growing interest in mixed methods and the more complete answer to certain research questions that they offer.

Combining findings

There are various ways in which quantitative and qualitative methods can be combined. Collating and comparing findings from different methods can be viewed as a way to corroborate results (Rossman and Wilson, 1985), elaborate (Clarke, 2003), complement (Greene et al., 1989), seek convergence (Mark and Shotland, 1987, Johnson and Turner, 2003), or enhance validity (Denzin, 1978). Within this research mixing methods aimed to compare results (corroborating or identifying differences), thus expanding knowledge in the area.

Although some mixed methods studies call for a strict sequential approach with each method being undertaken in isolation, a more holistic approach was used within this research. For example, findings from the narrative synthesis were used to hone the quantitative analysis. This component then formed the basis for the qualitative work with young people, which sought to gain better understanding of assets within health promotion. The qualitative research provided an opportunity to explore any findings from other sources that did not appear to make sense or contradicted each other. Through this process, one set of findings elaborates on results from another method, with collaboration and/or convergence noted along the way; the overall aim being to seek more comprehensive results than any one method would achieve by itself. There were additional regular iterations within the research with results compared

between strands of the research to enhance understanding; for example the literature was returned to following initial quantitative results and both sets of results referred to as findings emerged from the qualitative fieldwork.

Researching with and for young people

The involvement of the public within strategic planning and commissioning of new initiatives has been a constant theme within the NHS over the last few years; including, for example, World Class Commissioning (Department of Health, 2007) and the more recent Health and Social Care Act 2012 which aims to put people and communities at the heart of the health and care system[21]. Public Health guidance on changing health related behaviours includes as its first recommendation that the target population should be involved in the development of any intervention and that interventions should include not only an assessment of need but should build on the population's existing strengths or assets (National Institute for Health and Clinical Excellence, 2007). Over the last ten years, a range of resources has been produced to promote the involvement of children and young people in a range of activities from research to policy making (Butcher, 2010). Involving children and young people in research adds quality to the research, as children and young people are best placed to know their needs and prioritise what is important to them (Sharpe, 2009). Christensen and Prout (2002) outline four ways that children and young people have been identified in research:

1. Child as object (dependent and protected by adult interpreters)
2. Child as subject (more of a child centred perspective, but dependent on an adult to define who to engage with and how)
3. Child as social actor (autonomous child, no distinction between child or adult as participant in terms of methods or ethical standards)
4. Child as participant/co researcher (balance of power is volatile and changeable between adults and young people – adult may still determine how much participation is required).

At the outset of this research I contacted the local Children's Trust participation worker for guidance on how I could facilitate young person involvement with my research. On his recommendation I contacted one of the local Area Youth Forum's to

[21] http://healthandcare.dh.gov.uk/system Accessed 28/1/13

gain their views on the potential of my research, the outline of my participant leaflet and ideas as to the qualitative component. There was a great deal of support for the idea of an assets approach although also a considerable amount of explanation needed. This highlighted the need for me to be present at the qualitative sessions, rather than it being young person led, so that I could explain terminology where necessary and keep the discussion on track. It also emphasised the need to have a tight age range; the particular group I attended was made up of a mixed group of 12-19 year olds and the discussion was dominated by the older boys.

The choice of methods and level of participation is important in ensuring that research with young people is inclusive and accurately captures their views. The aim within the qualitative component of this research was to work *with* young people rather than *on* them; this is in line with suggestions by Mayall (1996). It has been argued that viewing children as objects denies young people access to power and knowledge and thereby increases their vulnerability and dependency (Kitzinger, 2000). The use of focus group discussions is one method of trying to redress the balance of power between researcher and researched (Tonkiss, 2004b). It has been proposed that the use of focus groups with young people provides opportunity to identify and explore the issues that they feel most strongly about (Brooks and Magnusson, 2006). Others have suggested that young people feel more confident to participate in research when carried out in a focus group setting (Stafford et al., 2003). However, as discussed later (*page 107*), not all young people feel comfortable with the idea of participating in focus groups and therefore interviews were also offered to encourage involvement with this research.

Ethical considerations

Involving young people within research raises ethical considerations. The Children Act 1989 sets out statutory codes of conduct but these are the minimum accepted standards. Before undertaking the qualitative part of the work, ethical approval was sought and granted from the University of Hertfordshire's Nursing, Midwifery, Social Work, Criminal Justice and Counselling ethics' committee (NMSCC/06/10/9/A). Information on ethics and consent regarding the original HBSC study is available within the HBSC England National Report (page 7, Brooks et al., 2011). Ethical guidelines for practice provide a higher set of standards; guided by core principles

including respect for persons, beneficence, non maleficence and justice. These principles are discussed below.

The principle of respect for persons means that research participation must be voluntary and participants must give their informed consent to participate. Within this research, all participants received a participant leaflet setting out the aims of the research, information on confidentiality and anonymity, and what participation would involve (Appendix 3: participant information leaflet). The participant leaflet assured potential participants that their participation was completely voluntary. The leaflet was discussed at the start of each session and young people's understanding of the research was checked. It was made clear that they could opt out at any time; signed informed consent was gathered before discussion and audio recording started.

Beneficence is the ethical obligation to do good, whereas non maleficence is the obligation to avoid harm. The possible benefits from this research were highlighted in the participant leaflet. The potential for psychological or emotional harm from discussing health issues was considered and information on support groups for a range of health issues was taken to all research sessions in case any upset was triggered. Feedback from participants was that the sessions were enjoyable; no obvious harm or distress was noted or reported, the information on support groups was not required by any participant.

The principle of justice demands a fair sharing of both risks and benefits. It is also important in the selection of research participants, conduct of the research and dissemination of results. Young people from a range of cultural backgrounds were included in the fieldwork. Data were stored carefully and participants' names were anonymised in the write up to reduce risks of disclosure to participants.

Confidentiality

Research confidentiality aims to ensure that information is not disclosed so that participant identities are protected. This may involve anonymising individuals, not revealing the location of the research and being careful not to disclose facts that may identify an individual. Confidentiality of participants' contributions to the interviews and focus groups was assured, though it was explained that there may be some exceptions where confidentiality cannot be guaranteed; for example, if a young person disclosed that they are being harmed or ill treated. In the UK, although there

is not currently a legal duty to report, the local authority and my professional code of conduct obliges me to report to local child protection designated leads, should I have suspicions of abuse.

Before running the groups, clarification from a designated nurse colleague was sought regarding child protection concerns. The guidance received was:

- Should any disclosure take place, to note any allegations carefully, in case it is later needed by other professionals or court,
- To be clear that my role is of researcher and I should therefore not try to counsel or advise.
- To contact local child protection services immediately to discuss any concerns.

No such issues or concerns were raised by participants during the fieldwork.

Having discussed the theoretical issues involved with mixed methods, this next section discusses the practical methods undertaken for each strand of the research; section 1 considers the quantitative component, section 2 details the qualitative fieldwork with young people and section 3 provides information on practitioner engagement. The chapter concludes by reflecting on the approaches taken.

Methods: Section 1: Quantitative research; mapping young people's assets in England

Introduction

One of the objectives stated was "*to identify which assets are associated with young people's health and well being in England*" (*page 22*). The narrative synthesis had identified a list of potential assets but this was mainly drawn from US research. To provide an English focus it was decided to undertake secondary data analysis of the Health Behaviours of School Aged Children (HBSC) study 2009/10; using this dataset to map core assets for young people within England.

> *"Population based epidemiological studies have not only the potential to identify important (combinations of) key assets on a population level but – based on representative samples – can also point out their public health*

relevance and prevention potential" (page 129, Wille and Ravens-Sieberer, 2010).

It is recommended that data are summarised first before analysis, starting with simple graphical techniques and moving to the more complex, with the most simple method chosen that is consistent with the needs of the data (Kirkwood, 1988). My role in the quantitative research was to undertake the initial descriptive analysis and plan the more detailed statistical analysis; guiding the investigation, deciding on which variables and outcomes to include. The in depth statistical analysis was undertaken in conjunction with a University of Hertfordshire statistician, with my being present at the sessions when the analyses were carried out to ensure I understood how the models were created. I then interpreted the findings from the statistical output.

The Health behaviours in school aged children study (HBSC)

In this section, detail is provided on the Health Behaviours of School aged Children (HBSC) study and the data set used in this quantitative analysis. HBSC is a long-standing study that dates from 1982, when researchers from three countries (England, Finland and Norway) recognised the need for comparable cross-national data on young people's health; the study is a WHO international collaboration. Scotland and Wales joined for the 1985/86 survey and Ireland for the 1997/98 survey. Although English researchers were among the founding members and carried out the first survey in 1983/84, England did not participate in subsequent rounds and re-joined the study for the 1997/98 survey. HBSC has grown over time to include 43 countries. Surveys are conducted every four years according to an internationally agreed Research Protocol[22].

The overall aim of the study is to gain new insights and increase understanding of adolescent health behaviours, health and well-being, with an emphasis on the social determinants and contexts of adolescent health. The evidence produced from HBSC is able to inform a wide range of policy and practice agendas.

The HBSC data set is a vast collection of health and wellbeing data. A broad analysis of the data is produced which provides an overview of the health and

[22] http://www.hbsc.org/publications/research_protocols.html Accessed 13/8/11

wellbeing of young people in England (Brooks et al., 2011); there are also comparator reports between other collaborating countries[23].

The survey considers young people's lives at different points of adolescence (English school years 7, 9 and 11; this corresponds to ages 11, 13 and 15 years old). These age groups are selected because they represent the onset of adolescence, the challenge of physical and emotional changes, and the years when important life and career decisions are beginning to be made.

Data were collected by a self-completed, standardised questionnaire administered through supervised sessions in the classroom. An HBSC research protocol is produced for each survey cycle providing scientific rationale for the questions within the study[24]. The questionnaire comprises an internationally agreed mandatory core set of questions, a range of available optional packages and country specific questions. Core questions are concerned with the health behaviour and the social and developmental context of young people (individual and social resources, health behaviours and health outcomes). The specific England only questions included questions on family life and parenting, PHSE (Personal, Health and Social Education), happiness, self efficacy, support from teachers, communication with grandparents, experience and participation in community life and peers smoking behaviour. Students' participation in the study was voluntary and their responses anonymous. Children who were absent from class on the day of the survey were not followed up. Information on response rates are provided within chapter 6 (Description of the data, *page 132*).

More information on the study including reports can be found at www.hbsc.org and www.hbscengland.com

Access to the dataset

Access to the study dataset was gained through contact with the English Principal Investigator (P.I.) for the HBSC study; a cleaned SPSS data file was provided. Both English co-Principal Investigators acted as supervisors for this doctoral research.

[23] http://www.hbsc.org/publications/international/ Accessed 11/11/12
[24] http://www.hbsc.org/methods/index.html Accessed 11/11/12

Sample size and statistical power

The sample universe for the English study consisted of pupils in the maintained and non maintained sectors, with the exception of special and hospital schools. Schools were sampled to achieve an equal number of pupils in each year group, stratified by the number of years covered by the school and by type of school.

The sampling unit within the HBSC study was an individual member of the English school population aged 11-15 years. Sample size calculations were undertaken by the HBSC study group to take account of multiple levels; for example, geographical location and school. Sample sizes of approximately 1500 in each age group were required to ensure a confidence interval of +/-3% around a proportion of 50% (HBSC International report, 2008).

Hypothesis and significance testing

The substantive hypothesis was that an association would be found between certain variables (assets) and a positive health outcome (life satisfaction).

Statistical significance refers to a measure that assesses the actual probability that findings are more than coincidental (O'Leary, 2004). If a variable has no effect on positive health then the regression coefficient is expected to be close to zero; SPSS calculates and reports the related “p-value”. The “p-value”, is the probability of being wrong if one rejects the null hypothesis (i.e. the null hypothesis in this instance is that there is not an association between an asset and positive health).

It should also be noted that, even when statistical significance is identified, this does not necessarily mean that the results have clinical or social significance. Social relevance may be determined through giving due attention to the actual size of observed differences and confidence intervals rather than solely concentrating on “p-values”.

Appendices 4 and 5 provide detail on the p values obtained from the regression analysis.

Steps in the analysis

Descriptive statistics were first employed to summarise the characteristics of the young people who participated in the HBSC study. Further analysis then used regression techniques to explore the relationships between positive health and the various demographic, health and social variables which could be considered as assets. Regression analysis is ideally suited to analyse associations between a quantitative outcome variable and several explanatory variables. Before the regression analysis was undertaken, issues of weighting and clustering were discussed and investigated.

A model of main effects was created and then possible 2 way interactions between the significant factors were considered. Another model was then created, adding in the factors found to be significant, either as a main effect or as part of an interaction.

All statistical analyses were performed using SPSS version 18 (SPSS Inc., Chicago, IL).

Weighting

Regression analysis, by default, gives equal weight to each observation in the dataset. When the HBSC study was undertaken, research staff were keen to ensure that young people from a range of ethnicities were included; however, this resulted in a dataset which over-represented ethnic minorities when compared to the England average. The data in the dataset were therefore weighted to make the dataset representative of UK ethnicity, based on the results from the 2001 census for 0-7 year olds (as this would be the age group represented by the 11-15 year olds included in this 2009-10 HBSC study).

Clustering

Before any regression analysis took place, the statistician used a multilevel modelling package to determine whether the clustering of cases would have a meaningful impact on the analyses. Data had been collected at class, school and stratum (geographical region) level and there may have been some similarities between individuals due to these clusters which would then need to be accounted for within the analysis. However, estimation techniques for fitting a logistic multilevel regression model with weights (as would be desired here) are not well-developed in

currently available software. When the dichotomised variable "life satisfaction" was investigated; the extent of clustering at the class, school or stratum level was slight. As a result, there was confidence that non-multilevel analysis methods would not yield results that were markedly different from those that would be obtained using multilevel methods.

Variables included

Life satisfaction was chosen as the outcome variable within this analysis as it captures both positive aspects of health and wellbeing as well as the absence of disease; it is considered to be a relatively stable measure over time (more information on this variable is included within chapter 6, "Outcome variables", *page 135*). Life satisfaction was dichotomised with those scoring less than 6 defined as having poorer life satisfaction and those scoring six and over deemed to have better life satisfaction; this is in line with other HBSC analyses (Currie et al., 2008). As the outcome variable was recoded as a binary outcome, logistic regression could be used to create the model. Previous English studies had converted all categorical variables to binary. However, I was concerned that if this approach was followed a wealth of data from the multi category responses would have been lost. Factors were therefore included as categorical variables within the regression analysis. The model was constructed in a stepwise fashion.

A range of demographic factors were included in the analysis, initially to describe the young people within the study but also to explore whether there were differences between subgroups of young people. The approach to the analysis involved much discussion and iterations; an initial view was to take the list of variables which most closely matched the factors determined from the narrative synthesis; another option was to try to analyse the data to correspond with previous researchers. A mixture of variables were chosen from the dataset to capture issues such as autonomy, relationships, communication and safety (as identified via the synthesis), whilst trying to cover different settings such as home, school and community. This aligns with the Search Institute's division of assets into internal and external and also resonates with the layers of the wider determinants of health (Dahlgren and Whitehead, 1991) discussed in chapter 1 (*page 19*). The variables included in the analysis are listed below (Table 5, *page 105*), grouped as to whether they are demographic, outcome or possibly predictor variables; with detail provided on how they are measured.

Further description of the measurement and definition of variables is provided within the reporting of findings (chapter 6, *page 131*). Several new variables were created from the dataset – variables to stand for communication with "mother figure" and "father figure" (to take account of the differing family structures that the young people were drawn from) and FAS (Family Affluence Scale). More detail on the measurement of affluence occurs in chapter 6 (Description of the data*, page 132*).

Limitations

The HBSC study is a cross sectional study and cannot, by the nature of its design, provide robust evidence on either causality or the direction of causality. Analysis of the dataset suggested associations between assets and life satisfaction, however, it cannot be stated that accumulation of these assets will improve life satisfaction. Although this information could be used to shape further research to identify how the manipulation of assets promotes health and wellbeing.

The HBSC study employs techniques to generate a representative sample; using a large dataset from a representative sample adds to the applicability and credibility of the research findings (O'Leary, 2004). However, as the study relies on self report and not all questions are answered, the findings may not be accurately illustrative of the views of young people in England. There might be reasons why students do not respond to some questions and this might be important in understanding the role of some assets on health. There is also the possibility of social desirability bias occurring when participants provide the types of answers that they believe are expected by the researcher. However, the self complete questionnaire was undertaken confidentially within a school setting, without peer influence and should therefore reflect the young person's views. Although difficult to determine the representativeness of the study findings, the analysis was based on over 4400 responses drawn from a range of young people across the country; the study is often quoted as a representative dataset (for example, within "Positive for youth" (HM Government, 2011)).

The quantitative analysis was a secondary data analysis making use of a dataset already in existence. This had benefits in terms of timely access to information and the wealth of data available. However, analysis was constrained by the questions already set. Other assets related to health and wellbeing might not be included within

the study questionnaire. This was one of the reasons for using mixed methods in that this data could be supplemented through using qualitative discussion to:

> "*allow people to speak in their own voice, rather than conforming to categories and terms imposed on them by others*" (page 1105, Sofaer, 1999).

Direct research with young people goes some way to address the problem identified with the use of surveys; that they may miss assets pertinent to young people (Rutten et al., 2009). The qualitative work therefore provided opportunities for young people to identify any other assets that they felt to be associated with health and wellbeing.

<table>
<tr><th></th><th>Qn.</th><th>Variable code</th><th>Variable</th><th>Response</th></tr>
<tr><td rowspan="6">Demographic, social and economic variables</td><td>1</td><td>M1</td><td>Gender</td><td>Male/Female</td></tr>
<tr><td>2</td><td>M2</td><td>Year Group</td><td>Year 7/ year 9/ year 11</td></tr>
<tr><td>7</td><td>eng_si6</td><td>Ethnic Group</td><td>18 options provided as well as “not known” and did not want to answer</td></tr>
<tr><td>46</td><td>m122</td><td>Family well off</td><td>Very well off/ quite well off/ average/ not so well off/ not at all well off</td></tr>
<tr><td></td><td>fas</td><td>Family Affluence Scale</td><td>Computed from 4 variables to provide low/ middle/ high ranking</td></tr>
<tr><td>48</td><td>si1</td><td>Area well off</td><td>Not at all well off/ not so well off/ average/ quite well off/ very well off</td></tr>
<tr><td>Outcome variable</td><td>30</td><td></td><td>Life satisfaction</td><td>1-10</td></tr>
<tr><td rowspan="14">Predictor variables &/or Assets</td><td></td><td>bestfatherfigureexclgrand</td><td rowspan="4">These variables looked at communication with the “father/ mother figure” if there was not a father/mother in the home</td><td rowspan="4">Very easy/ easy/ difficult/ very difficult/ don’t have or see this person</td></tr>
<tr><td></td><td>bestmotherfigureexclgrand</td></tr>
<tr><td></td><td>bestfatherfigureinclgrand</td></tr>
<tr><td></td><td>bestmotherfigureinclgrand</td></tr>
<tr><td rowspan="8">51</td><td>m82</td><td>Talk to father</td><td rowspan="8">Very easy/ easy/ difficult/ very difficult/ don’t have or see this person</td></tr>
<tr><td>m85</td><td>Talk to stepmother</td></tr>
<tr><td>m84</td><td>Talk to mother</td></tr>
<tr><td>m83</td><td>Talk to stepfather</td></tr>
<tr><td>m86</td><td>Talk to elder brother</td></tr>
<tr><td>m87</td><td>Talk to elder sister</td></tr>
<tr><td>eng_m84a</td><td>Talk to grandmother</td></tr>
<tr><td>eng_m82a</td><td>Talk to grandfather</td></tr>
<tr><td>54h</td><td>Fc42</td><td>Sit and talk about things together</td><td>Every day/ most days/ about once a week/ Less often/ never</td></tr>
<tr><td>20</td><td>m106</td><td>Academic Achievement</td><td>Very good/ good/ average/ below average</td></tr>
</table>

	Qn.	Variable code	Variable	Response
	21	Sop9a_1	Students participate in deciding class rules	Strongly agree/ agree/ neither agree nor disagree/ disagree/ strongly disagree
		Sop9a_2	Students have some control in deciding tasks	
		Sop9a_3	Students participate in deciding how to work on tasks	
	23	M107	Liking school	Like a lot/ like a bit/ don't like it much/ don't like it at all
	24	M108	Students like being together	Strongly agree/ agree/ neither agree nor disagree/ disagree/ strongly disagree
		M109	Students are kind and helpful	
		M110	Students accept me	
	47	Eng_liv1	People say "hello" and often stop to talk	Strongly agree/ agree/ neither agree nor disagree/ disagree/ strongly disagree
		Eng_liv2	It is safe for younger children to play out during the day	
		Eng_liv3	You can trust people around here	
		Eng_liv4	There are good places to spend your free time	
		Eng_liv5	I could ask for help from neighbours	
		Eng_liv7	I feel safe in the area where I live	

Table 5: Variables used within the analysis

Methods: Section 2: Qualitative research; exploring the asset process from young people's perspectives

Introduction

The qualitative component of this research included focus groups and interviews to explore the asset process from a young person's perspective and to address the "adult-centric" findings identified within the reviews of policy and existent literature. The objectives of this research included the identification of assets important to young people's health and wellbeing in England and clarification of young people's views regarding health and health promotion (*page 23)*. The qualitative research aimed to identify more detail on the timings of interventions, exploring how assets may work and incorporating young people's own words. Including young people as active participants in research raises their profile and helps ensure the relevance of research, the findings of which may impact their lives (Prout and James, 1997, Christensen and James, 2000, Fraser et al., 2004, Alderson and Morrow, 2011, James et al., 1998, Mayall, 2002). This section describes how the focus groups and interviews were set up and run.

Sampling

The method of participant selection is dependent on the aims of the research; for example, a random sample is needed if a representative group is wanted, whereas purposive sampling chooses people who have experience of the topic. The prime concern of this research was not in trying to generate generalisable results from the qualitative component but rather exploring the how and why of the asset process. The sampling method used here was therefore closer to purposive[25] or theoretical sampling[26] (Seale, 2004). The purpose of this sample was to include young people interested in talking about health, whilst recognising that these people did not (or could not) be representative of all young people in England.

[25] Purposive sampling selects participants on the basis of them having a significant relationship to the research topic. This may result in broadly reflective groups of the population of interest (rather than being representative of the population as a whole).

[26] Theoretical sampling selects participants with the aim of developing insight in relation to the research area; the idea being to explore ideas of particular groups rather than being reflective of the general public.

There was also an element of opportunistic sampling within the research. Initially, it was planned to select participants via a Children's Trust in the South of England. Participation in service development and delivery had always been a priority within this particular borough; for example, their Children and Young People's Plan was inspired and driven by local children and young people. This borough was chosen to gain maximum variation from the sample; parts of the borough are leafy and affluent, whereas other parts are densely populated containing some of the most deprived wards in the country. There are a range of cultural and ethnic backgrounds within the borough and it was hoped that, by drawing participants from diverse groups, a variety of views would be given. However, recruitment from the Children's Trust proved to be slower than expected. A request was therefore made to the Ethics committee to widen recruitment so as to also speak with young people from outside this borough; this was granted. All qualitative fieldwork took place in the South of England.

A range of strategies were employed to recruit young people interested in talking about health. These young people were drawn from a range of backgrounds so that as diverse a sample as possible could be generated.

Composition of the focus groups

Three focus groups were undertaken as part of the qualitative research. The groups were made up of young people in established friendship groups as there was no certainty that there would be an opportunity to revisit the participants at a later date; there was a need therefore to "hit the ground running". The first group of 5 girls knew each other well; three of them having been friends since they were 2 years old. They spent time together both during school and out of school. The other group of 6 girls were all students at a local school and had known each other since year 7; there was also a sibling pair within the group. The third focus group was made up of two boys who had been friends during school. It has been suggested that use of pre-existing groups allows easy conversations as there is already a shared understanding and comfortableness between members (Kitzinger, 1994). Nevertheless, others have claimed that using such groups may result in stilted conversations due to the power relations that may exist (Tonkiss, 2004b). It was important to be aware of any such issues and challenge any "norms" or phrases that were not understood. In the first

focus group, one girl took the lead and on occasion there was a need to step in and encourage wider participation in the discussion.

The aim had been to recruit 6-8 participants to each group. This size would allow a range of views to be captured whilst not being too large that debate was stifled. Details on the groups are given in Table 6 (*page 108*) and highlight the difference in size of groups; issues of recruitment are discussed below. Research has illustrated that older children often dominate in mixed aged groups and there are differences in communication styles between boys and girls (Scott, 2003). Therefore the groups were single gender and contained similar ages.

There are no rigid guidelines concerning the ideal number of focus groups that should be carried out, as it is often dependent on the complexity of the topic (Bowling, 1997). As research suggests that it is unlikely to get any new data from more than 5 groups (David and Sutton, 2004) holding three to five groups felt to be optimal; this was borne out by the findings generated. In all 3 focus groups and 2 interviews were carried out during the academic years 2011/12 and 2012/13; their characteristics are detailed below (Table 6).

	Number of participants	**Age range**	**Male: Female**
Group 1	5	14-15	All female
Group 2	6	14-15	All female
Group 3	2	18	Male
Interview 1	1	13	Male
Interview 2	1	15	Male
Total	**15**	**13-18**	**4 male: 11 female**

Table 6: Participants included within the qualitative research

The qualitative fieldwork participants all attended or had attended comprehensive schools in the South of England. The young people lived in diverse settings, from built up urban to semi-rural. Based on national ranking of deprivation scores, 9 participants came from areas within the top quintile of deprivation whilst just under half the young people (6) came from relatively affluent areas (bottom two quintiles of

deprivation)[27]. This was used to give an idea of the level of material deprivation within the geographical area that young people were drawn from though it cannot be assumed that these young people were from an affluent or more materially deprived family; it is simply an average for the local area. The young people came from a range of ethnic backgrounds including White British (4), White Irish (3), Other White (1), Black British/Caribbean (1), Black British/African (1), Any Other/ Any Other Mixed (5). Although the ethnicity monitoring form included 16 options it could not accurately capture some of the young people's heritages.

It was relatively straightforward to recruit two groups of girls. However, recruiting boys proved more difficult. Two possible focus groups were negotiated but these failed to recruit (reasons provided included: lack of time at the school to incorporate a focus group and the local participation worker moving posts). Another attempt to recruit via a Scouts group gained no interest. A request to Ethics was made, to include interviews within the qualitative part of the research; this was granted. Two boys initially expressed interest but one withdrew (he did not want to speak face to face, attempts were made to carry out the interview by phone or via email but he decided not to participate and did not want to provide reasons). Further requests for interview participants only attracted girls; one boy that was approached said "*he wasn't interested in the topic*" though his sister was. Other attempts to encourage involvement in research included via a youth participation worker and through a summer play scheme; both failed to recruit. Attendance at a community event recruited potentially two small focus groups (one mixed and one all male), however in the mixed group the boy asked if he could be interviewed separately rather than discuss things in front of the girl; this group therefore became an interview. It has been noted by other researchers that there is a general tendency for females to be more willing to talk about health issues than males (Radius et al., 1980).

[27] Office of National Statistics: Indices of Deprivation 2010. Deprivation is scored and local authorities ranked within the country; actual rankings are not given here to ensure anonymity. The term deprivation is used to refer to material deprivation.

Setting

The plan was to hold the groups and interviews in a neutral setting, as research context has been identified as an influence on the way children respond; for example, when research is carried out in schools, children may respond as though sitting a test and try to give the “right” answer (Scott, 2003). The setting was discussed with participants to identify what worked best for them: they were busy people with a variety of extracurricular activities. One of the groups and an interview were conducted at participants’ homes, with another group based in an office meeting room near the young people’s school. One interview and a focus group were held in a marquee during a community event in a park; this setting was not ideal due to lack of privacy and background noise.

Data collection

Data were gathered via digital audio recorder and then transcribed. It was planned to save the digital recordings onto a password protected computer. However, the software failed and instead the recording was kept in a locked cabinet. The use of recording allowed me to concentrate on guiding the discussion without having to concentrate on capturing all that happened in the group. Observational notes were also gathered to supplement these recordings. The word association activity required the group to make notes on A4 sheets which were gathered in at the end of the session; these were added to, following transcribing of the audio recording. Notes were taken during the conduct of the sessions to highlight topics or issues to be returned to or further explored. It also provided a back up, should there have been problems with the recording equipment. After each group, my initial impressions, feelings, reflections and interpretations were written up.

Session structure

The method of undertaking qualitative research varies to include a highly structured discussion, which facilitates comparison between groups, to fairly unstructured, which allows exploration of topics (David and Sutton, 2004). Within this research, the aim was for sessions to be semi-structured, with minimal initial intervention from myself to ensure that participants set the tone. However, as suggested by Kitzinger, this was balanced with enough intervention to encourage debate to continue (Kitzinger, 1994). This section outlines the session structures, providing information on the topic guides produced to frame the discussion.

