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Understanding the Relationship between Community Involvement and Health: Is Social Capital Important?

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Collaborating Organisation: Wakefield and District Health Action Zone

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Contents

Abstract

Local authorities and their partners are increasingly required to involve communities within decision making (DETR, 1998; 2000a). Community involvement, and the subsequent creation of networks, has been presented within national policy documentation as a means to tackle social exclusion and associated multiple deprivation (DETR, 2000a; SEU, 2001). Similarly, increased levels of societal integration have long been associated with improved health outcomes (e.g. Durkheim, 1952; Egolf et al, 1992). More recently, social capital, in its various interpretations, has been portrayed as an important resource for public health (Kawachi et al, 1997). Here, the relationship between community involvement and health has been explored and the value of social capital in advancing understanding of this relationship determined. Theories of social capital and well being interpretations of health informed the development of a qualitative methodology. In the first stage of research, a local authority case study was selected to examine the translation of policies into a new strategic framework for community involvement. Qualitative interviews and analysis of key documentation determined interpretations of community involvement. In the second stage, observations and interviews were conducted with a newly formed community group to explore experiences of involvement and their potential influence upon health. This approach enabled the investigation of bonding, bridging and linking forms of social capital (Szreter and Woolcock, 2002). Reflecting the extensive changes taking place within the local authority, the new strategic approach to involvement centred upon a model of engagement, yet the value attached to community development perspectives diverged across the sectors. Investigation of the involvement activities of the community group revealed that their limited capacity inhibited interaction with the newly created involvement structures. Capacity, in turn, determined the perceived levels of control and influence held by communities. In the absence of the capacity to respond to the challenges presented by involvement, community group membership yielded predominantly negative health related outcomes. It is concluded that community involvement can potentially influence health through two primary mechanisms; the development of resources and the facilitation of collective action. Therefore uncritical acceptance of community involvement as a positive resource for public health does not reflect the complexity of the relationship. Instead, the relationship is shaped by the heterogeneous nature of bonding, bridging and linking forms of social capital. Reflecting this, it is concluded here that Bourdieu's (1997) interpretation of social capital as interdependent with cultural and economic resources presents a valuable framework for the implementation of involvement.

List of Tables and Figures

List of Abbreviations

CEN	Community Empowerment Network
CPA	Comprehensive Performance Assessment
DETR	Department of the Environment, Transport and the Regions
DH	Department of Health
DTLR	Department for Transport, Local Government and the Regions.
HAZ	Health Action Zone
HAD	Health Development Agency
IMD	Indices of Multiple Deprivation
JRF	Joseph Rowntree Foundation
LGA	Local Government Association
LNRS	Local neighbourhood renewal strategy
LREC	Local Research Ethics Committee
LSP	Local strategic partnership
NHS	National Health Service
NRF	Neighbourhood Renewal Fund
NRU	Neighbourhood Renewal Unit
ODPM	Office of the Deputy Prime Minister
ONS	Office for National Statistics
PCT	Primary Care Trust
PIU	Performance and Innovation Unit
RCU	Regional Co-ordination Unit
SCCD	Standing Conference for Community Development
SEU	Social Exclusion Unit
SRB	Single Regeneration Budget
VAWD	Voluntary Action Wakefield District
WDCN	Wakefield District Community Network
WHO	World Health Organisation
WMDC	Wakefield Metropolitan District Council

Chapter One

An Introduction

1.1. Background

This PhD has been undertaken within the Hallam Studentship programme, and thus represents a collaboration between Sheffield Hallam University and the Wakefield and District Health Action Zone (HAZ). Prior to my appointment to the studentship, a research 'brief' had already been developed, specifying aims and objectives. Although there was scope for the modification and development of the research, it was to be located within the work of the Wakefield District HAZ team. Accordingly, the research framework has been developed within this agreement.

The underlying tenets of the aims and objectives specified at the inception of the studentship remain unchanged. However, they have been modified in concordance with developments in the Wakefield District, advances in the literature and my own research interests. The research itself has, in reality, been undertaken largely independently of the Health Action Zone due to its 'mainstreaming' into the newly formed Primary Care Trusts, thus providing an opportunity for increased flexibility and inductiveness within the research process.

1.2. Community Involvement and Health

This thesis is presented at a time when 'the community' features strongly within government policy. For the government, strengthening communities is integral to overcoming the problems of contemporary society. Regeneration and renewal programmes are built upon principles of community involvement, where harnessing a sense of belonging and pride are defined as central in breaking the cycle of deprivation experienced by the socially excluded (Social Exclusion Unit, 2001). A vision of community leadership underpins the modernisation of local government led by the Office of the Deputy Prime Minister[1]. The Local Government Act 2000 enshrined the role of community leadership in law and to enable its fulfilment, provided councils with a new power of well being. To ensure local government remains a leader, rather than the traditional paternalistic controller, in the revitalisation of local communities, the Act

[1] In 2006, the Office of the Deputy Prime Minister was replaced by the new Department for Communities and Local Government.

introduced a legal requirement to involve communities within this process (Local Government Act 2000, Section 4(3)). Within health, a shift toward a fully engaged scenario, which emphasises the importance of accepting greater responsibility for individual health and improved efficiency within the health services, has been identified as essential in reducing resource requirements (Wanless, 2004). The cumulative effect of these policies has been to dramatically increase the emphasis upon individual and community involvement within civil society.

Current UK policy resonates with, and in some cases explicitly draws upon, the theoretical tenets of social capital (e.g. Department of Health, 1999a; Neighbourhood Renewal Unit, 2003a). The recent popularisation of the concept can be attributed to the American sociologist Robert Putnam, who describes social capital as "the features of social organisation such as networks, norms, and social trust that facilitate co-ordination and co-operation for mutual benefit" (Putnam, 1995, p67). In investigating Italian regional government, Putnam reported that stocks of social capital determined the effectiveness of each authority. He argues that social capital is a necessary feature of a civic society; civic engagement facilitates the development of reciprocity, the norms required for a cohesive society. Therefore, formal structures of involvement are attributed a major role within the development and maintenance of social capital. Given the government's commitment to strengthening communities and, in doing so, stimulating a process of democratic renewal, it is unsurprising that Putnam's ideas have been so eagerly incorporated within policies.

In recent years, the initial enthusiasm for Putnam's interpretation has been tempered by a realisation that social capital is not always a positive homogenous resource (Portes, 1998; Baum et al, 2000; Ziersch et al, 2005). Instead, social capital, like other forms of capital, is subjected to inequalities that can only be understood within the context of local social and economic infrastructures. Increasingly, commentators are drawing upon Pierre Bourdieu's alternative presentation of social capital (e.g. Baum et al, 2000). For Bourdieu social capital, together with economic and cultural forms of capital, determines an individual's position within the social structure (Bourdieu, 1997). Bourdieu's theory recognises the unequal context in which social capital functions and therefore presents a potentially more useful analytical tool in contemporary society.

Throughout the past decade, social capital has been associated with an array of positive outcomes. One of the most dramatic impacts on the research agenda can be found in public health, where there is a long history of investigation of features of the social environment (e.g. Durkheim, 1952). Higher levels of social capital have been associated with improved health outcomes (e.g. Cattell, 2001; Kawachi, 2001). The enthusiasm for the concept led the UK's Health Development Agency to commission a series of investigations into its value as a tool for public health. Explanations of why social capital may represent an important determinant of health have emerged from decades of investigation into the related concept of social networks, with potential pathways focusing upon social support, the transmission of information, and more instrumentally, shaping access to material resources (Berkman and Kawachi, 2000).

The absence of a consensual definition of social capital has not inhibited an eagerness to increase stocks (e.g. NRU, 2003a), thus research must advance understandings of its dynamics to enable effective interventions. Furthermore, some critics argue that the current emphasis upon social capital has legitimised a dismissal of material factors in explaining health outcomes (e.g. Pearce and Davey Smith, 2003). Yet, inequalities in health have been shown to remain across the socio-economic hierarchy (Acheson, 1998) and necessitate incorporation of structural factors within any analysis of social capital. To avoid the mistakes of previous approaches to health promotion, where little has been achieved other than the perpetuation of inequalities (Campbell and Gillies, 2001), any attempt to improve the health of the population must address the wider social and economic infrastructure. The utility of social capital in such an approach has yet to be determined.

1.3. The Rationale

Although social capital lacks clear conceptual boundaries, its essence is that social networks are a valuable resource. The development of formal networks, the site identified by Putnam (1993b) as the most efficient in social capital generation, is being facilitated by current policy. In turn, if social capital is a determinant of health, then existing policies represent an important approach to public health. The current emphasis upon community within UK policy provides a unique opportunity to explore the relationship between community involvement and health. The overall aim of the research, broadly defined, is to explore the relationship between community

involvement and health and to establish the utility of social capital in advancing understandings of any relationship.

The thesis aim will be realised through the achievement of three objectives:

1. To determine how UK policy and legislation has influenced community involvement processes at the local authority level
2. To identify and explore potential influences of community involvement upon health
3. To determine the contribution of social capital to understanding of the relationship between community involvement and health

The first objective reflects the need to establish how opportunities for community involvement at the local level have been shaped by current policy. This will provide the necessary contextual framework for the practice of community involvement and any subsequent creation of social capital. Secondly, the potential for processes of community involvement to shape health outcomes will be determined. In considering this relationship, it important to emphasise that community involvement has long been advocated as an approach to securing health improvement, particularly within the international policy context (WHO, 1978). Thirdly, the role of social capital in understanding the relationship between community involvement and health will be determined. However, the focus upon social capital will not legitimise a dismissal of potential explanatory concepts and all outcomes emerging from processes of community involvement will be determined.

1.4. The Programme of Research

The current emphasis upon social capital within public health and wider government policy presents a challenge to researchers. The emerging evidence base suggests that social capital is subjected to the same inequalities as other forms of capital and is not equally accessible to all sections of society (e.g. Baum et al, 2000). Thus, smaller scale qualitative investigations are required to identify the factors specific to the positive functioning of social capital, as depicted by government policy. The nature of the studentship was conducive to such an approach; the thesis focused upon the geographic area within the boundaries of the Wakefield Metropolitan District Council (WMDC). Thus the Wakefield District represented a bounded case study in which the implications

of government policy upon the local authority and community and voluntary sector intersect could be analysed.

The objectives of this thesis demanded that two levels of investigation were undertaken; in the first, the local authority implementation of government policy was examined; the second shifted emphasis to individual community groups to provide the essential depth of analysis. This approach has revealed much about the essential components of effective social capital research, but more broadly, it has provided important observations on the relationship between community involvement and health and how this is shaped by the national policy context.

1.5. The Thesis Structure

This thesis is organised into eight chapters as follows:

Chapter One	Introduction
Chapter Two	Health: Definitions, Determinants and Policy
Chapter Three	Social Capital: Theorising a Link between Community Involvement and Well Being
Chapter Four	Exploring Community Involvement and Health: The Methodological Approach
Chapter Five	Community Involvement: The Wakefield District Context
Chapter Six	Community Involvement in Practice and the Edgeton Community Group
Chapter Seven	An Exploration of the Relationship between Community Involvement and Health: A Discussion of the Findings
Chapter Eight	Conclusions and Recommendations for Further Work

Chapter Two presents differing models of health and considers the implications of each to the development of interventions. Recent public health policy is then reviewed to determine the underpinning model of health and, in doing so, examine the potential for community involvement to be embraced as a tool for public health. In Chapter Three, evidence of an association between community involvement and health is examined. This review draws upon a range of concepts, including social networks, empowerment, and, in particular, social capital. Chapter Four presents the methodological approach adopted in the investigation of community involvement and health and in doing so, draws upon contemporary understandings of social capital in its different forms. Reflecting this, the methodology presents a two-stage programme of research undertaken at the district and community level.

In Chapters Five and Six, the findings of the research programme are presented. The Wakefield District's community involvement framework emerging from an analysis of key documentation and interviews with organisational representatives is identified. This framework provides the context in which community involvement activities at the second level of research are to be interpreted. The Edgeton Community Action Group formed the focus of this second research stage and the findings obtained from qualitative observational and interview data are presented within Chapter Six.

In Chapter Seven, the research findings are interpreted within the framework of the thesis objectives and therefore the evidence for a relationship between community involvement and health, and the role of social capital, is discussed. The conclusions drawn from the programme of research are presented within Chapter Eight.

Chapter Two

Health: Definitions, Determinants and Policy

Health is a multi-faceted concept with many different definitions; how it is defined implicates what factors are accepted as its determinants and thus is crucial in shaping intervention. In recent decades, the persistence of inequalities in health has forced examination beyond those factors traditionally associated with the medical model to incorporate social and economic factors. Therefore, effective approaches to public health require cross-governmental action. Here, the different models of health are outlined before discussing the approach of the government in the United Kingdom to public health.

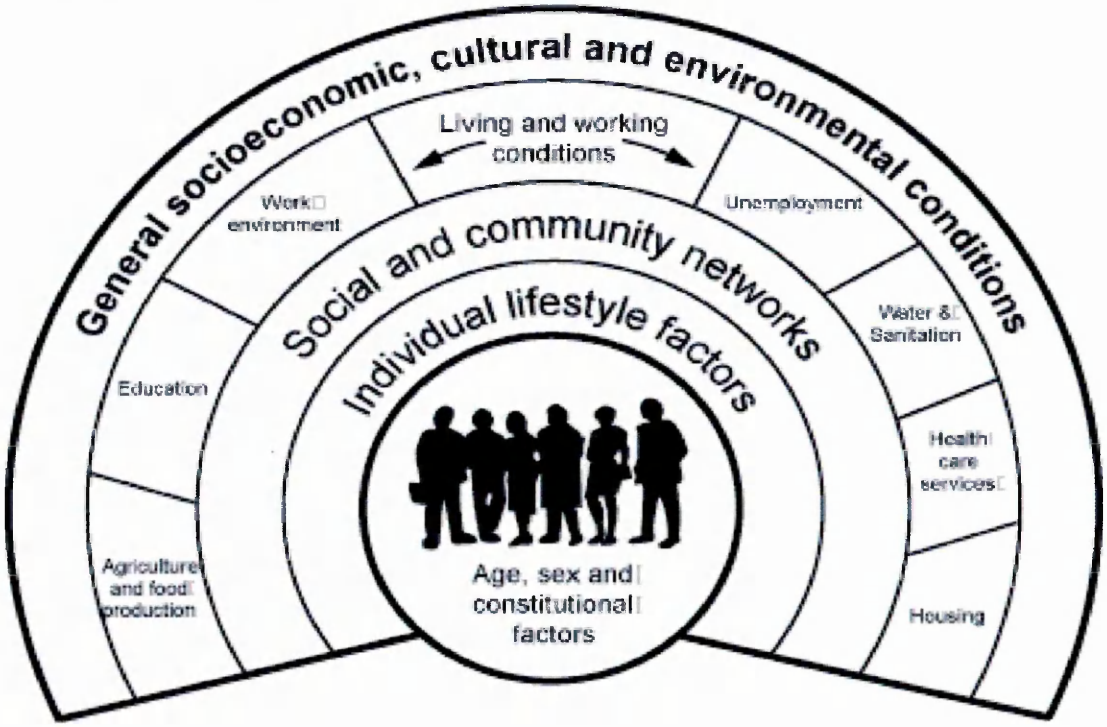
2.1 Health: Definitions and Determinants

Definitions of health typically fall within two broad categories, a medical model and a more holistic social model. A medical model views health as the absence of disease or illness and efforts to improve health largely focus upon traditional health care systems such as the National Health Service (NHS). Understandings of health are largely informed by individual lifestyle factors, such as smoking, diet and exercise and responsibility for good health is placed upon the individual. In contrast, a social model views health as a broader state of well being. The World Health Organisation's (WHO, 1948, no page number) definition of health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity" captures this approach. Health is more than simply the objective of living; rather it represents a resource for everyday life incorporating social, personal and physical capacities (WHO, 1986). Within this model a range of diverse factors are accepted as health determinants, including; peace; education; food; income; social justice; and equity. Thus, responsibility does not lie solely in the hands of the individual, but with society as a whole. This broad approach to well being necessitates that policy and practice incorporate health, social and economic sectors.