The sessions started with discussing issues of confidentiality and consent – ensuring that people knew what they had signed up to. The research was briefly outlined and an overview provided of what was expected to happen during the session. I set out my role and the roles of participants; explaining how their thoughts and views would be captured. Ground rules were set, based on their suggestions with additions and included:

- Stressing the importance of taking turns (only one person speaking at a time, no sub group discussions)
- Participants do not need to wait to be asked a question before talking, if there is something important that they want to say
- There are no right or wrong answers
- Allow others to speak so that everyone can be heard.
- Respect the right of others to express views that are not your own
- Speak clearly
- Respect the confidentiality of group members
- Identify any particular type of language that should not be used,
- Agree whether phones should be turned off or put on silent

The structure of the sessions was guided by Appreciative Inquiry which is a method used within asset mapping. "*Appreciative inquiry is a process for valuing and drawing out the strengths and successes... of a group*" (page 26, I&DeA, 2010). It is thought of as having 5 stages:

1. Define – set the positive vision – how do we create/sustain positive health
2. Discover – through storytelling, appreciative conversations etc. the strengths, experiences and gifts of the group
3. Dream – what might be
4. Design – discuss innovative ways of achieving the dream
5. Delivery – set an action plan

Concentration within the sessions was on the first three of the stages (Figure 8*, page 113*).

The topic guide for focus groups (Figure 10*, page 117*) kept the sessions "on track" without structuring them too tightly, a similar structure was followed for the interviews (Figure 11*, page 118*). Depending on the age of participants and the setting, flexibility was required as some participants were more forthcoming with information and keener to get involved than others. There were some sessions which required fairly regular prompting to obtain data; the girls groups were more free-flowing than the fieldwork with boys. As well as the postcards and word association prompts (discussed later in this chapter), graphs of some of the data from the quantitative analysis were used to start discussion.

The next sections outline the activities that were included within the qualitative fieldwork; ice breaker, discussion and postcards. The use of group exercises has been recommended to reduce input by the facilitator and encourage group interaction and discussion (Kitzinger, 1994). There was flexibility in the order of the components to take account of differences between interviewing and focus group discussions, be responsive to the participants and to incorporate learning of how things fared from one session to the next.

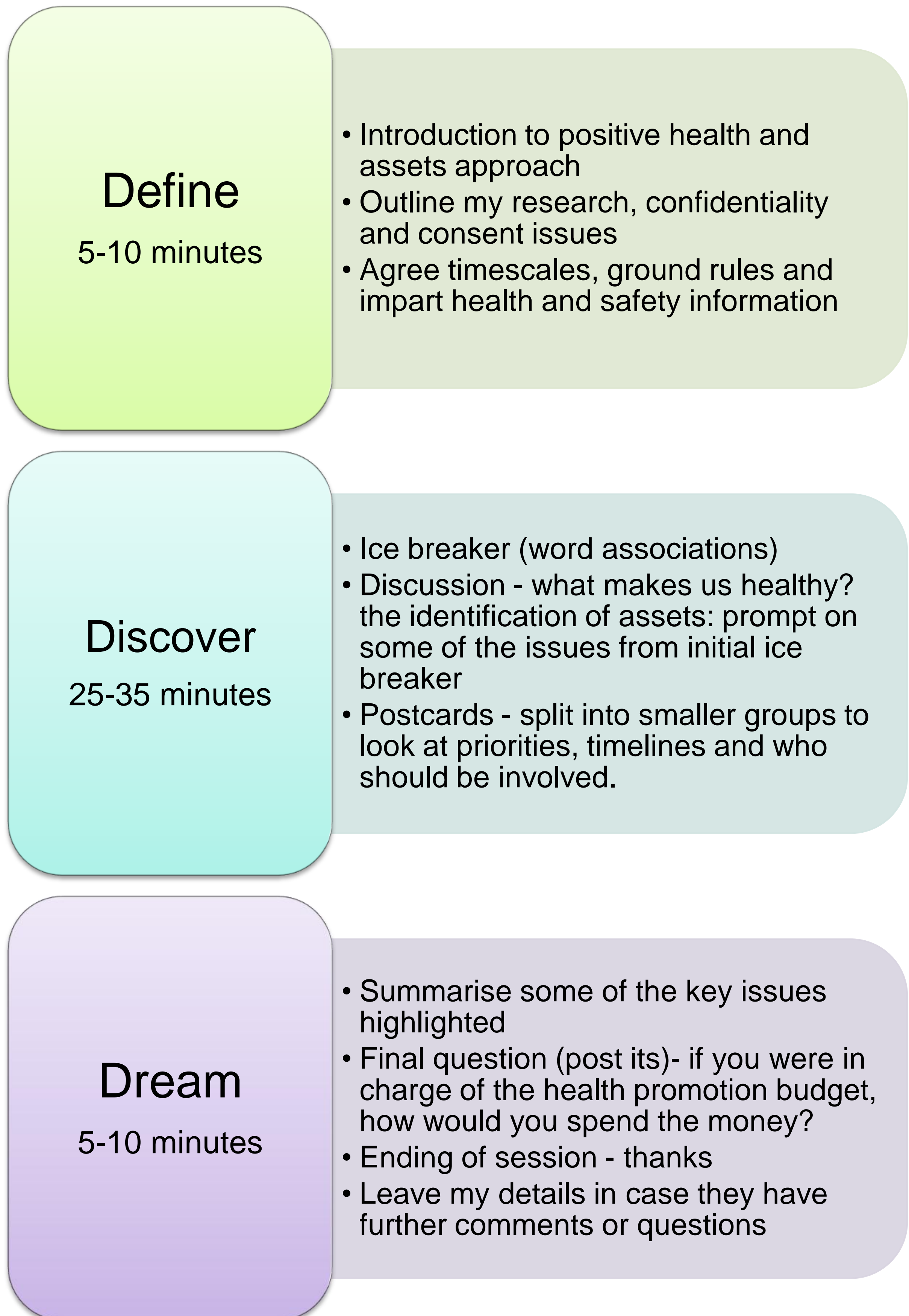


Figure 8: Typical focus group session structure (based on Appreciative Inquiry (Cooperrider et al., 2003))

Icebreaker

Aware that people may not have heard of assets, an initial icebreaker activity provided the chance to provide some background and get the group thinking about assets. This follows recommendations from the methodological literature to craft an ice breaker to act as a discussion starter (Morgan, 1996) and help young people relax into the research process (Boyden and Ennew, 1997). During my second progression viva, the external examiner suggested using a word game as an ice breaker; she had had success with this at previous focus group sessions. This involved placing words in the centre of a piece of paper and asking young people to think of positive and negative associations with the word – positives on one side and negatives on the other. She suggested just taking one minute per sheet of paper and then using findings from this to prompt further discussion. This activity has similarities with a word reflection approach taken to encourage youth participation (Sabo Flores, 2008).

The assets identified via the narrative synthesis, the quantitative research and the HBSC Seville DVD (HBSC, 2010) were chosen as the central words (Figure 9*, page 115*). 10 A4 sheets were produced with a word at the top of each and then the page divided in half to capture positive and negative associations side by side. Health maintenance behaviours (identified via narrative synthesis) were not included as it seemed too broad a topic for a 1 minute exercise – however, this was prompted on, later in the session. Some of the assets identified were made more general – for example, communication with father figure became communication. The ice breaker therefore got people thinking about negative and positive positions as an introduction to assets, without focussing too much on either side.

The initial "ice breaker" took longer than expected with the first focus group and, after a few pages, I asked the girls to choose the last 2 words to concentrate on, so that we could move to a more general discussion; they chose independence and money (out of "being optimistic", "safety" and "relationships"). With the second focus group, I split the group in half, with 3 girls working together on each sheet of paper. This worked well and a lively debate ensued. I encouraged the girls to choose the words they wanted to work on rather than being prescriptive and, as with the previous group, time-limited the activity which meant that not all topics were covered. The girls

chose: Group A: school, family, money and Group B: relationships, independence, being optimistic, neighbourhood. Words not chosen were: friends, communication, and safety. With the third group there appeared some reticence regarding aspects of literacy (for example, reading the participant leaflet which I explained verbally) so the ice breaker was not used. Instead, the words from the ice breaker were incorporated as prompts within the discussion.

Although the ice breaker was not used as an activity within the interview, the words were talked through as an introduction to the type of assets that had been identified.

The words used were:

	Reasons for choosing
Relationships	Narrative synthesis HBSC – qualitative research DVD
Safety	Narrative synthesis HBSC – qualitative research DVD Quantitative finding
Independence	Narrative synthesis HBSC – qualitative research DVD
Being optimistic	Narrative synthesis
Money	HBSC – Inequalities in young people's health report 2005/6 survey Quantitative finding
Communication	HBSC – Inequalities in young people's health report 2005/6 survey Quantitative finding
Family	HBSC – Inequalities in young people's health report 2005/6 survey HBSC – qualitative research DVD
Friends	HBSC – Inequalities in young people's health report 2005/6 survey HBSC – qualitative research DVD
School	HBSC – qualitative research DVD Quantitative finding
Neighbourhood	HBSC – qualitative research DVD Quantitative finding

Figure 9: Words used for the icebreaker activity

The positive aspects from some of these word sheets were used to start the discussion.

Discussion component of sessions

A broad schedule of questions and themes for discussion within the focus group and interviews was produced; covering some of the issues and disparities identified by the research to date. Questions were based on those piloted with the international focus groups (aired via DVD at the HBSC conference in Seville (28th to 30th April, 2010)). I had also taken my research proposal to a local Area Youth Forum in July 2010 (this is a regular youth meeting for those aged 11-19) to gain views and feedback; this indicated that some young people did not fully take to the concepts of assets and deficits, so terms such as positive aspects of health or health promotion were used within the fieldwork. The topic guides provided suggestions, rather than a fixed structure, so that discussion could stay responsive to the focus group participants (Figure 10) and interviewees (Figure 11).

Visual prompts were used when necessary within interviews and focus groups to start or re-energise discussion. The postcards were used to provide examples of different aspects of health and aided clarification of definitions (postcards are discussed in more detail below, *page 119*). The figure of the "life satisfaction ladder" used within the HBSC study was shown to clarify how health and happiness could be captured through the variable life satisfaction (Figure 15, *page 137*). Two graphs from the quantitative analysis were discussed in both interviews and the smallest focus group; the first illustrating the different life satisfaction scores between boys and girls (Figure 16, *page 138*), the second the differences in age group scores (Figure 17, *page 138*). This provided a prompt to start discussion of differences in health between genders and ages, then moving on to suggestions for the creation or promotion of health.

What is important for your health/how do you keep healthy? *(note terminology used)*

To prompt on themes such as:

- support from family and friends,
- role of school and neighbourhood.
- Autonomy/independence
- Positivity
- What comes first, how do assets & outcomes interact & inter relate (think about priorities, causation & timings)
- Have they noticed a difference over the teen years as to what's important for their health & wellbeing (dependent on the groups age)
- If they have a health concern, what do they do, who do they talk to (is this different for boys v girls, or different ages?)

What makes you happy and how?

prompts around:

- relationships between health & happiness
- coping strategies

The following areas have been suggested by other people as important health promoters. What do you think of their suggestions – are they important to you & why? Can you think of any others?

- Getting on with parents
- Having close friends
- Feeling comfortable in your neighbourhood/being safe
- Doing well at school

Whose job is it to help promote these "assets" – how can they do this & when? (Consider use of timeline)

Figure 10: Focus group topic guide

A similar structure was taken to guide the interviews.

Figure 11: Interview topic guide

What is important for your health/how do you keep healthy? *(note terminology used)*

- Talk through definitions of health, wellbeing & life satisfaction
- Look at graphs *(life satisfaction by age/gender)*
- Any suggestions of why these might be, why some people are healthier than others or report better health than others?

Describe assets & ask for some suggestions; prompt on but consider why/how these might then link to health:

- Positive social relationships – communication & support
- Safety
- Health maintenance behaviours
- Autonomy/independence
- Positivity
- Acceptance by others
- Liking school/ academic achievement

What would be the most important factor for health/happiness/life satisfaction?

How could health be promoted?

- Whose job is it
- When would be the best time
- If you were in charge, how would you do it

Any questions

Thanks

Postcards

This was the second planned activity within the focus group sessions – to move from discussion to something more "hands on". It has been recommended that when dealing with concepts (such as, health or wellbeing), it helps to have concrete examples (such as pictures or postcards) for those that might struggle with the abstract (Christian and Tubesing, 2004). Visual prompts have been successfully used by others to ease children and young people into a research process (Hill et al., 1996, Greene and Harris, 2011). The activity provided time to review some of the issues discussed before the end of the group session, in case there was anything where clarification was needed before the group dispersed.

The plan was to provide the group with a selection of postcards – some with pictures, others blank. The pictures included food items, animals, family groups, towns, communication items (for example, a post-box), celebrations, dancing and relationship emblems (several cards had pictures of hearts or heart shaped items, other cards depicted cartoon characters hugging); the cards were selected to try to reflect the assets identified through the narrative synthesis. The group would be given a minute to sort through and select one that spoke to them in relation to the promotion of positive health; if they were not able to find anything, they could write or draw something on the blank card. This could be something discussed in the group or something that they had thought of. The aim was to identify other aspects of health and health promotion; hopefully identifying key assets.

Time passed quickly in the first focus group and there was not time to look at the postcards. Because of this, I decided to start the second focus group with the postcard session so that they could think more about components of health and wellbeing, as definitions of positive health had been a bit of a stumbling block with the first group. However, although they were happy to rummage through the postcards and pick out cards they liked, they were not so willing to discuss why they thought their chosen cards were important for health – there appeared a reticence to provide this information so soon in the session. The postcards were used within one of the interviews to provide a visual reminder of aspects of health and wellbeing.

Post its - final session

As part of the closing session, key messages were requested of the participants; "If you were given the health promotion budget by government, how would you use it?" The same question was posed to all participants, regardless of whether within a focus group or interview. However, most participants responded verbally rather than using post its and these responses were captured via audio recorder and then transcribed.

Close of session

It was recognised that a final round up helps to finish a session and also provides a last chance to summarise key points. As well as a sense of closure, it also acted as a valuable data collection device (David and Sutton, 2004). Closing comments were guided by tactics for successful interviewing

> "*leave people with a feeling of success; for instance, indicate how valuable and insightful the observations generated have been*" (page 102, Arksey and Knight, 1999).

Participants took the participant information leaflet with them which included my university email address – I asked that they contact me if they had further comments or wanted to give any feedback which would help me to plan future groups or interviews (no comments or feedback were received).

Analysis

Although there is an extensive literature on how to conduct focus groups, there is limited advice as to analysis of the resulting data (Wilkinson, 2004). A particular challenge is how to capture the interactive nature of focus group data. Kitzinger reviewed forty focus group studies and

> "*could not find a single one concentrating on the conversation between participants and very few that included any quotations from more than one participant at a time*" (page 104, Kitzinger, 1994).

It is suggested that attention should be paid to the interactions that occur within the group, how subjects are discussed, whether there is debate and how ideas are shared (Duggleby, 2005). Audio data were recorded and supplemented with notes

on interaction within the group for analysis. Any group dynamics important to the research were emphasised in the findings, as suggested in the methodological literature (Carey, 1995, Stevens, 1996).

There has been considerable discussion regarding the rigour of qualitative research (Sandelowski, 1986, Rolfe, 2006, Tobin and Begley, 2004, Seale and Silverman, 1997, Koch, 1994), with some suggestion that the establishment of criteria for assessing the trustworthiness of qualitative research is unlikely to be achieved (Sparkes, 2001, Sandelowski and Barroso, 2002). This analysis was guided by the following features of rigorous qualitative analysis (Green and Thorogood, 2004):

- Provide a clear account of procedures used
- Analyse deviant cases
- Include enough context for the reader to judge interpretation
- Analyse the whole dataset
- Use more than one analyst or coder
- Compare findings to other studies
- Account for the researcher’s role in the research

It was felt that, by using this guidance, the credibility, applicability, consistency and confirmability of the results could be enhanced.

Credibility and applicability

The methods used, including describing the context and the participants, was detailed earlier in the chapter; this aids the credibility and applicability of the findings through providing a clear account of the procedures used (Lincoln and Guba, 1985). The whole dataset has been analysed, themes and findings have been compared between the different participant responses as well as to other studies. This helps ensure that the findings generated are credible for the participants. In terms of applicability, there is likely to be variation in the priorities of assets person to person in the wider population (explored within “Summary of qualitative findings”, *page 161*). However, the methods of discussing assets and generating suggestions for health promotion appear applicable to other settings or other groups of young people.

Consistency and confirmability

It is argued that tapes should be fully transcribed with detail provided on pauses, overlapping speech and raised voices; for example, as is done in conversation analysis (Seale and Silverman, 1997). However, it was difficult to transcribe all the audio recording as the participants often talked over each other. Where possible, the recording was fully transcribed but, in parts, some participants' voices were drowned out or not picked up clearly and so some of the talking was omitted from the transcription. This problem has been identified in others' research (Chapple, 2000). There were particular problems in accurate transcription from the interview and focus groups which took place at a community event; the fieldwork was undertaken in a marquee, with background noise from the generator, other attendees at the event and an ice cream van! The recordings were saved so that the research findings could be audited if necessary; a clear understanding of the process and how findings were reached are necessary for consistency (Koch, 1994).

The transcribed data were read through to get an overall impression and then annotated, summarised and significant words identified. Themes emerged over time as the recordings were listened to, and the transcriptions read, again and again. This was very much an iterative rather than linear process. The data were analysed using content analysis [28] with key themes identified and categorised. Themes were generated both inductively (from reading through the raw data) and deductively (through theoretical frameworks, narrative synthesis and quantitative findings) (Boyatizis, 1998). Illustrative quotations were also highlighted. In an effort to show the context to interpretation it has been noted where participants held different views from each other (inclusion of "deviant" cases). Methods to control for observer bias[29] would include having another researcher; this was not possible within this research, due to financial constraints. However, reflective notes have been kept which could be made available if necessary. Additionally, within the themes reported in the findings section, (*chapter 6: section 2, page 145*) it is noted how these have arisen;

[28] Content analysis is a quantitative approach for exploring textual data; analysing the presence and frequency of terms and concepts TONKISS, F. (2004a) Analysing text and speech: content and discourse analysis. IN SEARLE, C. (Ed.) *Researching society and culture.* London, Sage..
[29] Observer bias is the systematic difference between the "true" situation and the reported one observed by the researcher – differences can be due to perceptions and interpretation.

for example, whether from the original research aim, narrative synthesis or quantitative analysis.

Limitations

The qualitative component was based on a small number of participants (15 young people; 11 female and 4 male) drawn from the South of England. These groups had not been generated through random sampling. Whilst acknowledging that findings from focus groups form an insecure basis for generalisation (Tonkiss, 2004b), there were some similarities in participant views which might offer relevant insight to the wider population of young people in England. It should be noted that whilst it was relatively easy to recruit to two female focus groups there was some difficulty in recruiting young men to participate; there is therefore underrepresentation of boys within the qualitative research. The process of engaging with young people to discuss assets during the fieldwork also appeared to be more acceptable to girls than boys; the young women appeared happy to discuss health whereas more prompting was required to encourage discussion with male participants. On occasion, there were issues discussing health at a conceptual level, though this is in line with others' findings (Fattore et al., 2007, Backett-Milburn et al., 2003).

Although encouragement was sometimes required, participants did contribute independently, using their terminology to express their ideas about health. I found young people's language difficult to negotiate at times; many participants used the word "like" frequently within the sessions which often distracted me from the discussion. One participant described a relationship as "fair" which I took to mean OK, but then on further probing understood that he meant this was a really good relationship. The issue of adult interpretation of young people's meanings has been acknowledged by others as potentially problematic (Mayall, 1994, Bricher, 1999). Guided by other's research (Smith and Dunworth, 2003), I aimed to check back with young people during the sessions that I had understood their meanings, however, this can become disruptive to the flow of discussion. Interpretative differences with qualitative data are not limited to generational differences;

> *"there are frequently multiple interpretations to be made of qualitative data – that is their glory and their headache!"* (page 461, Cohen et al., 2007).

The inclusion of verbatim quotes aimed to demonstrate directly the young people's views to facilitate critique of any interpretation I might have made of their statements.

Although focus groups aim to capture the interaction of real social processes, they are not naturally occurring interactions. Pre existing groups may provide the type of social context in which ideas are formed. However, it has been argued that it should not be assumed that this approximates participant observation, for example, or "naturally" occurring data – they are artificial situations (Kitzinger, 1994). It cannot be inferred that this is what other groups would say outside of a research context. The "Hawthorne effect" is the term given to the phenomenon whereby people react differently because they know they are part of a study;

> "*the tendency, particularly in social experiments, for people to modify their behaviour because they know they are being studied, and so to distort (usually unwittingly) the research findings*" (page 107, Payne and Payne, 2004).

There is also the possibility of social desirability bias occurring when participants provide the types of answers that they believe are expected of the researcher. The focus groups are more likely to result in "group think". However; there was some lively discussion as views were debated. To encourage participants to answer as honestly as possible, they were assured they would remain anonymous. There is also the possibility of areas being "un-talked about". The majority of group participants were happy to discuss all areas raised and, although some prompting was needed with male participants, there were no stilted silences. The responses provided on assets could be considered as the answers the young people assume adults want to hear about; physical activity and healthy eating. However, there was some discussion of ideas around independence and opportunity as well as mental health. Following reflection after writing up the findings the only issue that appears missing is around sex and relationships; this is a potential "un-talked about" area.

Similar to other methods, the quality of the data generated is dependent on the design of the research. It is argued that the use of qualitative research may be "abused" by the way in which participants are selected, how the discussion is directed and how responses are interpreted and then disseminated (David and Sutton, 2004). Following suggestions from the literature, sufficient information has

been included to ensure that the findings are as credible, transferable, dependable and confirmable as possible (Marshall and Rossman, 1995). This adds to the quality of the findings.

Those who decided to participate in the focus groups may be different from those who were unable or did not want to volunteer. Being flexible to offer interviews ensured that other views were also captured, but again volunteers may have different views from non-participants.

Methods: Section 3: Practitioner engagement; exploring the practical implications of asset based models for health promotion

Introduction

It felt important that, as a professional doctorate, the research findings not only made a contribution to the science of health research but had application within professional practice. The idea of an assets approach and the findings from the research strands were therefore discussed with a small number of practitioners.

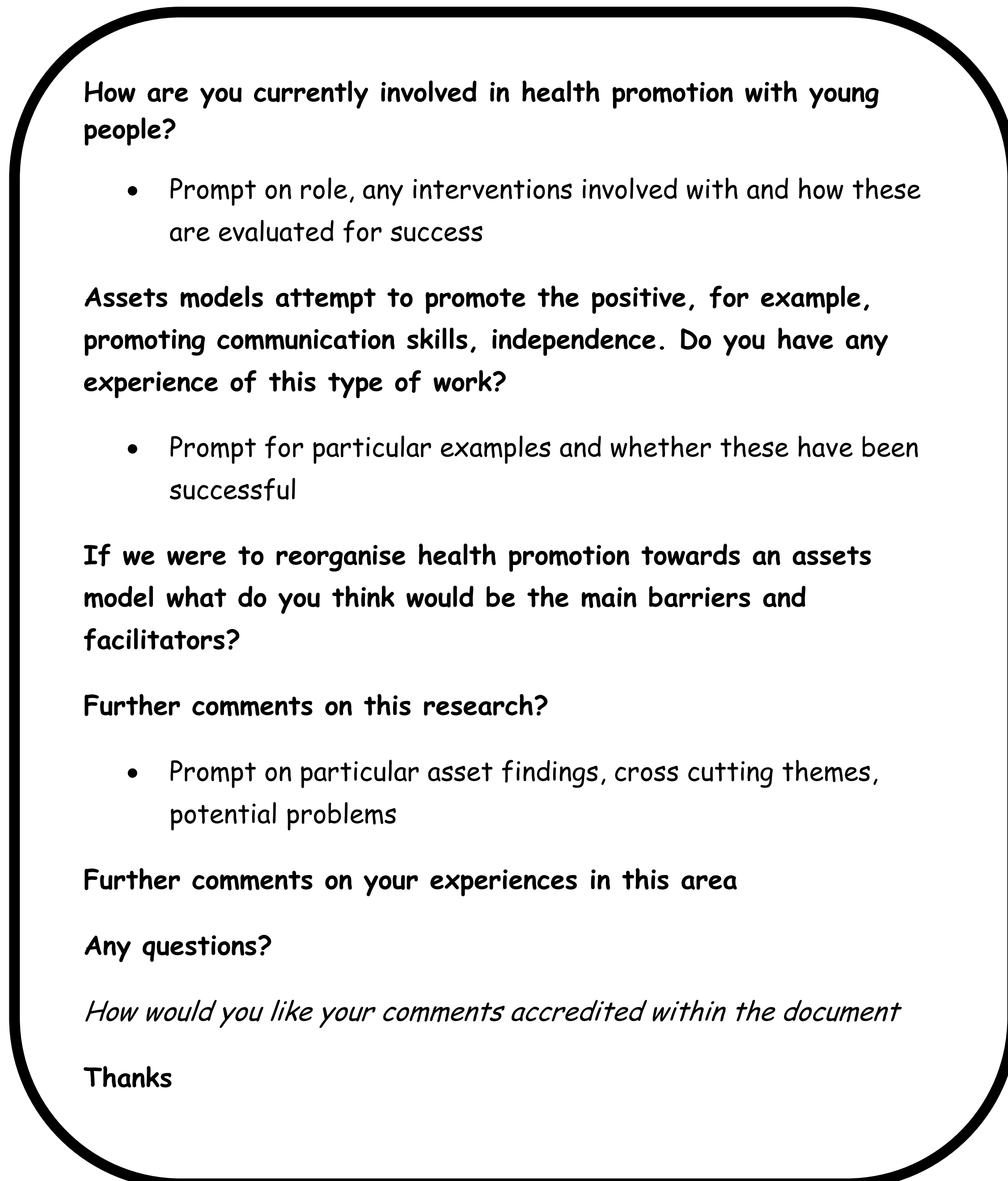
Sampling

A range of practitioners were contacted to take part in this consultation. Practitioner input was requested from people who were involved in improving young people's health, had experience of health promotion and/or commissioning of services for young people. It was intended that this discussion "test the water" with practitioners rather than trying to gain a sample from which generalised statements could be made. Five practitioners were approached and three agreed to take part.

Data Collection

The following tool (Figure 12) was used to gather information from practitioners. Depending on the preference of the responder information was collated verbally or electronically. I discussed the research by phone with all practitioners; two of these requested the tool so that they could send me more detailed information in their own time. During the phone conversations I provided an overview of the aim of this research, background to assets and deficits models and a very brief summary of findings so far. All verbal information was recorded and transcribed.

Practitioners were advised that their comments might be used verbatim within this research and asked how they would like to be referenced; job title was the preferred option.


How are you currently involved in health promotion with young people?

- Prompt on role, any interventions involved with and how these are evaluated for success

Assets models attempt to promote the positive, for example, promoting communication skills, independence. Do you have any experience of this type of work?

- Prompt for particular examples and whether these have been successful

If we were to reorganise health promotion towards an assets model what do you think would be the main barriers and facilitators?

Further comments on this research?

- Prompt on particular asset findings, cross cutting themes, potential problems

Further comments on your experiences in this area

Any questions?

How would you like your comments accredited within the document

Thanks

Figure 12: Data collection tool for practitioners

Limitations

These were the views of three practitioners who had different levels of experience in the field of improving health outcomes for children and young people. Their views cannot be extrapolated to the wider population of providers or commissioners. However, they do give a sense of some of the issues that practitioners might consider when re-orienting health promotion to the positive.

Reflection on approach chosen

The theoretical frameworks and paradigms that guide this research have been outlined in chapter 3 (*page 36*). This section reflects on how my professional background and personal views also influenced the approach chosen.

My background has mainly been within quantitative methods and this positivist sense of the world stays with me; for example, my initial view was that I would find an asset based approach to health promotion that could be tested and proven to be of value. However, quantitative analysis has had limited results in terms of evaluating successes from health promotion and I recognised a need to explore other avenues. A mixed method approach provided a pragmatic way of incorporating young people and practitioners' perspectives alongside a critical review of international evidence. This has provided more detail on assets and the asset health process than if I had stayed within my comfort zone of quantitative analysis.

There has been criticism of mixing methods as they have different underlying guiding principles. I found that these differing ideas and ideals pulled me in different directions. For example, I queried whether I was setting out with a hypothesis to test or whether I wanted to take a more exploratory approach – for example, within the quantitative analysis, I was torn between exploring the data to identify which assets may be linked with health and testing the list discovered from the narrative synthesis within the dataset. Similarly, with the focus groups did I "test" how relevant these assets were to their health or sit back and allow discussion to take more of an exploratory route? I was guided by the view that "*all good research combines elements of prediction and exploration*" (page 12, David and Sutton, 2004). I used a topic guide to remind myself to encourage participants' ideas together with checking their views on assets identified from other research routes. The iterative approach to

mixed methods also prompted me to revisit findings, to go back to the literature to compare my findings with what was already known.