Dahlgren and Whitehead (1991) present this interpretation of health in a model depicting determinants as layers of influence. As shown in Figure 2.1 below, demographics are at the base of the model, with lifestyle choices, social structures, living and working neighbourhoods, and wider social, economic and environmental

factors forming the respective and subsequent layers. The layers presented here are not static, but instead interdependent and mutually reinforcing.

Figure 2.1: Determinants of Health (Dahlgren and Whitehead, 1991)



This approach to understanding health is now well evidenced by decades of research into a range of health outcomes. Since the publication of the Black Report in 1980, research has consistently reported inequalities in health across a range of factors, including socio-economic status, gender, ethnicity and place (e.g. Acheson, 1998). The Black Report found that lower occupational groups experienced poorer health at every stage of life and their chances of premature mortality were reported to be two and a half times greater than individuals in higher occupation groups. Some twenty years on, research has shown that despite improvements in overall life expectancy, health inequalities in the United Kingdom have persisted and even increased (Pollock, 2002). In some parts of the country, the life expectancy remains the same as the national average in the 1950s (DH, 2003). Health inequalities across socio-economic gradients, where socio-economic position refers to the social and economic factors that influence the position of individuals and groups within society, is now one of the most consistently reported epidemiological findings (Lynch and Kaplan, 2000, p14).

Traditional approaches to health promotion targeting health behaviours alone are therefore no longer acceptable; indeed they have been shown to succeed only in altering the behaviour of the higher socio-economic positions (Burrows et al, 1995; Campbell and Gillies, 2001). For example, although the overall proportion of smokers has declined in the UK in recent years, this decline has been disproportionate across socioeconomic positions and higher numbers of smokers remain in manual occupational groups (Graham and Kelly, 2004). Explanations for this socio-economic gradient are likely to be complex and it has been suggested that seemingly negative health related behaviours may actually represent a coping mechanism against the stresses of living in poverty (Graham, 1987). The socio-economic differentiation of lifestyle factors has now been well documented (Davey Smith and Gordon, 2000; Macleod and Davey Smith, 2003) and necessitates simultaneous action across the range of interdependent health determinants (see Figure 2.1). The need for co-ordinated approaches to improving population health and tackling health inequalities appears to have been accepted within British policy making. In the past decade, there has been a shift within public health towards a new approach incorporating both individual and structural factors; this policy context will now be discussed.

2.2 UK Public Health Policy

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (Acheson, 1988, p1). Recent governments however, have interpreted this challenge differently. The Black Report was published during the first term of Margaret Thatcher's Conservative government. The ethos of this administration centred upon privatisation and welfare state cut backs, and unsurprisingly the publication of a document reporting dramatic inequalities between the highest and lowest occupational classes was largely ignored. In contrast, the Labour government commissioned an independent inquiry into the extent of health inequalities soon after it was elected to power in 1997. The findings of the inquiry (Acheson, 1998) provided the starting point for the development of a new approach to public health. Whereas the previous Conservative governments were largely dismissive of the role of structural factors in determining health, Labour appears to have incorporated them within its model of health. As John Reid stated during his appointment as the Secretary of State for Health, "it is not enough to say to all the individuals in our society that you can choose to make your own health, because the

different economic and social conditions under which we live either differentially hinder or help our choices" (2004).

The independent inquiry, better known as the Acheson Report (1998), found evidence that inequalities in both health outcomes and determinants existed across socio-economic group, ethnicity and gender. Informed by Dahlgren and Whitehead's model (see Figure 2.1 above), the inquiry adopted a socio-economic approach to health and concluded that action beyond the domain of the health sectors was required to avoid perpetuation of inequalities. Subsequently, the Acheson Report's thirty-nine recommendations incorporated government-wide action and identified the need for changes across public policy, including in taxation, benefits, education, employment, and transport.

The Labour government responded to these findings with a series of strategies, action plans and area based initiatives, such as Health Action Zones, Healthy Living Centres and Sure Start. Health Action Zones (HAZs) in particular were indicative of a fundamental shift within public health. HAZs were hailed as trailblazers; they were to develop innovative approaches to securing health improvement and delivering health and social care at the local level. Their introduction was announced soon after the first term election of the Labour government in 1997 by the then Secretary of State for Health, Frank Dobson. HAZ status was awarded for up to seven years upon submission of satisfactory evidence of need. In 1998, the first eleven HAZs were established and a further fifteen in a second wave in 1999. Despite being designed to pioneer new approaches, an increased emphasis upon targets served to limit their ability to implement any radical new approach to public health. That is, adopting a generic approach to public health does not lend itself to the reporting of disease-specific outcomes. In 2003, HAZs were essentially mainstreamed within the newly established Primary Care Trusts, the successor to Primary Care Groups and local health authorities.

The White Paper *Saving Lives Our Healthier Nation* (Department of Health, 1999a) provided an early insight into Labour's approach and the underpinning model of health. Although setting out an understanding of health that appears to demand a fundamental shift in policy, the White Paper centres upon new targets for death rates from the big killers, cancer, coronary heart disease and stroke, mental illness and accidents. Today,

it remains an important document within the history of public health policy in the United Kingdom in that it is the first national strategy that seeks action beyond the level of the individual. The White Paper was underpinned by two goals; to increase life expectancy and reduce morbidity rates within the general population; and secondly, to improve the health of the worst off in society and in doing so, reduce the extent of inequalities. To achieve these goals, a new three-way partnership between individuals, communities and the government was required. Within this partnership, individuals were "responsible for their own actions in health as in other areas" (para 1.26, p6), but the existence of "powerful factors beyond the control of the individual" (para 1.27, p7) required simultaneous action at the community and national level to tackle the root causes of ill health. It stated that

> health inequality can be reduced only by giving more people better education; creating employment so that people can achieve greater prosperity; building social capital by increasing social cohesion and reducing social stress by regenerating neighbourhood and communities; and tackling those aspects of the workplace which are damaging to health (1999a, para 6.20, p81-82).

The acknowledgement of such wide-ranging action is suggestive of a more inclusive model of health and well being. The emphasis upon community here is also of importance and is reflective of Labour's wider policy agenda, a point that is returned to in depth in Section 2.2.1 below. Within the White Paper (DH, 1999a) strengthened communities are perceived as essential in tackling health inequalities and wider patterns of deprivation, with social networks and a sense of belonging in the local community defined as important determinants of health. In this context, strong social networks are synonymous with a cohesive community, that is, a community where diversity is valued and members share a vision and sense of belonging (LGA, 2004).

Since the publication of *Saving Lives Our Healthier Nation*, successive documents continued to emphasise the importance of effective action at the community level to public health. These documents, including most notably the *Crosscutting Review on Health Inequalities* (DH, 2002) and *Tackling Health Inequalities a Programme for Action* (DH, 2003), reasserted the commitment to cross-departmental action. In the crosscutting review, ministers and officials from across government analysed the available evidence on health inequalities interventions, including the Acheson Report and lessons learned from the HAZ and Sure Start programmes, to develop a long term

strategy. The weight of the evidence led to the acceptance of a social model of health and involving local communities emerged as a key feature in achieving sustainable action. Successful approaches to improving health were found to share a number of key features, including; local assessment of need; representation of local people within planning and management structures; opportunities for joint working and appropriate targeting of both population and settings (DH, 2002, p3). The findings led to the development of themes to guide the approach to health inequalities; strengthening disadvantaged communities; breaking the cycle of inequalities; tackling the major killers; improving access to services; and targeting interventions.

The different strands to the health inequalities strategy were brought together in the more recent publication *Tackling Health Inequalities a Programme for Action* (DH, 2003), developed after a public consultation process. The action plan condensed the Crosscutting Review's five themes into four; supporting families, mothers and children; engaging communities and individuals; preventing illness and providing effective treatment and care; and addressing the underlying determinants of health (para 2.7, p10). The first of these, supporting families, mothers and children, reflected the importance assigned to intervention at the earliest stage of life to break the cycle of deprivation by the Acheson Report (1998). Again, engaging communities and individuals was perceived as essential in strengthening the capacity of communities to enable local problems and deprivation to be tackled. To date, such action has been guided largely by the National Strategy for Neighbourhood Renewal, which is described as "the cornerstone of a more coherent and integrated approach to the complex problems of deprived communities" (DH, 2003, para 3.17, p17). This strategy is discussed in more depth in Section 2.1.1 below. The third theme, preventing illness and providing effective treatment and care, builds upon the policies presented within *The NHS Plan* (DH, 2000a) and *Saving Lives: Our Healthier Nation* (DH, 1999a) and is largely concerned with traditional approaches to health promotion, such as smoking cessation, improving diet and screening programmes. Within the fourth and final theme, addressing the underlying determinants of health, proposed action focuses upon reducing child poverty, improving housing, creating better and safer environments, improving skills, improving employment prospects and developing transport. Thus there is recognition that action across government is required to achieve success. *Tackling Health a Programme for Action* (DH, 2003) also emphasises the need for joint

action at the local level, identifying Local Strategic Partnerships (LSPs) as key in facilitating co-ordination and participation. LSPs are a new structure, typically co-terminus with local authority boundaries, introduced as part of the modernisation of local governance (see section 2.1.1 for further discussion). The partnerships bring together the local statutory sector, voluntary and community organisations, the private sector and local people, participation of all these bodies is considered integral to the success of the programme for action (DH, 2003, p44).

Together, these action plans and strategies provide a basis for a co-ordinated approach to public health. However, it was not until the Treasury commissioned Derek Wanless to produce two reports on future health needs and the necessary resources to support them that a true shift in public health emerged. The first of these reports, *Securing our Future Health: Taking a Long-term View* (2002), set out the resources required to deliver high quality health services. The required resources were projected to differ with the productivity of health services and the level of engagement with health. Three scenarios were described, solid progress, slow uptake and fully engaged. Wanless concluded that facilitating full engagement in health, a process that required an expansion of the public health function, would dramatically reduce the required investment levels in health.

The challenge of implementing the fully engaged scenario formed the focus of the second of Wanless' reports, *Securing Good Health for the Whole Population* (2004). Several failures were identified as inhibiting the ability of people to engage with their health, including; a lack of information; lack of consideration of the wider social costs of behaviours; and socio-economic and ethnic inequalities. Addressing these failures, together with an expansion of the public health workforce capacity, were required to tackle the major issues within public health: smoking, obesity, diet and physical activity. Until this had been achieved, Wanless concluded that activity would continue to fall within the solid progress scenario. The step change required to shift to the fully engaged scenario led Wanless to amend Acheson's (1988) long standing consensual definition of public health to become "the science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations and public and private communities and individuals" (para 2.12, p27).

The scale of the change demanded by the fully engaged scenario was greeted with enthusiasm by the public health community, who had long felt isolated within what had been perceived to be a 'National Sickness Service' (Gilliver, 2004). Public health appeared to have a new momentum, fuelled further by the anticipated governmental response to Wanless, a new public health strategy. This Department of Health strategy came after a period of lengthy public consultation in 2004, entitled *Choosing Health Making Healthy Choices Easier.* At the outset, the White Paper acknowledged that the previous response to public health challenges were no longer adequate in the twenty first century. However, enthusiasm was dampened by the strong emphasis upon individual choice (Mawle, 2005; Shaw et al, 2005). Informed choice formed one of three underpinning principles, alongside personalisation and working together. The Government were to provide support to people to enable them to make health choices, support that would include the creation of a new information service, Health Direct. Once these choices had been made, assistance would be given in maintaining them through the introduction of new Health Trainers. The rights and responsibilities associated with decision making were also addressed within the White Paper, largely through the introduction of a ban on smoking in the majority of public places. The second of the principles gave reason for greater optimism. The personalisation principle acknowledged the inherent failure of services to meet the needs of some sections of the population, particularly those living in deprived areas. Section 2.1 above (see page 3) presented evidence of previous public health initiatives which had succeeded in improving the health of only the more affluent, as such, services required tailoring to the population needs. The final principle, working together, reflects much of the earlier policy discussion, neither the government nor individuals can succeed in improving health alone.

Again, the community emerged as a key theme within *Choosing Health*, indeed a whole chapter was devoted to "local communities leading for health". The chapter reasserted the importance previously attached (e.g. DH, 1999a) to the community in shaping social networks, a sense of security, facilities and resources, and socio-economic circumstances,

> Well ordered and stable communities, with good access to services, clear leadership, cohesion and strong partnerships between local government,

> business, the voluntary sector, health services and community organisations provide an environment that helps people make healthy choices (DH, 2004, p77-78).

This environment is perceived to enable healthy choices through a process of empowerment, with strong communities playing "a significant role in promoting individual self-esteem and mental wellbeing and reducing exclusion" (ibid, p79). As will be discussed in Chapter Three, empowerment has remained an important concept to public health since the 1970s. Reflecting this, supporting community action was described as central to the White Paper (ibid, p81) and a new pilot scheme was introduced, Communities for Health, to encourage new forms of community leadership. In addition, cross-cutting action, particularly the National Strategy for Neighbourhood Renewal, was defined as helping to achieve healthier communities through action "to develop local ties, improve community cohesion, local prosperity and local environments, and to reduce inequalities, crime and social exclusion" (ibid, p101).

The discussion thus far has highlighted the government's assertion that effective public health policy must go beyond the actions of the Department of Health. A key feature of the approach has been the notion of strengthened communities; this feature resonates closely with policy developments across government, most notably the Office of the Deputy Prime Minister[1] (ODPM) and the Home Office. The Labour government has established new units within these departments to tackle the complex problems facing areas experiencing multiple deprivation, the Social Exclusion Unit (SEU) and the Neighbourhood Renewal Unit (NRU). Both units have been central to the development of the new National Strategy for Neighbourhood Renewal (SEU, 2001). Neighbourhood renewal however, cannot be considered in isolation from the wider modernisation of local government, which has led to the introduction of structures responsible for improving well being and securing the involvement of communities within the process.

2.2.1 The Wider Policy Agenda

In its first term (1997-2001), Labour embarked upon a programme of local government reforms to tackle what was perceived to be an inward looking and paternalistic culture

[1] The Department for Communities and Local Government replaced the Office of the Deputy Prime Minister in 2006, which in turn had subsumed the portfolio of the Department of Environment, Transport and Regions.

(Pratchett, 1999; Rao, 1999; Snape, 2000). The Labour government alleged that this culture undermined the accountability of local government and in turn, democratic legitimacy. The result was local councils acting as weak community leaders, largely detached from their electorate. At the centre of Labour's vision for reformed local government was the concept of community leadership. This vision was first set out in the 1998 Department of the Environment, Transport and the Regions' (DETR) White Paper *Modern Local Government in Touch with the People* and enshrined in law by the Local Government Acts of 1999 and 2000. Success in the role as community leader was dependent upon the ability of local government to respond to the demanded cultural change. This change was supported by new legislation aiming to increase the accountability and transparency of council business. Most significantly, the White Paper announced the abolition of the committee system of decision making and its replacement with new political management structures (DETR, 1998). Local authorities were to adopt one of three models of management: a directly elected mayor with a cabinet; a cabinet with a leader; and a directly elected mayor with a council manager. All models incorporated provision for an enhanced scrutiny function to review performance and enhanced mechanisms to ensure probity (Davis and Geddes, 2000, p15). In addition to increasing transparency and accountability, the new structures aimed to reduce the time spent by councillors in committees, thus enabling the investment of more time in their communities.

Levels of accountability and transparency were also to be enhanced through subjecting local government to increased scrutiny through the introduction of the best value regime and new comprehensive performance assessments (CPA) (DTLR, 2001). The CPAs would for the first time, assess the overall corporate performance of councils and through best value, the performance of councils is directly compared against specified standards. Additionally, it has been suggested that best value represents recognition by government that the private and voluntary sectors can provide valuable skills to service delivery (Edmans and Tarifa, 2001). Through re-establishing confidence within local services, best value was to provide a catalyst in building mutual respect and trust (DTLR, 2001, Para 7.24). The new duty of best value was enacted in the Local Government Act 1999 and provided local authorities with a statutory requirement to undertake processes of consultation with service users and local taxpayers.