Although I wanted to include high levels of participation within the research, I was frustrated with many aspects of putting this into practice. I found parts of the process of gaining ethical approval rather difficult to navigate. The ethics committee wanted a supporting letter from the Children's Trust that was supporting recruitment of participants. Although the manager was happy to provide this, she queried the need for ethical approval; they were avid supporters of participation and included young people regularly in their policy production and decision making processes (without ethical approval). To support the ethics process I had arranged access to an existing youth group to discuss my research and gain their views. However, at the group, the youth leader took over the topic of health and led a discussion with the young people which went off on a complete tangent. I was torn between asserting power to bring it back on topic and sitting back, listening to those issues that were being discussed as important to the young people that were there. An example of the problematic negotiations around participation were discussed by Mayall writing of her research with child participants, who were eager to be involved but also wanted to help write up the research. She describes the frustration of wanting to include but also understanding the time involved with analysis and writing up – so that these children may have grown out of their then stated views "*they move on but the data are fixed in amber*" (page 14, Mayall, 1996). It has been argued that it is not always possible or appropriate to include young people as full participants within research (Clavering and McLaughlin, 2010). I therefore decided to include participation via focus groups and interviews to capture the young people's views and ideas but retain control of the research aims, objectives and writing up of findings.

Qualitative methods have been criticised as being value laden and subjective, as some feel that results may be swayed by the researcher; clear notes were therefore taken after each session and the group discussions audio recorded. The benefits of keeping reflective notes whilst undertaking qualitative research have been discussed by a number of researchers (Koch, 1994, Clarke, 2009, Bowling, 1997). These notes provided an opportunity for me to check that the findings were an accurate recording and also remain as a part of this research should future audit be required.

The focus group discussions flowed well, whereas the interviews required more intervention from me. Due to the small number of sessions included for this research it was difficult to conclude whether the differences between the focus groups and interviews were due to the differences in gender, age or the approach of interview versus focus group. Within her PhD thesis, Williams discusses the literature regarding responses when there is a gender discrepancy between interviewer and interviewee; she also found that boys were more reticent in providing information than girls (Williams, 1998). Different findings (or more data) might have been achieved if I had been able to engage young people as peer researchers.

Concluding comments on methodology and methods

A mixed methods approach was chosen to provide as comprehensive a picture as possible of assets models of health promotion for young people in England. Although initially, the adoption of a mixed methods approach was a pragmatic solution to address issues raised within the narrative synthesis findings, the subsequent research results emphasised the benefit of using this methodology in terms of increased understanding that would have been missed if a single method had been adopted. Whilst this research included different methods and paradigms it was brought together by the underlying theoretical frameworks of assets models and New Social Studies of Childhood.

The quantitative analysis aimed to address the lack of knowledge highlighted by the narrative synthesis by identifying assets associated with health for young people in England. (Only 2 English papers had been included in the narrative synthesis). By using data from a representative sample of English young people this research aimed to create generalisable findings. Regression analysis can produce a list of statistically significant assets, though they may not be socially significant. The review of policy had identified a concentration on improving aspects of young people's future selves rather than a focus on contemporaneous health improvement. Whilst using data from a self complete survey intended to capture young people's views, findings were constrained by the questions included. Qualitative research offered opportunity for exploration of why some assets were important and facilitated identification of young people's views and terminology. (Only 1 qualitative analysis had been included in the narrative synthesis). Processes linking positive attributes with health maintenance behaviours and autonomy had been proposed in research

included in the narrative synthesis; the qualitative fieldwork aimed to extend this and provide more in depth understanding of the possible processes at work. As this research formed part of a professional doctorate, the views of practitioners were sought to gain a sense of implications for health promotion.

Chapter 6: Findings

Introduction

This mixed methods research aimed to identify which assets might improve young people's health. Through a critical evaluation of existing assets models it had been demonstrated that there was a lack of knowledge regarding both the identification of assets relevant to English youth and an understanding of the processes linking assets to improved health. It was therefore unclear as to which assets would be a priority for English young people and how such assets could be promoted to improve health.

Within this chapter, the results of the analyses are provided; findings from the quantitative analysis are presented below in section 1, followed by the qualitative research findings in section 2 (*page 145*). The regression analysis identified a list of assets associated with life satisfaction from a sample of over 4400 English young people. Qualitative analysis proposed a range of important assets, adding depth to the statistical associations and suggesting processes linking assets and health. The convergence and divergence of findings are brought together in Chapter 7 (*page 166*).

Section 1: Mapping assets in England

The aim of the quantitative component was to identify the main assets associated with young people's health and wellbeing in England, thus addressing the lack of specific information about this population group highlighted by the narrative synthesis. This first section provides the results from the quantitative analysis. It initially summarises the data, providing a description of the characteristics of the young people included in the study. The results from the regression analysis are then provided.

Description of the data[30]

The 2009/10 English study included 4404 "valid cases" aged 11, 13, and 15 years, drawn from a random sample of school students in years 7, 9 and 11 in England. Though, due to rounding, related to weighting (*page 99*) the total study population becomes 4410 young people. There were 30 schools included in the study. The overall response rate of questionnaires was 91.5%; 1% were refusals (parental or student); 3.5% were away from school due to sickness, and 4% were absent for other reasons[31].

Demographics
School

The majority of respondents attended a comprehensive school for young people up to the age of 18 (48.5%), with 22.9% attending comprehensive schools for those aged up to 16. Other types of school included: independent, grammar, middle and "other secondary". Participation was encouraged from schools across the country so that there was a spread across the regions; most participants were from the South East (23%) followed by East Midlands (20.3%), Yorkshire and the Humber (19.9%) and London (16%).

English Region	Number of schools	Number of participants	Percentage of participants by region
North West/ Merseyside	2	301	6.8
Yorkshire and the Humber	6	876	19.9
East Midlands	5	896	20.3
West Midlands	1	61	1.4
Eastern	1	397	9.0
London	8	713	16.2
South East	6	1018	23.0
South West	1	148	3.4
Total	**30**	**4410**	**100.0**

Table 7: Number of participants per region

[30] Some of these figures have been reported in the HBSC National report; permission to use the data for descriptive purposes has been granted from HBSC England.
[31] This includes a diverse group; for example, children on holiday, excluded/suspended, participating in the performing arts, at appointments such as dentist or doctor.

Age group

The study questionnaire asked the young person to tick which school class they belonged to – whether in year 7, 9 or 11. There was a fairly even spread between the year groups. However, some young people omitted to respond (263 cases, 6%). An age group variable was therefore calculated taking into account year group and age; this reduced the number of missing values. This more complete variable presents a fairly even response by age group, though with slightly fewer in the oldest age group.

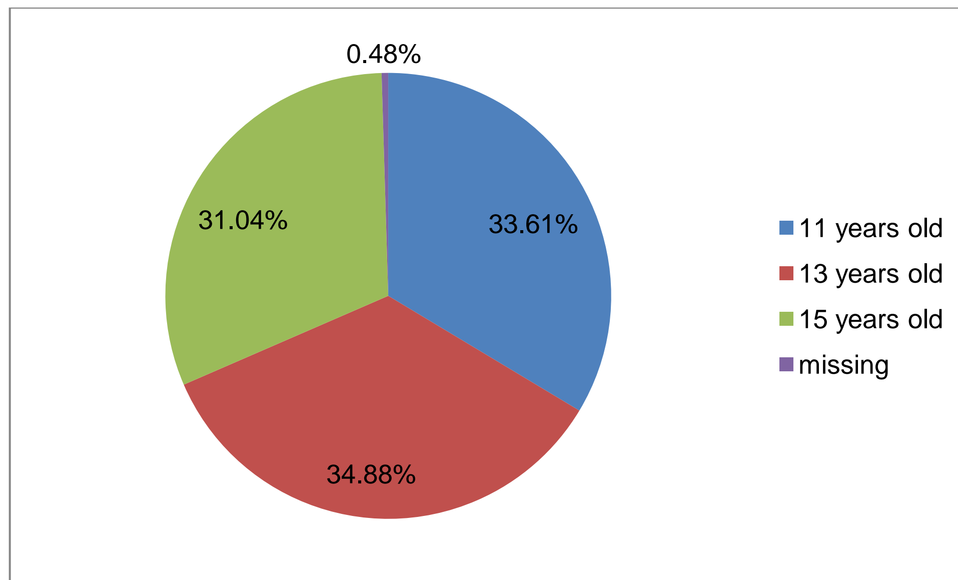


Figure 13: Age distribution of respondents

Gender

Young people were asked to tick whether they were a boy or girl. There was a fairly even split between male (48.8%) and female (51.1%) participants.

Ethnicity

Participants were asked to describe their ethnic origin by ticking the relevant box; 18 ethnicity options were given, plus a further 2 of not wanting to say or not knowing. 4196 young people supplied information on their ethnicity (169 missing and a further 45 not knowing or not wanting to say). The majority of respondents (78.8%) were White British. 92% of respondents (4064 young people) had been born in England.

Language

Young people were asked which language they most often spoke at home; this was a free text response. 559 students did not respond to this question. The most commonly reported language was English with 83% of responses. Although there were a variety of languages spoken, there was no one language which was reported by over 1% of respondents (except English).

Household composition

The HBSC study asks students about their family life. The questionnaire includes questions on participants' family structure, whether they live with both their parents and asks for detail on the composition of their main home (and second home if they have one). The questionnaire makes it clear that not everyone lives with both parents. All young people responded to the questions in relation to whether their mother and father lived in the main home; 91% of participants' mothers lived in their main home, with 9% living elsewhere. Only 67% of fathers lived in the main home, with 33% living elsewhere. 13% of young people had a step parent living with them and just over 10% had at least one grandparent living in their main home.

Most of the respondents had siblings. Family sizes varied, with the median number of brothers reported (by 37%) as 2 and median number of sisters (by 38% of responders) as 2. Very few children reported having no siblings. However, in some cases, very large families were reported (several cases of families with more than 8 siblings; one respondent with 16 brothers). This may highlight reporting errors or the complex network of siblings that some young people have; for example, step and half siblings. Alternatively, this may be an interpretation issue; within some languages (for example, Spanish) a similar word is used for brother and sister.

23.6% of students stated that they shared their time at a second home; though 5.7% of young people did not respond to this question. Most young people did not spend equal time between homes, the majority of respondents spending "less than half" their time at their second home or only visiting occasionally.

13 children (0.3%) of the sample lived in foster care or a children's home, although a further 85 (1.9%) lived with "someone or somewhere else" which might include private fostering with extended family.

Affluence

The socioeconomic status of young people is measured in a variety of ways by the HBSC study; including assessing the occupational status of parents, family affluence and family poverty. In this analysis, family affluence has been included as a measure of young people's socioeconomic status. The HBSC Family Affluence Scale (FAS) measure is based on a set of questions regarding the conditions in which young people live and covers car ownership, bedroom occupancy, holidays and home computers. The FAS measure has several benefits, such as the low percentage of missing responses from young people and its cross-national comparability (Currie et al., 2008). This is in contrast to the parental occupation measure which tends to suffer from missing data.

The scoring of these four questions is recoded to form a new FAS variable with low, middle and high values of family affluence. Just fewer than half the young people in the study came from families coded as having high levels of family affluence.

FAS category	**Count**	**Percentage**
Low	390	8.8
Medium	1644	37.3
High	1936	43.9
Missing	440	10.0
Total	**4410**	**100.0**

Table 8: Participants by Family Affluence category

Outcome variables

Of the young people who participated in the HBSC study, the majority reported being in positive health with good life satisfaction (Table 9).

Question	**Survey question**	**No. Responding**	**Results**
M104	Would you say your health is Excellent/Good/Fair/Poor?	4343 (68 missing)	Excellent 27%, Good 55%
M105	Life satisfaction 1-10	4297 (114 missing)	Mean score 7.37

Table 9: Summary of positive outcomes

Mean life satisfaction scores and self rated health are closely associated, with increasing satisfaction scores related to “good” and “excellent” health.

Figure 14: Average life satisfaction by self rated health

Health

The first question in the general health section asks young people to rate their health; self rated health is a subjective indicator of general health. They are given four possible options: Excellent, Good, Fair and Poor. 4343 young people answered this question with the majority rating their health as “good” (55%); the second most popular response was “excellent” (27%). Only 2% of respondents rated their health as poor.

Life satisfaction

Life satisfaction is an important measure of well being – considering not just the absence of illness but also the presence of a positive state. Life satisfaction is considered to be a fairly stable measure over time, in contrast to self rated health which may be affected by short term minor illnesses (Pavot and Diener, 1993). “Life satisfaction” was therefore used as the outcome variable within the regression analysis as it appeared to provide a more robust measure of positive health and wellbeing.

Young people were asked to rank their satisfaction with life by use of a picture ladder (Figure 15). 4297 young people responded to this question with a mean score of 7.37 illustrating that most young people were fairly well satisfied with their lives.

Here is a picture of a ladder.

The top of the ladder '**10**' is the best possible life for you and the bottom '**0**' is the worst possible life for you.

In general, where on the ladder do you feel you stand at the moment?

Tick the box next to the number that best describes where you stand.

10 **Best possible life**
9
8
7
6
5
4
3
2
1
0 **Worst possible life**

Figure 15: Life satisfaction ladder

Although 85.2% of young people reported good life satisfaction (i.e. a score of 6 or above); there was a difference between girls (82.6%) and boys (88.4%). To take account of the fact that more girls than boys responded to the survey, responses have been plotted as percentages rather than actual numbers (Figure 16).

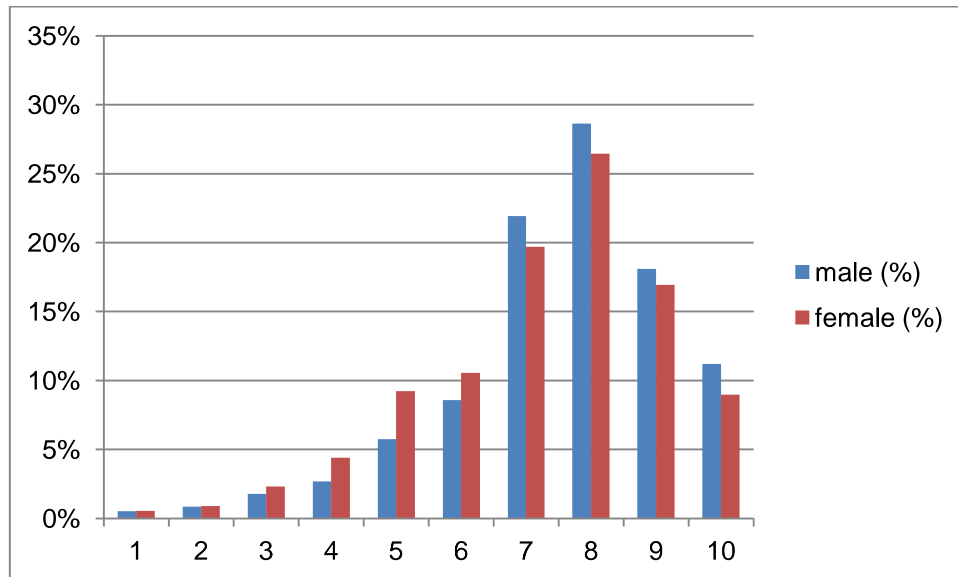


Figure 16: Life satisfaction scores by gender

A difference in life satisfaction scores was reported by age, with the youngest age group reporting higher average life satisfaction scores than the oldest.

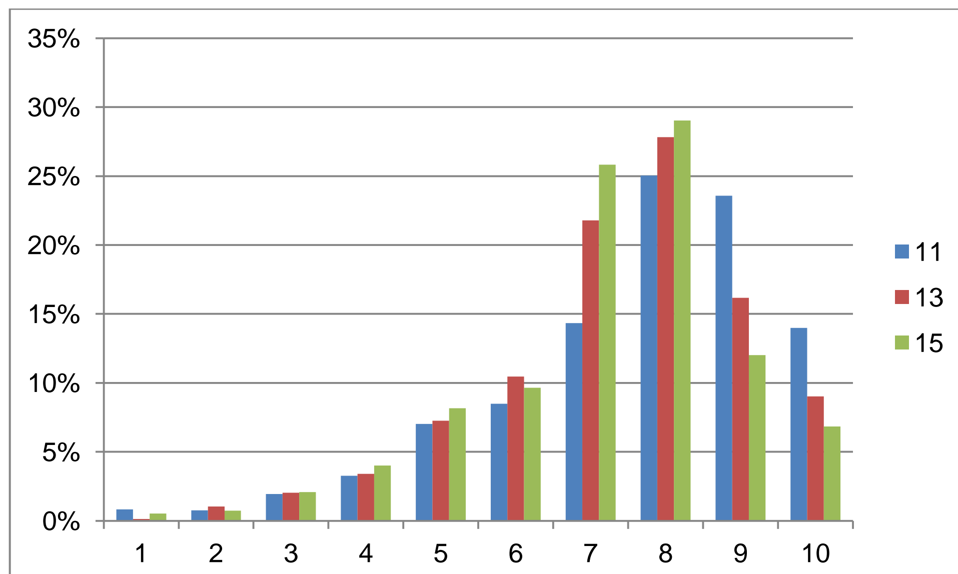


Figure 17: Life satisfaction scores by age

There are also underlying gender differences which occur and widen at each age level:

Life satisfaction score	**11**		**13**		**15**	
	Male	Female	Male	Female	Male	Female
6 and above	87%	85%	89.6%	82%	88.7%	80%

Table 10: Life satisfaction by age and gender

Higher life satisfaction appeared associated with higher Family Affluence Scale score (FAS); though there were differences in life satisfaction between gender in each FAS category:

Life satisfaction score	**FAS low**		**FAS medium**		**FAS high**	
	Male	Female	Male	Female	Male	Female
6 and above	79%	72%	88%	80%	90%	87%

Table 11: Life satisfaction by affluence and gender

Summary of descriptive data

Within the HBSC data, the majority of young people reported positive health and wellbeing outcomes. Schools from across the country were included with a range of ethnic groups represented. Life satisfaction levels appeared influenced by gender, age and Family Affluence Scale scores.

This next section includes the statistical analysis and explores associations between assets and life satisfaction.

Significant assets: results from the regression analysis

Within the methods chapter, Table 5 (*page 105*) summarised the 34 variables included in the regression analysis. The selection of these variables was guided by findings from the narrative synthesis whilst still allowing exploration of other possibilities. Following the "ecological theme" from the narrative synthesis, variables covering the different domains that young people interact with were included, i.e. school, home and neighbourhood. Variables which captured certain aspects of the related conceptual frameworks discussed in chapter 3 were included; for example,

external assets ("Positive family communication") and elements of social capital ("you can trust people around here") as well as internal assets ("Liking school") and individual capabilities ("Academic Achievement").

Figure 18 summarises the themes that had been identified as potential assets or an important component of the asset-health process, related variables were then included in the quantitative analysis. For example, under the grouping of **student autonomy**, the variables "students participate in deciding class rules", "students have some control in deciding tasks" and "students participate in deciding how to work on tasks" were included.

gender	age	ethnicity
affluence	communication	academic achievement
student autonomy	liking school	
getting on with others	neighbourhood happiness	
safety		

Figure 18: Summary of variable themes included in quantitative analysis

The regression equation was constructed in a stepwise manner, as described within the methods chapter ("Variables included" section, *page 101*). The variables that formed the regression equation are summarised below (Figure 19); these 12 variables had regression coefficients significantly different from zero at the 5% level.

Variable name
Students accept me
Talk to mother
Liking school
Family well off
I feel safe in the area in which I live
Talk to elder sister
Gender
Grade (year group)
Academic achievement
Family affluence scale
Talk to elder brother
Students are kind and helpful

Figure 19: Variables included in the regression equation

Further tables (Appendices 4 and 5) summarise the regression equation and provide information between scores for each of the variables and information on interactions. Interactions allow for the situation where the effect of a variable alters with another variable; for example, below, the effect of family affluence appeared to impact more on boys' life satisfaction than girls'. It was felt that one of the interactions, although statistically significant, was likely to be spurious and so the model was refitted without this term (see discussion below). Whether both or simply one interaction term was included within the regression equation, the same variables were identified (slight alterations occurred to the coefficients, but direction and strength of relationship were not altered).

The first variable included in the model captured the responses to the statement "students accept me as I am". The coefficients make sense across the levels of response in that those responding "Strongly agree" were more likely to have higher levels of life satisfaction than those who disagreed; the coefficient reduces across the levels of response which gives support to the suggestion that there is a relationship between these variables. Similarly, finding it easy to communicate with your mother was associated with higher life satisfaction and again, as communication becomes less easy, there was less of an association with higher life satisfaction. This logical trend in association across response levels was also seen for liking school and the family affluence scale; higher life satisfaction was reported by those liking school and those with higher levels of family affluence. (It should be noted that when reading from the tables in Appendices 4 and 5, *pages 255 and 257*, the baseline score for FAS were those with highest affluence whereas the baseline for the other variables tends to be the lowest score or least agreement with the statement).

For the variables, "being well off" and "academic achievement", the positive responses were associated with greater life satisfaction than the more negative responses. Higher life satisfaction was associated with being "Very" or "Quite" well off and both "Good" and "Very good" academic performance.

Feeling safe in the area where students live was also associated with higher life satisfaction. However, the lack of association with the more negative responses may be due to the numbers of those responding, in that the top category was larger than

the second category, which in turn was larger than the bottom three categories, which were all very similar.

An area requiring further investigation includes “talking to elder sister”; from the negative coefficients, it appears that having an elder sister, regardless of how well you communicate, impacts negatively on life satisfaction. Significant associations between “Talking to elder brother” (m86) and life satisfaction were seen with those responding to having “easy” communication having better life satisfaction than those reporting “difficult” or “very difficult”. Other comparisons were not significant, possibly because there was no effect but perhaps more likely because there were insufficient numbers in the "very easy" category. The association between ease of talking to elder brother and life satisfaction appeared logical. However, the negative association of “talking to elder sister” and life satisfaction warranted further investigation. It is possible that this was a spurious finding and might not be replicable; further analytical investigations involving tabulations and descriptive statistics between numbers of siblings, talking to elder sister and gender did not provide any useful potential explanations for this finding. Further exploration was therefore undertaken but no support of this result identified. A literature review was carried out but nothing found to explain this finding, the results of discussions within focus groups are included in the next section. It is possible that there is a different nature of relationship with an older brother than an older sister which impacts on life satisfaction.

The only significant interaction term for gender and “finding students kind and helpful”, implied that for boys, agreeing that students are kind and helpful is more associated with higher life satisfaction than strongly agreeing they are kind and helpful i.e. those that strongly agree have lower life satisfaction than those that just agree with the statement. There were no other statistically significant differences between categories, or for girls. As such it was decided that this interaction term was likely to be spurious and the model could be refitted with it omitted (Appendix 5: regression output with one interaction term (ignoring m1*m109)).

The other interaction term included within the model was between gender and family affluence score. There was a statistically significant association between higher family affluence and life satisfaction for boys, but this was not the same for girls.

A decision was taken not to undertake any further sub analysis. Although it would be possible to construct models separately for boys and girls, or for all the year groups; the initial plan had been to identify assets that were important to all young people that could be promoted universally. With this in mind, it did not make sense to create several different very specific models as these may not then make sense in terms of the implications for practice; an important component of this research. However, the fact that messages may need to be tailored for specific ages or genders should be borne in mind.

Summary of quantitative findings

The aim of the quantitative component was to identify the potential assets associated with offering a role in the maintenance and protection of young people's health and wellbeing in England. Life satisfaction was used as the outcome variable to capture the concept of positive health. Analysis was undertaken in two stages, firstly describing the data and then undertaking regression analysis. The initial descriptive analysis identified that although the majority of young people reported good levels of life satisfaction (mean score 7.37, Figure 15: Life satisfaction ladder*, page 137*) there was variation by age, gender and Family Affluence Score. A group of potential assets for young people in England were identified through regression analysis. Two significant interactions were identified within the model and included gender with Family Affluence Scale and gender with "finding students kind and helpful"; on further analysis this second relationship was thought to be spurious and the model was refitted without this term. The regression model identified that across the multiple environments of the young person the following potential assets were statistically associated with higher life satisfaction (acceptance by peers, being able to communicate with mother, liking school, family affluence, academic achievement and feeling safe). The variable coefficients followed a logical pattern across responses giving support to the suggestion that there is a relationship between these variables and life satisfaction.

This supported some of the findings from the narrative synthesis (constructive social relationships, safety and positive attributes). No association appeared to be found within the dataset between positive outcomes and communication with others, measures of autonomy and a range of neighbourhood variables ("it is safe for young children to play out during the day", "you can trust people round here", "there are

good places to spend your free time", "I could ask for help from my neighbours"). However, it should be remembered that the variables included within the model are those that best predict higher levels of life satisfaction and, although autonomy or other factors may be important, they might not have been the best predictors within this population. The apparent negative association between life satisfaction and having an elder sister was investigated via the literature and qualitative fieldwork to understand whether this was simply a spurious regression finding.

The next step for this research was to work with young people to understand why these factors might be important in terms of positive health; for example, to understand better the processes and pathways between assets and positive outcomes. Qualitative fieldwork facilitated the exploration of some of the issues highlighted via the narrative synthesis that were not significant in the regression analysis. The qualitative component also had a role in its own right to identify assets and processes associated with young people's health and wellbeing. The convergence and divergence of findings are discussed within chapter 7 *(page 166).*

Section 2: Exploring the asset process from young people's perspectives

The overarching research aim was to inform health promotion policy and practice in England through the identification of the assets and processes associated with young people's health and wellbeing. Objectives of the qualitative component included understanding more from the young person's perspective; for example, exploring how health could be promoted, suggesting when interventions should occur and in what setting, prioritising which assets were most important and clarifying how assets should be defined or measured. The work endeavoured to address some of the concerns raised in previous chapters regarding the apparent shaping of much of existing policy and research by adults' views of what is best for young people's health. It provided an opportunity to clarify some of the findings from the narrative synthesis and quantitative research; for example discussing the issue of structured and unstructured activities (narrative synthesis) and the impact on life satisfaction of having an elder sister (regression analysis). Qualitative fieldwork facilitated the capturing of young people's voices, identifying their language and terminology. This section summarises the findings from the qualitative research.

Emergent themes

The qualitative research with young people aimed to elicit narratives relating to their perceptions of health and assets to capture "...*their language and concepts, their frameworks for understanding the world*" (page 108, Kitzinger, 1994). This was important in terms of how knowledge generated through this research is used; ensuring that health promotion is relevant and therefore engaging. The following section summarises the themes that emerged through the qualitative component of this research, including quotes from participants and suggestions regarding definitions and terminology. Information on processes and causal pathways are included where these were discussed. Assets are distilled from these themes and summarised at the end of the chapter.

The names attributed to the quotes below have been altered to provide some anonymity to the participants, the ages given were those at the time that the fieldwork took place.

Independence and opportunity

Independence as an asset arose inductively and deductively; being included as a theme within the word association but also picked up through discussion of several of the other assets. Young people discussed issues of **freedom** and responsibility, learning and development as well as **opportunity**. In terms of causal pathways, they explored how independence could promote the ability to develop a good social life, which in turn could lead to good emotional health. Issues of independence and opportunity are returned to when health promotion initiatives are discussed later in this chapter.

From the discussion in Group 1 (girls from a mix of areas including semi-rural and more affluent) the main themes to develop were independence and being given opportunity to be more self-reliant. Mostly they saw self-sufficiency as a good attribute; however, they also shared an idea that this could have negative implications.

> *" I think some people are too independent, not in the sense that they can look after themselves but in the sense that, when they're put with group work in school, they either take over or do it all on their own. They can't listen to any one else"* **(Anna, aged 15: Focus Group 1)**

A variable may have positive or negative impacts. The group highlighted that there needs to be better understanding of processes rather than assuming a checklist of variables which would always have positive outcomes for all young people. The group also suggested that there might need to be an idea of moderation within a variable. Although both independence and opportunity could act as assets, how these are captured or measured would be important in a study.

Linked with the concept of independence were issues of choice and control. The second focus group discussed the idea of making healthy choices. Aspects of parental control and individual choice were discussed by an interviewee (male, from semi-rural affluent area).

> *"When they're younger, their parents control their lives. When they get older, they start to make more of their own choices, so when they're at primary school they can't go into town and buy sweets. When you're older your*

> *parents don't really know what you do with your life much more, so you could buy sweets on the way home and your parents wouldn't know about it".* **(Tom aged 13: Interview 1)**

Independence from parental control provides young people with opportunity to exercise choice which may in itself promote life satisfaction; however, the choices made may subsequently have an impact on health that is not necessarily positive.

Communication

The importance of good communication as an asset for health was identified through the narrative synthesis and the quantitative analysis. From the word association activity, one group identified how your family "*guides you in the right direction*". However, if speaking with family members was not possible, some of the young people discussed alternatives such as talking to people at school.

Being able to communicate with your family was seen to be a great positive in terms of health (the following participants were drawn from materially deprived geographical areas).

> *"I think it's, for me, it's like there's always somewhere for me to go so I've always got someone to talk to and there's always like somewhere to go to speak about whatever problems I have and get it out, basically".* **(Joseph, aged 15: Interview 2)**

> *"Good communication makes like a good relationship".* **(Cenk and Sam, aged 18: Focus Group 3)**

Having access to someone who would listen was an important part of staying positive and healthy for many young people.

In discussing communication, I asked participants who they would approach if they had a concern. It was very clear from their responses that this would depend on the subject. It was also influenced by the result they wanted; the girls in the first focus group discussed how, if they wanted a specific action, they would probably go to a parent, but if it was for someone to listen, they would go to friends. They were concerned that talking to parents might have unwanted outcomes:

> ***Several girls talking over/across each other (Focus group 1)****: "Parents get overly worried...blown out of proportion...you'd get questions every day"*

Being able to communicate with a range of supportive individuals helped facilitate wellbeing, as different individuals would be better placed to offer support in different situations.

Friends and friendliness

The important health promoting aspects of ***"constructive social relations"*** was identified in the narrative synthesis. The word association activity in the two girls' focus groups highlighted the significance of friends and friendliness as a theme linked to several other assets. For example, the friendliness of a neighbourhood was felt to be valuable, as was having friends at school. Both were thought to be critical in terms of the promotion of communication.

There was a clear importance of friends in terms of developing in a healthy way and this was discussed by focus group participants and within the interviews. The idea of pressure from peers and boyfriends, in terms of appearance, was also picked up through the word association activity in one of the girls' groups.

> *"Being in a group is healthy, you learn from each other, I don't know whether this is good but ... healthy eating or sporty things, if you were like a bit fat ..., but this might be a bad thing, but if you were a bit fat and everyone in the group... you want to fit in. If you were in a good group it could make you healthier, if you're with your friends they can help you".* **(Emily, aged 14: Focus group 1)**

Friends offer support but may also provide pressure to fit in or behave in a certain way. The positive and negative aspects of friendship were also discussed in an interview.

> *"You might have friends that don't really care, it sort of depends on what sort of a group you hang out with, you may have friends that do drugs or drink and don't really care about their health, and you may be friends with a group of people who are smart and educated about your health and your diet"* **(Tom aged 13: Interview 1)**

The idea of a “variable” acting as an asset or risk factor stresses the importance of clear measurement and definition.

The complementary roles of friends and family were talked about in several of the groups and interviews. Some participants felt that it was easier to talk with family members whilst others preferred friends. An interviewee states that he would talk to friends and family if he had a problem, but provides suggestions as to why friends might be more accessible.

> *“My best friends and my family; I think they’re equally important but I think young people will tend to go their friends first because, I don’t know, they’re around you more coz for school, school days about 6 hours, 6 hours in the day that you’re with your friends, and then you go home and let’s say your parents aren’t even home from work yet”* **(Joseph, aged 15: Interview 2).**

Having a range of trusted people available to listen is likely to facilitate communication and ensure that problems can be aired.

When talking about how people make friends and establish friendship groups, the girls in one group discussed how you start off with those people in your close neighbourhood and you are drawn from a similar background. However, this may change when you move to a secondary school and begin mixing with a wider range of students.

> *“We’ve been friends, since I was 2. So, we’ve just grown up and probably had the same sort of lifestyle. We have lots of things in common. I’ve been friends with these 2 since I was 11; you become friends when you have the same likes”.* **(Anna, aged 15: Focus Group 1)**

> *“That changes at secondary school I see people in my year that have been influenced by those around them. I guess we’ve grown up”* **(Emily, aged 14: Focus Group 1)**

> ***Several girls talking over/across each other (Focus Group 1)****: “They want to be like someone so they change... changing lifestyles...You don’t see that at primary schools... no because everyone was younger and you’ve been*

friends since you were a baby. A lot of change happens at secondary school to fit in".

The idea of fitting in had both positive connotations in terms of support but also negative overtones in terms of being pressured to act in a certain way.

School: support/pressure and opportunity

School as a broad theme arose deductively due to findings from both the narrative synthesis (relations and setting) and the quantitative analysis ("student acceptance" and "liking school"). Issues of support/pressure and opportunity were identified inductively through the participants' discussions.

Through the word association activity, the idea of support at school came through as part of the causal pathway between school and health. Some of the young people mentioned "compulsory" activities, such as having to do PE, or being encouraged to eat vegetables at primary school. From the discussion it seemed as though young people were fighting between the need to be independent yet aware that these were things that they were not always keen to choose (or be seen to choose) to do.

In terms of school support, it was suggested by some participants that "opportunity" should be promoted rather than providing particular services. One girl stated that she would be "*too embarrassed*" to attend the pastoral care service. Staff were felt to be more approachable if they were younger or the students had managed to build rapport with them. This was developed over time – i.e. having the same teacher for several years, or attending a club which the teacher led. They also discussed how it was easier to get on with teachers when you shared similar interests; for example, if you were good at a subject or attended one of their clubs.

> *"If you aren't as active in sport then I don't think the teachers would take much notice of you. We get more attention in the lessons because we do the clubs. We can have a laugh with them as they know us better"* **(Anna, aged 15: Focus Group 1)**

> *"Say you were in a mixed class, the teacher would be closer with the people who were better at maths –because if you're good at it, not because they're taking favourites but they know you understand it. In PE they know the*

captains of the teams. The more you know them the more you would go to them". **(Emily, aged 14: Focus Group 1)**

Support from school staff appeared dependent on forging relationships which was easier the more time spent together.

The second focus group (girls from a range of cultural backgrounds, urban location including some materially deprived wards) mentioned the difference between primary and secondary school.

> *"At primary school it's about having fun you don't care about how you look, your mum does your hair. At secondary school it changes everyone tries to look good, even if you don't really care about hair and makeup you still try to look nice".* **(Ayse, aged 14: Focus Group 2)**

The transition from primary to secondary school changed how young people saw school from a time of having fun with peers to having to fit in or gain acceptance.

The second focus group mentioned that they were interested in their "extension" and "citizenship" classes and talked me through the range of health topics they had covered – from sexually transmitted infections to body confidence. Similarly one of the interviewees talked about the health assemblies that were provided at his school and how this was a useful vehicle to provide health promotion messages. The participants from the boys' focus group discussed the importance of facilities at school in promoting health, for example, football clubs, sports resources etc. The school setting, through curricular and other avenues, was seen to provide a useful context for health promoting activities.

Family: support/pressure

The broad theme "family" arose deductively due to its inclusion as a word association term influenced by the narrative synthesis finding "constructive social relations"; there was also prompting regarding family **communication** due to quantitative findings. However, issues of positive **support** and pressure arose inductively through the analysis of some of the discussions. Within the second focus group, the girls were asked to select postcards that said something to them about health and wellbeing. Participants chose pictures of hearts, family groups and relationships; these ideas of love and family support appeared important yet the

participants did not want to discuss them and hurriedly shuffled them back into the central pile.

In terms of a causal pathway between family and positive health, participants discussed how families might influence young people both physically and emotionally.

> *"You need money to buy like healthy food like certain people buy like vegetarian food or meat or you could get [laughing] frozen food or packet food for microwave. It depends on how your family brings you up... man... like if you start from a young age like if your mum feeds you organic food you'll follow that... more on your upbringing.."* **(Sam and Cenk, aged 18: Focus Group 3)**

> *"I think it's the way that I was brought up basically to keep a positive mind on things and try my hardest to turn the negative into the positive"* **(Joseph, aged 15: Interview 2)**

A family's values and aims are likely to shape how a young person views and interacts with the world.

One interviewee discussed the influence of parents on young people's health; he distinguished between parents that cared about their children and would promote their health, with parents that did not seem to care about what their children did.

> *"if you're in a bad home maybe then your parents might not encourage you to do sport than if you're in a good home and your parents care more about you and your health. If you're in a bad home your parents might not care about you and you may not feel encouraged to do these things".* **(Tom, aged 13: Interview 1)**

This interviewee implied that parental support acted as an asset for young people through encouraging healthy behaviours.

The girls in group 2 felt that being "*strong minded*" and self confident were crucial to negotiating health issues in the teenage years and that friends and family both had parts to play in supporting young people's positive development. They felt a sense of support from friends but felt that parents and family played a stronger role.

" Parents are always more important... you still listen to your friends... but you make it seem like you listen to your friends more". **(Maya, aged 15: Focus Group 2)**

This was different from the first focus group that placed more emphasis on friends. However, this second group admitted that they would not let friends or family know that family had a bigger influence. An interviewee noted that it depended on the quality of the family and friends as to which had greater influence.

"I don't think either are more important, you can learn different things from both of them ... if you have a good family and good friends you don't tend to choose over them which you like more... if you have a really bad group of friends that aren't well brought up or educated then you may choose your family depending on what they tell you if you have really horrible parents who don't care about you but you have good friends who try to tell you that what your parents are telling you is wrong you might choose your friends it depends on what sort of mood or personality of friends and family" **(Tom aged 13: Interview 1)**

Again this highlights how a construct such as "family" may have positive or negative impacts on health; the health promoting asset within this appears to be "**support**".

Due to the findings in the quantitative analysis, I asked some of the participants about their views on siblings. The overwhelming response from the girls in the second focus group was that they felt elder sisters were a good influence and source of **support** in building their own confidence. Four of the group had elder sisters and they said that these relationships helped in being a healthy influence – giving honest feedback on what they looked like, encouraging physical activity and building confidence.

"Having an elder sister is definitely a good thing. As well as your parents, they can build your self confidence, she'll be honest with me, she'll tell me plain and straight and sometime friends can be fake. It's good to have an elder sister". **(Maya, aged 15: Focus Group 2)**

The importance of family in terms of honest support was emphasised.

The girls in group 1 all provided details of their siblings, whether they had brothers or sisters and whether they were older or younger. Themes that came from the sibling discussion included comparisons and influence. Some parents compared their children, but the girls only mentioned comparisons in relation to academic achievements, though one did mention a more developmental/chronological comparison.

"I have 2 older sisters who are 18 and 16 and a younger brother.

Do they influence what you do?

I think they did.

Are you compared to them?

Yes, by my parents I am. My older sister is really like quite clever, she's clever but C is really clever. It made her look like she wasn't that clever when she really was. Baby has it all to come: "Angel child" ".

(Anna, aged 15 and Emma, aged 14: Focus Group 1)

Families make comparisons between siblings which can be picked up by the young people as labels. One girl also spoke concerning how they may influence each other in terms of what subjects they took and whether they were sporty or not.

"My younger sister is turning into the bad parts of me, which I feel really bad about. You can't give me a responsibility from the age of 2, when she was born, being responsible for me and her". **(Emily, aged 14: Focus Group 1)**

"I think she's looking up to you. You can't really help it; it's just the way you are". **(Anna, aged 15, speaking to Emily: Focus Group 1)**

Some young people were keenly aware of comparisons between siblings and how they may be seen to be to blame for their younger siblings' development.

Safety

This theme was identified in the literature and therefore included in the word association activity. When discussing the idea of neighbourhood, safety was highlighted as a key concern for the participants. The young people discussed the issues that made an area feel safe, for example, they noted the importance of an area being well lit, with no bad media coverage and a police presence. This provides

suggestions as to the enhancements that could be carried out within a neighbourhood to promote perceptions of safety.

The young participants suggested ideas linking the asset of safety with the promotion of health, discussing the processes involved; for example, how living in a safer area allowed you more freedom, your parents were more willing to let you go out, which, in turn, enabled you to see friends or go to the gym. They also discussed the importance of feeling safe at school to their wellbeing. Understanding the processes of how assets improved health was an objective of the qualitative research.

Money

Affluence was identified in the quantitative analysis and therefore included as the word "money" for the word association activity. Young people linked money to happiness (emotional health) as it allowed them to buy things and experiences; they talked about access to activities (gym and basketball), socialising, the "right" brands and food. This theme was confirmed inductively. When suggestions were requested as to how families might promote health; it was stated that they "*pay for everything*" and/or could provide healthy food or fund out of school activities. Participants from a more materially deprived neighbourhood talked considerably about how the cost of some health promoting activities was prohibitive; they mentioned as examples, basketball (£9 for court hire) and access to healthy food.

> *"A lot of things cost a lot. Down the park you see a lot of people. A lot of things are expensive, like £3; young people don't really want to spend that much just to socialise with each other... so ... which is one reason you see a lot of young people on the road because, one, they want to socialise with each other but two, nowhere for them to go. That's why there's a lot of positivity to youth clubs".* **(Joseph, aged 15: Interview 2)**

The process linking affluence or money with improved health was explained by the young participants as facilitating access to health enhancing opportunities, for example to healthier food, gyms and membership of clubs such as Scouts. Young people are likely to have different levels of responsibility in terms of whether they pay for their own food or social activities; this may influence their views as to what is important for health promoting interventions.

Affluence was not just linked with health as to the opportunities it could buy. One of the girls groups also talked about how money helped them feel good through donating it, or the sense of reward from earning it. Such a concept links money with the building of internal assets (positive attributes).

Positivity: caring and coping

The narrative synthesis had identified positivity and "positive attributes" (Table 4, *page 74*); the phrase "being optimistic" was included in the word association activity to capture these positive concepts. The young people talked in relation to the importance of optimism and a willingness to change – examples given included taking up healthier lifestyles or coping with new situations. This adaptability links with the theme of "fitting in" discussed within the themes above – for example, changing the way you are at secondary school to fit in with others and whether you take up certain activities to gain acceptance.

In terms of staying healthy and remaining positive, one interviewee talked about his coping strategy.

> *"I also try to focus coz there will always be someone that will say something about you but what I try to do is forget about it and keep going".* **(Joseph, aged 15: Interview 2)**

This type of positive attribute appears more than just an optimistic look on life but rather, a learned behaviour of how to manage certain situations.

An interviewee mentioned the idea of "caring" several times within the session. This appeared to be the terminology he favoured to cover a range of positive attributes. He considered how parents who care would aim to help their children and bring them up healthily. But he also mentioned young people who did not appear to care and how this impacted on many parts of their lives.

> *"one of the one's that I've seen smoking... who I know doesn't try very hard... he's in a lower group and its quite clear that they don't really care"* **(Tom, aged 13: Interview 1)**

This could be interpreted in a number of ways, for example, young people may feel alienated in a lower group and strike a position of "not caring", or, because they

“don’t care” to put in effort they might end up in a lower group, additionally this relationship might be somewhat self perpetuating. Several times within the interview he talks about how, if you “care” you will make healthy decisions or encourage others to be healthy. The importance of “caring” or taking a positive stance, by parents and young people, was suggested to impact on educational achievement and taking up health improving behaviours; for example, those young people in a lower group, might not appear to try but are also not encouraged or supported by their parents to achieve.

Positivity was also suggested to come from the way children were brought up; two focus group participants stressed the importance of upbringing.

> *“Some people will think like they’ll be stuck in this kind of environment all their life and won’t bother and they might not be doing well at school or something.*
>
> *Again it probably goes back to family – if you’re not in a positive environment you’re not going to be optimistic to life*
>
> *Yeah.. it’s family upbringing”.* **(Cenk and Sam, aged 18: Focus Group 3)**

Family appeared important in terms of the framework provided to structure the way young people developed, providing support and opportunities as well as expectations for behaviour.

Health promotion initiatives

When asked about health promotion initiatives, Group 1 thought that the talks at school (within curriculum time and through assemblies) should not just focus on physical health (healthy eating and lifestyles) but also social and emotional health. These young people were critical of the lack of attention in secondary school regarding social and emotional health.

> *“When we’re talked to about it it’s always like general health like, keep your body healthy, doing sport or eating healthy. When we’re talked to about health it’s never really to do with social aspects”.* **(Anna, aged 15: Focus Group 1)**

The differences between primary and secondary school were highlighted in terms of opportunities within the curriculum. One girl within this first focus group talked

nostalgically regarding the social skills building activities at primary school, *"I loved circle time[32]".* It is not clear why time is allocated to these activities within primary education but not secondary, although this may not be the case universally. The second group considered the difference between options for intervention at primary and secondary school; at primary school pupils were given vegetables on their plate and encouraged to try them, whereas at secondary school it was an option that people did not tend to take. However, without that initial coercion several of the group said they would not have eaten vegetables when they were younger.

An interviewee suggested possible interventions at school such as providing more pictorial information regarding health effects. He also mentioned the use of one to one health support, for example counselling for emotional health or personal trainers for physical aspects.

> *"Maybe someone like a counsellor, to say something at the beginning, I'm here because you want me to be, I'm not here to force you"* **(Tom, aged 13: Interview 1)**

It appeared that any health promoting initiatives that were made available should be offered in a way that could be taken up as a positive choice by the participant.

The first group did not think that interventions were necessary in terms of easing the transition between primary and secondary school; in fact were quite vociferous that this would be counterproductive in terms of making people dependent on someone else to ease this transition – they felt that young people needed the **opportunity** of being able to cope.

> *" I think people want to be independent you can't help that process.*
>
> *You need to be independent. You need to think for yourself.*
>
> *You can't be helped at that stage - You might rebel- It might be too easy.*
>
> *The fact that we go in not knowing much about secondary school makes you more independent about certain things, you learn yourself how to cope with it,*

[32] Circle time is a group activity, routinely used within primary schools as part of PSHE to promote self esteem and positive behaviours; children sit together to talk, listen, read books, sing songs, solve problems etc. MOSLEY, J. (1996) *Quality Circle Time in the Primary Classroom: Your Essential Guide to Enhancing Self-esteem, Self-discipline and Positive Relationships*, LDA.

if you have someone there guiding you, helping you constantly you wouldn't learn yourself".

(Emily, aged 14, Anna, aged 15 and Emma, aged 14: Focus Group 1)

The process of developing confidence and **independence** was seen as important in promoting the ability to cope with life.

This idea of choice and **opportunity** was mentioned by participants. An interviewee talked about the health promoting aspects of being part of the Scouts. He felt that the Scouts provided opportunities for physical activity, but also for fun.

"It's not something I feel forced to do, my parents gave me a choice to do it and I wanted to do it". **(Tom, aged 13: Interview 1)**

Other participants talked of activities that they had chosen, for example, singing at church (interviewee, aged 15) and the Duke of Edinburgh's award (girls' focus group 2). It appears that some health promoting initiatives could be delivered subtly, provided as an option or opportunity that young people would choose to take.

Within the narrative synthesis, attention had been drawn to the disagreement that exists between some researchers favouring the health enhancing possibilities of structured activities whereas others stressing the importance of unstructured time. There appeared differences in responses from the qualitative research participants which seemed related to background levels of affluence. Young people from the most affluent areas favoured opportunities for independence whilst acknowledging that they took part in structured, paid for activities – whereas those from more deprived geographical areas seemed to have sufficient independence but could not access a range of activities that had costs attached. One interview that took place in a more deprived neighbourhood stressed the importance of taking activities to young people.

"I'll probably arrange more functions for them ... so like ... functions like this which are in the park ... create an attraction, loads of people here. As a young person sees a young person doing it, gives them inspiration to do something as well." **(Joseph, aged 15: Interview 2).**

This qualitative fieldwork has highlighted the potential of both structured and unstructured activities to improve health; however, success appears dependent on the individual's circumstances. Health promoting initiatives might be seen as interventions or opportunities, but to be effective are likely to require adaptation to local need to ensure equitable accessibility; without this tailoring, health inequalities may persist or worsen.

Participants were asked how they would intervene if they were in charge of health promotion either at a school level, or if they were Prime Minister. The second focus group examined issues such as what is convenient in terms of access or cost; they did not want to get rid of sweet shops but recognised it was too easy to nip to the local shop and buy sweets (cheap) than go to Tesco (farther away) and buy fruit; so they suggested that shops should sell a range of products.

> *"in sweet shops and things like that its really like difficult coz if you see a chocolate bar its 10p and if you want some fruit you have to go Tesco which is a longer walk. Then you might be late for school. It's like difficult to get access to like healthy foods; the sweet shop is like just round the corner... cheaper than healthier food... an easy option*
>
> *Don't get rid of the sweet shops*
>
> *It just needs to be more easy access for young people"*
>
> **(Maya, aged 15 and Ayse, aged 14: Focus Group 2)**

The third focus group also highlighted the importance of making healthy choices cheaper and more accessible.

> *"I would provide more sports facilities in the boroughs – a lot of free stuff, free sport stuff.*
>
> *If I were in charge I would make health food cheaper, more affordable, more accessible".* **(Cenk and Sam, aged 18: Focus Group 3)**

Young people's perspectives on health promotion were captured; they suggested that to improve health, access to healthier activities and food had to be made easier and cheaper.

Some of the young people thought that there should be cheaper gym membership and that they should get student prices. They suggested that clubs at school could tie into local gyms and in terms of the food on offer that there were healthier dessert options. The lack of availability of free facilities was highlighted by the smallest focus group; these were young men that had left school and felt that the cost of participating in many activities was prohibitive.

> *"It can improve your health if you live in a nice neighbourhood, you kind of encourage you get outside, play sport, there might be parks in your area or a leisure centre... facilities, you need facilities, that's what's lacking in xxx (town name)"* **(Cenk and Sam, aged 18: Focus Group 3)**

Healthy choices for many young people were not always easy to access due to scarce availability or cost.

Summary of qualitative findings

The aim of the qualitative component was to identify the assets and processes associated with health and wellbeing for young people. This was a small sample of young people in the South East of England drawn from diverse backgrounds. The young participants confirmed and named a number of assets and processes important in promoting their health. They identified the importance of support from family and friends, communication, independence, opportunity, positivity, health maintenance behaviours, safety and money. All participants emphasised the importance of relationships, safety and positivity; these were seen as core to promoting their health. There was variation between participants as to which relationships had the biggest impact on their health (family versus friends) with those from more materially deprived backgrounds favouring family. Communication skills were important and having a range of trusted individuals that were available to listen was also stressed. The importance of other assets varied between young people, possibly the most striking being what "opportunity" meant to them; young people from the more affluent geographical areas wanted opportunity for greater independence, whereas those from less affluent areas wanted opportunities to access health promoting facilities. In terms of understanding asset health processes, the groups suggested: how money could improve health through facilitating access to a range of goods and services, complex relationships between support and good

communication with each helping develop the other (family support was important when young but as friendships developed these often “took over” the supporting role in terms of health creation, maintenance and promotion). The concept of family support encapsulated providing guidance, acting as role models, setting expectations and being positive. It was suggested that independence was produced through supportive relationships and provision of opportunities for growth. Opportunities for independence were greater if young people felt safe in their neighbourhood (or their parents felt the neighbourhood was safe).

Research objectives included understanding more from the young person’s perspective; for example, how health should be promoted, when any intervention should occur and in what setting, what assets were most important and how assets should be defined or measured. Although some of the participants stressed that for them the idea of opportunity was more important than specific interventions, for others the opportunity to stay healthy was reliant on facilitated access (which might necessitate intervention). The relative importance of structured versus unstructured activities appeared dependent on individual circumstance. This emphasises the importance of tailoring interventions to the priorities of the group which, in turn, relies on assessing these accurately. Alternatively, the promotion of assets could be woven through other activities or initiatives to ensure that a range of settings are more health enhancing. Some of the health promotion initiatives suggested were at the macro level, such as improving the healthiness of stock sold in shops or making access to physical activity cheaper. The school setting was also identified as a useful arena for health promotion; within curriculum time, through the use of assemblies, incorporating emotional health promotion alongside physical, one to one interventions such as counselling or personal training and through extracurricular activities. In terms of successful interventions, the idea of choice was stressed – that taking part should not be forced. There was discussion regarding timings of any interventions with a view to promoting health at primary school or around the time of transition to secondary school. The ideas of opportunities and choice were important. Many young people wanted opportunities for self development, particularly in terms of communication and positive sense of self which, in turn, would enable them to continue to grow and develop.

The review of policy and the narrative synthesis had identified a lack of young people's involvement in both policy and research; the incorporation of young people's views and terminology within policy and practice could increase the relevance of messages and initiatives. Researching directly with young people was useful in identifying the wording that these young people had for assets; for example "Fitting in with the group" (student acceptance), "strength of character" (positive sense of self) and "caring" (positive attributes). This resonates with advantages of using focus groups given in the methodology literature which includes their ability to uncover young people's views and language (Kitzinger, 1995);

> "*I want to understand the world from your point of view. I want to know what you know in the way you know it*" (page 34, Spradley, 1979).

Although the terminology identified is likely to be most relevant to the young people in this sample it highlights the importance of checking young people's definitions when embarking on any future asset mapping with young people or phrasing of health promotion.

The qualitative fieldwork facilitated exploration of spurious findings generated through the regression analysis. The negative impacts on life satisfaction that appeared to be associated with having an elder sister was not thought to be a true finding from the qualitative participants' perspective. Though, of course, this qualitative fieldwork was based on a small sample of participants. One of the focus groups did talk about negative pressures within families when the idea of siblings was discussed, however, there was no difference noted between sisters and brothers.

Issues of definition and measurement were highlighted by participants. They noted that some ideas termed "assets" could have positive or negative impacts on their health and wellbeing. For example, the idea of student acceptance or "fitting in" could encourage positive behaviours such as taking up sports or negative behaviours such as smoking; it could not be assumed that student acceptance was therefore a health promoting asset without understanding what impact it had. Similarly an issue was raised regarding measurement; for example, independence was thought to be an asset in moderation, but too much independence might cause negative impacts on health and should therefore be more accurately termed a risk

factor. There appears a need within research to measure precisely the asset (health promoting) part of the variable; for example, measuring “positive support” rather than the more generic “relationships”. This might be achieved through supplementing quantitative surveys with qualitative research or reviewing the wording of questions included within a survey.

The convergence and divergence of findings with other components of the research are discussed within chapter 7 (*page 166).*

Concluding comments on findings

The quantitative and qualitative strands of this research have identified a range of health promoting assets and young people have provided suggestions as to how they might be promoted.

Data from the quantitative analysis (based on information from over 4400 young people) provided support to some of the findings from the narrative synthesis and afforded insight into the assets associated with higher levels of life satisfaction for a sample of young people in England. Through regression analysis, the following variables were identified as important to English youth; “students accept me”, “communication with mother”, “communication with brother”, “liking school”, “family affluence”, “neighbourhood safety”, “academic achievement” and “students are kind and helpful” However, the underlying reasons for associations between assets and health were not readily apparent and would require speculation or assumption to generate reasons; the use of qualitative data helped shed light on the processes linking assets and health. The fieldwork provided the chance to explore a questionable association suggested by the statistical modelling (communication with older sisters having a negative impact on life satisfaction) and unpick divergent views on structured versus unstructured activities that had been discovered through the narrative synthesis. The use of mixed methods to elaborate on findings correlates with suggestions by Clarke (2003).

The use of focus groups and interviews has demonstrated effective ways of gathering information on assets from young people, though in this research negotiating access proved more difficult with boys than girls. The qualitative thematic

analysis was based on a sample of 15 participants, which, whilst it may not be representative of other young people, provided suggestions as to the following assets as important to English youth; “independence”, “communication”, “support”, “safety”, “health maintenance behaviours”, “money”, “positivity” and “opportunity”. The qualitative findings illustrated that although there appeared to be some universal core assets (constructive relationships- communication and support, safety and positivity) there was also some variation as to the priority the young people placed on other assets (independence) and how they interpreted an asset (opportunity – meaning opportunity for independence or opportunity to access activities). The participants suggested pathways or processes as to how these assets could be used to improve health; for example, “independence to make choices and exploit opportunity for development”, “support and communication helps increase positive sense of self (strength of character)”. Variation in importance placed on assets suggests that initiatives may need to be tailored to tackle health inequalities. Safety and money were seen as facilitators to access opportunities and gain independence. Working directly with young people also identified the terminology that they used. The qualitative data helped answer the “so what” or “what next” questions by suggesting how this knowledge about assets could be used within health promotion; this was an important facet of this professional doctoral research.

Each method contributed some new knowledge which would have been missed if this approach of mixing methods had not been taken. The quantitative research proposed a list of assets from a large sample of young people which could be generalised to a larger population. The qualitative research suggested processes which might explain the associations between assets and health. The fieldwork also highlighted the variation in assets and prioritisation of those assets between individuals. The following chapter brings together the findings from the narrative synthesis and the qualitative and quantitative components and critically discusses them. The findings and a proposed assets model for health promotion are considered with practitioners to gain a view as to how these research findings could be incorporated into practice.

Chapter 7: Discussion of findings: an assets based model for young people's health promotion

Introduction

This research has identified a range of assets that are associated with health and wellbeing. In this chapter, the findings are first summarised and their convergence and divergence discussed in relation to theory and other research. There is an acknowledgement that the findings are based on different sample sizes from different populations and that the methods are based on different paradigms; however the research is brought together through the underpinning theoretical frameworks provided by assets models and the New Social Studies of Childhood.