The White Paper, *Modern Local Government In Touch with the People,* set out plans, later enacted by the Local Government Act 2000, to introduce a new power to promote economic, social and environmental well being (DETR, 1998). Thus, local government was enabled to take action to improve quality of life, and in doing so, assigned a major role in co-ordinating the local public health response. Given that the Department of the Environment, Transport and Regions (DETR) was leading this new policy, it is perhaps unsurprising that the power was not described in this way. Instead the power of well being would provide the "over-arching framework for local government" and "enshrine in law the role of the council as the elected leader of their local community" (DETR, 1998, Para 8.9). To ensure co-ordination, local authorities were assigned the additional duty of the development of a new strategy to fulfil the promotion of well being and contribute to the achievement of sustainable development. Consultation and participation within this process were to become "embedded into the culture of all councils" (DETR, 1998, Para 4.6) and became legislation with the passing of the Local Government Act 2000. The ability to implement the strategy was enhanced by new provisions enabling joint working, including pooling budgets and integrating service provision, thus building upon the provisions set out in the Health Act 1999[2]. Again, these provisions are conducive to the public health function set out by the Department of Health.

The Labour government avoided adopting an overly prescriptive approach towards community strategies, acknowledging the need for each individual strategy to reflect local circumstances and need (DETR, 2000a). However, each strategy would aim to enhance the quality of life of the local area and contribute to sustainable development through action to improve economic, social and environmental well being (ibid, Para 9). This aim would be underpinned by four objectives; the strategy must:

> allow local communities to articulate their aspirations, needs and priorities; co-ordinate the actions of the council, and of the public, private, voluntary and community organisations that operate locally; focus and shape existing and future activity of those organisations so that they effectively meet community needs and aspirations (DETR, 2000a, Para 10).

Community involvement is perceived as central to the success of community strategies (DETR, 2000b; 2001b). Much like their depiction within DH policy (e.g. DH, 2005,

[2] The Health Act 1999 set out provision for joint working between local and health authorities.

p82), communities are perceived to hold a wealth of untapped resources such as knowledge, experiences, skills, and energy. Through a process of involvement, communities are enabled to develop a sense of ownership of the plans and in turn are empowered to undertake future projects and actions (DETR, 2000a, para 68). Achieving this form of development however, requires a commitment to involvement beyond simple consultation (DETR, 2000a, Para 51). The DETR recommended that structures are established to enable the diverse views of communities to be heard and ensure that they inform the development of community strategies (DETR, 2000a, Para 66). Elsewhere, the government provides more insight into what are considered to be appropriate structures,

> Area consultation and decision making arrangements have a valuable role to play in helping to involve citizens in decisions which affect them, particularly on neighbourhood issues. We want local authorities to make more use of area forums, public assemblies, and citizen user's boards (DTLR, 2001, Para 2.47, p20).

Responsibility for the new community strategies has been placed upon the new local strategic partnerships (LSPs) briefly discussed above (see Section 2.2). The concept of LSPs was originally developed by the Social Exclusion Unit (SEU) as part of their analysis of the problems of deprived areas. A Policy Action Team established as part of this analysis, recommended that a single partnership body be established to provide a co-ordinated approach to tackling social exclusion at the local level (DETRd, 2000). This recommendation was accepted by the DETR and local authorities are now required to establish a LSP[3]. The LSP is defined as a,

> a single-body that: brings together at a local level the different parts of the public sector as well as the private, business, community and voluntary sectors so that different initiatives, programmes and services support each other and work together; is a non-statutory, non-executive organisation; operates at a level which enables strategic decisions to be taken and is close enough to individual neighbourhoods to allow actions to be determined at community level; and should be aligned with local authority boundaries (DETR, 2001b, p10).

[3] Only the eighty eight most deprived local authority areas identified as eligible for neighbourhood renewal funding are required to establish a local strategic partnership, their establishment is however, recommended in all areas.

The production of a community strategy by this partnership structure is seen as necessary given the nature of quality of life, as DETR has stated

> the issues which affect local quality of life cross administrative, geographical, and organisational boundaries. An effective response therefore demands partnership working across sectors, involving not only the key public agencies but also the private, community and voluntary sectors and local people (2001b, p10).

This quote resonates closely with the holistic approach to public health set out in Section 2.1 above.

Principles of involvement are fundamental to the effectiveness of LSPs, indeed they are expected to actively seek the participation of the community and voluntary sector (DETR, 2001b, p10; SEU, 2001, Para 5.28, p51). However, LSPs alone were considered insufficient in enabling the full participation of local communities and the government recommended that local views were inputted through additional mechanisms, such as consultation processes and narrower partnership bodies (DETR, 2001b). In recognising that communities may not possess the resources to respond to the new opportunities for involvement, the provision of funding and support to community groups was suggested as a means to facilitate the required capacity building process (DETR, 2000a; 2001b). Within the LSP structure itself, communities were provided with the opportunity to participate either as a service provider or as advisers on local need (DETR, 2001b). As an adviser, community and voluntary sector representatives would provide knowledge on the impact of service provision on local people. The local community empowerment network (CEN), a structure created through the neighbourhood renewal programme, is responsible for facilitating the appointment of representatives to the LSP. To enable this process, the LSP and CEN are required to develop a protocol for joint working setting out the number and types of places available to representatives and the nature of their role (NRU, 2003b). Additionally, funding has been made available to the CEN (single community programme[4]) to support and develop the community and voluntary sector to enable their participation within the LSP (NRU, 2003a).

[4] The single community programme was created after the three separate funding streams, the Community Chest, Community Empowerment Fund and Community Learning Chest were amalgamated (RCU, 2003).

The policy reviewed thus far has highlighted links between the National Strategy for Neighbourhood Renewal (SEU, 2001) and the new structures for local governance. Its focus upon tackling social exclusion at a local level is perceived by Labour to compliment local government reform (ibid) and the repeated references to it by Department of Health policy suggests that it is perceived as an integral component of the new approach to public health. The strategy, developed by the Social Exclusion Unit, adopts an area-based approach to tackling conditions in the most deprived areas stating that it is at the neighbourhood level that inequalities are most acute; targeting a wider geographic area would obscure pockets of deprivation. It perceives the multi-faceted issues facing these areas, such as unemployment, low income and abandonment, as creating a vicious cycle of exclusion (SEU, 2001, p17). The programme of neighbourhood renewal presented within the strategy is directly concerned with tackling the inequalities created by this cycle. This is reflected in its two underpinning goals; to have lower worklessness; less crime; better health; better skills; and better housing and physical environment in all the poorest neighbourhoods; and to narrow the gap on these measures between the most deprived neighbourhoods and the rest of the country (ibid, p25). To support its implementation, a £800 million Neighbourhood Renewal Fund was created and distributed amongst the eighty-eight most deprived local authorities, with eighty-two percent of the most deprived wards in England being concentrated within these areas (DETR, 2000c).

At the local level, the LSP is again crucial in co-ordinating and facilitating action. In addition to the community strategy, it is responsible for developing and implementing local neighbourhood renewal strategies that will set out the approach to tackling pockets of deprivation within its boundaries. As such, the involvement of residents within eligible neighbourhoods will be supported to ensure their needs and priorities are to the fore (SEU, 2001, para 5.26, p51). Neighbourhood management, a model of involvement devolving control to the local level, is described within the National Strategy as a radical means of achieving this. Thus reflecting the belief that "the most effective interventions are often those where communities are actively involved in their design and delivery, and where possible in the driving seat" (SEU, 2001, para 1.19, p19). Devolution of this degree is perceived within the strategy as facilitating the empowerment of communities.

Although much of the Labour government's early policy emphasised the importance of involvement, the concept remained ill defined. The Neighbourhood Renewal Unit provided much needed clarity in the publication of its guidance on the administration of the single community programme and defined four goals of community participation (2003c, p5). These four goals, governance, social capital, service delivery, social inclusion and cohesion, sought to delineate both what was meant by community participation, the NRU's preferred term, and what could be achievable through effective implementation. The first goal, governance, reflects the implicit aim of community participation to enable communities to develop a voice and participate in decision making, and in turn, increase the accountability of service providers. Secondly, participation aims to develop the confidence and capacity amongst individuals and groups to enable their involvement within activities. In doing so, mutually supportive networks can be built that contribute to the development and maintenance of social cohesion. Therefore, this goal is defined as social capital (see Chapter 3, Section 3.2 for a full discussion of social capital). The third goal, service delivery, centred upon the aim to enable communities to both influence service delivery and participate within the delivery itself. The goal of social inclusion and cohesion reflects the NRU's aim to develop empowered communities, that is, communities capable of building a common vision, a sense of belonging, and a positive identify that values diversity.

An implicit aim of the National Strategy for Neighbourhood Renewal is to overcome the failures of previous short-term initiatives, yet a wide range of area based initiatives are defined as contributing to tackling neighbourhood level deprivation (SEU, 2001). In its first term, the government's enthusiasm for local interventions led to a complicated maze of regeneration programmes throughout England. It was not unusual for a deprived area to receive funding from several different area based initiatives, such as Objective 1 and 2, Single Regeneration Budget, Health Action Zones, Education Action Zones and Sure Start. Labour addressed the confusion it had, in part, created by introducing a new Regional Co-ordination Unit (RCU), assigned with the task of reviewing and rationalising the maze of area based initiatives. The result has been the mainstreaming of some funds (e.g. Health Action Zones) and the streamlining of others (e.g. single community programme, see the above discussion). Those that remain, such as New Deal for Communities and Sure Start, share many of the principles of the aforementioned policies and programmes. These initiatives demonstrate the

government's emphasis upon the community as a vehicle to secure the development of area's experiencing deprivation.

2.3 Conclusions

Evidence documenting the increasing inequalities in health in the United Kingdom necessitates the adoption of a socio-economic model of health in approaches to public health. The policies reviewed here suggest that there is at least some commitment by the government to tackling the root causes of ill health through a combination of national and local level action, although the recent *Choosing Health* White Paper (DH, 2004) indicates increased emphasis upon health behaviours. Within this policy agenda, it is clear that communities are considered an important target for action with strengthened communities perceived as a mechanism through which the cycle of deprivation can be broken. The involvement of communities is a strong theme throughout and is perceived by the government to be both empowering and essential for the development and maintenance of social networks, and therefore social capital.

Similar emphasis is placed upon processes of involvement out with the Department of Health, most notably in the Office of the Deputy Prime Minister's modernisation of local government and a new approach to neighbourhood renewal. Implementing a holistic approach to public health requires cross-departmental action; the policies reviewed here suggest that the opportunity exists to develop such an approach. However, it remains undetermined how a focus upon communities, and their involvement, represents an effective tool for public health. The potential association is explored and examined further within Chapter Three. In doing so, this review draws upon the concepts that have emerged from the policies outlined here, social capital, cohesion and empowerment.

Chapter Three

Social Capital: Theorising a Link between Community Involvement and Well Being

The preceding chapter identified the community as an important theme within recent government policy, with communities representing the target of a new approach to public health. Constructs of the community have a long history within public health, with concepts such as cohesion, social networks and more recently, social capital all reported to have a positive association with health. Despite decades of investigation however, these concepts remain ill defined and the evidence base remains contested. The current policy emphasis demands that the conceptual boundaries are clearly defined; in achieving clarity, approaches to public health can be implemented with enhanced effectiveness. Therefore, the features of community associated with health are defined and examined here.

3.1. Healthy Communities?

Community constructs, and more generally the social environment, have been associated with health outcomes throughout the last century. Since Emile Durkheim's (1952) classic sociological investigation of suicide reported a positive relationship between social integration and health, studies have consistently shown an individual's embeddedness within their social environment to be an important determinant of health. One such example is Roseto, an Italian-American town in Pennsylvania, United States. Prior to the 1960s, Roseto was characterised by a high level of ethnic and social homogeneity, close family ties, and cohesive community relationships, features that were reported to distinguish the community from neighbouring areas (Egolf et al, 1992). At this time, Roseto was found to have improved health outcomes, relative to neighbouring areas. However, the observed health differences began to disappear in the late 1960s amid reports that the community was becoming increasingly americanised, with traditional values being replaced with more materialistic aims. Therefore, Egolf and his colleagues (1992) attributed the observed lower mortality rates to homogeneity and close-knit family and neighbour networks.

Such observations have stimulated decades of investigation into the influence of the social environment upon health. Although the focus has varied, the underpinning tenet has remained the same; through some mechanism, strong ties with social groups are health enhancing. Until recently, social networks have dominated research in this field, a concept that incorporates both the structure and characteristics of networks and the functional support that can be derived from them (Stansfield, 1999). Successive investigations have reported associations between levels of social networks and mortality from almost every cause of death (Kawachi and Berkman, 2001; Fratiglioni et al, 2000; Wallen and Lachman, 2000). Research has shown that social support reduces mortality rates by up to three times, an association that is comparable in strength to that of the reported association between smoking and health (Kawachi and Kennedy, 1997). Thus it is immediately clear why social networks have been subjected to such intense investigation.

Despite the volume of literature documenting an association between social networks and health, adequate explanations for it are lacking. To date, no single causal pathway has been identified and, given the complexity of the concept, may not even exist. The challenge to practitioners is thus clear; the implementation of any intervention aiming to increase social networks requires conclusive demonstration of the pathways to improved health to warrant continued investment of limited health sector resources. Indeed it is this issue that led to the curtailing of the innovative approaches adopted by Health Action Zones (see Chapter Two, Section 2.2). However, any identified pathways remain theorised rather than proven. For example, Berkman and Glass (2000), in a comprehensive review of the significance of social networks within epidemiology, identify four mechanisms through which health may be influenced; social support; social influence; social engagement; and access to material resources.

Research into the physiological effects of exposure to stress has suggested that social support has an important health protection function. A stressor is at its simplest level a demand placed upon an individual that alters his/her stability (Antonovsky, 1979, Steptoe, 2001). Steptoe (2001, p41) has identified three main categories of stressor, acute life events, chronic stressors (e.g. social isolation) and everyday hassles and irritations; therefore, individuals are exposed to stressors throughout the life course. Despite this, exposure does not inevitably trigger a stress response; instead the stress

response is dependent upon the resources available to the individual to respond to the demands of the stressor. According to the buffering model, social support can provide the resources required to prevent the stimulation of a stress response (Cohen, 2003). The central tenet of this model is that social support modifies coping mechanisms and as Cohen suggests, the presence of support may alter what is interpreted to be a stressor, and where a stressor is identified, serve to increase the perceived ability to cope with the situation. Given the well-documented associations between prolonged exposure to stress and range of negative health outcomes, including impaired functioning of the immune system (Pinel, 1997) and depression (Brunner and Marmot, 1999), the potential health protecting function of social support is clearly evident.

The buffering model portrays social support as health protecting during exposure to a stressor, Stansfield (1999) argues that the association between social support and health is broader than suggested by this model. The buffering model attributes social support with facilitating enhanced coping mechanisms, for Stansfield, this is beneficial to health in its own right. Through altering the perceived ability to control the environment, or efficacy, individuals are likely to experience improved levels of self-esteem (Stansfield, 1999). Concepts of efficacy, judgements of personal capability, and self-esteem, judgements of self-worth, have both been positively associated with health, independently of social support functions (Bandura, 1997). Research has documented a link between strong levels of self-efficacy to improved health outcomes (Schwarzer and Fuchs, 1995). For Bandura (1997), the development of self-efficacy is an empowering process, with an individual being empowered when high levels of control over their life are possessed (Tones, 1998). The importance of empowerment within public health was formalised by the 1986 Ottawa Charter for health promotion, which defined the concept as a key principle (WHO, 1986). As such, many public health practitioners, particularly advocates of community development approaches, have drawn upon principles of empowerment. For example, Laverack and Wallerstein (2001) argue that empowerment is essential in enabling the social and political changes necessary to redress individual and community powerlessness. It is perhaps unsurprising then, that it has emerged as an important concept in the policies reviewed in Chapter Two. The concept of empowerment, and its significance within community development, is discussed in greater depth in Section 3.4.1 below.

Returning to Berkman and Glass' (2000) analysis, the second mechanism through which social networks may be associated with health is social influence. Social networks enable enhanced levels of information transmission and facilitate the development of shared norms, thus becoming a potential source of behaviour regulation (Berkman and Glass, 2000; Kawachi and Berkman, 2001; House et al, 2003). Indeed, the extensiveness of social networks has been found to be inversely related to negative behaviours (Berkman and Glass, 2000).

Social networks are central to the promotion of social participation and engagement. As Berkman and Glass (2000, p147) describe, "through opportunities for engagement, social networks define and reinforce meaningful social roles including parental, familial, occupational, and community roles, which in turn provide a sense of value, belonging and attachment." The authors describe the meaning assigned to an individual's life by belonging to a network. It is this aspect of social networks that links most closely with the related theories of cohesion and integration. Chapter Two (see Section 2.2) highlighted the importance assigned to cohesion by the Labour government, with policies stating that inequalities can be overcome by increasing levels of cohesion (e.g. DH, 1999a).

A fourth pathway through which social networks can be health promoting is through facilitation of access to material resources. This tangible relationship to health is easily demonstrated by considering the advice sought from either a friend or colleague when submitting a job application or searching for health care (Steptoe, 2001; Berkman and Glass, 2000). This pathway resonates with the earlier body of work of Granovetter (1973) and his concept of weak ties. For Granovetter, loosely knit ties were essential in achieving social and economic mobility, a concept that overlaps closely with emerging theories of bridging forms of social capital. This issue is returned to and discussed in more depth in a review of the theory of social capital in Section 3.2 below.

The explanations outlined above all focus on the role of social support in preventing disease, but as Stansfield notes (1999), it could be equally important in aiding the recovery of illness. Berkman's (1995) review concluded that there was strong and consistent support for the assertion that social support is an important factor in determining survival rates after onset of illness.

The volume of evidence reporting associations between social networks and health outcomes provide the foundations for the popularisation of a new concept within public health. Social capital, a concept that focuses on the value of social networks, has shifted the debate beyond the level of the individual to incorporate collective features of societies. Throughout the past decade, a growing number of studies have reported a positive association between social capital and a wide range of health outcomes (e.g. Kawachi et al, 1997, Cattell, 2001). The theoretical underpinnings of the concept are explored in the following section before examination of the empirical evidence of an association between social capital and health.

3.2. What is Social Capital?

The recent enthusiasm for social capital has not been restricted to the domain of public health; fields as diverse as psychology, economics and politics have all embraced the concept. The result has been a vast array of interpretations of social capital, as each author has adapted its definition and characteristics to suit their own purpose. Despite this divergence, it is essentially concerned with the features of social interaction that enable collective action, as Woolcock and Narayan's commonsensical definition describes:

> The basic idea of social capital is that a person's family, friends, and associates constitute an important asset, one that can be called on in a crisis, enjoyed for its own sake, and leveraged for material gain. What is true for individuals, moreover, also holds for groups. Those communities endowed with a diverse stock of social networks and civic associations are in a stronger position to confront poverty and vulnerability, resolve disputes and take advantage of new opportunities (2000, p226).

Although the wide ranging application of social capital has led some to argue that it has been oversimplified and diluted to the extent that it no longer presents an effective framework for discussion (Muntaner et al, 2001; Hawe and Shiell, 2000), the contrary argument is made here. The enthusiasm for the concept within so many diverse fields presents a rare opportunity for social capital to provide the foundations of a genuinely holistic approach to public health[1]. Therefore increased understanding is required to

[1] See Chapter Two, Section 2.1 for a discussion of the evidence necessitating such an approach to public health.

enable the implementation of effective social capital based interventions. The need for conceptual clarity is particularly pertinent within the current political context where the development of social capital is implicit within many policies and initiatives (e.g. NRU, 2003a; see Chapter Two, Section 2.2.1 for further discussion). Although many versions of social capital have emerged from the literature, three theorists remain pivotal; Robert Putnam; Pierre Bourdieu; and James Coleman. It is their work that provides the framework for contemporary debate and thus each of these theories are discussed in turn.

3.2.1. Robert Putnam: A Theory of Civil Society

Although not the first to present a theory of social capital, Robert Putnam can be attributed with its popularisation. For Putnam, social capital is "the features of social organisation such as networks, norms, and social trust that facilitate co-ordination and co-operation for mutual benefit" (1995, p67). Civic engagement, the connections held with the local community as well as political activities (Putnam, 1996, p1), is central to his theory and is identified as the preferred site for the development of reciprocity. Reciprocity is one of the norms identified as leading to the development of social capital and refers to the belief that a favour will be returned in the future (2000, p134). In turn, reciprocity enables the development of trust, which Putnam describes as the lubricant of social life (1993b, p3). Networks of civic engagement also serve to enhance the transmission of information and thus enable individuals to determine the trustworthiness of others (ibid, p4). Putnam argues that the effectiveness of information transmission increases with the density of interaction and over time, individualistic motives are reduced thus stimulating the development of trust. It is through these features that co-operation is enabled, and thus, provide a template for future co-ordinated action. Because of this, Putnam argues that social capital is self-reinforcing and cumulative, "successful collaboration in one endeavor [sic] builds connections and trust – social assets that facilitate future collaboration in other, unrelated tasks" (1993b, p4).

For Putnam, strong traditions of civic engagement are essential for good government, an assertion drawn from his investigations of regional government in Italy. Utilising voter turnout, newspaper readership, and membership in voluntary groups as measures of civic engagement, he observed that higher levels of these behaviours were associated with a more effective regional government in Italy (1993a). Despite being equal in

structure, some governments were found to be corrupt and inefficient whilst others demonstrated innovation and success (1993b). Levels of civic engagement within the Italian regions were proposed to be embedded within history, as Putnam describes, "enduring traditions of civic involvement and social solidarity can be traced back nearly a millennium to the eleventh century, when communal republics were established in places like Florence, Bologna, and Genoa, exactly the communities that today enjoy civic engagement and successful government" (1993b, p3). Therefore stocks of social capital were perceived as being dependent upon a historical context of civicness. As such, much of Putnam's work has focused not on the processes through which social capital is developed (Whitely, 1999), but on the outcomes of social capital, claiming that it "makes us smarter, healthier, safer, richer, and better able to govern a just and stable democracy" (2000, p290). However, Putnam does acknowledge that social capital can represent a new approach to development (1993b, p5) and advocates a focus upon community development to foster the resource (ibid, p9).

More recently, Putnam has applied his theory to contemporary American society, concluding that levels of civic engagement, and therefore social capital, have continued to decline since the 1960s (Putnam, 1996, 2000). This decline is attributed to a range of factors including; reduced leisure time; disruption of marriage and family ties; a restructuring of the economy; and most importantly, television (Putnam, 1996, p3). The cumulative effect has been, "we voted less, joined less, gave less, trusted less, invested less time in public affairs, and engaged less with our friends, our neighbors [sic], and even our families" (2002, p1). The recreation of social capital within American society is described by Putnam as "no simple task" (2000, p402) but necessary to secure the development of communities. The extensiveness of the decline of formal relationships with civic structures has led some commentators to claim that they are no longer relevant within contemporary society (Campbell et al, 1999; Baum et al, 2000; Campbell and Gillies, 2001). However, Putnam does not assess the contemporary importance of civic engagement; rather he concludes that it is the decline of formal networks that has led to the erosion of civil society.

Putnam's presentation of social capital has captured the imagination of policy makers; the Labour government, in aiming to strengthen communities to tackle issues such as social exclusion and inequalities, have embraced Putnam's assertion that it is the

reported decline in social capital that has led to the increasing disengagement with community life (Putnam, 1996). In turn, Putnam argues that higher levels of social capital underpin effective systems of governance (Putnam, 1993b). It is perhaps unsurprising then that the creation of social capital is implicit within much recent government policy and particularly within the programme of neighbourhood renewal (e.g. NRU, 2003a; see Chapter Two, Section 2.2.1). However, almost every tenet of Putnam's theory has been fiercely attacked within the academic literature.

Firstly, his enthusiastic emphasis upon the positive outcomes generated by social capital has led to a neglect of its downside (Portes, 1998). However, Putnam does concede in later writings that the co-operation enabled by social capital is not inevitably mobilised for altruistic purposes (Putnam, 1996, p1). Instead, the resource can be drawn upon to advance the development of organisations perceived by those out with their membership as negative. This strong sense of in-group loyalty, although benefiting the members, may then become exclusionary and reinforce pre-existing social stratifications and inhibit the development of the wider community (Fukuyama, 1999; Harpham et al, 2002; Narayan, 1999; PIU, 2002; Putnam, 2000; Wakefield and Poland, 2005). This 'bonding' form of social capital is available only to members of a given group or community and can be contrasted with 'bridging' forms that cut across these structures. Bridging forms are required, in addition to bonding forms, to ensure that social capital is not utilised to develop the cohesiveness of a group structure at the expense of the wider population. Divergences between forms of social capital are returned to in more depth in Section 3.2.4 below.

Secondly, the central tenet of Putnam's theory is that social capital is necessary for systems of good government. Despite this, Alcock and Mason (2001) argue that there is little consideration of how systems of governance can shape the development of social capital. Indeed, Putnam deals with this issue in a very brief statement on tax deductions on charitable donations (1995, p77), job training initiatives and urban renewal (1993b, p6 and p9). However, he does conclude that government can be both the problem and solution in social capital creation (Putnam 2000). As reported in Chapter Two, the modernisation of local government is creating new opportunities for the engagement of the community and voluntary sector within the local political processes, and thus can potentially shape stocks of social capital. The recent emergence of linking relationships

as a distinct form of social capital has enabled this issue to be explored systematically and investigations into linking forms are reviewed in Section 3.2.4.

A third, and more damning, criticism is made by Portes (1998); he argues that Putnam's work is inherently flawed and succeeds only in confusing cause and effect. This statement is derived from Putnam's utilisation of indicators of public engagement as a measurement of social capital itself as well as an outcome of it (Baron et al, 2000; Pevalin and Rose, 2003). As such, and related to the earlier point that Putnam fails to consider the processes in which social capital is developed, the sources and outcomes of social capital are obscured with each becoming a proxy for the other. Similarly, the measurement utilised by Putnam have legitimised a neglect of the context with which social capital is developed (Whitehead and Diderichsen, 2001). However, Putnam's own theory was originally focused upon the locality, in that he aimed to uncover the factors that gave rise to effective regional government in Italy. It is his aggregation of individual behaviour (e.g. newspaper readership) to the community, city or country level that has attracted criticism.

The conditions giving rise to social capital have become increasingly important in recent years, with growing evidence that social capital is not a homogeneous resource. Rather access to it is shaped by structural factors such as gender (Sixsmith and Boneham, 2002), ethnicity (Campbell and MacLean, 2003), social position (Sharp, 1999; Baum et al, 2000; Campbell and Gillies, 2001) and age (Baum et al, 2000; Cattell and Herring, 2002). In contrast to Putnam, differential access to resources forms the central tenet of Pierre Bourdieu's alternative theory of social capital.

3.2.2. Pierre Bourdieu: A Three Capital Theory

Bourdieu's concept of social capital is encompassed within a wider theory of the structuring of the social world. According to Bourdieu (1997), the position occupied in society determines almost all aspects of life and society is itself structured by the distribution of capital. Therefore, the volume and form of capital held by an individual determines an individual's position within social structures (1991, p231). Capital, as defined by Bourdieu, can exist in three fundamental forms, economic, cultural and social, all of which are interdependent insofar as they can be exchanged for one another. As Bourdieu describes,

> Economic capital, which is immediately and directly convertible into money and may be institutionalized in the form of property rights; as cultural capital, which is convertible, on certain conditions, into economic capital and may be institutionalized in the form of educational qualifications; and as social capital, made up of social obligations ('connections'), which is convertible, in certain conditions, into economic capital and may be institutionalized in the form of a title of nobility (1997, p47).

Consider first cultural capital in all its different forms; levels of cultural capital are in part determined by the possession of goods such as books, dictionaries and pictures, but also by an individual's beliefs and disposition, or everyday interpretations of culture, as well as more institutionalised forms, such as formal educational qualifications. Additionally, an individual's beliefs and dispositions have the potential to function as a fourth form of capital, symbolic. Symbolic capital is largely synonymous with prestige and reflects an individual's enhanced social standing by virtue of their expert knowledge on a given topic. Bourdieu argues that such knowledge is obtained during a child's socialisation and its development is therefore dependent upon the volume of cultural capital held by the child's family (1997, p49). In turn, a family's stocks of cultural capital are determined by the leisure time available to them, or as Bourdieu describes, time free from economic necessity (ibid). The interaction between the three forms of capital was demonstrated in research carried out by Butler and Robson (2001) in three middle-class areas in London. They found that stocks of cultural capital were necessary to enable interaction with local government, and therefore, the subsequent development of social capital. Successful interaction with local government was found to be dependent upon residents' ability to draw upon "detailed knowledge, case preparation, articulacy and social confidence" (Butler and Robson, 2001, p2159).

This theorised transmission resonates with Putnam's presentation of social capital as self-reinforcing and cumulative. That is, if a family does not have the resources available to it to invest in cultural capital, it is likely that future generations will possess only low volumes of the resource. Again, this has important implications for interventions aiming to develop capital in areas experiencing exclusion; additional means will have to be sought to ensure cultural knowledge is transmitted to all individuals.

Within Bourdieu's theory, social capital represents a third form of capital and is defined as:

> The aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition - or in other words, to membership in a group - which provides each of its members with the backing of the collectively-owned capital, a 'credential' which entitles them to credit, in the various senses of the word (Bourdieu, 1997, page 51).

That is, through attachment to a network, access is given to the collective volume of resources held by its members; this collective resource provides each member with a resource greater than that held individually. For Bourdieu, these relationships do not necessarily exist in a practical state but can also be bestowed by sharing an attachment to a common name (e.g. family, class or school). Putnam too acknowledges that a common symbol or ideology can represent a useful resource in its own right, but perhaps correctly asserts that such networks do little to enhance levels of "social connectedness" (Putnam, 1996, p2). Social capital stocks, for Bourdieu, reside within the network itself, thus the volume of social capital available to an individual member is determined by the size of the network and on the volume of other forms of capital possessed by the individual network members (Bourdieu, 1997, p51). As such, both material and symbolic benefits can be derived from group membership; like Putnam, this is dependent upon the development of normative structures, described by Bourdieu as rights and subjective obligations (e.g. feelings of gratitude, respect and friendship). Similarly, these features of social organisation are not immediately present within a network, but instead develop over time. Eventually, the members obtain mutual knowledge and their position as network members is recognised by adhering to the acceptable boundaries of interaction. For Bourdieu, it is this feature that distinguishes relations rich in social capital from loosely based neighbourhood or workplace networks. For members to invest resources into a network, the value of the benefits must be greater than the demands of their input. With this collectively owned capital behind them, representatives of the group are bestowed with a stronger and more powerful 'voice' than that of any individual contribution. Therefore, the relevance of Bourdieu's presentation of social capital to the current policy context is clear, given that there is increasing emphasis upon securing the involvement of the community and voluntary sector within systems of local governance.

Social capital, like cultural capital, can be converted into economic capital, and both social and cultural capital can be derived from economic forms. To illustrate this point,

Bourdieu uses the example of purchasing a gift; although investing time and attention into selecting the most appropriate gift for an individual may not appear to be a worthwhile economic activity, it has clear implications for future social exchanges (1997, p54). Similarly, Putnam (1993b) argues that social networks can provide individual members with access to employment opportunities that would not otherwise be available. In the case of cultural capital, its transmission is dependent upon the free time available within the family, which can, through extending the period of education, delay entry into the labour market. Conversely, educational qualifications are increasingly required for access to many positions of employment.