The discussion of findings clarifies the core assets of particular relevance to young people's health in England. These findings are consolidated to form an assets model to shape health promotion strategies and initiatives. This approach to health promotion was explored in relation to other literature and discussed with practitioners to understand the barriers and facilitators that exist in altering practice (*page 195*). Variations were identified in both health and assets by age, gender and affluence; the implications such variations have for practice are explored.

Overview of findings from individual strands

This research was formed of three components; narrative synthesis, quantitative and qualitative analysis. These strands drew on different sized samples from different populations; the narrative synthesis had a mainly international focus, the HBSC dataset was created from a large representative sample of 11-15 year olds within England, whereas the qualitative fieldwork included 15 participants aged 13-18. The quantitative sample was fairly evenly split between males and females whereas the qualitative sample was majority female. There were also differences in levels of affluence; less than 9% of the HBSC sample reported low family affluence whereas 60% of the qualitative participants came from areas of low affluence.

The narrative synthesis was undertaken to critically explore what was known already regarding assets and young people with the quantitative work focussing on the English context and the qualitative fieldwork building on and expanding these findings. The qualitative research had a particular focus of identifying young people's

perspectives and definitions. Within this section a summary is provided of the findings from each of the research strands. Following this overview, the findings are consolidated and critically discussed.

Underlying objectives of the narrative synthesis included gaining an understanding of young people's views of health promotion, the optimal settings and timings to promote health. A final objective was to understand measurement issues. It identified the following assets and approaches associated with positive health:

- Assets (constructive social relationships, safety, health maintenance behaviours, autonomy/independence, positive attributes/sense of self)
- Approaches to health promotion (holistic: interplay of risk and protective factors and ecological: context of health promotion)

Limited information was available to clarify the processes linking assets to health. Within the synthesis, only 2 English papers were identified and only 1 paper (US) had undertaken qualitative research.

The quantitative analysis aimed to resolve the lack of knowledge relating to the core assets for English youth and to include young people's voices by analysing information gathered via self complete survey by young people in England. The regression analysis found the following variables associated with life satisfaction:

- Constructive relationships: Communication (Talk to mother and elder brother were positively associated, a negative association was found with "talk to elder sister")
- Positive attributes: (Liking school, Students are kind and helpful)
- Safety: (I feel safe in the area in which I live)
- Students accept me as I am
- Academic achievement
- Gender
- Grade (year group)
- Affluence: (Family well off, Family affluence scale)

Whilst the majority of young people reported positive health and wellbeing outcomes, life satisfaction scores appeared influenced by:

- Gender (boys reported higher life satisfaction than girls),
- Age (life satisfaction scores reduced with age for girls) and
- Family Affluence Scale scores (higher affluence associated with higher life satisfaction).

The qualitative research added depth and meaning to the quantitative findings. It gave an opportunity to hear young people's views about what mattered for their health, the process of health promotion, measurement issues and definitions. The thematic analysis identified the following associations with positive health for English youth:

- Constructive relationships: communication and support
- Independence
- Health maintenance behaviours
- Safety
- Money
- Positive attributes: positivity, "strength of character"
- Opportunity

The participants suggested pathways or processes as to how these assets could be used to improve health:

- Support and communication were highlighted as necessary to develop a positive sense of self ("strength of character")
- Safety and money were seen as facilitators to access opportunities and gain independence.
- Neighbourhood and school were identified as settings for health to be promoted.

The young people were drawn from different backgrounds and although there were some core assets that appeared important to all, there was also variation in priorities and definitions.

Discussion of consolidated findings

A diagrammatic summary of the findings (Figure 20, *page 170*) is provided to highlight how assets were ascertained. In the following section, the findings are discussed with reference to other relevant research findings and theoretical concepts to highlight convergence and divergence. Consideration is given to the evidence available to support the importance of individual assets in promoting health with young people and to justify whether they are significant enough to be included within an assets model to shape health promotion. Through this discussion distinction is made between those assets where there appears universal support for their role in promoting health (core assets) and those where level of support varies.

This section then reflects on issues regarding variation by demographic variables and finishes by bringing together some of the cross cutting themes identified within the findings. A model to guide health promotion is provided, with discussion of how the promotion of assets could be incorporated into practice, exploring both barriers and facilitators to implementation. Practitioners provided a view as to whether an assets model would be feasible in practice.

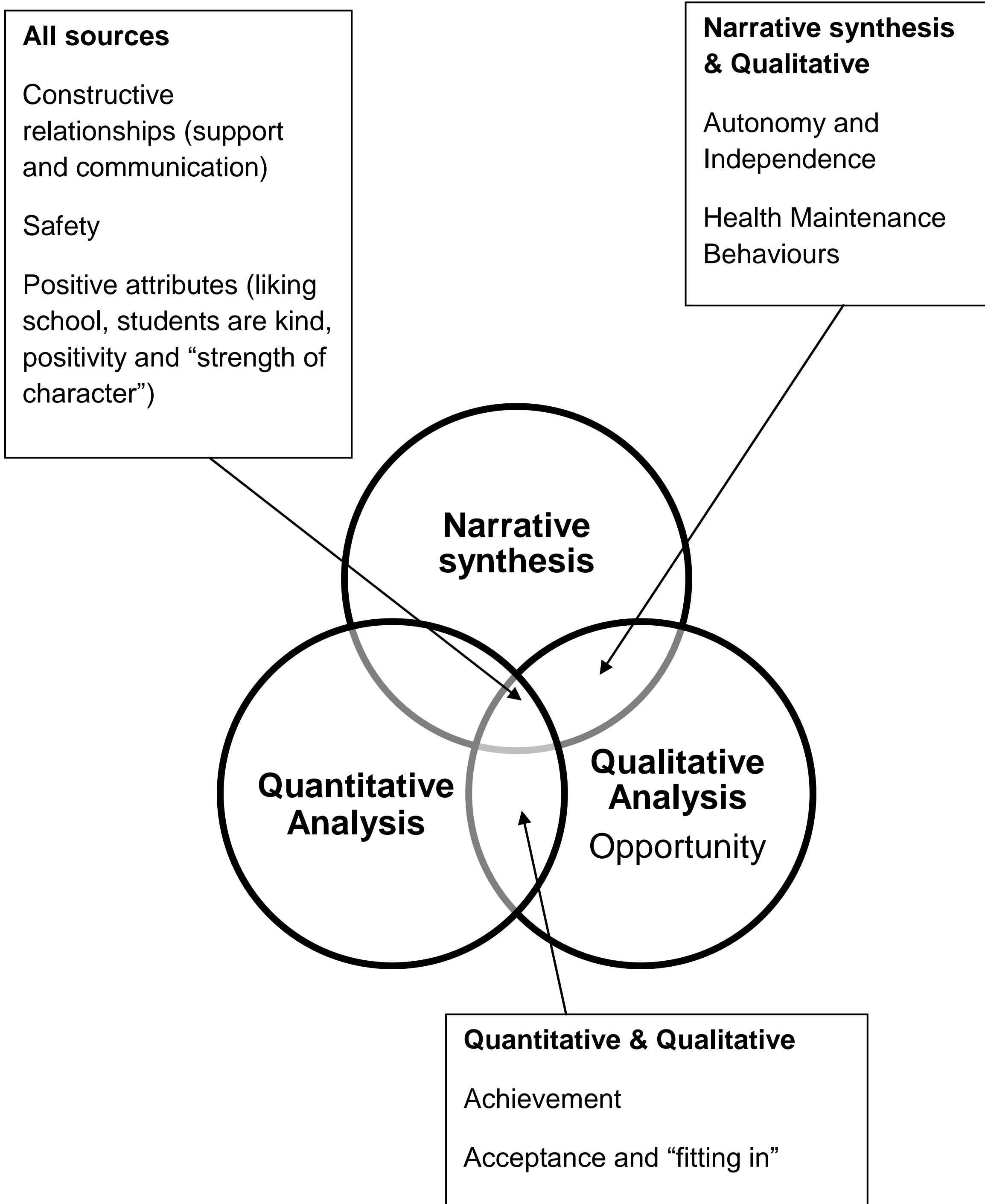


Figure 20: Diagrammatic summary of research findings

Constructive relationships (support and communication)

> "*Good relationships in the home, school and neighbourhood play a part in ensuring that young people can develop social competence and contribute to cohesive societies*" (Slide 18, WHO, 2007).

There appeared overwhelming support for constructive relationships as a core asset to promote young people's health. This was evidenced through the narrative synthesis which identified an association between constructive relationships and healthy outcomes (Table 4, *page 74*). Positive associations between life satisfaction and social relationships were found through the regression analysis within the domains of family, school and community. The focus group participants identified that good relationships with family and friends were necessary in supporting their health and wellbeing. The important role of families and friends as sources of influence and encouragement was highlighted as well as their "caring" role. These findings resonate with other studies which show that adolescents have a continuous need for close relationships with parents; having someone to talk with and also "feeling loved" impacts positively on their wellbeing (Mosley-Hanninen, 2009). Explanations regarding the pathway included the positive support provided to young people in developing relationships, communication, self confidence and independence; parents were viewed as acting as role models and guides, shaping and influencing a young person through their upbringing. Families also had a role to play in paying for access to health promoting activities. Development of supportive family relationships could be encouraged through parenting programs; the narrative synthesis identified that the creation and maintenance of rewarding relationships is teachable. The importance of supporting parent-family relationships has been mentioned in Choosing Health (Department of Health, 2004a) and the Children's National Service Framework (Department of Health, 2004b); the aim being to promote positive emotional health as well as prevent mental illness in later years (Stewart-Brown, 2005).

Constructive relationships are fostered through close communication. The association between better life satisfaction and communication with mother identified through the regression analysis correlates with findings from other studies; adolescents reporting easy communication with their mothers are more likely to report good or excellent health (Currie et al., 2008). Possible explanations of the

connection between communication, relationships and positive health have been suggested as indicating levels of social support within the family (Laursen, 1995), development of a shared language through close communication sustains connectedness (Mosley-Hanninen, 2009) and that good communication with parents helps develop young people's own communication skills (Currie et al., 2008). Links have been demonstrated between strong communication skills and independence; allowing young people to make the most of opportunities and easing transition from school to work or training (McNeil et al., 2012). Communication skills could be promoted within a range of contexts and by a range of practitioners.

Although ease of communication with elder brothers was found to be associated with good life satisfaction through the regression analysis, communication with sisters appeared negatively associated with life satisfaction. The role of siblings in developing a child's ability to interact socially has been discussed in the literature. Sibling support has been associated with higher self-esteem and life satisfaction (Milvesky, 2005, Sherman et al., 2006) as well as an increased ability to resolve conflict (Kitzmann, 2002). Sibling support has also been shown to compensate for low parental and peer support (Kitzmann, 2002). The negative quantitative finding of sister communication and life satisfaction did not appear to fit this pattern and was therefore discussed with focus group participants. However, female participants from the focus groups did not agree that having older sisters was a threat to their life satisfaction; they felt supported by their older sisters. There was mention of anxieties caused when parents made comparisons with more successful older siblings. However, on the whole it was felt that an older sibling provided support and increased younger siblings' confidence. This may therefore be a spurious relationship identified via the regression analysis and highlights a benefit of this mixed methods research of discussing findings with young people.

Positive relationships that promoted young people's health included the notion of support. The idea of support was identified through the narrative synthesis and qualitative analysis; it is also recognised within the wider literature. A meta analysis emphasized the importance of positive aspects of parental support and control (Hoeve et al., 2009). A range of thriving behaviours in adolescence has been linked to having an "authoritative" parent (Wai Chu et al., 2012); the important positive impact on young people's health of unconditional support from parents has been

identified (Spoth et al., 1998). However, over controlling parenting styles can have a negative impact; for example on the development of autonomy (Marsiglia et al., 2007). It appears that young people benefit from having boundaries set and a level of supervision, but this needs to be balanced with appropriate opportunities for independence (Roth and Brooks-Gunn, 2000). Support from family was noted as important in terms of becoming more self-reliant and learning to cope with different experiences. Parenting programs may have a role to play in assisting some parents with balancing support and control.

Constructive relationships with friends appeared important in promoting health and wellbeing. This links to findings elsewhere which demonstrated that positive emotional support from peers promotes positive health (Brooks et al., 2009). Whether family were a more important source of support than friends or vice versa was disputed amongst participants of the qualitative fieldwork and highlights an area where there is likely to be variation amongst the population. Those from less affluent backgrounds appeared to favour family over friends, although as the sample was small it is impossible to draw firm conclusions. Within the wider literature it has been suggested that whilst self esteem becomes more aligned with peer approval through adolescence parents' opinions remain significant (Franco and Levitt, 1998). Some of the young people within the qualitative component of this study acknowledged that support provided them with the "strength of character" to negotiate situations. However, should they require help, it would depend on the wished for outcomes as to whether they would request this from family or friends. Ensuring young people have good communication skills facilitates making friends and provides them with a wider range of sources of support. The possible differing priority given to trusted sources of support by young people should be borne in mind when surveying assets within the youth population.

School based relationships may impact on improved life satisfaction. The variable "Students like being together" was included as a possible asset within the quantitative analysis but was not found to make a significant contribution to the final regression model, although, within the narrative synthesis, getting along with both teachers and classmates was highlighted as impacting positively on health (Lindberg and Swanberg, 2006, Duncan et al., 2007). The importance of a personal connection with teachers has been identified as a protective asset and is particularly significant

when parental support is low (Brooks et al., 2012). Participants in the qualitative work identified that teachers sometimes had a supporting role to play; however, the effectiveness of this appeared to be down to student-teacher relationships and individual characteristics of the teacher (age and likeability). In discussing the impact of student relationships on health, qualitative research participants identified the importance of friendship and positive support but also pressure to fit in, which could have both negative and positive impacts on health. This variation in the significance given to student and teacher relationships could suggest that, although important to some young people, this may not be a core asset within the promotion of all young people's health. This highlights the importance of building in flexibility to capture degrees of variation when undertaking any mapping of assets.

The findings above correlate with other asset approaches; for example, Search's development assets include "family support", "positive family communication", "other adult relationships", "adult role models" and "positive peer influence". However, there is likely to be variation person to person as to which relationships have greatest impact on positive health. This has implications for both surveying and promoting assets. In measuring assets, there may be a range of assets that young people can draw on which equally promote their health; not all may be needed for everyone, for example, if they have strong relationships with family and friends, relationships with teachers may not add anything to their overall wellbeing. This suggests that the impact of some assets on health may require a qualitative assessment rather than purely quantitative; a few good relationships may add more to health than lots of average relationships. This challenges some existent assets theory that proposes equal weighting of assets and the more assets a person has the better their health outcomes (Search Institute, 1997, 2006). There are also implications for health promotion practice; whilst core communication and support assets could be promoted universally, it might be that some initiatives need to be tailored to take into account population variations.

Safety

Safety was identified as a promoter of young people's health on several levels, from the settings in which the young person lives, to the ability to make relationships and develop independently. Within the narrative synthesis the concept of safety incorporated both physical and emotional aspects of safety; associations between

health and community safety were identified through variables such as social connectedness (Granger, 2002) and neighbourhood cohesion (Marsh et al., 2007). Physical safety was captured by the variable "I feel safe in the area in which I live" which was positively associated with life satisfaction within the regression model. One of the girls' focus groups linked affluence with school safety, in that there was more likely to be playground fights at schools in some areas than others.

> *"I don't want to brag about our school but fights don't really happen coz it's not the same type of people, not in a bad way. Because the school is considered to be better, you wouldn't expect that and then people don't tend to fight... it's the expectation and the brand that they have on the school".*
> **(Anna, aged 15, focus group 1)**

This resonates with the 2010 English HBSC study; boys with the lowest Family Affluence scores were the least likely to report that they felt safe at school (Brooks et al., 2011). Children living in poverty are more likely to perceive their neighbourhoods as insecure and sometimes dangerous (Joloza, 2012). The focus groups also discussed how feeling safe in your local area was more likely to allow you independence, in terms of going out to see friends or going to the gym. This correlates with a finding from the narrative synthesis which identified school and neighbourhood safety as a promoter of greater social competence (Youngblade et al., 2007). Parents are likely to restrict children's freedom if they have concerns over neighbourhood crime and safety (Kalish et al., 2010). These findings echo other asset models such as The Search Institute which includes the external assets, "Caring neighbourhood" and "safety" within their developmental asset framework. Research converged on identification of safety as an important asset for young people's health in England suggesting this is a core asset.

There are possible implications regarding definition or measurement of these concepts of safety. A set of composite indicators were developed to assess neighbourhood sense of belonging within the HBSC study and the "safety" variables identified within the regression analysis are part of this set. They may act as a proxy for the fuller set and highlight the priority assets for community connectedness for this population or they may standalone as separate measures for safety and connectedness. In order to promote young people's health directly and indirectly,

there are potential areas for action for school, police and the wider community in terms of improving both safety and perceptions of safety.

Positive attributes

A range of individual level positive attributes were associated with health and wellbeing. This section discusses nuances in the findings while recognising that "positive attributes" captures a core asset for promoting young people's health. The narrative synthesis identified attributes such as being caring, or compassionate, having integrity (Scales, 1999), values (Smith and Barker, 2008) and moral commitment (Roth and Brooks-Gunn, 2000). These types of concepts are not asked about within the HBSC study, although "liking school" as a positive attribute is discussed below. Participants within the qualitative component of this research identified a range of positive attributes linked with health such as optimism, "caring" and "strength of character". "Strength of character" was used within one focus group as a phrase to encapsulate a positive characteristic which helped people thrive and navigate through risks, this characteristic was described as developing through support from family and friends. This links to some of the positive attributes identified in the narrative synthesis; for example, self efficacy, confidence or a positive sense of self were identified as resources which promote successful adaption during adolescence (Roth and Brooks-Gunn, 2000, Vieno et al., 2007). These positive characteristics appear important not just in terms of seeking out positive experiences but also in helping to reduce the impact of situations which could be injurious to health. Antonovsky had argued that it was not necessarily the resources available to someone but the ability to make use of them (an individual's Sense of Coherence) that was important (Antonovsky, 1987). There are links with the resilience literature, in that it is not necessarily sufficient to have particular protective factors, but be supported to use them which creates a level of resilience (Schoon and Bynner, 2003). The idea that it is insufficient simply to "have" an asset to promote health but rather a young person requires the opportunity to employ them successfully, challenges the approaches that rely on counting assets to assess health (Search Institute, 1997, 2006) and suggests the importance of also including qualitative assessment.

The variable "Liking school" was a significant factor within the regression equation. There was some variation between gender and age; more girls than boys reported liking school (30.2% versus 24.7%), and more 11 year olds than 15 year olds "liked school" (43.3% versus 15.4%). This is in line with the international report of the 2005/6 HBSC study (Currie et al., 2008) and the previous English HBSC study (Brooks et al., 2009). School satisfaction is felt to indicate the emotional aspects of life at school; with positive school experiences promoting health (Samdal, 1998). However, with increasing stress during exam years, a student's ability to "like school" may be heavily influenced by these pressures. It seems likely that "liking school" is not a standalone core asset but a reflection of the young person's positivity.

Viewing other students positively appeared associated with higher life satisfaction for some young people. Variations in responses appeared influenced by gender, affluence and/or age. The variable "Students are kind and helpful" appeared to be associated with life satisfaction for boys but not girls within the regression model. The English 2010 HBSC study identified that 65.2% of those with high FAS scores compared with 54.4% with a low score agreed that students were kind and helpful, a difference between girls (65.6%) and boys (60.7%) was noted, there also appeared a decline with age from 71.7% for 11 year olds to 56.3% of 15 year olds. Similar patterns of response were reported internationally (Currie et al., 2008). The variation identified may have implications for how assets are assessed and promoted (further discussion on demographic variation, *page 186*).

The impact of age and gender on positive traits and reporting of health is worth exploring. As discussed above, life satisfaction scores are highest in the youngest age group. As they get older, children tend to report poorer communication with both parents, their positive perceptions of school also tend to decline over time, as does the rating of their health and participation in health behaviours (Currie et al., 2008). Although life satisfaction reduces over time for all young people, this is more marked for girls than boys; there are suggestions that girls worry more than boys (particularly as regards personal appearance) and that anxiety in relation to exams impacts older teenagers more than younger ones (Coleman et al., 2011). The proportion of young people who report regularly feeling low increases with age and is significantly higher for girls than boys (Brooks et al., 2011). Adolescence is a time when identities are being forged. The idea of self concept is closely linked with self esteem; as young

people are surer of their identity, their self esteem grows. As girls and boys move through puberty at different times (Kumar and Clark, 2002), there is likely to be difference in how they rate their satisfaction with life, but this may be linked with self esteem, positive sense of self or hormones as well as level of assets.

The relationship between positive attributes and health warrants further unravelling as both positive and negative states of mental health are likely to impact on a person's self assessment of their life at a given time. Measures of Sense of Coherence (SOC) and life satisfaction have been shown to be impacted by depression (Henje Blom et al., 2010, Brooks et al., 2011, Piko, 2006); whilst somatic problems and anxiety have also been associated with low levels of wellbeing, (Lindberg and Swanberg, 2006). If mental health impacts on how a survey is completed, then results may simply reflect the person's wellbeing on that day; for example, those feeling more positive may be more likely to record feeling safe, having better relationships and a higher overall satisfaction with life.

The associations between affluence and health have been mentioned above, however, affluence may also or alternatively act as a proxy within the possible relationship. It has been proposed that the prevalence of mental disorders in young people is related to the educational qualifications of the parent, with this acting as a proxy for socioeconomic status; the highest rates of mental disorders are in those young people whose parents have no qualifications (Green et al., 2005). Students from more affluent homes tend to report higher academic achievements, liking school, ease of parental communication, more peer relationships, positive health behaviours and higher life satisfaction (Currie et al., 2008). If young people from less affluent backgrounds have poorer mental health, this may impact on how they rate their lives and the assets within them; conversely those from more affluent backgrounds may report more positively. It is possible that affluence impacts directly on health but also acts as a proxy for mental health, this has implications for measurement and promotion. If a measure of mental health were incorporated into assessment of assets this might help separate out the level of impact affluence has on overall health.

Positive attributes such as positive mental health appear closely related with positive outcomes, but the intricacies or direction of the association is not clear. It has been suggested that self esteem has many connections with health from being a direct outcome of health to an independent cause of health with many mediating and correlating relationships in between (Emler, 2001). Some papers within the narrative synthesis included self esteem as an outcome (DuBois et al., 2002, Garst et al., 2011, Youngblade et al., 2007). It is not clear whether some positive attributes are assets or a measure of the asset-health process; for example, SOC could be seen as an internal asset or a measure of how someone makes use of other assets to create health. Research has identified self esteem as a crucial resource for resisting negative impacts of experiences (Kort-Butler and Hagewen, 2011) as well as proposing it as "*the most important developmental asset*" for young people (Wang et al., 2011). There may be an argument to measure for mental illness or, more positively, self esteem or Sense of Coherence (SOC) alongside any asset measurement so that these issues can be analysed more deeply and incorporated into any health promotion initiative.

Academic achievement

Perceived school performance has been linked with school satisfaction and a positive school ethos, life satisfaction and positive health outcomes (Rask et al., 2002, Voelkl, 1995, Huebner et al., 1999, Suldo et al., 2006). The regression equation identified "Academic achievement" as a significant predictor of life satisfaction. (This relates to the HBSC survey question "in your opinion, what does your class teacher think about your school performance compared to your classmates?). This therefore, is related to perception of performance rather than actual achievement. The variable shows variation in life satisfaction with gender, age and affluence. The 2010 HBSC study identified that girls perceived their achievements as better than boys (74.8% versus 68.2%). However, as almost 10% more girls than boys achieve the target of five GCSEs A*-C (Coleman et al., 2011) the gendered difference on self-assessed academic achievement may be a true reflection of how young people are doing academically at school. The 2010 HBSC study noted a decrease in perception of academic achievement with age with 75.9% of 11 year olds believing they were doing well compared with 69.1% of 15 year olds. The 2010 English HBSC study demonstrated a difference between good academic

achievement for those with a high FAS score (74%) and those with a low score (71.2%). The assets "academic achievement" and "liking school" were discussed as a circuitous relationship within one focus group; i.e. those who did well (not just academically but also in sporting achievements) tended to have better relationships with, and support from, teachers. It is possible that, rather than a core asset, the perception of academic achievement could be part of the relationship between other assets (such as constructive relationships and/or positive attributes) and improved health.

Acceptance and "fitting in"

Feeling accepted by others was associated with positive health in both the quantitative and qualitative analysis. The variable "students accept me" was a significant contributor to predicting life satisfaction in the regression model. There was a slight difference in the proportions "feeling accepted" between girls (73%) and boys (75%); percentages "feeling accepted" also declined over year group from 77% in the 11 year olds to 72% for 15 year olds. These are lower positive results than the 2006 English HBSC study; girls were more likely to agree that classmates accepted them though the difference was slight (boys 80%, girls 81.4%); 11 year olds more likely to feel accepted (86%) than 15 year olds (79%) (Brooks et al., 2009). The qualitative research identified the importance of "fitting in"; it appears that young people need to feel that they are part of a group and that this "fitting in" provides them with a level of support and/or confidence which promotes their health. Although independence was seen as an important asset for some focus group participants, there was a level which could be seen as "too independent" where they no longer "fit in" and might not be accepted by peers. As noted in the results section "independence and opportunity" (*page 146*):

> *"I think some people are too independent not in the sense that they can look after themselves but in the sense that when they're put with group work in school they either take over or do it all on their own, they can't listen to any one else"* **(Anna, aged 15: Focus Group 1)**

Some participants also identified that the views of peers might impact negatively on health:

"At primary school I used to do football and loads of clubs, and obviously because there's a smaller amount of people you thought you were really good and then you go to secondary school and you realise you're not. You can still be good but there's loads more people and that might put you off... you might think there's no point" **(Taylor, aged 14: Focus Group 2)**

Negative impacts of peers have been identified in the literature, for example, with gaining acceptance by peers leading to disordered eating (McVey et al., 2002). Whilst others have shown a complex effect of peers, both improving health behaviours and increasing psychological distress (Lewis and Rook, 1999). It highlights the need for specificity in definition and measurement of assets; that "acceptance by peers" might cause positive and negative impacts on health. This was also noted within a focus group, that the peers around you might influence your wellbeing either positively or negatively:

"if they're putting you down all the time and not treating you in a good way then you're not going to feel good about yourself.. if people around you... they say they like what you're wearing, you look good today, then it helps you" **(Maya, aged 15: Focus Group 2)**

This asset could be part of the association between health and other assets (such as constructive relationships and/or positive attributes) rather than a core asset by itself. It highlights the need to gather information on "acceptance" or peer influence qualitatively as well as quantitatively to assess the impact on health.

Autonomy and independence

Autonomy and independence were associated with positive health within the narrative synthesis findings and the qualitative analysis. The narrative synthesis identified autonomy and independence as assets and therefore the following variables were included within the regression analysis (students participate in deciding class rules, students have some control in deciding tasks, students participate in deciding how to work on tasks) but were not found to contribute significantly to the final regression equation. The variables associated with healthy outcomes from the narrative synthesis ranged from broad assets, such as active decision making (Duncan et al., 2007, Morgan and Haglund, 2009) and sense of mastery (Lindstrom, 1992) to more specific such as taking responsibility for physical

activity (Bronikowski and Bronikowska, 2009), making a commitment to achieve (Benson, 2002, Granger, 2002, Smith and Barker, 2008) or using spare time constructively (Benson, 2002). The ideas of active decision making and taking responsibility were echoed in the focus groups; these were seen as important attributes facilitating making the most of opportunities which would allow the young people to grow and develop healthily. Some of the participants proposed that greater independence would allow them to take up opportunities to experience new situations. This aligns with the idea of a strong Sense of Coherence allowing better use of available resources (Antonovsky and Sagy, 1986) and the resilience literature that highlights the idea of development through experience (Rutter, 1987, Werner, 1995, Resnick, 2000). Participants suggested that wellbeing would be promoted through the actual new experiences but also through proving to themselves that they could cope. However, there was variation between participants; some young people who were already relatively independent stated that access to facilities was more important in promoting their health (these young people had left school, were earning their own money and discussed the challenges of making healthy choices with the limited money they had). If this level of variation is seen across the population this might explain why autonomy was not picked up in the regression analysis. This could be an example of an asset that has a different level of priority person to person dependent on their circumstances. Its role in promoting health appears somewhat dependent on the availability of positive attributes, safety and/or constructive relationships. It is therefore proposed to include independence within the assets model for health promotion but not as a core asset.

Some of the qualitative research participants stressed a need to retain control of their lives and their “growing up”, which was preferable to health promotion initiatives that might challenge this control. For example, they stated that although being made to eat healthier food was a good thing when younger they would not accept it now. Although this finding is based on small numbers of participants, it links with the concept of the “autonomous child or young person” which is an important facet of the New Social Studies of Childhood (Prout and James, 1997).

Health maintenance behaviours

The practicing of a range of health maintenance behaviours was linked with positive health outcomes. The narrative synthesis and qualitative analysis identified that healthy outcomes were associated with eating habits (Lindberg and Swanberg, 2006, Morgan and Haglund, 2009, Duncan et al., 2007) and physical activity (Bronikowski and Bronikowska, 2009, Smith and Barker, 2008). Returning to the quantitative dataset, to consider how young people responded to some of the health maintenance behaviours included in the survey, highlighted that these behaviours were practiced by the majority; for example over 98% of the study population stated that they took regular exercise.

The focus groups suggested that following a healthy diet and exercising could be more successful if supported by families, friends and the community. The influence of positive role models in promoting health has been identified internationally (Wang et al., 2011). The qualitative research participants expanded on the role of family and health maintenance behaviours by emphasising the need for a certain level of affluence to access both healthy food and gyms. They also stressed the important health promoting role of local infrastructure; the availability and accessibility of facilities. Young people with more positive outlooks may place more of a priority on improving their health; "caring" by young people and parents was identified as an influence on uptake of certain behaviours (for example, within the discussion of "Friends and friendliness" *page 148*, "Family: support/pressure" *page 151*). The area of promoting positive mental health and its subsequent impact on physical health is worthy of further research, it is also an area which could be explored in terms of incorporation into asset measurement.

Health maintenance behaviours directly influence healthy outcomes but are also associated with positive outcomes through the idea of positive attributes and relationships. Within the narrative synthesis healthy behaviours were found to be associated with a positive sense of identity (Smith and Barker, 2008, Benson, 2002, Granger, 2002, Scales, 1999), sense of meaning (Lindstrom, 1992, Bronikowski and Bronikowska, 2009) and self esteem (Youngblade et al., 2007); it was concluded that health maintenance behaviours appeared to link with positive attributes and autonomy (*page 85*). It is possible that health behaviours are part of the health promoting process, rather than an asset in their own right. It was therefore decided

not to include health maintenance behaviours as a standalone health asset in the health promotion model.

Opportunity

The idea of opportunity appeared associated with positive health outcomes for some participants in the qualitative research who stressed the importance of opportunity for development and experience in improving health. When talking in relation to how assets could be used to promote health, there was a lack of interest by some participants in particular initiatives or interventions. However, for other participants there appeared an acute awareness of how opportunities were severely restricted due to lack of access to resources. The concept of opportunity had varying nuances with some participants linking it closely to freedom and independence whereas others saw it as more closely attuned to resources.

Health promoting opportunities were discussed within the qualitative fieldwork; being able to go through different experiences and learn from those encounters. Opportunity to gain mastery of new experiences has been demonstrated in the literature to build self esteem which in turn improves life satisfaction (Wang et al., 2011). In revisiting the findings from the narrative synthesis following the initial focus groups, it was noted that some papers had identified opportunity as important to the asset-health process whereby young people could develop positively; in one paper, this was in relation to young people developing into healthy adults (Granger, 2002) and in others it was the importance of self efficacy or self regulation that was seen as the asset which enabled opportunities to be exploited (Dawes and Larson, 2011, Vieno et al., 2007, Gestsdottir et al., 2011, Bronikowski and Bronikowska, 2009, Urban et al., 2010). This links with the conceptualisation of the young person as an active social agent (Prout and James, 1997).

Although there appears dissonance between the findings from the focus groups and the Search Institute's asset model, there are links with resilience and salutogenesis. Search's model appears to favour structured activities, young people attending youth programmes or religious institutions, rather than being "*out with friends with nothing special to do*" ("Constructive use of time": asset 20, Search Institute, 1997, 2006). Personal Youth Development also favours structured activities, although recognising that time away from parents fosters independence and self sufficiency (Roth and

Brooks-Gunn, 2000). Within the literature, there appeared to be positive relationships between young people's participation in extracurricular activities and wellbeing (Kort-Butler and Hagewen, 2011); with activities providing adolescents with room to develop as people, build skills, widen social networks and increase self esteem (Fredricks and Eccles, 2006). The theories of resilience and salutogenesis both recognise that young people need to have a range of experiences to develop coping skills. These discrepancies in research findings (structured activity versus opportunity) might be due to the difference between American and English contexts, or from taking adults or young people's perspectives. There may also be variation with age; younger children requiring more structured activities, whereas teenagers requiring a certain level of non-structured time to develop independence. The importance of capturing young people's own views rather than being reliant on the views gathered via adult defined responses to a questionnaire has been raised elsewhere in the literature;

> *"... grounding research in participants' perspectives without filtering these views through researchers' pre-established constructs and categories" (page 299, Spicer, 2004).*

Additionally, the concept of opportunity as a health promoting asset may exist within the context of constructive relationships, safety and positivity. Without such support, opportunities might be exploited in ways that damage health. A final explanation might be due to the range of activities already undertaken by the young person. Some of the research participants already had access to a range of structured activities (for example, Scouts and Duke of Edinburgh schemes) and therefore simply wanted some free time (opportunity for independence), whereas others might already have this level of independence but were unable to access structured activities due to lack of resource. The idea of "core and balance" has been discussed within family systems theory (Zabriskie and McCormick, 2001, Klein and White, 1996) and has resonance here, in that young people need a mixture of "*stability and change, structure and variety, and familiarity and novelty*" (page 31, Ward and Zabriskie, 2011). "Core activities" tend to be those every day, low cost opportunities that are undertaken routinely whereas "balance activities" provide novel experiences that expose individuals to unfamiliar challenge (Ward and Zabriskie, 2011). This highlights the importance of definition and measurement; different people

are likely to assign differing meanings and priorities to the health promoting aspects of opportunity. The asset “opportunity” was included within the assets model for health promotion whilst recognising that it might not be a priority asset for all young people and its success in promoting health might depend on the availability of other assets; positive attributes, constructive relationships and/or safety.

Demographic variables

The overarching aim of this research was to construct an assets based model to shape health promotion strategies and initiatives for young people in England. As well as identifying important assets, the research aimed to understand how this knowledge could be used to promote health. As both quantitative and qualitative analysis identified variations by gender, age and affluence it seemed important to understand the relationship between certain demographic variables and health, as this may need to be taken into account when considering implications for practice. Within these following sections variation in positive health is discussed as captured by a range of outcomes, including, for example, life satisfaction.

Gender

Boys (88.4%) were more likely than girls (82.6%) to report better life satisfaction (scoring 6 or above) – this is a similar finding to the previous English study, 87.9% for boys and 82.9% for girls (Brooks et al., 2009). Some gendered differences in adolescent wellbeing and health determinants have been reported elsewhere; girls are more likely to report poorer health outcomes, higher consumption of healthier foods and are less likely to engage in risk behaviours (Currie et al., 2008). Further examples of gendered variation include; more boys than girls demonstrate above average self efficacy and a sense of cognitive control over their environment (Baban and Craciun, 2010) whilst social anxiety, low self esteem and depression is more common in adolescent females than males and this may reduce their scoring of life satisfaction (Henje Blom et al., 2010, Galambos, 2004). Sense of Coherence scores have been found to be higher in boys than girls of the same age (Honkinen et al., 2008, Mosley-Hanninen, 2009). Several of the participants in the qualitative fieldwork acknowledged that girls may regard their lives more harshly and proposed suggestions as to why this might be:

"Females go through like a harder time as they get older, men tend to deal with things a lot better. Girls go through a lot of physical and emotional changes which might be why they rate themselves lower than males". **(Cenk and Sam, aged 18)**

"*boys also go through a lot of problems but they don't show it as much probably like, a lot of things are hidden when it comes to a boy, girls are more outspoken*" **(Joseph, aged 15)**

Possible further explanations for the gender differences include: role expectations for girls are less clear than for boys (Antonovsky and Sagy, 1986), girls are more aware of inner conflicts (Honkinen et al., 2008), puberty has a greater impact on girls (Galambos, 2004) and there are greater negative impacts from community, society and media on girls (Mosley-Hanninen, 2009). It has been postulated that young people's rating of their health is a reflection of how parents rate their children's health; for example mothers are more likely to describe their sons as healthy whereas their daughters as only "fairly healthy" (Williams, 1998).

Whether young women have poorer health outcomes or perceive their health more poorly than male counterparts both have implications as to how assets are measured and promoted. There may be recognition that an asset score for young women may always be lower than for young men, however whether this can be improved through asset promotion would require further research. It is also unclear as to whether universally promoting core assets would simply perpetuate such health inequalities. Gender differences are compounded with the effects of age and Family Affluence Score as discussed below.

Age

Although more than 8 out of 10 young people reported good levels of life satisfaction, there was a difference in scores between age groups, with life satisfaction lowest for the eldest age group; 15 year olds (84%), followed by 13 year olds (86%) and 11 year olds (86%). This compares with the English 2006 study – 84%, 83.7%, 88.1% respectively and is consistent with international data that highlights a similar trend (Currie et al., 2008). Participants in the qualitative fieldwork suggested that a

reduction in levels of life satisfaction over time for some young people could be due to the increasing pressures they faced.

> *"I think as you get older there's more pressure on you so there's more things that are required of you, to do more, like people have higher expectations of you and then like specially as a young person you're being watched nearly all the time so.. but when you're younger you don't get watched so much they don't expect that much from you. When you're older, as people watch you, you get judged more ... you get judged more, focussed more"* **(Joseph aged 15).**

This waning of life satisfaction over time is in contrast to the resilience literature which suggests that coping skills develop over time and therefore we would expect to see a development of positivity, more assets and an increase in life satisfaction as young people age. The theory of salutogenesis also suggests that Sense of Coherence (SOC) increases with age over the lifespan (Eriksson, 2007). However, it has been proposed that it can be affected by life experiences (Antonovsky and Sagy, 1986) and recent research has identified a weakening of SOC during adolescence (Moksnes et al., 2012). This might imply that assets, Sense of Coherence, coping skills etc need to be promoted at earlier ages to improve and sustain positive health through adolescence.

The aggregated data disguised the differences between the genders across the age groups; whilst boys' life satisfaction increased from age 11 (87%) to 13 (89%) and then stabilised, girls' life satisfaction was highest at age 11 (85%) and then decreased to 82% at 13 and 80% at 15. The HBSC international report for 2009/10 also found that the significant decline in life satisfaction between the ages of 11 and 15 was larger for girls than for boys (Currie et al., 2012). A possible reason for the gender disparity is the likelihood that girls aged 11-15 are more likely to be experiencing hormonal changes than boys of the same age (Gådin and Hammarström, 2005). Another suggestion is that girls are often expected to self manage chronic conditions (such as diabetes and asthma) at earlier ages than boys, which sometimes results in poorer control of symptoms than when parents are still involved in supervision of treatment (Williams, 1998). It is possible that girls' poorer life satisfaction scores may reflect both poorer health in some cases compounded by

a sense of not being able to cope with additional responsibilities. This variation by age and gender may need to be taken into account within strategies to improve young people's health.

Affluence and Money

There is a wealth of evidence linking physical health and income inequalities within the adult population (Black et al., 1982, Acheson, 1998), though whether such health inequalities exist during adolescence has been debated (Sacker et al., 2002). This may be due to the way that income inequality and material deprivation are measured. Whilst there seems little impact on life satisfaction of young people aged 11-15 as captured by income based measures of poverty (Knies 2012) some patterns of health outcomes do appear associated with material inequality, for example child accidents, dental health problems and teenage pregnancy (Blair et al., 2010). The HBSC 2010 study identified that those with high family affluence were more likely to report better life satisfaction (89%), followed by medium affluence (84%) and low affluence (75%). These are similar to the findings from the 2006 English study – High 88.1%, medium 83.5% and low 76.1%. The regression analysis identified this difference through the interaction between gender and affluence, with better life satisfaction and high FAS scores significantly associated for boys but not for girls. Internationally it has been demonstrated that adolescents with higher family affluence tend to report higher life satisfaction (Currie et al., 2012). The Search Institute have noted that higher levels of assets are associated with young people from more affluent backgrounds (Benson, 2002). Qualitative fieldwork participants could understand why family affluence was linked with health and life satisfaction. The groups spoke in relation to the direct impact that affluence had in terms of providing access to gyms and healthy food. Participants also discussed how money acted as a facilitator to buy books to help with school work, thereby improving achievement levels. Within the discussion of safety above, the link has been made between feeling safe at school and affluence (*page 174*). Children and young people living in poverty have identified a range of concerns including: anxiety over insufficient income coming into the household to meet needs, restricted opportunities, not fitting in as they do not have the same possessions as their peer group and having to undertake more chores in the house as their parents are

working long hours (Joloza, 2012). Research with children aged 8-12 identified the importance that some young people placed on branded goods; "*If a child is wearing branded trainers they are seen as popular and able to fit in with their peers*" (page 347, Elliott and Leonard, 2004). For young people from less affluent backgrounds there may be a role in facilitating access to health promoting activities to reduce health inequalities. However, ensuring that young people are not bullied through lack of particular possessions or access to costly opportunities is likely to be more difficult to resolve. It appears that variations in affluence do impact young people's health and life satisfaction; money provided a certain level of autonomy and linked with "acceptance".

Cross cutting themes

Reducing factors or processes to a term such as assets or deficits may be problematic. There was an understanding within the qualitative analysis that some variables could have negative and positive impacts on health and therefore there were concerns regarding labelling them as assets. For example, the participants discussed how "student acceptance" might have negative or positive impacts on health – encouraging healthy eating or causing anxiety in relation to body image. The precision of definition has been highlighted within the resilience literature, in that tight classifications are required to ensure that researchers are measuring the same thing (Fergus and Zimmerman, 2005). It has been proposed that to obtain conceptual clarity of "*fuzzy aspects*" the construct should be broken down into measurable components, though this may lose some of the construct's essence (page 129, Green and South, 2006). The precision of definitions within research are imperative to ensure that assets are captured accurately.

The method of how an asset is measured may also require work; whether an asset is a binary variable or more of a scale, for example. The qualitative research participants mooted the idea of moderation with the asset "independence/autonomy", for example, being independent but not too independent; there was an emphasis on being able to "fit in". This measurement issue is in contrast to some survey methods of quantifying assets (for example, Leffert et al., 1998), where an individual either has the asset or does not. However, it is acknowledged that some surveys do

include scales to quantify assets (for example, HBSC). Various researchers have proposed frameworks for measuring assets; for example, the 10-factor model of developmental strengths (Donnon and Hammond, 2007) and The Search Institute's framework of 40 assets (Benson, 2002, Scales, 1999). However, these tend to weight all assets equally. Discussion regarding constructive relationships challenged this by suggesting that there may be core relationships which promote health the most; increasing numbers of relationships may not increase health further for all young people (*page 171*). It has been proposed that assets work together, so that, the more assets a young person has, the more likely they are to engage in health promoting behaviours (Murphey et al., 2004). Clustering of assets such as self esteem, family communication and community involvement have been linked with an individual taking greater responsibility for their health, stress management, nutrition and exercise (Wang et al., 2011). However, within the discussion of positive attributes above there appears a need for more precision in measurement of some of these assets or attributes, unpicking which assets are measuring similar qualities and which act as standalone, distinct measures. (For example, whether health maintenance behaviours and perceived achievement are more likely to be evidence of positive attributes rather than distinct assets). The potential association between several "assets" and positivity has implications for practice as holding a low level of assets might suggest either promotion of certain assets is needed and/or an intervention to promote mental health. There was also discussion as to whether simply having an asset was sufficient to improve health, or rather, should the focus be on how and whether the asset was used; possibly it is the process of engaging in experiences that promote health (*page 176*). Understanding the context of a young person alongside measurement could provide important information for health promotion; for example, providing opportunities for independence could act as an asset for a well supported 15 year old but might promote risk for an 11 year old. A dual assessment of assets alongside risks has been proposed as one way of gaining a full measure of health status (Jackson et al., 2012). This could be further enhanced through supplementing with qualitative information to understand the asset-health promoting process.

Issues regarding measurement of both assets and outcomes influence the viability of taking an assets approach. One of the key interests of commissioners and policy makers is being able to demonstrate making a difference. This may be easier when taking a traditional deficits approach; for example, it has been argued that using mortality and morbidity statistics is easier than positively measuring health (Kemm, 1993). The measurement of positive health outcomes is problematic. Health and wellbeing can be measured through indices or multi-domain measures to capture the many facets that make up health in its most positive sense. Ten domains have been proposed to measure the well-being of the UK and many of the measures within them are of relevance to children (Joloza, 2012). A recent review of existing indicators has suggested that there needs to be agreement on a measure for use within research and interventions that captures both objective and subjective measures of wellbeing and positive health (Hicks et al., 2011). There are a number of child specific quality of life measures that have been developed (for example, PEDsQL, Kidscreen, KINDL-R, for more detail see the discussion in Child Public Health (pages 154-158, Blair et al., 2010). A "Framework of Outcomes for Young People" has recently been designed which focuses on social and emotional capabilities (McNeil et al., 2012). Examples of subjective indicators to capture health and well being include both the TellUs survey[33] in England and the WHO Health Behaviours of School aged Children Study (HBSC)[34]. The Sense of Coherence (SOC) scale (*see Chapter 3 for more detail*) provides a potential method of measuring how meaningful, manageable and comprehensible young people find life. New Philanthropy Capital has developed a multidimensional questionnaire for use with 11-16 year olds, to demonstrate wellbeing impacts of interventions; measuring eight aspects of subjective wellbeing[35]. Agreeing a measure of positive impacts will help in the collation of evidence to demonstrate that health promoting interventions are having an effect; it will also help in standardising or comparing results.

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[33] The TellUs survey was developed and conducted by OfSted and provided a wealth of self-reported information based around the five core dimensions of the Every Child Matters framework; although since the coalition government came to power this survey has not received further funding.
[34] http://www.hbsc.org/ Accessed 30/7/12
[35] http://www.philanthropycapital.org/how_we_help/Well-being/default.aspx Accessed 19/5/12

Assets model for health promotion

This research aimed to construct a model to shape health promotion practice and policy for young people in England. It is a descriptive model, explaining the assets that appear to be of significance to the young people included in this study.

To be happy and healthy, young people are likely to need a combination of assets. The narrative synthesis, quantitative and qualitative analysis have all suggested important assets for young people's health. The consolidation of these findings has drawn out those assets that appear core to promote universally with young people, those that appear to vary in priority dependent on young people's circumstances and those that do not appear to be standalone assets for English young people (but rather, closely aligned to other assets or part of the asset-health process).

All research strands (narrative synthesis, quantitative and qualitative) identified the importance of constructive relationships, particularly issues of support and communication. There was also unanimous corroboration of assets incorporating the concepts of safety and positivity. The ideas of independence and opportunity were identified by the narrative synthesis and qualitative research. These assets appear important in promoting health within the context of holding other core assets. From the qualitative analysis, there appeared variation as to the definition of opportunity as a health promoting asset. These assets combine to form a theoretical asset model for promoting health with young people in England (Figure 21).

The model is not a checklist to measure young people against, but rather a framework which could be used in a variety of ways. Within asset mapping with groups of young people, it could be used to prompt discussion of the core assets, understand priorities and identify areas where intervention may support improvements in health. This model could be used to assess interventions; ensuring core assets are included within activities so that health may be promoted. The ecological theme identified by the narrative synthesis highlighted the importance of health promoting settings; this model could be used to encourage healthy public policy to embed assets within a range of settings thus facilitating a sustained impact on health.

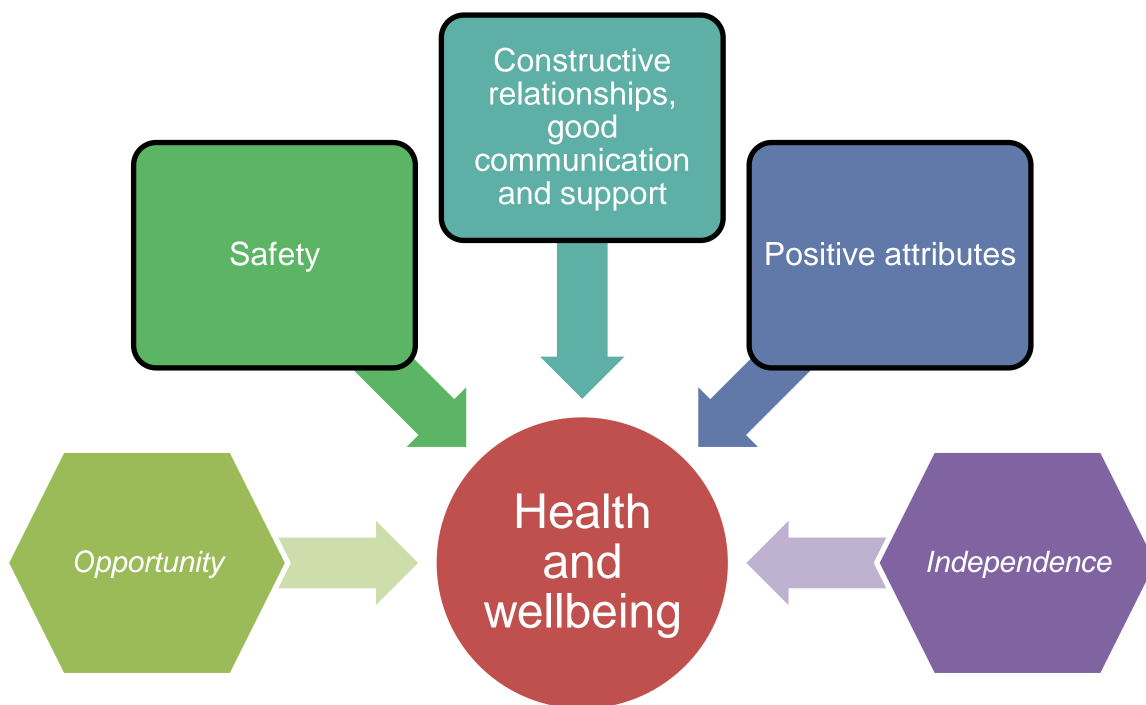

Figure 21: Assets model to shape health promotion with young people

The following section discusses how the research findings can be incorporated into practice with reference to research in the field, experience and views from practitioners.

Incorporating assets into practice

It has been suggested that implementation of new health promotion activities is dependent on a range of factors, including current practice, how easily existing practice can be changed and how innovation in practice is viewed (South and Tilford, 2000). The adoption of an assets based approach is likely to require change for practitioners; from utilisation of "*a new vocabulary*" (page 839, Porter, 2010) to, potentially, "*a change in attitudes and values*" (page 6, I&DeA, 2010). As this research has been undertaken as part of a professional doctorate in health research, views from practice regarding how the above asset model might be applied were important. A practitioner whom I discussed the research with could see the benefits of this approach:

> "*Interesting new approach for professionals to adopt, more opportunity to work with families and young people in a meaningful way and to improve relationships with families.*"
>
> Children's services commissioner

New methods of working are likely to have implications for policy; these are discussed within chapter 8 (*page 212*).

Promoting assets, reducing health inequalities

The findings from this research produced a list of assets that appear associated with healthy outcomes for young people in England. The narrative synthesis also identified two themes to potentially guide health promotion practice; ecological (the context for health promotion) and holistic (the idea of addressing risk and protection). Variation occurred as to the priority that young people within the qualitative fieldwork placed on certain assets. Whilst core assets may be promoted universally there might need to be flexibility to assess needs and map assets within some groups to tailor interventions and ensure that health inequalities do not deepen. This resonates with an approach taken within the Healthy Child Programme which talks of progressive universal services; universal services are provided to all young people, whereas some groups will require a more targeted offer (Department of Health and Department for Children Schools and Families, 2009). There are similarities with the concept of proportionate universalism. The Marmot review "Fair Society, Healthy Lives" suggested that focusing solely on the most disadvantaged would not reduce

health inequalities sufficiently, but rather actions should be universal, with a scale and intensity proportionate to the level of disadvantage (Marmot, 2010).

Both the quantitative and qualitative components of this research identified affluence as a variable associated with life satisfaction and the reporting of assets. Whilst the aims of improving affluence and reducing income inequalities falls within wider government policy, it has been suggested that some of the impacts of deprivation may be reduced through assets approaches. For example, good parenting has been demonstrated to alleviate some of the negative impacts of poverty (Stewart-Brown, 2005) and there is a growing body of research on the efficacy and effectiveness of family based programmes to support parents in developing positive parenting skills (Wai Chu et al., 2012). Research has noted that high levels of self regulation allow young people to make the most of even the most resource poor environment (Urban et al., 2010). The promotion of these types of positive attributes and abilities will be important to enable young people to make the most of the assets and opportunities available to them regardless of their family's level of affluence. However, the promotion of assets, both at the individual and family level, should occur alongside, rather than instead of, policy to reduce deprivation or material inequalities.

Timing of interventions

No intervention type studies were discovered in the literature that identified the best time to intervene to promote assets and thereby improve young people's health. Whilst there has been much interest in early intervention, ensuring that babies are provided with the best start in life (Allen, 2011) and expanding the Health Visiting workforce by 4,200 additional workers by 2015 (Department of Health, 2011), a conference at the University of Kent (September 2011) challenged this "*extreme focus on early childhood*". It was argued that, by focussing on one area of a child's development, other areas are being neglected. An education consultant suggested that by the age of 8, as children sleep better and socialise better, they are easier to manage for parents and so there is a relaxation by parents whilst they wait for adolescence (Gill Hines, The Times, 17/9/11). However, this may be the time to intervene to address underlying determinants of behaviours that will impact health later on (Jackson et al., 2012). Interventions occurring towards the end of primary school could build a firm foundation from which young people can enter the teenage

years. Participants within the qualitative fieldwork stressed the huge differences between primary and secondary school, most of which were discussed negatively. This is possibly also a good time to start promoting opportunities for self development, encouraging young people to increase their independence and advancing their positive beliefs in themselves. It may help to tackle the early peak seen in young people's life satisfaction; age 13 for boys and age 11 for girls (Brooks et al., 2011). Whilst health and social care are focussing on the very early years it will be a challenge to encourage an expansion of support throughout the primary and secondary school period; however a case could be made for strengthening and expanding parenting programmes by aligning with other existent targets such as educational achievement and school attendance, for example.

The importance of pre-adolescence was supported when the potential of assets models was discussed with practitioners. A Children's Trust manager stated the following:

> "*During my 5 years working in the Connexions Services, schools were constantly saying that the principles on which the service was established i.e. to provide information, advice and guidance for 13-19's, came too late. Consistently primary head teachers were identifying the 8-11 year olds as the crucial age group for intervention and guidance on issues of bullying, positive mental and physical health, prior to their transition into larger school environments. It is also a key time to raise personal aspirations*."

The second half of primary school seems an opportune time to intervene, to ensure that young people are ready to cope, find meaning and manage the next stages of their development. Although based on small numbers and therefore possibly not generalisable to the larger population, some of the focus group participants were strong advocates of the initiatives they had experienced at primary school and stated that they would be more resistant to overt interventions once at secondary school.

The school setting: promoting support, communication and opportunity

The literature identified the importance of "*infusing asset-building approaches into the school community*" (page 8, Scales and Roehlkepartain, 2003), recognising that schools were over burdened with add-on interventions (Weissberg and O'Brien, 2004). Taking an assets approach within the school setting could ensure that many

assets are promoted through daily routines, rather than requiring targeted initiatives. This has benefits for sustainability through integration within existing school activity plus meets the need for those young people who might disengage from any overt initiatives aimed at improving their health. There is a distinction between health education provided within a school and a health promoting school; a health promoting setting, for example, would ensure that

> "*the ethos of the setting and all the activities are mutually supportive and combine synergistically to improve the health and wellbeing of those who live or work or receive care there*" (page 270,Tones and Green, 2004).

The "Healthy Schools"[36] programme required that schools take a whole school approach to review the opportunities, services and activities that would promote health and wellbeing in the school setting. This initiative appears to fall in and out of favour at a national level with subsequent varying levels of governmental funding committed to the programme. Healthy public policy is discussed further in implications for policy (*page 212*)

Although IQ is fairly well established after the first years of a person's life, it has been argued that social and emotional capabilities are more readily changed in the teenage years (McNeil et al., 2012). Constructive relationships within the school setting were identified via both quantitative and qualitative components of this research in relation to improving young people's health. Evidence based programmes delivered in schools have been identified as ideally placed to cultivate a range of assets, such as social and emotional skills, connectedness and protective health behaviours (Hale and Viner, 2012). Participants of one of the focus groups also discussed improved communication with teaching staff once a relationship had been built up. Within the Positive Youth Development (PYD) movement in the US, relationships with staff are built through having low ratios between staff and young people (Garst et al., 2011). The potential benefits of improving relations between teachers and pupils have been highlighted particularly where there are low levels of family cohesion (Brooks et al., 2012). Schools could review the opportunities that

[36] http://www.education.gov.uk/schools/pupilsupport/pastoralcare/a0075278/healthy-schools Accessed 17/12/12

they currently provide to engage with young people and support them in a range of areas.