Bourdieu's theory necessitates simultaneous analysis of wider structural factors, namely economic and cultural capital. Therefore, attempts to create social capital would be ineffective in the absence of consideration of the economic and cultural resources available to an individual. As such, Bourdieu's theory has been identified as potentially the most valuable in informing social capital interventions (Portes, 1998; DeFillipis, 2001), particularly within public health (Campbell and McLean, 2002; Pevalin and Rose, 2003; Morrow, 2002). Bourdieu's interpretation of capital resonates with the model of health presented in Chapter Two (see Figure 2.1), that is a range of interdependent factors must be addressed to tackle the determinants of health.

However, Bourdieu's theory of social capital does not offer the same delineation of the concept as that presented by Putnam and his work has been criticised for failing to provide a "full specification" of the concept (Szreter and Woolcock, 2002, p10). Although his focus upon the interdependent nature of the three forms of capital is an important reminder of the need to incorporate structural factors within any public health intervention, it does little to advance our understanding of the different forms of social capital and indeed those that would enhance the accumulation of economic capital. Furthermore, trust is a central tenet of contemporary interpretations of social capital and, as will become clear in the subsequent discussion, is commonly used as a proxy for the resource. Yet trust does not feature within Bourdieu's interpretation of social capital. Instead, this insight must be drawn from the broader theories of social capital.

3.2.3. James Coleman: An All Encompassing Theory of Social Relations

For Coleman, social capital is "a particular kind of resource available to an actor... It is not a single entity but a variety of different entities having two characteristics in common: they all consist of some aspect of social structures, and they facilitate certain actions of individuals who are within the structure" (1990, p302). It is described as a largely positive resource "facilitating the achievement of goals that could not be achieved in its absence, or could be achieved only at a higher cost" (1990, p304). Therefore, social capital in this sense refers to the features of social structures that enable members of that structure to undertake action.

Within any social relations, social capital can exist in three forms; obligations, expectations, and the trustworthiness of structures; information channels; and norms and effective sanctions. Obligations here refer to what Putnam labels reciprocity, and are described as the carrying out of favours for one other creating a large numbers of outstanding favours, or "credit slips" (Coleman, 1997, p84). At any given time, credit slips remain outstanding on both sides of relationships and individuals with higher numbers of outstanding obligations have more social capital available to them. It is through this system of favour exchange that the achievement of goals is facilitated, with an individual being able to draw upon an outstanding obligation to achieve a desired outcome. However, before this situation can develop, there must first be a level of trust between members of the social structure; an individual is more likely to carry out a favour if they trust it will be repaid in the future.

Information sharing is defined by Coleman as important in providing the basis for action and is therefore identified as a second form of social capital. Acquiring information can be a resource intensive exercise, but drawing upon the information held by an individual's connections can overcome this (1990, p304). Coleman identifies norms, and their sanctions, as a third form of social capital. Within any group, members are encouraged to act in the interests of the group by established norms built upon mutuality. The establishment of such norms would clearly be advantageous within the community and voluntary sector given the increasing opportunities for their participation within the political process. However, it is also possible, as Coleman acknowledges, for norms to constrain as well as facilitate action with powerful norms acting to inhibit rather than encourage innovation.

Coleman, like Putnam, argues that although all social relations and social structures facilitate social capital, certain forms of networks are more important in the formation of the resource. The degree of closure within any network is identified as a key determinant of favours being undertaken by individual members (Coleman, 1990). According to Coleman, a closed network is formed when its members hold some relationship with one another, rather than loose ties. These relationships, or closure, serve to sanction certain behaviours. As Putnam also asserts (1993b), it is this process that enables the development of trust within the group structure.

Coleman makes it clear that social capital can be distinguished from other forms of capital by a key feature; it is not a property of the individual but rather inheres in the structure of relations between and among individuals. It is because of this feature of social capital that Coleman describes it as a public good, meaning that the actor responsible for its creation is not necessarily the beneficiary of its outcomes. This definition of social capital has been described as being not a mechanism, a thing, nor an outcome, but simultaneously any or all of them (DeFilippis, 2001). It is this all-encompassing concept that has led to criticism and has been attributed with 'leaving the door open' for mass application and interpretation of social capital (Portes, 1998).

3.2.4. Social Capital: Its Theories and Forms

The points of divergence between these theories are clear. Putnam is largely concerned with the virtues of associations created within voluntary organisations and other forms of civic engagement. These horizontal relations are attributed with the development and maintenance of effective government and a strong economy, amongst many other positive societal features (e.g. Putnam, 2000). In contrast, Bourdieu's social capital is concerned with a much broader spectrum of associations and their transmission into cultural and economic forms of capital. Understanding the distribution and structure of the different forms of capital within a society is defined as essential in understanding the functioning of the social world. Although trust does not feature within Bourdieu's theory, it is a central tenet within both Putnam and Coleman's interpretation. Social capital development for both these authors is dependent upon the formation of trust, which in turn enables individual group members to undertake favours for one another. Bourdieu and Coleman both value close knitted relations as a source of social capital, while Putnam emphasises the importance of networks of civic engagement.

Although Putnam's theory of social capital has dominated the recent literature, authors typically select the aspects of each theory best suited to their purpose and subsequently weaken the conceptual clarity. In attempting to capture its complexity, the identification of three distinct forms, bonding, bridging and linking, is argued here to represent a valuable contribution to the ongoing debate. Similarly, Szreter and Woolcock (2002, p13) describe this distinction as an important conceptual refinement. Section 3.2.1 established that bonding forms represent the focus of Putnam's theory, and equally for Bourdieu and Coleman, and is potentially damaging in the absence of bridging forms. The sources and level of functioning of each form is illustrated in Figure 3.1 below. As shown in Figure 3.1, bonding forms refer to cohesive, or close knit, relations within a group such as those held between friends. In contrast, bridging forms of social capital are generated by the relationships held between different groups or communities within the same layer of society (Narayan, 1999). The features of social interaction of significance here are respect and mutuality (Szreter and Woolcock, 2002). Thus, Narayan (1999) argues that bridging social capital is essential to the development of a cohesive society;

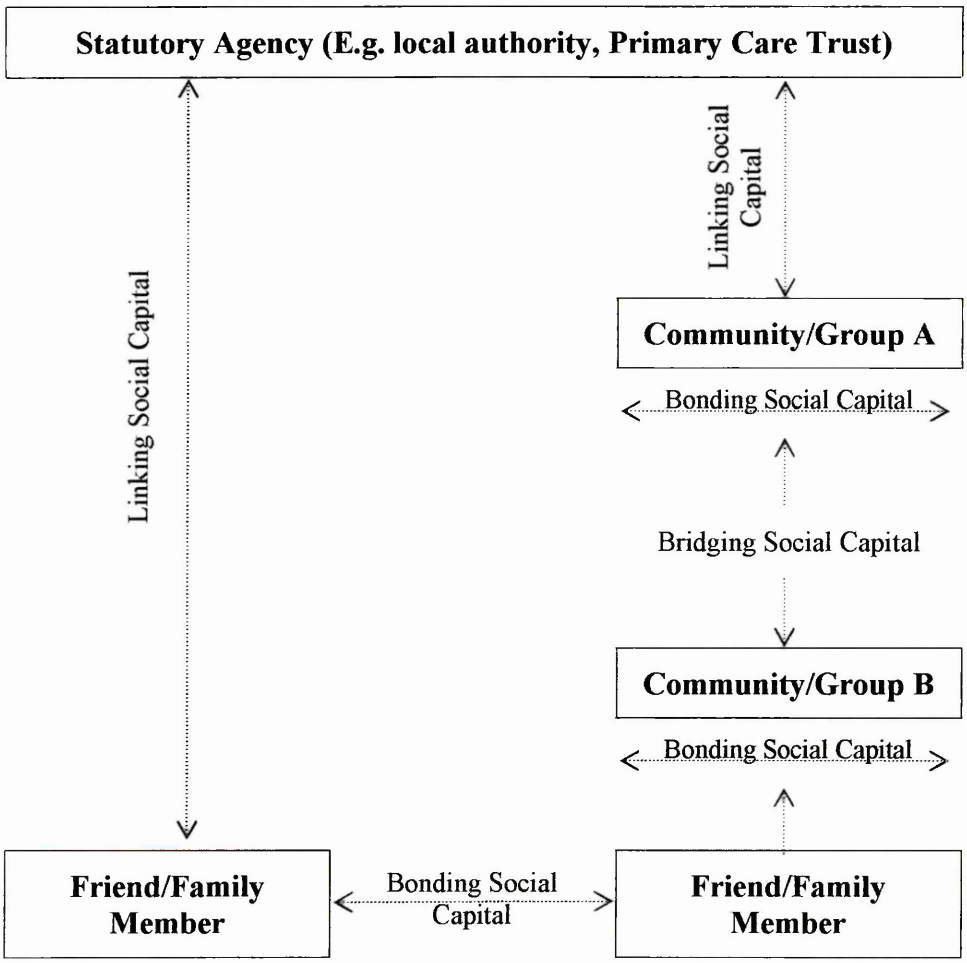
> while primary groups and networks undoubtedly provide opportunities to those who belong, they also reinforce pre-existing social stratification, prevent mobility of excluded groups, minorities or people, and become the bases of corruption and co-option of power by the dominant social groups. (ibid, p13).

For Narayan, the defining feature of bridging forms is the heterogeneity of group membership, with ties cutting across ethnicity, gender, class, religion and wealth (ibid, p7). Reflecting this diversity, bridging forms of social capital facilitate access to resources external to a community or group and therefore are important in enabling development (Putnam, 2000). Thus, there are clear parallels between bridging constructs of social capital and Granovetter's (1973) concept of weak ties (see Section 3.1 above).

As shown in Figure 3.1, it is also possible for bridging relations to form between two groups with diverging levels of power and status, such as between local government and communities. Relationships of this type are defined by Szreter and Woolcock (2002, p14) as a distinct subset of bridging forms and labelled linking social capital. Linking forms are generated by the ongoing interaction between actors of the state and

communities, with Szreter and Woolcock drawing upon the examples of formal education, medical practice and broader service delivery to illustrate such relations. At this level of functioning, the concept of embeddedness is of some significance and refers to the cross cutting ties between the state and communities (Evans, 1996). Social capital is thus developed when some element of the state becomes integrated within the community (ibid). For example, a local authority employed community worker can invest substantial time and effort into the development of an area and, over time, form trusting relationships with residents. Therefore the introduction of linking forms represents an important shift beyond the community level to incorporate hierarchical systems of power and control.

Figure 3.1: Forms of Social Capital



The relationship between government and social capital emerged as a central tenet within Putnam's theory (1993b) and social capital is defined as essential for its effective functioning. For Narayan (1999), bonding forms are largely irrelevant within this relationship, instead bridging and linking social capital are argued to represent the key

determinants. In this context, embeddedness enables the development of trust within governance, but additionally, and as stated in Section 3.2.1, systems of governance can shape stocks of social capital by determining the legal, constitutional and social infrastructures (Maloney et al, 2000; SEU, 2001; Alcock and Mason, 2001; Lowndes and Wilson, 2001; Szreter and Woolcock, 2002; Marinetto, 2003). Relationships of this type are described by Evans (1996) as complimentary, in that the actions are mutually supportive to both government and communities. In providing a new legislative framework for the implementation of involvement activities at the local authority level, the current policy context presents an opportunity to further examine the processes underpinning the formation of linking forms of social capital.

The policies reviewed in Chapter Two (see Section 2.2.1) suggest that there are two potential processes through which stocks of social capital can be influenced, the creation of opportunities for involvement and the support provided to enable their realisation (e.g. funding/advice/training). Depending on the response, the actions of local government can either mobilise or constrain social capital development (Putnam, 2000; Lowndes et al, 2002). In this sense, local authorities are "the gate-keepers to executive power and as the holders of significant resources, are crucial to creating the opportunities for active citizenship" (Marinetto, 2003, p110). In investigating the scope for local government influence upon social capital, Maloney et al (2000) found that over a half of the surveyed voluntary organisations in Birmingham maintained regular contact with both council members and officers and one third had received grant support. In representing both complimentarity and embeddedness, this interaction between local government and communities provides a means to develop linking forms of social capital.

Elsewhere, Lowndes et al (2002) found that although some local authorities had responded to the new requirements to involve communities (see Chapter Two, Section 2.2.1) by establishing devolved systems of administration, these structures failed to provide any genuine opportunities for involvement. Lowndes et al concluded that although the national policy creates a context in which local government can positively influence stocks of social capital, the outcomes are dependent upon each authority's interpretation of the new requirements. That is, tokenistic levels of involvement fail to establish ongoing interaction between local authorities and their communities. It is

suggested then, that there must be a commitment to the devolution of power to generate opportunities for social capital development.

The literature reviewed thus far suggests that social capital is a resource that facilitates action through the features of social organisation, such as trust and reciprocity. As perceived by Bourdieu (1997), social capital cannot be considered in isolation from economic and cultural forms of capital and any efforts to increase social capital must simultaneously consider these forms. Therefore, social capital is understood to be a mechanism through which access to other resources can be achieved, and a mechanism to which there is differential access (Baum and Palmer, 2002). This interpretation is conducive to a holistic approach to public health, as set out within Chapter Two, which tackles the wide-ranging determinants of health and thus is perceived to be the most appropriate for analysis within contemporary society. Finally, any analysis of social capital must consider the varying sources and subsequent forms to ensure its complexity is captured. The evidence of an association between social capital and health is explored in the next section to establish the potential for the formulation of public health interventions.

3.3. Social Capital: A Tool for Public Health?

Since Putnam's popularisation of social capital, the concept has been associated with a vast range of improved outcomes, including crime, economic development and health. The work of Richard Wilkinson in the United Kingdom and Ichiro Kawachi in the United States can be attributed with developing social capital into one of the most important contemporary concepts within public health. Since the mid-nineties, Wilkinson has undertaken a series of investigations that have led to a renewed interest in the relationship between the social environment and health. For Wilkinson (1997), the breakdown of cohesiveness in societies is attributable to levels of income inequalities, where cohesion refers to the extent of connectedness between different societal groups. His hypothesis of relative deprivation states that mortality rates are lower in those countries with the lowest income differentials, thus inequalities in income are responsible for health outcomes (Wilkinson, 1997). Absolute levels of income are dismissed as unimportant beyond the point of development at which the population's basic needs are met. Instead, it is the experience of the social hierarchy associated with income inequalities that is considered key in influencing health. As

Wilkinson describes, the hierarchy "presents itself as though it were a hierarchy of human adequacy from the most capable and successful at the top down to the most inadequate failures at the bottom" (1999, p13). Social comparisons elicit a sense of relative deprivation for those at the lower end of the hierarchy and become a source of anxiety as individuals fear they are less successful, less attractive, intelligent and socially inferior (Kennelly et al, 2003; Wilkinson, 1999, p13). In contrast, in more egalitarian societies, the experience of a social hierarchy is reduced and negative social comparisons replaced with a sense of confidence and ease. Social interaction here is guided by the norms of reciprocity and mutuality instead of individualistic material gain.

Michael Marmot and his colleagues have provided further evidence of the potentially damaging effects of social hierarchy upon health in a series of investigations known as the Whitehall studies. All participants were civil servants, thus variations in levels of deprivation were minimised (relative to the wider population). Despite this, a four fold difference in the mortality rates between the highest and lowest employment grades was reported (Marmot, 1999). Differences in mortality were not restricted to the extreme ends of the hierarchy, a gradient was found across the employment continuum, with participants at each employment grade having lower mortality rates than those in the grade directly below them. This finding led Marmot and his colleagues to argue that explanations for mortality rates must look beyond the established risk factors (Marmot and Smith, 1991). Like Wilkinson, Marmot suggests that psychosocial constructs are important in understanding inequalities in health. Further investigations have revealed that the degree of control exercised at work is an important explanatory factor, with the incidence of coronary heart disease reported as being twenty percent higher in employees with lower levels of control (Marmot, 1998).