Support within the school setting could also be built through developing young people. The qualitative fieldwork participants mentioned how much they rely on their friends for support if they have a problem. There is the potential to explore more peer health promotion within schools; training young people to deliver health messages in their terminology.

School has been noted to have a "*powerful linking capacity*", helping to mobilise strengths in the community and family as well as drawing them into the school setting to support development (page 136, Benson, 2002). Extracurricular activities are an example of this, often linking school and the community. This resonates with the social capital literature which emphasises the two way benefits between an individual and a community when a sense of cohesion is created (Kawachi, 2010).

Ecological theme: the settings for health promotion

The idea of overt health promoting initiatives that might be shunned by some young people has been discussed within this research (*page 157*), this emphasises the importance of health promoting roles of settings. The narrative synthesis identified the value of regarding all contexts for health promotion; as well as school, this included neighbourhood, voluntary groups and other communities. Whilst a settings approach resonates with the wider determinants of health (Figure 2, *page 19*). Consideration of how resources for young people could be created within their communities has been identified as a currently underdeveloped aspect of health promotion (Brooks et al., 2012). However, with the move of public health departments from Primary Care Trusts to local authorities from April 2013, it is an ideal opportunity to explore this area of community development. It also resonates with the idea of neighbourhood cohesion which has been discussed by the coalition government as part of their "Big Society" initiative.

The neighbourhood may need to consider how young people can be provided with opportunities to volunteer and be active participants in community life. Some local authorities do not support volunteering by under 16 year olds, so this may require changes to local policy. However, young people may well be able to participate as decision makers within schools and councils through initiatives such as Youth

Parliament. Comments gained from a local authority Children's Trust manager backs these ideas:

> "*The Children's Trust team organises and facilitates a wide range of opportunities for young people to develop their self esteem and communication skills, including the development and support of the borough participation structure of a Youth Parliament and Area Youth Forums*"

Some local authorities recognise young people as active social agents and are keen to encourage their participation in local democracy; they recognise that this has benefits for both young people and the community. However, some areas may need encouragement to move to a position where young people are seen as having something to offer and can work with the community (I&DeA, 2010, Morgan et al., 2006). The Aiming High strategy identified the importance of encouraging a positive approach to young people for society and increasing participation in constructive activities for young people's health (HM Treasury and DfCSF, 2007).

Research included in the narrative synthesis debated the relative merits of structured and unstructured activities. This was echoed within the qualitative component of this research, some participants stated that instead of health promoting initiatives they would rather be provided with more independence to try out new things, however other participants wanted the opportunity to access health promoting activities but were denied this due to prohibitive costs. This suggests that there may need to be some tailoring of initiatives to take account of young people's circumstances. Ensuring that opportunities are available that young people can access relatively autonomously may reduce their need to seek out other challenges that might have associated risks. It is recognised that many structured activities may not be available to some young people due to access issues and costs.

Holistic theme: risk reduction and asset promotion

An assets approach to health promotion could be added to existing ways of working rather than requiring a complete overhaul of service delivery. Assessing assets within a community through asset mapping could be included alongside the traditional needs assessment; a dual assessment. The "holistic" approach to health promotion, addressing risk and protective factors together, was identified through the narrative synthesis; promoted by both positive youth development practitioners and

prevention scientists (Catalano et al., 2002). This approach has also received support in a recent report on improving children's health outcomes (Children and young people's health outcomes forum, 2012). It has been proposed that promoting young people's strengths whilst addressing risk behaviours may be the most effective approach in improving young people's health (Jackson et al., 2012, Pollard et al., 1999). This method has been trialled in primary care in Vermont, with practitioners talking about young people's accomplishments alongside risk behaviours, acknowledging adolescent's responsibility for their health and encouraging critical thinking in relation to media messages (Duncan et al., 2007). This idea of considering assets alongside a more general health assessment (Wang et al., 2011) also helps incorporate issues discussed in the previous chapter regarding whether low recording of assets also signifies symptoms of anxiety and/or depression. The Healthy Child Programme from 5-19 years was developed in the UK to provide a framework to improve outcomes for children and young people within this age group (Department of Health and Department for Children Schools and Families, 2009). One of the suggestions within the report was for Health Development reviews carried out at the start of primary school, in school years 6 or 7 and with mid teens; whilst many areas continue with the initial review, the later reviews are not common place. However, they would provide an excellent opportunity to review a young person's health (including assets alongside risks) and identify whether there was a need for any targeted promotion or signposting to universal services.

Assets approaches are more than a flipside of deficits; it is the process of involvement and the voicing of strengths which is argued to bring benefits alongside asset identification and promotion (I&DeA, 2010). An asset mapping with young people could be the start of a community development process, identifying the strengths and resources that the group hold, understanding the qualitative aspects of assets, priorities for those individuals and encouraging engagement. In line with the progressive universal approach in the Healthy Child Programme (Department of Health and Department for Children Schools and Families, 2009), core assets could be promoted through being embedded in universal services, whilst asset mapping identifies where progressive services could support.

Mental and physical health promotion

"*Public health messages need a total makeover so patients and clinicians base their activities on a modern understanding of health and wellbeing, which ties mental and physical health together*" (McCulloch, 2009).

The idea of positive mental health was discussed within this chapter (*page 190*); questioning whether assets such as "academic achievement" or "health maintenance behaviours" are part of the health promoting process, standalone assets or part of the outcome measure. If having a positive sense of self, a "strong character" or a robust ability to self regulate[37] is a core need for a young person to make the most of the opportunities available to them, these need to be addressed simultaneously with any initiatives for physical health improvement so that optimal health and well being is attained. One of the girls' focus groups was critical that emotional and social health were not promoted within their school alongside the more physical aspects of health promotion. They noted that this was a change from primary school when there had been time set aside to discuss social and emotional wellbeing (Health promotion initiatives, *page 157*). A recent e-petition has urged HM Government to introduce mental health into the KS3 and KS4 Personal, Social and Health Education (PSHE) curriculum as there is presently no routine focus on mental health within secondary schools[38]. Regardless of how mental health is captured within the asset process it appears fundamental that activities to promote mental health should be included as part of general health improvement in a range of settings. There is growing evidence that promoting mental wellbeing has a more sustained impact on young people's health than deficit based health promotion (McNeil et al., 2012).

Facilitators to integration

The holistic theme discussed above (*page 200*) suggests the tactic of incorporating asset models within existing risk-focused structures. The introduction of assets approaches in this way could encourage a change in direction without a major overhaul of services. When discussing my research with practitioners a range of examples were provided as to how assets approaches could be incorporated into

[37] "*the ability to flexibly activate, monitor, inhibit, persevere and/or adapt one's behaviour, attention, emotions and cognitive strategies in response to direction from internal cues, environmental stimuli and feedback from others in an attempt to attain personally-relevant goals*" MOILANEN, K. (2007) The adolescent self-regulatory inventory: the development and validation of a questionnaire of short term and long term self regulation *Journal of Youth and Adolescence,* 36**,** 835-848.

[38] http://epetitions.direct.gov.uk/petitions/37535 (petition closing 24/8/13) Accessed 29/10/12

"business as usual". For example, within a current Drug and Alcohol programme[39], although many targets follow a deficit approach (reducing crime, abstaining from substance use), others have an asset focus (taking personal responsibility for engagement with services). A teenage pregnancy coordinator stated that, as well as ensuring that young people have access to contraception and education, one of their programmes took a more positive slant and "*focuses primarily on self esteem and aspiration*". Through this, both risks and strengths are identified and addressed. A Children's commissioner affirmed that their therapy services and joint services for disabled children include an assets approach in terms of strategic aims and vision.

> "*They all have outcomes stating their aim is to increase young people's independence, communication skills, physical movement. These services' assessments of children and young people take into account strengths in their goal setting so are in part asset based*".

If more services were to measure and address strengths, there would be potential to gather a body of evidence on the impact of this approach which, in turn, could be used to prompt reflection on effective practice.

Methods of facilitating change in practice may include relatively simple steps, for example, research in the US found that a simple sticker on a young person's medical record prompted practitioners to discuss assets as well as risk behaviours (Duncan et al., 2007). Where an assets approach had already been utilised, the feedback provided stated that young people were receptive to this type of model (teenage pregnancy coordinator). Capturing the impact of adopting an assets approach through supplementing outcomes measurement with other indicators might provide sufficient evidence to commissioners and policy makers; for example, it has been suggested that indicators should demonstrate how services enhance residents capabilities and resilience (Fisher, 2011).

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[39] Drug and alcohol recovery payment by results pilot projects. http://www.dh.gov.uk/health/2011/07/drug-and-alcohol-recovery/ Accessed 1/9/12.

Barriers to integration

Practitioners may well want to take a different approach but might find it difficult due to the structure that they work within. As discussed within her doctoral dissertation, Whiting suggests some potential barriers to an assets approach (Figure 22):

- Financial investment may be required to develop the necessary knowledge and expertise within key health promoters
- It may prove to be more time consuming than current health promoting strategies
- There may be resistance to change ingrained methods

(page 48, Whiting, 2012b)

Figure 22: Potential challenges of an assets based approach

These are similar to those barriers identified in relation to community development and engagement (Fisher, 2011):

- Capacity and motivation of individuals to get involved
- Skills and abilities of staff (private, public and third sector); knowledge and experience as to how best engage with communities
- Dominance of professional culture
- Awareness of local power relationships
- Organisational systems
- Dynamics of local and national political systems

The following suggestions were provided when the use of assets models was discussed with practitioners. Many of these correlate with the lists above:

"*change in mindset, harder to identify/shape interventions and measure success? Harder to secure funding and organisational/structural barriers would impact...interventions to improve health may not be "health" specific (might be more about education or family support etc)"*

Children's services commissioner

"*A main barrier would be the habits of doing things on deficit model for too long*".

Teenage pregnancy coordinator

"Would require real integrated working or organisational reconfiguration"

Children's services commissioner

The range of barriers identified range from scarcity of asset-focussed practitioner skills to issues with culture and mindset. However, the majority of these could be overcome so long as the political will was there to support change. Implications for policy are discussed in chapter 8. Motivation for change is more likely if evidence could be captured showing that an assets approach brought about improvements in young people's health and wellbeing. In turn, this requires a method of accurately measuring assets, capturing an asset based intervention and then evaluating the outcomes. In January 2012, the Secretary of State for Health requested a review of Children and young people's health outcomes. A range of recommendations has come from this multidisciplinary work. The Forum identified the need to look at outcomes in 5 year age bands rather than for all children and young people aged 0-19 so that significant transition points (for example, the move to secondary school and move from paediatrics to adult care) could be captured (Children and young people's health outcomes forum, 2012). If implemented this might facilitate the measurement of health status more accurately and suggest opportunities regarding the timing of interventions. The Forum also acknowledged the need to include gender and socio-economic status within health outcome measurement so that inequalities in health could be tracked and tackled (Children and young people's health outcomes forum, 2012). One of the additions to the suggested list of outcomes included a measure of emotional health and resilience. Unfortunately, there does not appear a clear response from government as to whether these recommendations will be actionned, or in what timescale. In the interim there might need to be a shift from reliance on outcomes as a measure of success to include a range of other indicators (Franceschini et al., 2010). For example, it has been noted that young people report higher levels of satisfaction with practitioner engagement if their accomplishments and strengths are discussed alongside risk behaviour (Duncan et al., 2007).

Concluding chapter comments

This mixed methods research identified a range of assets that appear associated with young people's health and wellbeing in England. The discussion of these results with reference to theory and other research identified areas of convergence and divergence. From the consolidated results a model has been formed to guide health promotion practice and policy. The core assets include: constructive relationships, safety and positive attributes. Support and communication were key attributes of constructive relationships with a range of people including family, friends and teachers. Safety and perceptions of safety were important in promoting young people's health; this asset incorporated elements of both physical and emotional safety. A range of individual level positive attributes were associated with health and wellbeing emphasising the important relationship between physical and mental health. The core assets are supported by assets of independence and opportunity; these appeared to require the existence of other assets to be truly health promoting.

The identification of variation in the priority given to assets from person to person was a benefit of including qualitative research. Variation appeared influenced by age, gender and affluence; for example, some young people wanted more independence to make the most of opportunities available to them, whereas others had sufficient independence, but could not make use of opportunities due to lack of finances. This variation in health status and valuation of assets may suggest areas of focus in the tackling of health inequalities.

The incorporation of assets into practice has been discussed with reference to the literature and practitioners' views. This has focussed on development of support and communication, improving safety and perceptions of safety and the importance of promoting mental health alongside physical health. Positive mental health and/or good levels of self regulation have been discussed as imperative to ensure that young people can seek out and make the most of the opportunities available to them, negotiate risk and cope with the stresses of growing up. This aligns with the theory of salutogenesis which highlights that whilst having a range of resources is important it is the ability to draw on these to make sense of life, find meaning and manage circumstances that promotes health (Antonovsky, 1979). Whilst no evidence exists to suggest the best time to intervene to improve adolescent health, the

continued focus on early intervention for infants may distract practitioners from implementing initiatives that focus on later childhood.

The narrative synthesis identified two themes to guide health promotion and these provided suggestions for implementing an asset based approach. The holistic theme considered the interrelationship between risks and assets; dual assessments are one method of incorporating asset measurement into existing individual level health assessments, whilst community asset mapping could be integrated into the traditional needs assessment. The ecological approach identified the multiple contexts for health promotion. A range of settings have been discussed that could be made more health enhancing; healthy public policy would facilitate this. Implications for policy are discussed in the next chapter (*page 212*).

An unresolved issue remains regarding asset definition and measurement. The concept of student acceptance was discussed as potentially having negative and positive impacts on health and so the way it is defined and measured is important. There has been discussion within this chapter regarding whether variables such as "health maintenance behaviours" and "academic achievement" are standalone assets or are so closely linked with positivity or constructive relationships that they are part of the asset-health process. A challenge has been raised to existing theory regarding the quantitative summation of assets (Search Institute, 1997, 2006) whilst not taking account of the qualitative aspects within these assets. The possible impacts that mental health might have on both asset and outcome measurement have also been considered.

Chapter 8: Conclusion

Introduction

This research commenced by highlighting why consideration of young people's health and well-being represents a significant public health issue. Improvements in young people's health appear to have stagnated; this is in contrast to younger children who have experienced improving levels of health. Health inequalities exist within the UK adolescent population and between the UK and other countries. This need for an increasing focus on adolescent health has recently been corroborated (Kipping et al., 2012).

Whilst there is a strong interest in improving young people's health, there appeared a lack of agreement as to how this should best be done. A review of policy identified a preponderance of problem focussed and targeted initiatives. The advantages and disadvantages that may result from continuing to pursue a deficits approach have been explored. One of the Marmot review's key messages on improving health and challenging health inequalities was that:

> "*Effective local delivery requires effective participatory decision making at local level. This can only happen by empowering individuals and local communities*" (page 15, Marmot, 2010).

Reviews of policy and research highlighted the lack of young people's involvement and therefore a potential failing in making health promotion relevant or engaging to this group. An assets approach offers a response to this challenge, encouraging young people to be seen as co-producers of their own health.

Contribution to knowledge

The strength of this programme of research is that it adds to the body of work that exists regarding assets models by providing new insight into the relatively little researched area of assets approaches to health promotion with young people in England. The papers included within the narrative synthesis took different approaches to consider how health could be promoted, from analysis of survey data to intervention study, from theoretical discussion to evidence review. A range of papers were included incorporating expert opinion and research based on work with

hundreds of thousands of young people. Existent knowledge in the area of assets models with young people tended to come from the US and was adult-centric; many assets appeared normative rather than resonating with young people's views and terminology. The assets and themes distilled from the narrative synthesis included the following: constructive social relationships, safety, health maintenance behaviours, autonomy, positive attributes, ecological and holistic approaches to health promotion. Limited information was identified on the asset-health process. Through exploring and critiquing the existing literature, the outcomes from the narrative synthesis were used to guide the development of the research programme.

A mixed methods approach was adopted as a pragmatic way of gaining the most complete picture of assets models of health promotion for young people in England. The use of both qualitative and quantitative methods resonates with a suggestion by one of the leading researchers from the Search Institute:

> "*it is a mistake for practitioners and policy makers to concentrate on only the assets that regression studies suggest are the 'most important'*" (page 118, Scales, 1999).

The use of a mixed methods approach yielded credible and rich data, facilitating translation of previous international research into useful insights for England. Results were more comprehensive than could have been achieved through single methods; generalisable findings were produced from the quantitative analysis and meaning added to these findings through the exploratory qualitative fieldwork. Although different methodologies were used, drawing on different research paradigms, they were pulled together by the underlying theoretical frameworks of assets models and the New Social Studies of Childhood.

The research aimed to identify the assets important in promoting young people's health in England, to understand young people's and practitioners perspectives of pursuing an assets approach. Whilst regression analysis was a useful tool to identify a list of assets associated with life satisfaction for English young people, it also identified some potentially spurious relationships and interactions; qualitative analysis provided further interpretation of these initial results. Research findings provided support to some of the existing international literature on assets (the importance of constructive relationships, safety, autonomy and positivity) and an

additional understanding of the asset health creating process through provision of opportunity. The qualitative analysis also identified variation in definition and priority of the assets of autonomy and opportunity. The importance of the multiple contexts that young people inhabit was identified for health promotion strategies (the "ecological" approach to health promotion identified via the narrative synthesis). The assets identified are likely to resonate with practitioners as they link closely with the wider determinants of health framework (Figure 2*, page 19*) considering individual lifestyle factors, social and community networks as well as living and working conditions. The "holistic" theme from the narrative synthesis suggested a pragmatic approach to incorporating assets into practice through including asset mapping alongside the traditional needs assessment.

The construction of a model to shape health promotion strategies provides a contribution to theory development. The research highlighted that although three core assets appeared important universally, there was variation in the priority that young people gave other assets. Through actively seeking young people's perspectives, a refinement of understanding was gained. This emphasises the importance of viewing assets frameworks as more than simply a checklist of assets but including flexibility within an assets approach to capture aspects that might vary person to person. This provides support to other research findings which has noted that young people may require different assets in different settings or at different times in their lives, (Fergus and Zimmerman, 2005). The difficulty of standardising and quantifying assets has been discussed, but taken together with the acknowledgement that weighting assets equally within a diverse community may give misleading results suggests that any asset mapping or surveying should include a qualitative component to gain the most useful insight to young people's health improvement. This challenges some existing assets models which rely on a quantitative measure of assets to assess health (Search Institute, 1997, 2006).

The promotion of mental health appears an important facet of the asset based approach to health promotion. Positive attributes appeared closely linked with constructive relationships and other aspects of the asset-health process (such as engaging in health maintenance behaviours, perceptions of academic achievement and student acceptance/ "fitting in"). Young people require the motivation to seek out and make the most of opportunities, which relies on a healthy level of intentional self

regulation (Gestsdottir et al., 2011) or strong Sense of Coherence (Antonovsky, 1987). Being mentally well enables young people to negotiate risk and cope with the stresses of growing up. The attainment of positive health outcomes requires the accumulation of assets that incorporate both emotional and physical aspects. This holistic view of mental and physical health promotion reflects the direction proposed by Lord Darzi (Darzi, 2008). Using the model proposed to discuss assets, prompts on positive attributes and encourages their promotion within health improvement strategies.

This chapter provides comments on dissemination, implications for policy, a discussion of limitations of this research and identification of areas for further research.

Dissemination

> "*If we seriously mean to improve life conditions for children, we must, as a minimum precondition, establish reporting systems in which they are heard themselves as well as reported on by others*" (page 101, Qvortrup, 1997).

Research findings will only affect policy and service development if the findings are effectively disseminated. Researchers have a duty to ensure that evidence is distributed so that research contributes to the body of knowledge (Bowling, 1997, O'Leary, 2004). As a member of the English HBSC study team, I have access to a range of international networks and forums, to enable the feeding of research findings into policy and practice. Several mechanisms are already in place which enable Health Behaviours in School aged children (HBSC) study findings to be fed into policy making and implementation processes. WHO publishes the international reports from each survey. The English team works closely with the Department of Health and the Department for Education to contribute to the overall development of an evidence base for young people's health.

There is a high level of interest in the potential of assets approaches and is likely to appeal to NHS, local authority and education professionals. Previous presentations that I have given on assets models have been well attended, drawing a multi-disciplinary audience, (the research findings "Promoting positive body image: An assets based approach" presented on two occasions; at the Association of Young People's Health (AYPH) conference on 23rd October 2008 at the Resource Centre,

London, and at the Research in Adolescent and Child Health (REACH) Interest group meeting on 3rd December 2008 at the University of Hertfordshire). I presented an overview of this doctoral research at the International Assets Conference at the British Library 26th/27th September 2011; initial results were therefore disseminated internationally.

Implications for policy

There still appears a prevailing deficits culture within policy (Morgan and Ziglio, 2006) although there has been some change since starting this research. The occasional asset model has been surfaced within government policy and strategy; for example, within the "Big Society" initiative (Cabinet Office, 2010) and the recent Health Visiting Implementation Plan (Department of Health, 2011). The creation of health enhancing settings and communities through healthy public policy would facilitate improvements in health without resorting to stand-alone initiatives. The World Health Organisation (WHO) defined healthy public policy as "*creating supportive environments to enable people to lead healthy lives*[40]", thus encouraging the integration of health promotion into daily activities (Baric, 1993). This builds on WHO's definition of health as a resource for life rather than an endpoint in itself (WHO, 1986). Healthy public policy aligns to the government's interest in wellbeing; for example, the Healthy Communities programme[41] and the Subjective Well-being Annual Population Survey[42].

Healthy public policy is associated with the influencing of wider determinants of health (Tones and Green, 2004) and could impact some of the health improving assets identified within this research through addressing the health promoting role of settings. Safety and perceptions of safety appear to have associations with young

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[40] Adelaide Recommendations on Healthy Public Policy. Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988 http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index.html Accessed 3/12/12

[41] http://www.local.gov.uk/c/document_library/get_file?uuid=867e0406-35a5-4e91-910d-6b13305d2319&groupId=10171 Accessed 17/12/12

[42] http://www.ons.gov.uk/ons/rel/wellbeing/measuring-subjective-wellbeing-in-the-uk/first-annual-ons-experimental-subjective-well-being-results/first-ons-annual-experimental-subjective-well-being-results.html Accessed 17/12/12

people's health; young people and their parents need to feel that the neighbourhood is safe for young people to have the freedom to visit friends or use local facilities. This may be impacted by whether police are visible locally and the level of street lighting (Joloza, 2012). Using policy to create settings that are supportive of health ensures that health is embedded; this salutogenic, universal approach is less likely to stigmatise individuals (Tones and Green, 2004).

The NHS is undergoing huge amounts of change, including the introduction of Clinical Commissioning Groups (CCGs), the National Commissioning Board (NCB) and Commissioning Support Organisations. Public health is also affected, with a move of departments from Primary Care Trusts to local authorities and the creation of Public Health England. There is therefore much attention on the roles of NHS practitioners to identify what they do and how best this should be delivered. For example, a large part of the school nursing function will be commissioned by local authorities, whilst Health Visitors will be commissioned by the NCB until 2015 when this role also moves to local authorities. This is an ideal time to specify the expectations of health promotion practice. Although practitioners might be willing to adopt assets approaches, it is likely to have resource implications, through training or increased time with participants (Whiting, 2012a). It is therefore possible that unless assets approaches are encouraged through local or national policies it might be challenging to embed them throughout practice. The Healthy Child programme provides a framework for health promotion with children and young people, yet much of the content takes a deficit focus (Department of Health and Department for Children Schools and Families, 2009). However, the multitude of current changes in initiatives and organisations provides a perfect opportunity to refresh the content and include more of a focus on asset approaches.

It has been suggested that mixed methods research can serve a transformative process through airing participants voices and views to policy makers (Stewart et al., 2008). The inclusion of young people as participants to shape provision aligns with the government's policy "Positive for youth" (HM Government, 2011) and ensures that policies are developed based on young people's perspectives rather than adult interpretations and views (Dryden et al., 1998). Carrying out asset mapping within communities acknowledges young people's social agency (Mayall, 2002) and has

additional benefits of building wellbeing through participation (I&DeA, 2010). It has been proposed that public services can enhance the resilience of a population by including the following ideas within policy (Fisher, 2011):

- **Trust and respect**: provision must be non-stigmatising
- **Recognising and releasing capabilities**: instead of identifying people as being in need, services should provide opportunities to build self esteem and identify the skills and resources they have
- **Listening to and involving people**: incorporating service users not only enhances the responsiveness of services but may also unlock capabilities of the population

This research has involved young people and listened to their views through self complete survey, interviews and focus groups. Enabling young people to voice their perspectives on assets within this research produces a source of evidence for use within policy. Healthier public policy could therefore have both direct and indirect benefits on young people's health and wellbeing; building resilience through incorporating perspectives and encouraging the health enhancement of settings, for example.

A potential challenge to policy could be around early intervention to ensure that this is not at the expense of adolescent health. This is pertinent with public health departments moving into local authorities. The focus within many local authority Children's service directorates is on early intervention to impact academic achievement (for example, commissioning children's centres to improve school readiness[43]). Indicators within the Public Health Outcomes Framework tend to focus on the early years of childhood rather than on adolescence; the exception being Teenage pregnancy. This may result in there being less scope to support asset building processes to improve adolescent health. However, using the tactic of dual assessment or incorporating assets into Joint Strategic Needs Assessments (JSNAs) might be an opportunity to raise the profile of assets models. Similarly current targets (for example, school attendance and educational achievement) could be used to promote the need for expanding support to families and extending

[43] For example, the Early Intervention Grant http://www.education.gov.uk/childrenandyoungpeople/earlylearningandchildcare/delivery/funding/a0070357/eig-faqs Accessed 17/12/12

parenting programmes to those of school aged children. Recent recommendations from the Children and young people's health outcomes forum are welcomed though they are not yet evident in policy; for example, suggestions to review outcomes for 0-19 year olds in 5 year age bands, focus on significant transition points (such as from primary to secondary school), measure emotional health and track health inequalities (Children and young people's health outcomes forum, 2012).

Limitations

This concluding chapter has highlighted the contributions that this research has made; however, it is also an appropriate place to consider limitations of the programme of study. Limitations to the particular methods used have been addressed in the methods chapter (Chapter 5: Methodology and methods*, page 88*).

Although the focus within this research has been in considering the important assets that promote health, it should be borne in mind that there may be other impacts on young people's lives that have not been included. In considering the variation in young people's health outcomes that can be explained by assets, it was concluded by the Search Institute that:

> "*Neither asset building nor the risk and protective factors approach explains the majority of what is going on in young people's lives*" (page 118, Scales, 1999).

Though in part, this may be due to the way that such factors are measured, a case has been made to include the capturing of qualitative aspects of assets as well as simply counting them. It highlights the need for robust youth engagement to facilitate asset mapping, identification of the issues relevant to young people and careful consideration of how this is then acted on.

Through discussion of current policy and underpinning concepts, salutogenesis was taken to focus the narrative synthesis, particularly as this took a universal stance towards creating health. However, this research has identified inequalities in life satisfaction and variation as to which assets young people might prioritise. Whilst it was argued that the targeted interventions explored in the policy review might not have achieved the improvements in health intended, there is the potential to further add to health inequalities if assets are promoted universally without regard to

differences in young people's demographic factors. There may be a case for progressive or proportional universalism to tackle some of the health inequalities that exist. The most effective way of utilising this knowledge on assets to improve health and reduce inequalities is an area which requires further research.

Areas for further research

Although the interest in assets approaches has grown during the time this research has been undertaken, the UK is really still in its infancy as regards practically implementing an assets approach (Brooks et al., 2012). Areas for further research have been identified by considering the outcomes of this research and comparing them with the original research aim ("*to construct an assets based model to shape health promotion policy and practice for young people in England*") and underlying objectives. This research has proposed a model for guiding asset based health promotion strategies, further work is needed to test out whether this model will improve health and gauge to what extent it will have a better impact on health than a deficit model.

There is a need to explore how promoting positive mental health, self esteem and/or self regulation impacts the ability for young people to actively seek opportunities to promote their health and wellbeing. Discussion throughout this research has highlighted the intricacies linking emotional wellbeing and physical health, how assets are perceived and life satisfaction rated. Research is needed to understand the dynamic relationships between assets; for example, feeling safe and supported promotes mental health, yet good mental health supports building relationships and feelings of safety. Recognising the elements within the relationships that exist might facilitate methods of promotion. Incorporating a measure of Sense of Coherence (SOC) or self esteem, alongside measurement of assets, might provide an opportunity to identify some of the interactions discussed within this research between mental health and perception of assets.

The Health Behaviours of School Aged Children Study provided a wealth of data for this research. If possible, for further studies it might be useful to include questions on positive attributes to enable further exploration of relationships between mental health and assets. Additionally, there might be scope to include a free text area to

capture young people's views; for example, asking directly "what would most improve your health?"