However, some commentators are more cautious in embracing relative deprivation and concepts of hierarchies as key determinants of health and express concern that the theory serves to legitimise a rejection of the role of absolute income levels. George Davey Smith, John Lynch and their colleagues lead the attack on Wilkinson's work and in reviewing the available evidence, conclude that the association between income inequality and health is less consistent than suggested by Wilkinson. For example, Pearce and Davey Smith (2003) point out that in New Zealand, mortality rates have

fallen while income inequality has increased. Elsewhere, Lynch and his colleagues reported that the magnitude of the association was dependent upon which countries were included within the analysis (2000, 2001). These authors reject the psychosocial interpretation in favour of neo-materialism. At the centre of this approach is the notion that the societal factors responsible for the production of income inequalities are the same factors that produce the neo-material living conditions, such as housing, education and public health services (Lynch, 2000; Pearce and Davey Smith, 2003; Coburn, 2004). Thus, income inequality is viewed as only one manifestation of a wider set of background historical, political, cultural and economic factors and should not be used as the starting point in any theory of health inequalities (Lynch, 2000). Despite the ongoing debate within the literature, the two perspectives should not be viewed as extremes, but rather as complimentary. Indeed, proponents of both perspectives acknowledge that each approach has value if it acknowledges the potential role of both psychosocial and neo-material factors (Kawachi et al, 2002; Lynch et al, 2000a). As Wilkinson (1997, p184) himself states

> to think that the involvement of psychosocial processes in the relationship between income distribution and health means that we can forget about income distribution and concentrate on psychosocial interventions is the opposite of the truth. What it really means is that income distribution is an important determinant of the psychosocial welfare of a society.

The intensity of this debate, in focusing upon the concept of cohesion, has created a platform the entrance of social capital into the public health literature. In America, the work of Kawachi and his colleagues have served to consolidate social capital as an important concept within public health. Like much of the earlier social capital research, Kawachi et al (1997) utilised large-scale survey data to investigate associations between social capital proxies, trust and group membership, and health. In acknowledging that trust and group membership may fail in capturing all the features of social capital, they were measured as independent indicators rather than combined to create a single social capital. It was reported that both indicators were significantly related to mortality rates, with higher levels of trust and group membership being associated with lower mortality rates, even after controlling for income. Kawachi et al concluded that there was an association between levels of social capital and state-level mortality in America and, in resonating with Wilkinson (1997), suggested that social capital is the mediating link between income inequality and mortality.

More recently, Kawachi and his colleagues (1999) investigated the health effects of social capital at the individual level. Using secondary data, responses to "would you say that in general your health is excellent, very good, good, fair or poor?" (Kawachi et al 1999, p1188) formed a self-rated health measurement. Measures of social capital were obtained from the American General Social Survey and incorporated trust, reciprocity and group membership, all of which were aggregated to the state level. Increased levels of fair or poor health were reported in states with lower levels of social capital, an association that remained significant, albeit at a reduced level, after controlling for income. Kawachi et al reported that social capital, like social networks, exerted the same level of risk upon health as did smoking and obesity. However, it should be emphasised that despite reporting an association between social capital and health, the strongest predicator of health was found to be individual factors such as income, age, and race. Thus adding weight to the argument that social capital must not be utilised to legitimise a dismissal of structural factors (e.g. Lynch, 2000).

Lochner, with Kawachi and other colleagues (2003), expanded the existing evidence base to determine the extent of such associations at the neighbourhood level. Again, three social capital indicators, reciprocity, trust and associational membership, were drawn from secondary data. A complex statistical model was built to incorporate these indicators, together with mortality and deprivation rates. All three social capital indicators were reported to be lower within areas experiencing deprivation and Lochner et al concluded that social capital displayed an inverse relationship to mortality rates from all-causes.

Despite the eager acceptance of Kawachi's findings, contrasting evidence has been produced. For example, Kennelly et al (2003) found little evidence of a positive relationship between social capital and health. Kennelly et al's initial analysis revealed trust, membership of associations and voluntary work to be positively correlated to health but the strength of the relationship decreased as additional factors were included within the statistical analysis. As income was found to be positively associated with health, Kennelly et al argue that their findings serve as a reminder that social capital cannot be allowed to overshadow material influences upon health. In attempting to explain the contrast with the findings of others such as Kawachi (e.g. 1997), they

suggested that they had utilised a "more complete model of health" (Kennelly et al, 2003, p2375), rather than relying on correlation data alone. In conclusion, Kennelly et al criticised the reliance upon indicators of trust within surveys to capture the complex nature of social capital.

The rapidly accumulating evidence of a relationship between social capital and health within America led the Health Development Agency (HDA)[2] to explore the potential association within an English context. In one of a series of investigations, Cooper et al (1999), using data from the Health and Lifestyles Survey, General Household Survey and Health Survey for England, reported that social capital was associated with rates of limiting longstanding illness, general health and stress levels at the neighbourhood level. Interestingly, they found a gender difference, with high levels of social capital being associated with good general health and limiting longstanding illness among women only. Although social capital was found to be associated with health after controlling for socio-economic factors, the strength of the relationship was weaker than that between socio-economic status and health. As emphasised by Cooper et al, the social capital indicators used were originally designed for another purpose and as such, the findings should be interpreted with caution.

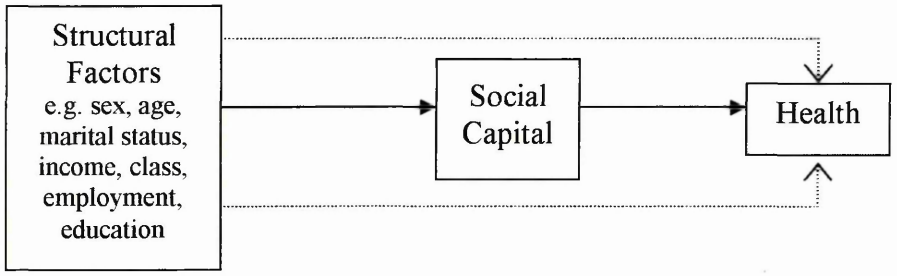
As a continuing part of the HDA programme of research, Pevalin and Rose (2003) examined the effects of social capital upon health utilising the British Household Panel Survey. Unusually, a theoretical model incorporating wider structural factors informed analysis. The model, shown in Figure 3.2 below, hypothesised that social capital moderated or mediated the effects of structural factors upon health and may itself be determined by structural factors. According to this model, social capital is disproportionately beneficial to those experiencing deprivation in that it represents a means to buffer against the potentially health damaging effects of life in poverty.

Their investigation utilised social participation, crime, neighbourhood attachment and contact with friends as proxies of social capital. Increased rates of mental illness and poor self-rated health were found amongst individuals with low levels of social participation, low neighbourhood attachment and experiencing high levels of crime. Low levels of social support, as measured by contact with friends, were also associated

[2] The Health Development Agency has now been disbanded and the National Institute of Clinical Excellence has subsumed its responsibilities.

with an increased likelihood of mental illness and poor self-rated health. In testing the hypothesised model shown in Figure 3.2, neither social capital nor social support was found to mediate or moderate the direct effects of structural factors neither upon health nor upon mental illness.

Figure 3.2: Proposed causal association between structure, social capital and health (Pevalin and Rose, 2003, p4).



Further analysis highlighted the issue of reverse causation inherent within health research; do low levels of social capital lead to poor health, or does poor health produce lower levels of social capital? They found that social capital and social support played only a minor role in the onset and recovery from health and illness and thus contradicted the earlier work of Berkman (1995) (see Section 3.1 above). However, Pevalin and Rose (2003) reported that common mental illness and poor self-reported health was associated with reduced levels of social participation. Age and education were also found to be determinants of level of participation, with older age groups and lower levels of education reducing the likelihood of social participation. Thus, it is clear that this social capital proxy is differentiated by structural factors and the equity of opportunities to develop the resource must be considered.

Findings that social capital is not necessarily a homogenous resource has led to increasing recognition that the use of large-scale population studies, which incorporate only a few variables, over-simplify the concept of social capital. More detailed understandings of the pathways by which social capital improves health are crucial, knowledge that can be obtained from detailed, qualitative studies of specific communities (Baum and Palmer, 2002). Importantly, a growing body of evidence obtained from qualitative studies is providing insight into the heterogeneous nature of social capital.

Baum and Palmer (2002) conducted forty interviews with residents in an Australian town to explore patterns of participation and perceptions of the community as a healthy place to live. The authors remind us of the importance of 'opportunity structures', the organisation of the physical and social environment, in shaping access to social capital. Baum and Palmer reported that the facilities and resources enabling residents to mix within neighbourhoods were highly valued. For example, children's play areas, parks and shops were perceived to serve as common meeting grounds in which interactions could take place and social relations formed. In addition to the physical space within an area, a biographical association was found to influence the sense of community experienced, which in turn influenced the participation within local activities. This finding supports previous research that has shown that a community's history is an important factor in determining willingness to participate (e.g. Goodman et al, 1998; Chanan et al 1999; Campbell and Jochelovitch, 2000; Raco and Flint, 2001).

Supporting an increasing body of research (e.g. Campbell and Gillies, 2001), fear of crime was a strong theme in Baum and Palmer's (2002) data. In conclusion, Baum and Palmer state that a community's social and physical infrastructure, through influencing opportunities for social interaction, is a determinant of social capital accumulation. Conceiving social capital as a resource offering inequality of access builds upon the earlier work of Baum and her colleagues (2000), who found that lower levels of involvement in both social and civic activities were associated with low income and educational levels. Baum et al (2000) argue that this provides reaffirmation of Bourdieu's social capital theory, with the results showing that social capital is determined by the availability of other resources.

Campbell et al (1999), as part of the HDA's series of investigations, utilised in-depth interviews and focus groups to examine community networks and relationships in ward-level communities in England. Two wards in Luton were selected, one of which was characterised by relatively low levels of health, and the other by relatively high levels. They found that levels of trust, perceived citizen power, "a belief in the power of ordinary people to influence local community life" (Campbell et al, 1999, p135), and civic engagement was higher amongst the high health ward; with perceived citizen control having the most important health-enhancing function. This interpretation of perceived citizen control appears to overlap with Bandura's concept of self-efficacy

(1997) and empowerment, both of which have a long history within public health (e.g. Laverack and Wallerstein, 2001). Despite having lower levels of perceived citizen control, Campbell et al (1999) reported that residents of the low health ward had higher levels of local identity and local community facilities. Campbell et al concluded that certain dimensions of social capital, and more specifically certain network types, as defined by Putnam, were more health enhancing than others. The authors suggested that the low health ward, in having a stronger identity, might have access to a restricted range of network and social capital types. This is suggestive of higher levels of bonding than bridging forms of social capital, a finding which lies in contrast with the hypothesis made elsewhere that it is bonding forms of social capital that present the greatest health benefits through an increased social support function (PIU, 2002). However, it does provide support for Bourdieu (1997) in that it emphasises the importance of diverse networks that would, according to Bourdieu, increase access to diverse resources. Furthermore, this finding has important implications for the national policy agenda, which has advocated the fostering of a sense of belonging as a means to increase cohesion within communities and thereby tackle inequalities (e.g. DH, 1999b). Campbell et al's (1999) finding therefore provides further weight to the argument that social capital alone cannot mediate the root causes of health.

Campbell and Gillies (2001) later carried out a 'micro-qualitative study' in two wards in the same town in the South East of England. Eliciting participants' life history revealed that romanticised views of the past were used as reference points upon which to interpret experiences of the contemporary community. Levels of trust were reported to have declined, although the interview extracts provided in evidence of this could equally be interpreted as being indicative of increasing fear of crime. It is likely that the two are inextricably linked; as Campbell and Gillies report, if people are too afraid to go out of their homes, they are less likely to participate within local activities which in turn is likely to mean fewer people are known in their locality. Again, the physical resources within an area were found to be an important determinant of social capital (see earlier discussion of Baum and Palmer, 2002). Their participants cited the increased safety measures taken now as a contributory factor to a decline in 'neighbourliness', making comparisons to the days when doors were left unlocked and neighbours encouraged to make spontaneous visits. The physicality of dwellings was also reported to be influential, with tower blocks having an absence of communal space together and a high

turnover of inhabitants, thus suggesting an absence of homogeneity within social capital as a resource. Further evidence for this conclusion was reported in the finding that time and energy resources were the principal factor cited for participation or non-participation. Socio-economic resources were also implicated in this relationship, with levels of participation lower in the more deprived ward, a finding that has been replicated elsewhere (e.g. Williams, 2002; McCulloch, 2003). Nevertheless, they conclude that social capital is not a homogenous resource that is equally created, sustained and accessed by all members of a particular community (Campbell and Gillies, 2001, p345).

It is clear from the literature reviewed thus far, that there is an implicit assumption that every social network equates to a stock of social capital. However, failure to consider the characteristics of each network inhibits understanding of the mechanisms that create and maintain social capital in its different forms. Instead, the extensiveness of social networks should represent the starting point of analysis, rather than the end point.

The work of Cattell and her colleagues has continued to contribute to understandings of social capital through qualitative research and has served as a reminder of the dangers of oversimplifying analysis. Cattell (2001) explored the relationship between social capital and health using self-reported health status and common sense understandings of health in two communities in East London. Resonating with research conducted elsewhere (e.g. Campbell and Gillies, 2001; Baum and Palmer, 2002), biographical history within an area and the facilities and resources within an area were reported to be a determinant of social capital stocks. Fear of crime yet again emerged as a key theme in this research.

Cattell (2001) reported that the majority of respondents did not participate within social and civic organisations and identified several distinct forms of resident's networks. The networks differed according to the level of closure, bridging and bonding ties; although Cattell does not utilise these terms. Health protecting or damaging attributes and attitudes were related to network type, for example hope, fatalism, pessimism, self-esteem, and perceptions of control. Those with more restricted networks were found to be more likely to express feelings associated with negative health outcomes. In contrast, those involved in local activities were argued to benefit from health promoting

qualities. The more highly active residents interviewed reported feeling in control of their lives, having higher self-esteem, and hope for the future for themselves, their families and their community. Like Campbell et al (1999), Cattell concluded that the more varied the network, the greater the range of resources accessible, and the greater the potential benefits for health. This finding thus highlights the growing concern that type of involvement and the nature of the association have not yet been effectively empirically investigated (Veenstra, 2000).

Cattell and Herring (2002), in further research in East London, confirmed earlier findings that the physical environment and historical associations within an area were important determinants of the experience of community. However, unlike much research that has dismissed formal forms of participation as being largely irrelevant to contemporary life (e.g. Baum et al, 2000), qualitative analysis revealed its' potential to exert both positive and negative influences upon health. Some community activists were found to have become disillusioned with the statutory sector as a result of repeated frustrations in trying to secure resources or facilities for their area; although the majority of individuals experienced increased confidence, a sense of satisfaction, esteem or reward, opportunities to acquire new skills and get to know people (Cattell and Herring, 2002, p74). Participation, both formal and informal, was found to be particularly important to well being when individuals experienced an illness or disability. Participation within this context served to provide a new sense of purpose to daily life, which would otherwise have lacked meaning. Thus, and contrasting with the work of Pevalin and Rose (2003), Cattell and Herring identify a potentially valuable role for participation in the recovery from or coping with illness and disability. This finding reiterates earlier work on social networks (Berkman and Glass, 2000) that suggests that engagement provides individuals and groups with meaningful social roles, and thus represents a potentially valuable resource for health promotion.

In a review of her research, Cattell (2004) identifies an additional, and important, condition for social capital, stability. She observes that housing allocation policies led to a decline in community spirit, with the demographic change altering the pattern of informal social control (p952). Residents interviewed reported that there was a need for newcomers to the area to learn the informal rules regulating interaction within the East

London estate. Thus, Cattell concludes that changes in the social structure damage the norms underpinning social capital.