Other interrelationships have been discussed within this research which could benefit from further investigation; for example, how internal and external assets work together, or how risk and protective factors interact. Additional research is needed to understand the causal pathways between assets and health. Although this research has proposed some suggestions for the asset-health processes, a longitudinal approach or intervention study would facilitate comprehension of how benefits and protection accrue through the accumulation of assets. The appreciation of how assets could be manipulated to improve health and the identification of optimal timings for intervention would enable more effective health promotion.

Underlying the above is the importance of measurement, both in terms of precision of definition of an asset and measurement of outcome. Participants in the research noted that some variables termed "assets" could have negative or positive impacts on health; for example, "fitting in/student acceptance" could cause young people to adopt healthy or unhealthy behaviours. Key is the precision of definition as there may be some assets that also become part of the outcome; for example, does self esteem act as an asset by itself or is it part of how a young person rates their life satisfaction. Similar problems have been noted within the resilience literature where it is felt that a lack of common terminology has slowed "*development of the field*" (page 404, Fergus and Zimmerman, 2005). Incorporating qualitative components to asset mapping rather than trying to standardise and count up assets might ensure that assets are better understood.

Measurement of success of these approaches would rely on having a measure of positive health. This correlates with other research findings that acknowledge that further progress needs to be made to understand the measurement of thriving in adolescence (Lerner et al., 2010) and to understand how resilience is measured (Windle et al., 2011). A recent review of wellbeing indicators identified that agreement needs to be reached as to the objective and subjective measures to be adopted, so that there can be comparability between studies and populations; the ONS have a "Measuring National Well-being Programme" to take this work forward (Hicks et al., 2011). There is a range of scales available that capture aspects of

positive health but these need to be tested through incorporation into young people's research; if found to be valid and reliable, they could then be incorporated into future policies, health programs and research. This in turn would provide important information on how we can provide the supports and opportunities necessary to improve young people's health.

Within this research variation has been seen in outcomes and the priority assigned to assets by age, gender and affluence. Within the discussion of the regression analysis findings the possibility of sub-analysis was raised; for example the potential of building regression models by gender, age or family affluence. However, as the aim of this research was to identify a model for universal health promotion this was not undertaken. Further research could be undertaken to explore these variations which may then identify implications for policy or health promotion practice.

The narrative synthesis identified the lack of qualitative research on assets with young people. This research was an initial step in addressing this but acknowledges that it was a small sample of participants and it could be built on. It would be useful to undertake research with groups of young people from different backgrounds to assess the usefulness of this model in other contexts. Asset mapping may help to detect the priority assets specific to that person or community. However, linked to this is a better understanding of the best ways of undertaking asset mapping with young people, when this should take place and who is best placed to undertake this when young people inhabit so many different communities. It would be interesting to hear from some of those young people who wanted to volunteer for the research but then opted out of the focus groups, to discover what might encourage them to participate (unfortunately I was not able to obtain responses from non participants to answer this). Young person led research may identify areas that were not talked about within this research thus potentially generating different suggestions for priority assets; peer led research may be one method of engaging with under-represented groups.

Concluding comments: using assets to improve young people's health

This mixed methods research contributes to the science of health research and professional practice through the identification of a set of core assets associated with positive health for young people in England and their consolidation into a health promoting assets model (Figure 23). This process highlighted the benefit that could be gained through combining different research methods; enhancing generalisable findings by adding depth and understanding. The model provides a framework to shape health promotion through practice and policy.

The list of core assets is important in its potential to influence settings and policy to be more health promoting, but the process of engaging young people is key in terms of understanding what matters most to them (the very process of active involvement can also be health promoting). This research has added to existent knowledge through young people's involvement, by capturing their terminology, acknowledging their definitions and highlighting issues of variation. This has particular importance in terms of tackling health inequalities and ensuring initiatives or opportunities are relevant. Although this research was undertaken with a salutogenic focus, to identify universal assets that could be promoted for all, there appears a need for some flexibility in this approach to take account of young people's varying priorities and to ensure that health inequalities are not perpetuated. This resonates with the idea of progressive or proportionate universalism (Marmot, 2010, Department of Health and Department for Children Schools and Families, 2009).

It is time that there was an increased focus on improving young people's health. Embedding the promotion of assets in policy and practice is a possible way of achieving better health outcomes in a sustainable and non-stigmatising way. This assets model provides a framework to guide such work.

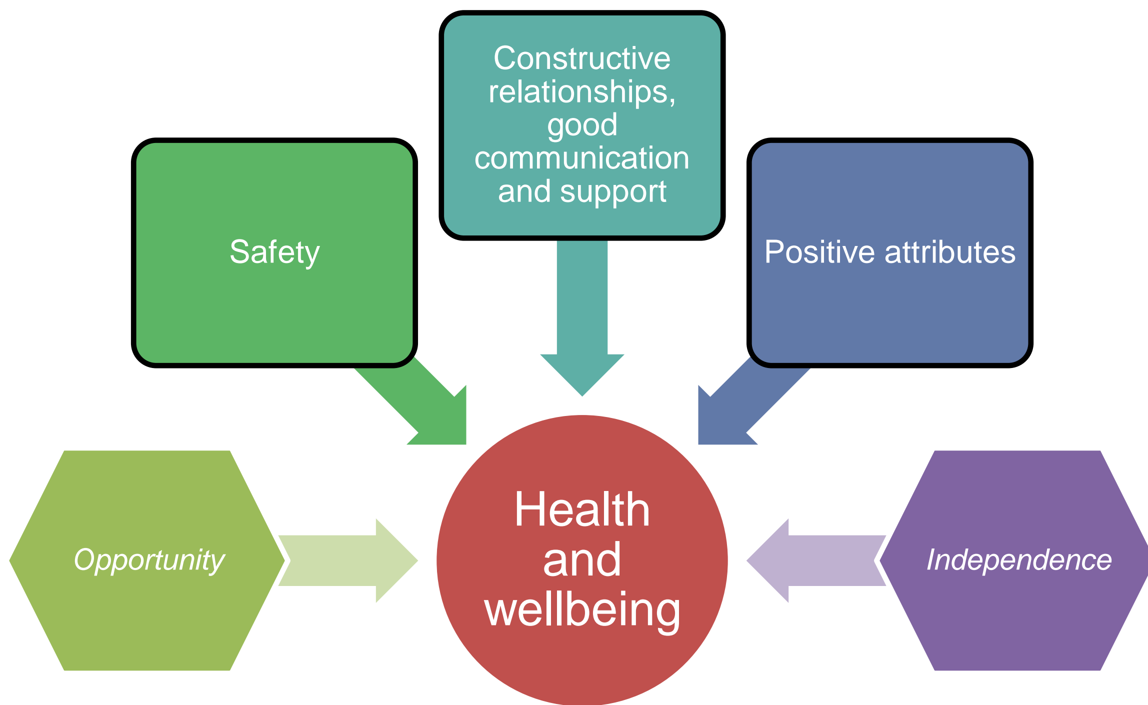

Figure 23: Assets model to shape health promotion with young people

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Appendix 1: MESH terms and hits (2009)

	Search Term	Hits
1	Exp HEALTH PROMOTION/	35956
2	“health promotion”.ti,ab	12920
3	Exp YOUNG PEOPLE/	0
4	“young people”.ti,ab	10585
5	Youth.ti,ab	20242
6	(adolescen* OR teen*).ti,ab	127650
7	*ADOLESCENT/	18884
8	3 or 4 or 5 or 6 or 7	160771
9	1 or 2	41271
10	Asset*.ti,ab	3954
11	8 and 9 and 10	21

Appendix 2: summary of papers included in the narrative synthesis

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Benson, 2002)	US	Discussion paper	Positive development: prevention of high risk behaviours, enhancement of thriving outcomes, resiliency in the face of adversity	Description of the evolution of the Search Institute's 40 developmental assets as both a theoretical framework and a research model. The 20 external assets refer to the positive developmental experiences that adults offer young people. The 20 internal assets are competencies and skills that young people develop over time. Assets are assessed in a 156 item survey instrument which also captures information on risk and thriving behaviours. Higher levels of assets are linked with thriving behaviours and reduced risk taking. Sources of asset building potential are hypothesized as: sustained relationships with adults, peer group influence, socialising systems, community level social norms and intervention programs.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Bronikowski and Bronikowska, 2009)	Poland	Control trial	Self assessed fitness, levels of physical activity, cardiorespiratory fitness and Sense of Coherence (SOC)	Significant improvement in physical fitness in those who developed individual responsibility for planning their own activities and had self determined individualised objectives.
(Caldwell and Witt, 2011)	US	Discussion paper and review of case studies	Positive youth development	Importance of play, leisure and recreation to the development of identity, autonomy, competence, initiative and social connections.
(Dawes and Larson, 2011)	US	Qualitative analysis of interview data	Positive youth development	Young people can only develop if they engage with the activities offered; these interviews identified the importance of motivation which could be encouraged through the setting of personal goals such as learning for the future, developing competence and pursuing a purpose.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Donnon and Hammond, 2007)	Calgary, Canada	Quantitative analysis of survey data	Youth resiliency (pro social behaviours) plus at risk behaviours.	Questionnaire contains 94 items which measure 10 factors or 31 specific strengths associated with the resiliency framework. Youths scoring high on resiliency factors were more likely to be involved with prosocial behaviours rather than "at risk" behaviours.
(DuBois et al., 2002)	US	Quantitative analysis of survey and interview data	Emotional and behavioural health	Information was collected on levels of social support, self esteem, coping skills and relationship experiences over one year. There appeared to be no significant direct effects of participation in a mentoring program on the emotional or behavioural adjustment of young people over the year studied.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Duncan et al., 2007)	US	Evidence review	Social, biological and emotional health of adolescents	Review of lists of assets and protective factors that have been devised through theory and experience; for example, common features promoted by programs in preventing adverse behaviours and identification of attributes shared by adolescents not engaging in risky behaviours. These strengths/assets are then translated into how they can be promoted within a medical office setting; generosity, independence, mastery and belonging.
(Fenton et al., 2009)	UK	Quantitative analysis of survey data	Positive body image	Adolescents who self-identified as having a positive body image were more likely to report ease of communication with a father figure, feeling intelligent, perceiving their family was well off and a belief that teachers were interested in them as people.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Garst et al., 2011)	US	Discussion paper & review of research	Positive youth development	The camp experience provides opportunities for positive youth development through re-connecting with nature, group living, skill development and the building of positive social relationships.
(Gestsdottir et al., 2011)	US	Discussion paper & inclusion of quantitative information from the 4-H study of positive youth development	Thriving behaviours as measured by the “five Cs”: competence, confidence, caring, character, connection.	Young people who are able to self-regulate can optimise the opportunities available to them, to make the most of assets and enhance their positive development

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Granger, 2002)		Discussion paper	Positive youth development	It is noted that more research is needed to help understand how assets vary by cultural context, social identity, gender, place, developmental age and historical time, for example. Paper also stresses the role of systems – not just promotion of assets, but understanding of how family, neighbourhood and school work together to provide the right conditions to support promotion.
(Kia-Keating et al., 2011)	US	Discussion paper; review of risk and resilience literature	Positive school outcomes	Sense of belonging, self-efficacy, pro-social behaviour, pro-social values, regulation, hope, engagement, monitoring
(Lindberg and Swanberg, 2006)	Sweden	Quantitative analysis of survey data	Subjective wellbeing "how are you these days?"	Significant positive associations found between wellbeing and relations to teacher/school, relations with peers and healthy eating habits.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Lindstrom, 1992)	N/a	Discussion paper	Healthy children	Taking a salutogenic view may result in a reduction in stress and illness for children involved in parental divorce. Health promoting strategies could include the encouragement of increasing comprehensibility of the situation through provision of information to young people, trying to make meaning out of the situation and maintenance of contact with both parents.
(Mainella et al., 2011)	US	Discussion paper; qualitative & quantitative review of programs	Achievement of potential	Play in natural settings provides young people with the opportunity to develop skills, connect with the environment and with other people. Outdoor play is associated with increased levels of physical activity and emotional health Unstructured play also allows young people freedom to develop their own activities.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Marsh et al., 2007)	US	Quantitative analysis of survey data	Sense of Coherence (SOC)	Considered how risk and protective factors were associated with SOC at different environmental levels. Factors predicting SOC included both risk and protective elements – stable community and family environments tended to increase SOC.
(Morgan and Haglund, 2009)	England	Quantitative analysis of survey data	7 indicators including: Self reported health and wellbeing, health promoting behaviours and risk taking behaviours	Social capital (as measured by sense of belonging, autonomy and control, and social networking) is associated with young people's sense of wellbeing. The most consistent relationships across all outcomes were seen for family and school sense of belonging and being involved in neighbourhood activities.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Murphey et al., 2004)	US	Quantitative analysis of survey data	Associations with health promoting behaviours (wearing a seat belt, taking aerobic exercise and wearing a bicycle helmet) plus inclusion of risk behaviours.	6 assets were chosen, informed by Search Institute assets and positive youth development frameworks. They included: “grades in school”, “talking with parents about school”, “representation in school decision making”, “participation in non-sporting youth programs”, “volunteering in the community” and “feeling valued by the community”. Number of assets was significantly associated with the likelihood of health promoting behaviours, independent of the effects of grade level, gender, race/ethnicity and mother’s education.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Roth and Brooks-Gunn, 2000)	US	Evidence review	Successful adolescent development	Summarises ingredients of successful development programmes, for example: • The 5 Cs – Competence, confidence, connection, character, caring. • The Search Institute's 40 assets Conclude that no consensus exists as to what constitutes a successful youth development program, but rather identification is via a positive approach and acceptance that simply preventing problem behaviours does not necessarily equip young people fully with the skills needed for a productive adult life.

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Scales, 1999)	US	Discussion paper	Lowered risk behaviours and increased thriving behaviours	Discussion of findings from Search Institute's developmental assets surveys. Some assets are more solidly based on research than others. Acknowledgement that relationships between assets are not known. Differences in levels and patterns of assets exist between different cultural groups. Importance of everyone in building assets, not just service providers and intervention programmes but also role of community and neighbourhood.
(Smith and Barker, 2008)	US	Quantitative analysis of survey data	Engagement with health promoting & thriving behaviours (and risk behaviours)	Internal values, identity and motivation to achieve, as well as support from family, peers and school were found to be associated with the study outcomes, including; physical activity, routine bed time, visit to healthcare professional, use of seat belt, good grades, valuing diversity, does homework and demonstrates restraint

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Urban et al., 2010)	US	Quantitative analysis	Positive youth development	Intentional self regulation ability interacts with participation in extracurricular activity; those with the greatest capacity to self regulate benefit the most from involvement in activities
(Vieno et al., 2007)	Italy	Quantitative analysis of survey data	Psychosocial well being (self reported life satisfaction and psychological symptoms)	Associations were investigated and tested between different sources of social support from parents and friends, school sense of community and self efficacy on psychosocial wellbeing. Self efficacy was found to have a mediating role between the different forms of support and young people's wellbeing.
(Ward and Zabriskie, 2011)	US	Discussion paper; review of quantitative and qualitative research	Positive youth development	Family leisure involvement provides an essential context for positive youth development through improving family communication, promoting physical activity and creating identity

Reference	Setting	Type of paper	Outcome	Main findings and themes
(Weissberg and O'Brien, 2004)		Evidence review	Positive youth development – social and emotional learning	CASEL[44] identifies 5 teachable competencies: Self awareness, social awareness, self management, relationship skills and responsible decision making linked with prosocial behaviours. Review concludes that single component strategies do not yield large, enduring improvements in children's behaviour; more complex interventions including school, community and family are needed.
(Youngblade et al., 2007)	US	Quantitative analysis of survey data	Outcome composites reflected positive and negative developmental outcomes	Looked at association between family, school and community risk and promotive factors with several outcome indices. Multiple positive family, school and community characteristics were related to adolescent social competence, health promoting behaviours and self esteem.

[44] Collaborative for Academic, Social and Emotional Learning

Appendix 3: participant information leaflet

About this project

We are asking if you would like to talk to us as part of a group, to help us understand more about what health and wellbeing means to young people.

Much of the information we have on young people's health comes from research designed by adults. We think that you may have different ideas about your health than adults do. That is why we're keen to hear from you, to find out your own views about health and wellbeing. In the future, young people's health could then be measured in a way that makes sense to them.

Before you decide if you want to take part, it's important to understand what taking part will mean for you. So please read this leaflet carefully, have a think about it and talk it over with your friends and family if you want.

Why are we running these discussion groups?

Some people feel happier to talk in a group than in a one to one interview.

Do I have to take part?

No, this is up to you. You are free to stop taking part at any time during the research without giving a reason.

What will happen to me if I take part?

The group will be made up of 6-8 young people of a similar age. A researcher will also come along to the group and may ask questions to encourage you to talk about different parts of health and wellbeing. It should take between 30 and 45 minutes.

If it is OK with you we will audiotape the discussion so that we know what has been said and don't have to take lots of notes while you talk. We will delete the tapes at the end of the project. It is up to you whether we use your name when we write up the research, if you want us to leave your name out or use a made up one that is fine, please let us know.

What do I have to do?

If you're happy to take part, please bring the signed consent form with you to the discussion group. When you come to the group the researchers will answer any questions you have, collect your signed forms and check that you are still happy to take part. You will be able to stop taking part at anytime.

Is there anything I should be worried about if I take part?

No. All that is needed from you is your time to attend the group and for you to join in the discussion if you want to. We are interested in everyone's ideas so there are no right or wrong things to say.

Will anyone else know I'm taking part in the project?

We will keep your information in confidence. It is up to you if you want to be named in the project. If you do not want us to use your name when we write up our notes, please let us know.

Who is organising and funding this research.

This research is part of my research degree (doctorate in Health Research). I am sponsored by the University of Hertfordshire.

Who has reviewed the project?

Before any research goes ahead it has to be checked by a Research Ethics Committee. They make sure that the research is fair. Your project has been reviewed by one of the University of Hertfordshire's ethics committees.

What if I have more questions?

For more information about this project please contact me, Cath Fenton, at c.m.fenton@herts.ac.uk

If you have concerns about the study or the way you have been treated you can contact me or my supervisor, Fiona Brooks, f.m.brooks@herts.ac.uk

Thank you for reading this.

Version 8: October 2011

University of Hertfordshire UH

What does "health" and "wellbeing" mean to you?

University of Hertfordshire UH

Appendix 4: regression output with both interaction terms

m105bin[a]		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B)	
								Lower Bound	Upper Bound
1	Intercept	-2.419	.755	10.277	1	.001			
	[m110=1]	1.435	.332	18.719	1	.000	4.198	2.192	8.041
	[m110=2]	1.243	.291	18.212	1	.000	3.467	1.959	6.137
	[m110=3]	.765	.298	6.576	1	.010	2.148	1.197	3.854
	[m110=4]	.156	.311	.252	1	.615	1.169	.635	2.152
	[m110=5]	0[b]	.	.	0	.	.	.	.
	[m84=1]	1.592	.390	16.649	1	.000	4.913	2.287	10.554
	[m84=2]	.960	.384	6.240	1	.012	2.612	1.230	5.548
	[m84=3]	.456	.396	1.324	1	.250	1.578	.726	3.430
	[m84=4]	.221	.435	.259	1	.611	1.247	.532	2.924
	[m84=5]	0[b]	.	.	0	.	.	.	.
	[m107=1]	1.369	.267	26.298	1	.000	3.931	2.330	6.634
	[m107=2]	.962	.221	18.893	1	.000	2.616	1.696	4.036
	[m107=3]	.218	.231	.890	1	.346	1.243	.791	1.955
	[m107=4]	0[b]	.	.	0	.	.	.	.
	[m122=1]	.956	.402	5.640	1	.018	2.600	1.182	5.722
	[m122=2]	1.109	.378	8.618	1	.003	3.031	1.446	6.356
	[m122=3]	.628	.369	2.898	1	.089	1.875	.909	3.865
	[m122=4]	.206	.400	.265	1	.607	1.229	.561	2.692
	[m122=5]	0[b]	.	.	0	.	.	.	.
	[eng_liv7=1]	1.035	.326	10.084	1	.001	2.816	1.486	5.337
	[eng_liv7=2]	.523	.305	2.944	1	.086	1.687	.928	3.065
	[eng_liv7=3]	-.048	.307	.024	1	.876	.953	.523	1.739
	[eng_liv7=4]	.195	.344	.322	1	.570	1.216	.619	2.387
	[eng_liv7=5]	0[b]	.	.	0	.	.	.	.
	[m87=1]	-.277	.212	1.704	1	.192	.758	.500	1.149
	[m87=2]	-.453	.177	6.556	1	.010	.636	.450	.899
	[m87=3]	-.443	.225	3.862	1	.049	.642	.413	.999
	[m87=4]	-1.117	.253	19.548	1	.000	.327	.199	.537
	[m87=5]	0[b]	.	.	0	.	.	.	.
	[m1=1]	-.322	.587	.302	1	.583	.724	.229	2.288
	[m1=2]	0[b]	.	.	0	.	.	.	.
	[m2=1]	-.528	.173	9.358	1	.002	.590	.420	.827
	[m2=2]	-.218	.153	2.030	1	.154	.804	.596	1.085
	[m2=3]	0[b]	.	.	0	.	.	.	.
	[m106=1]	.809	.307	6.943	1	.008	2.245	1.230	4.096
	[m106=2]	.936	.289	10.467	1	.001	2.549	1.446	4.492

[m106=3]	.426	.287	2.204	1	.138	1.531	.872	2.688
[m106=4]	0[b]	.	.	0	.	.	.	.
[fas=1.00]	-.939	.241	15.213	1	.000	.391	.244	.627
[fas=2.00]	-.364	.186	3.809	1	.051	.695	.482	1.002
[fas=3.00]	0[b]	.	.	0	.	.	.	.
[m86=1]	-.183	.246	.554	1	.457	.833	.514	1.348
[m86=2]	.530	.216	5.997	1	.014	1.698	1.112	2.595
[m86=3]	.242	.213	1.289	1	.256	1.274	.839	1.935
[m86=4]	-.402	.227	3.127	1	.077	.669	.429	1.044
[m86=5]	0[b]	.	.	0	.	.	.	.
[m109=1]	-.150	.540	.077	1	.781	.861	.299	2.480
[m109=2]	-.026	.485	.003	1	.957	.974	.377	2.520
[m109=3]	.106	.483	.048	1	.826	1.112	.431	2.866
[m109=4]	-.257	.487	.278	1	.598	.774	.298	2.008
[m109=5]	0[b]	.	.	0	.	.	.	.
[m1=1] * [fas=1.00]	.653	.366	3.179	1	.075	1.922	.937	3.941
[m1=1] * [fas=2.00]	.744	.286	6.777	1	.009	2.105	1.202	3.686
[m1=1] * [fas=3.00]	0[b]	.	.	0	.	.	.	.
[m1=2] * [fas=1.00]	0[b]	.	.	0	.	.	.	.
[m1=2] * [fas=2.00]	0[b]	.	.	0	.	.	.	.
[m1=2] * [fas=3.00]	0[b]	.	.	0	.	.	.	.
[m1=1] * [m109=1]	-.234	.686	.117	1	.733	.791	.206	3.035
[m1=1] * [m109=2]	1.058	.614	2.970	1	.085	2.880	.865	9.590
[m1=1] * [m109=3]	.435	.618	.494	1	.482	1.544	.460	5.187
[m1=1] * [m109=4]	.397	.649	.374	1	.541	1.488	.417	5.311
[m1=1] * [m109=5]	0[b]	.	.	0	.	.	.	.
[m1=2] * [m109=1]	0[b]	.	.	0	.	.	.	.
[m1=2] * [m109=2]	0[b]	.	.	0	.	.	.	.
[m1=2] * [m109=3]	0[b]	.	.	0	.	.	.	.
[m1=2] * [m109=4]	0[b]	.	.	0	.	.	.	.
[m1=2] * [m109=5]	0[b]	.	.	0	.	.	.	.

Appendix 5: regression output with one interaction term (ignoring m1*m109)

m105bin[a]		B	Std. Error	Wald	df	Sig.	Exp(B)	95% Confidence Interval for Exp(B)	
								Lower Bound	Upper Bound
1	Intercept	-2.755	.702	15.413	1	.000			
	[m110=1]	1.383	.334	17.114	1	.000	3.986	2.070	7.674
	[m110=2]	1.199	.292	16.903	1	.000	3.316	1.872	5.872
	[m110=3]	.736	.300	6.029	1	.014	2.088	1.160	3.758
	[m110=4]	.112	.313	.129	1	.719	1.119	.606	2.065
	[m110=5]	0[b]	.	.	0	.	.	.	.
	[m84=1]	1.590	.391	16.544	1	.000	4.906	2.280	10.556
	[m84=2]	.971	.385	6.350	1	.012	2.641	1.241	5.622
	[m84=3]	.498	.397	1.573	1	.210	1.646	.755	3.586
	[m84=4]	.224	.436	.264	1	.608	1.251	.533	2.936
	[m84=5]	0[b]	.	.	0	.	.	.	.
	[m107=1]	1.371	.269	26.021	1	.000	3.941	2.327	6.675
	[m107=2]	.956	.222	18.607	1	.000	2.602	1.685	4.017
	[m107=3]	.233	.232	1.009	1	.315	1.262	.801	1.988
	[m107=4]	0[b]	.	.	0	.	.	.	.
	[m122=1]	.964	.405	5.666	1	.017	2.623	1.186	5.802
	[m122=2]	1.162	.379	9.408	1	.002	3.196	1.521	6.716
	[m122=3]	.690	.371	3.467	1	.063	1.994	.964	4.123
	[m122=4]	.241	.403	.357	1	.550	1.272	.578	2.800
	[m122=5]	0[b]	.	.	0	.	.	.	.
	[eng_liv7=1]	.915	.341	7.200	1	.007	2.498	1.280	4.874
	[eng_liv7=2]	.511	.319	2.562	1	.109	1.666	.892	3.114
	[eng_liv7=3]	-.013	.317	.002	1	.968	.988	.530	1.838
	[eng_liv7=4]	.221	.350	.398	1	.528	1.247	.628	2.478
	[eng_liv7=5]	0[b]	.	.	0	.	.	.	.
	[m87=1]	-.247	.213	1.350	1	.245	.781	.515	1.185
	[m87=2]	-.453	.177	6.589	1	.010	.636	.450	.898
	[m87=3]	-.411	.225	3.333	1	.068	.663	.426	1.031
	[m87=4]	-1.116	.251	19.712	1	.000	.328	.200	.536
	[m87=5]	0[b]	.	.	0	.	.	.	.
	[m1=1]	.274	.187	2.139	1	.144	1.315	.911	1.897
	[m1=2]	0[b]	.	.	0	.	.	.	.
	[m2=1]	-.532	.173	9.488	1	.002	.588	.419	.824
	[m2=2]	-.235	.153	2.357	1	.125	.791	.586	1.067
	[m2=3]	0[b]	.	.	0	.	.	.	.
	[m106=1]	.772	.308	6.260	1	.012	2.163	1.182	3.959
	[m106=2]	.938	.290	10.482	1	.001	2.554	1.448	4.505

[m106=3]	.404	.288	1.964	1	.161	1.497	.852	2.632
[m106=4]	0^b	.	.	0	.	.	.	.
[fas=1.00]	-.914	.243	14.171	1	.000	.401	.249	.645
[fas=2.00]	-.368	.188	3.833	1	.050	.692	.478	1.000
[fas=3.00]	0^b	.	.	0	.	.	.	.
[m86=1]	-.253	.245	1.071	1	.301	.776	.480	1.254
[m86=2]	.533	.217	6.040	1	.014	1.704	1.114	2.607
[m86=3]	.259	.213	1.476	1	.224	1.296	.853	1.969
[m86=4]	-.428	.228	3.518	1	.061	.652	.417	1.019
[m86=5]	0^b	.	.	0	.	.	.	.
[m109=1]	-.161	.399	.163	1	.687	.851	.389	1.861
[m109=2]	.491	.347	2.006	1	.157	1.634	.828	3.224
[m109=3]	.378	.339	1.239	1	.266	1.459	.750	2.837
[m109=4]	-.037	.340	.012	1	.914	.964	.495	1.877
[m109=5]	0^b	.	.	0	.	.	.	.
[eng_liv1=1]	.604	.328	3.392	1	.066	1.829	.962	3.476
[eng_liv1=2]	.012	.256	.002	1	.963	1.012	.612	1.673
[eng_liv1=3]	-.197	.263	.562	1	.454	.821	.491	1.375
[eng_liv1=4]	.014	.273	.003	1	.958	1.014	.594	1.733
[eng_liv1=5]	0^b	.	.	0	.	.	.	.
[m1=1] * [fas=1.00]	.625	.365	2.923	1	.087	1.868	.913	3.822
[m1=1] * [fas=2.00]	.742	.285	6.799	1	.009	2.101	1.202	3.671
[m1=1] * [fas=3.00]	0^b	.	.	0	.	.	.	.
[m1=2] * [fas=1.00]	0^b	.	.	0	.	.	.	.
[m1=2] * [fas=2.00]	0^b	.	.	0	.	.	.	.
[m1=2] * [fas=3.00]	0^b	.	.	0	.	.	.	.