3.3.1. Social Capital and Health: Understanding the Relationship

Like many features of the social environment, there is a wealth of research supporting an association between social capital and health but little evidence exists of definitive causal pathways. The hypothesised links build upon knowledge of the relationship between social networks and health and potential explanations can be categorised into two broad effects, contextual or compositional. Following this distinction, a compositional explanation would argue that the observed association was produced by the characteristics of the individuals who inhabit a given area rather than being an effect of living within that area. Such effects include social class, ethnicity and gender (Mallinson et al, 2003). In contrast, a contextual effect refers to the "features of the social or physical environment which influence the health of those exposed to it" (Berkman and Kawachi, 2000, p338). In the case of social capital, a contextual influence may be exerted in a number of ways, including; the adoption and reinforcement of health behaviour through norm transmission and information dissemination; mobilisation of collective action; and the provision of affective support.

Given the core features of social capital, it is easy to conceive the means through which social capital can potentially influence health behaviour. The increased levels of information sharing in a network characterised by high stocks of social capital can increase the dissemination of key health messages (Kawachi et al, 1999). However, it is equally conceivable that negative information could be transmitted through the same process. Similarly, and as suggested elsewhere (e.g. Lochner et al, 2003), social capital may influence health through shaping the behavioural norms within a group. Using the example of smoking, within a close group of friends, it is likely that the success of a cessation attempt by one member is likely to be increased when the remaining members are non-smokers. Within the group structure, the predominant behaviour is non-smoking, which serves to sanction the cessation attempt and provide a form of social control. Again, this process can also operate to damage health. Consider the same group of friends; if the group were largely smokers, then the cessation attempt would contravene the group's predominant behaviour pattern. Indeed, research has shown that strong normative pressures to maintain smoking behaviours have been exerted upon individuals (Stead et al, 2001).

For many authors, collective action is the core feature of social capital and it represents a third potential means through which an influence upon health can be exerted. As Berkman and Kawachi (2000) have argued, the facilitation of individuals to act co-operatively towards a mutual goal enhances the level of protection for local services. For example, action groups typically form when a perceived valuable local service or amenity is threatened. Through a series of co-ordinated actions, such as petitions or protests, the group may succeed in protecting a key local service. The health benefits of the preservation of a local school or health centre can be easily conceived. Equally, as described by Kawachi (2001), the same process can operate at the level of the state with participation within the political process securing benefits such as health care and education.

These potential pathways echo those presented earlier in Section 3.1 in relation to social networks and health. Lochner et al (1999, p269) correctly raises the question, what is the added value provided by the sole focus upon social capital? As argued by Kawachi and Berkman (2000), this is perhaps best answered by establishing the conceptual boundaries, if any, between social capital and related concepts such as social networks, cohesion and empowerment. Elsewhere, it has been suggested that social capital builds upon community development research that has pointed to links between participation, empowerment and health (Campbell and Gillies, 2001).

Given the continued absence of a consensual definition of social capital, and importantly, a conclusive pathway to health outcomes, further research is required (Lochner et al, 1999; Lynch et al, 2000b; Kawachi, 2001). As a growing body of qualitative studies reveal, social capital is not a homogeneous resource and the factors determining access to it must be explored. This interpretation of social capital resonates with the model of health presented in Chapter Two (see section 2.1); a wide range of interdependent factors determines health and it is difficult to conceive how investment in social forms of capital alone will secure health improvements (Kawachi, 2001, p33).

Despite the absence of a consensual definition, it is clear that any theory of social capital focuses upon the features of social and civic relations that enable the achievement of outcomes, either at the individual and collective levels; where these

features include trust, norms and information sharing. Utilising the term social and civic relations allows analysis of both informal and formal networks, and thus incorporates both family relations and formal group membership. Perceiving social capital to be a facilitator of both individual and collective action has been argued elsewhere to be the most advantageous approach in advancing the concept (Dekker, 2001, Jochum, 2003; Pevalin and Rose, 2003). As Pevalin and Rose (2003) have argued, social capital can be the property of both individuals and the wider community, "these are not mutually exclusive, are partially interchangeable, and the amount of social capital in the community is not the simple addition of the social capital of the individuals within the community" (p3).

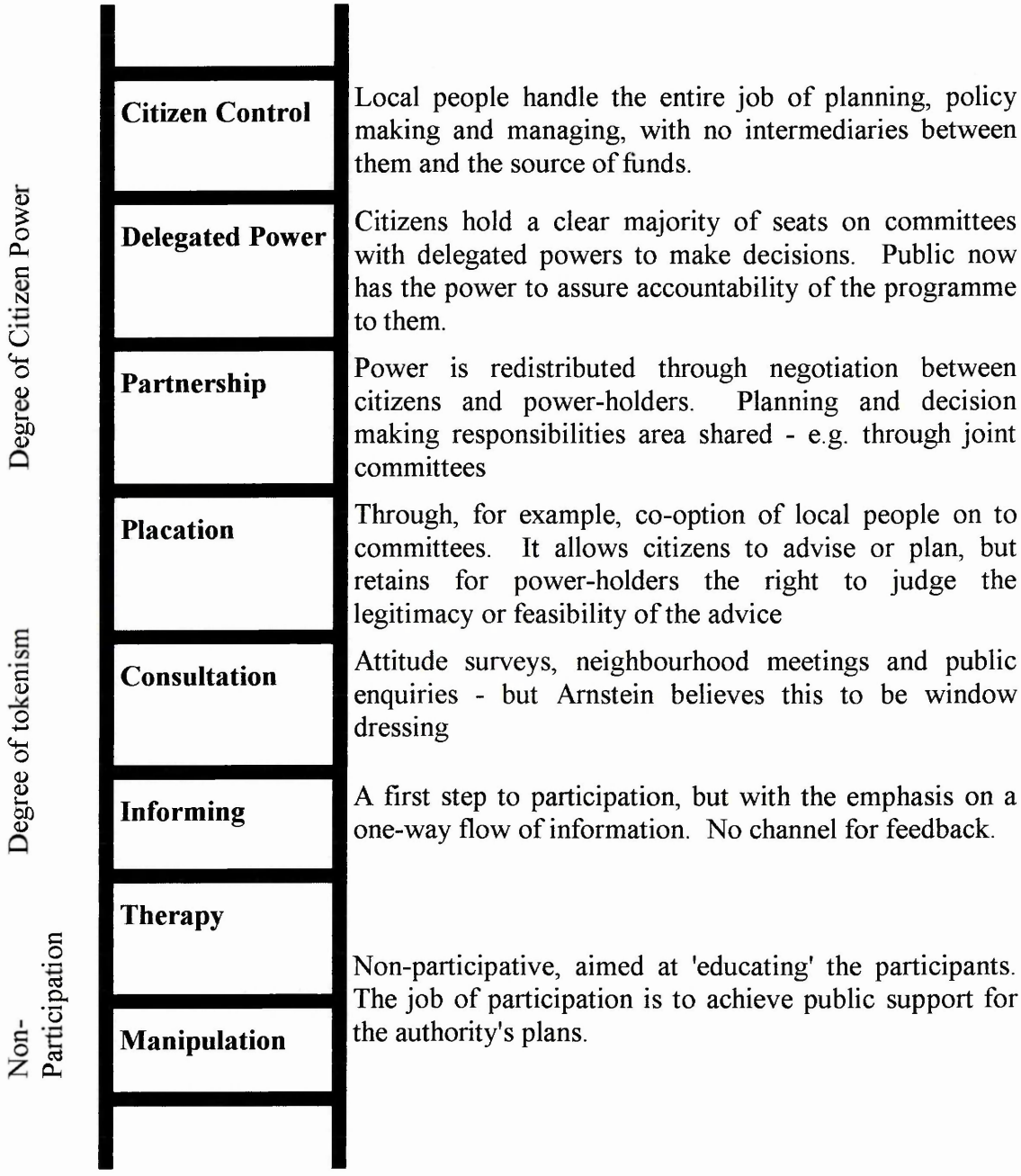
Throughout the preceding discussion, the overlaps between the theory of social capital and the current policy agenda have been highlighted. The provisions for increased levels of community involvement within this agenda have clear implications for the number and structure of networks held within and between communities. As such, the potential for enhancing stocks of social capital is apparent. The work of Maloney et al (2000) and Lowndes et al (2002), for example, have shown that local government can shape social capital but the direction of the relationship is largely dependent upon the interpretation of involvement. To enable understandings of how increased opportunities for involvement may influence levels of social capital, it is necessary to establish the differing models of involvement. Section 3.4 below explores these models.

3.4. Defining Community Involvement

Although involvement within the current policy context refers to all local partners, it is the involvement of communities that is discussed here. Despite the increased opportunities for community involvement introduced within the Local Government Act 2000 and subsequent policy guidance (e.g. DETR, 2001a; 2001b), the actual process of involvement remained open to the interpretation of individual local authorities. Given that community involvement has been defined and practiced in many different ways, from attendance at a public meeting or individual involvement within community activities to the delivery of public services by the community and voluntary sector (DETR, 1997; Chanan, 2002), the potential to enhance levels of social capital may not be realised by all local authorities. The diverse application of the term has led to numerous interpretations and its synonymous use with the related terms of engagement

and participation. An array of models have been developed to capture this diversity; one of the most cited models remains Sherry Arnstein's (1969) ladder of participation, shown in Figure 3.3 below.

Figure 3.3: Arnstein's (1969) ladder of participation



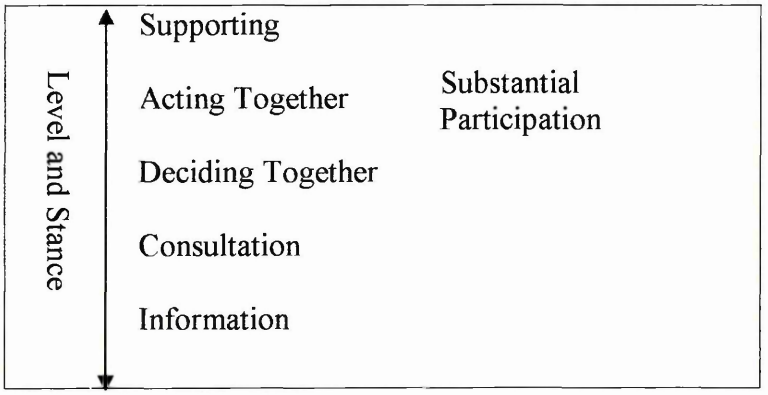
Arnstein (1969) depicts participation as a range of distinct processes, ranging from the provision of information to communities in control of action. Each level of participation occupies a 'rung' in a hierarchy, with non-participative approaches at the bottom and citizen power at the top. The opportunity for groups or communities to

influence action increases with each rung, thus power differentials are central to Arnstein's model.

Applying the concept of social capital to this model, it is clear that there are limited opportunities for the formation of sustained networks, or embeddedness (Evans, 1996), at the lower levels of participation. Despite this, effective implementation of the four lowermost levels may serve to increase levels of trust in public bodies and thereby provide the foundations for the future development of networks between communities and local government. In contrast, partnership, delegated power and citizen control approaches to participation are dependent upon the formation of relations centred upon a shared goal. The development of norms such as reciprocity will be determined by the structure and purpose of the individual network.

However, the hierarchical implications of Arnstein's ladder have been criticised for devaluing the forms of involvement represented on the lower rungs (Martin and Boaz, 2000). Martin and Boaz argue that while information provision does not facilitate devolution, it is still a necessary and essential component of democratic governance. Proponents of this perspective favour an alternative interpretation of involvement processes, such as that made by David Wilcox. Wilcox (1994) altered Arnstein's model to create a framework of participation in which the potential value of each level is recognised. The model aims to provide a practical tool to practitioners seeking to involve people within their structures or processes. Wilcox's model, shown in Figure 3.4 below, describes participation as constituting five stances; information; consultation; deciding together; acting together; and supporting independent community interests.

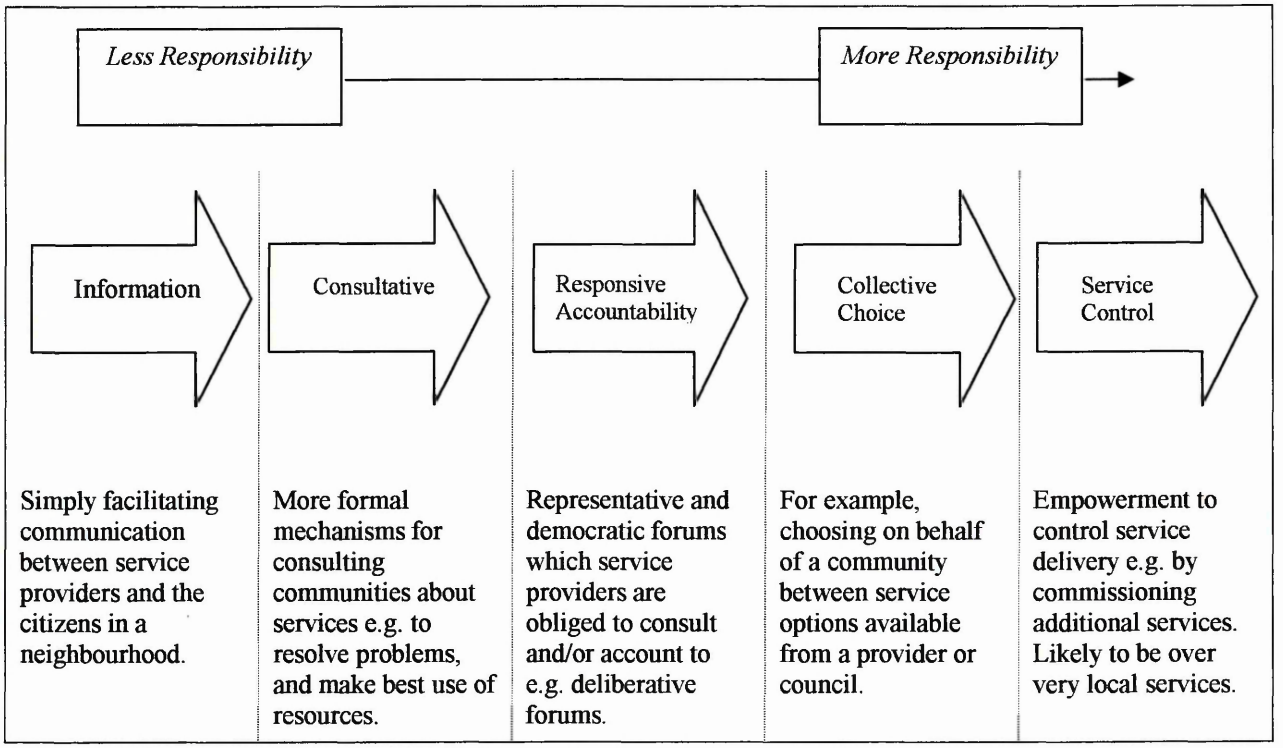
Figure 3.4: Wilcox's Model of Participation (Wilcox, 1994).



For Wilcox then, information provision offers a minimum level of participation; consultation builds upon this by allowing feedback but control remains largely with the initiator. Yet higher levels of control are given in the third level where people are invited to participate within decision making. Control then increases to carrying out the actions within acting together, and finally, people can be supported to act independently through a system of advice and support. Like Arnstein's model, power and control differentiate each level; the level of devolution, or stance implementation, is dependent upon the needs and wishes of the initiator. For example, if a local council is legally required to undertake a particular course of action, then Wilcox argues that information provision is the best response. However, when there is more than one course of action available, consultation should be undertaken. In contrast, if the initiator wishes to facilitate the empowerment of a particular group, then the fifth stance, supporting local initiatives should be adopted. Despite the importance of power within Wilcox's model, its devolvement is more limited than Arnstein's model with the uppermost level, supporting, implying that communities are never enabled to obtain full control over, for example, the delivery of a service. Nonetheless, the opportunities for social capital development replicate Arnstein's model, in that they increase with the level of devolved power and control.

Recently, the government has presented a further alternative interpretation of involvement; this is shown in Figure 3.5 below (ODPM, 2005). Again, information and consultative processes are depicted at the lower end of the spectrum and service control at the top. However, unlike the models of Wilcox and Arnstein, the level of responsibility held by people differentiates the different stages. For example, a voluntary organisation would be assigned financial, administrative and legal responsibilities when controlling service provision. Popple and Redmond have argued that responsibilities are central to the New Labour interpretation of active citizenship; people are expected to contribute towards their communities in a "something for something society" (Popple and Redmond, 2000, p397). Although this model provides much needed clarification of the government's interpretation of involvement, its strength in guiding the practical implementation of involvement processes is unclear.

Figure 3.5: The Spectrum of Responsibilities (ODPM, 2005, p14).



These models reiterate the earlier statement that community involvement is not a single entity, but a range of processes offering differential levels of influence to communities and groups. All forms of community involvement hold some value, when implemented appropriately, but there is a clear hierarchy of activity with approaches at the higher end of the ladder or spectrum presenting improved outcomes for all parties. Evidence obtained from decades of community involvement within regeneration initiatives (e.g. Hastings et al, 1996) has shown that it is an essential component of effective decision making and partnership working. This is achieved, in part, through the unique knowledge and understanding of local problems or needs held by communities. This represents a valuable resource that no number of officials can provide (Campbell and Jovchelovitch, 2000; DETR, 1997; Skinner, 1997; Taylor, 2000). It is important to emphasise that poorly managed involvement can produce the opposite effect. Previous involvement efforts have shown that seeking the views of the public in consultation processes without any intention to use this information to inform decision making will do little other than hindering future involvement activities by damaging levels of trust between communities and local government (e.g. Joseph Rowntree Foundation, 2003).

Secondly, involvement contributes to the achievement of sustainability. Involving local communities and residents within the delivery of a service facilitates the development of

a sense of ownership over that service. This in turn increases the likelihood of local communities guarding and protecting the improvements achieved beyond the duration of the initiative itself (Hastings et al, 1996). In the absence of a sense of ownership, initiatives may succeed only in generating rejection by local communities and subsequent alienation from the outcomes (Armstrong, 1993; DETR, 1997; Twelvetrees, 2002). For example, a new community centre developed in the absence of community involvement is unlikely to be well utilised.

Sense of ownership and effective decision making are, at least to some extent, achievable at each level of community involvement, albeit dependent upon successful implementation. However, higher levels of community involvement have the potential to provide additional outcomes within the community itself, namely the development of skills and confidence (Taylor, 2000). It is at this level that the theory and practice of community development enters the debate.

3.4.1. Community Development

Each of the above models present a level of involvement at which communities or groups are in control, however, they do not incorporate analysis of the resources required to participate at this level. In reality, people may not have the time, skills, knowledge, or even desire, to participate in the means offered by the initiator. For many commentators and practitioners, effective involvement can only be secured by a process of community development (Armstrong, 1993; Chanan et al 1999; Duncan and Thomas, 2000; Smith and Beazley, 2000). It is through this process that the powerless sectors of a population are enabled to regain control over the factors that affect their lives and participate fully within society.

The renewed emphasis upon the principles of involvement within the UK policy agenda has led to the development of a consensual approach to community development. This shift has been led largely by organisations such as the Community Development Foundation and the Community Development Exchange (formerly the Standing Conference for Community Development). The Community Development Exchange defines community development as a process that joins up environmental, economic, social, demographic, technological, political and other issues empowering communities to work on their own agendas to improve quality of life (SCCD, 2001, p2). In aiming to remove the barriers preventing participation within the issues determining quality of

life, it is therefore a "distributive process, concerned with the allocation of resources and power to citizens within a pluralist framework" (Shaw and Martin, 2000, p402). As this definition suggests, no single action or initiative would succeed alone, and as such, community development is perhaps most usefully conceived of as a range of practices (Gilchrist, 2003; Robinson and Elliott, 2000), or as an "umbrella term" (Henderson, 1995, p10). To clarify the practice of community development, the SCCD identified the values and commitments underpinning activities distinct to community development. These are shown in Table 3.1 below.

Table 3.1: The Values and Commitments of Community Development
(Source: SCCD, 2001, p3-4)

Values	**Description**
Social Justice	Enabling people to claim their human rights, meet their needs and have greater control over the decision-making processes which affect their lives.
Participation	Facilitating democratic involvement by people in the issues which affect their lives based on full citizenship, autonomy, and shared power, skills, knowledge and experience.
Equality	Challenging the attitudes of individuals, and the practices of institutions and society, which discriminate against and marginalise people.
Learning	Recognising the skills, knowledge and expertise that people contribute and develop by taking action to tackle social, economic, political and environmental problems.
Co-operation	Working together to identify and implement action, based on mutual respect of diverse cultures and contributions.
Commitments	
Challenging discrimination and oppressive practices within organisations, institutions and communities.	
Developing practice and policy that protects the environment.	
Encouraging networking and connections between communities and organisations.	
Ensuring access and choice for all groups and individuals within society.	
Influencing policy and programmes from the perspectives of communities.	
Prioritising the issues of concern to people experiencing poverty and social exclusion.	
Promoting social change that is long-term and sustainable.	

Reversing inequality and the imbalance of power relationships in society.
Supporting community led collective action.

The term community development must be distinguished from a related, but separate term, capacity building. As Skinner (1997, p1-2) has defined, capacity building is

> development work that strengthens the ability of community organisations and groups to build their structures, systems, people and skills so that they are better able to define and achieve their objectives and engage in consultation and planning, manage community projects and take part in partnerships and community enterprises.

Although clearly a developmental process, the process itself is typically defined by an external agent and is therefore contrary to the underpinning principles of community development.

The processes of empowerment, learning and democracy underpin these values and commitments. Social justice demands that work is undertaken with people rather than for them and the imposition of solutions or structures is avoided. As such, community workers adopt a supportive and enabling role and work with communities to develop both informal networks and formal organisations that will challenge and re-negotiate existing power relations (SCCD, 2001, p8). It is this way of way of working that facilitates a process of empowerment, both at the individual and community level (Lindsey et al, 2001). Empowerment was reported to be an important concept within the pubic health literature in Section 3.1 above. As individuals and groups become increasingly empowered, or levels of efficacy are enhanced, they are enabled to climb the ladders of participation. In the absence of such a process, it is unlikely that communities will regain control over the issues that determine their quality of life (Laverack and Wallerstein, 2001).

Community development also enables a process of learning. Through involvement within the activities of a community group, there is an acquisition of skills, knowledge and understanding. This in turn increases confidence and enables individuals to occupy new roles and responsibilities both within and out with the group structure, for example, within a formal regeneration partnership. Through the empowerment and learning

processes, community development aims to increase awareness of the issues that affect people's lives, together with a desire to change them. It is through this feature that the influence of the work of Paulo Friere can be most clearly seen. Friere's (1970) work on the conscientisation of oppressed sections of society has developed many of the ideas underpinning contemporary approaches to community development. Through a process of conscientisation, individuals are enabled to recognise the social, political and economic conditions that oppress them and eventually a state of praxis is reached, that is, a common understanding and development. This in turn enables collective action to transform the oppressive local circumstances.

The potential of community development to transform communities has secured its position as an important process within public health. Indeed, it has been utilised as a means to secure improved outcomes in a diverse range of projects (e.g. Robinson and Elliott, 2000; Lindsey et al, 2001). Reflecting this, the Department of Health advocates its use in tackling coronary heart disease stating that it enables "communities to make their own decisions about how to achieve better health for themselves, their families and the wider community" (DH, 2000b, p19). However, it also represents an important generic strategy to tackling inequalities and thus presents a potential vehicle for the effective application of a holistic model of health (see Chapter Two, Section 2.1 for further discussion). That is, by enabling communities themselves to identify and address their needs, the subsequent action will not become departmentalised into a single government agency. Equally however, demonstrating the value of such an approach within the context of national targets is difficult (see Section 3.1).

Despite the centrality of empowerment within community development, the implicit power differentials are rarely discussed. Similarly, recognition of the tensions inherent within the process is largely absent from the literature and government policies. Given that community development aims to enable the powerless to regain control over the issues that determine their quality of life, it follows that another individual or body must be prepared to devolve their existing level of control. Within the context of present policy agenda, the tensions between representative and participatory forms of democracy remain unresolved (Raco and Flint, 2001). Furthermore, questions remain over the legitimacy of those members of a community who are empowered to vocalise the needs of their local area. That is, do their needs reflect those of the wider

community? As Laverack and Wallerstein (2001) observe, it is possible that the empowered individuals have the energy, time and motivation to participate and may serve to exclude the wider community. A third tension also exists in community development in that it is typically an external agency that facilitates the empowerment process, thereby, the community is dependent upon the resources provided by this body to achieve the end goal. Each of these tensions requires careful consideration in the implementation of any approach to community development.

3.5. Conclusions

It is suggested then that community involvement, informed by principles of community development, can help to overcome, alienation, isolation and despair among local people by giving them some control and ownership of local developments (Chanan et al, 1999). At the centre of any approach to community development is the creation of local networks and therefore the overlaps with social capital are clear. Indeed Putnam (2000) has identified community development as an effective means of creating the resource. Social capital (e.g. Pearce and Davey Smith, 2003), and empowerment (Labonte, 1994; Starkey, 2003), have been criticised for failing to consider the wider structural factors that determine health; utilising Bourdieu's (1997) interpretation forces simultaneous analysis of capital in all its forms and thus can potentially redress this imbalance. Such an approach would enable the new opportunities for community involvement to represent an important tool for public health. However, no single presentation of social capital has thus far succeeded in capturing the complexity of its different forms. In particular, the increasing evidence of heterogeneity in access to social capital warrants further investigation before conclusions are drawn on its value to public health.

Chapter Four

Exploring Community Involvement and Health: The Methodological Approach

4.1. Theoretical Perspectives

Although no single theoretical perspective has been adopted, social capital has been a central theory within the development of the research approach. The literature reviewed in Chapter Three led to the definition of social capital as the features of social and civic relations that enable the achievement of outcomes, both at the individual and collective levels; where these features include trust, norms and information sharing. Similarly, this review highlighted the importance of incorporating social capital in its various forms, and the localised context in which they arise, within any analysis. The categorisation of social capital into distinct forms, bonding, bridging and linking, has progressed the concept beyond the universal good portrayed by Putnam (2000). Instead, there is growing consensus that bonding forms, in the absence of bridging and linking social capital, can serve to perpetuate inequalities rather than eradicate them (Harpham et al, 2002). Reflecting this assertion, previous research has shown that social capital is not a homogeneous resource, instead, access is regulated by a range of factors such as gender (Sixsmith and Boneham, 2002); ethnicity (Campbell and McLean, 2002), social position (Sharp, 1999; Baum et al, 2000; Campbell and Gillies, 2001) and age (Baum et al, 2000; Cattell and Herring, 2002). Given such empirical evidence, understanding the local context in which social capital is developed is essential to capture its complexity.

To investigate social capital in all its forms (bonding, bridging and linking), examination of the different sources was required. That is, Chapter Three (see Section 3.2.4) suggested that bonding, bridging and linking forms of social capital are generated by the formation of relationships both internal and external to local communities. Therefore a methodology was developed that enabled investigation across community, town and District levels. Bourdieu's presentation of social capital as one of four forms of capital was also of significance. In emphasising that the volume of social capital available to communities is dependent upon the possession of economic and cultural forms of capital, this interpretation supports the adoption of a social model of health. For example, Figure 2.1 presents health determinants as interdependent layers and

suggests intervention is required at all layers to ensure improved health outcomes. Given this stance, health was explored from the broader perspectives of well being and quality of life to facilitate discussions of health beyond the interpretation of being simply the absence of disease.

Chapter Three, Section 3.3 reviewed the varying methodological approaches of previous investigations of social capital and health and concluded that large scale surveys failed to capture the complexity of the concept. Instead, social capital is increasingly accepted as a heterogeneous resource shaped by the local context in which it is generated. For example, Baum and Palmer (2002) emphasised the importance of physical space in shaping opportunities for interaction and bonding forms alone are likely to increase existing social stratifications (Narayan, 1999). Therefore, understanding of social capital is best advanced by qualitative analysis of specific communities (Johnston and Percy Smith, 2003). A qualitative methodology allows identification of the complex factors both enhancing and constraining the development of the different forms of social capital. In the absence of such knowledge, the variables incorporated within quantitative analysis will represent an incomplete model and, in this sense, support is given to Campbell and McLean's (2002, p31) assertion that converting the concept into a "hard nosed epidemiological variable is premature."

Thus, the literature guided the adoption of a qualitative case study, a methodological approach that enables examination of both context and of the perspectives of those researched. Qualitative research has been defined by Denzin and Lincoln as the study of "things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (2003, p5). It enables the development of concepts that help advance understanding of social phenomena in natural settings, thus giving emphasis to the meanings, experiences and views of the researched (Pope and Mays, 1995). To enable the methodology to be refined and developed further a preliminary, or familiarisation, stage of research was undertaken, an approach which has proven to be successful elsewhere (Crowley et al. 2002). This stage served to develop knowledge and understanding of the context of the research location.

As set out in Chapter One, all research was located within the Wakefield District in West Yorkshire. The preliminary research involved visiting the towns and villages of

the Wakefield District, where informal discussions were held with representatives from organisations and groups involved within community involvement processes. This stage enabled several key outcomes; it contributed to an understanding of the diversity of the District (e.g. urban/rural, industries, relative deprivation and affluence); it enabled the development of an appreciation of the history of community involvement; it created a sense of and 'feel' for the communities; it enabled the identification of key structures, organisations and groups; it led to the development of relationships with gatekeepers and therefore secured subsequent access requests; and finally it provided an opportunity to identify previous and ongoing research and thus reveal areas potentially experiencing research fatigue and general apathy. Importantly, the overall effect of this stage was to enable the development of research questions, initially generated from the preceding literature review, which were appropriate and relevant to the context in which the research was to be located.

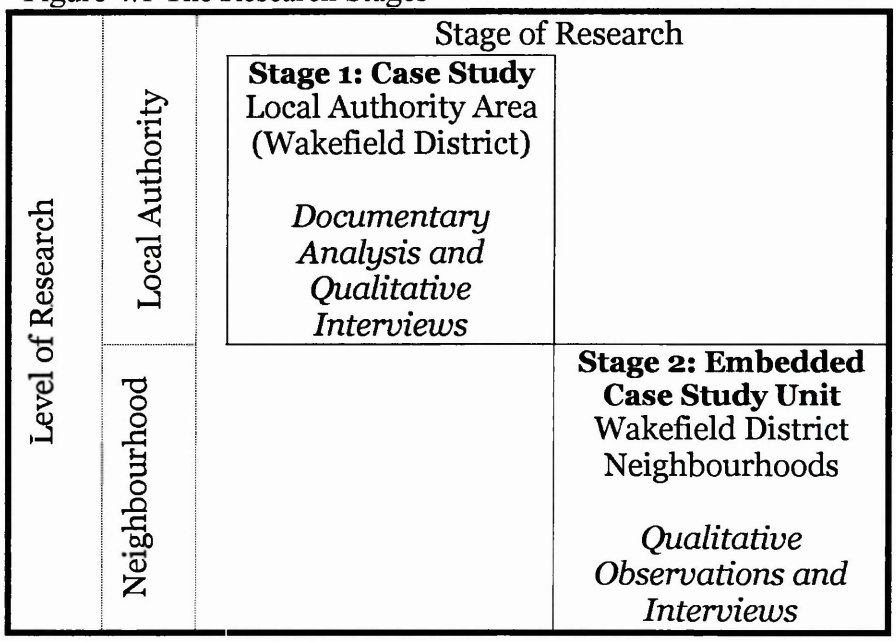
4.2. Research Overview

As stated within Chapter One, the aim of this thesis is to explore the relationship between community involvement and health and to establish the utility of social capital in advancing understandings of any relationship. To realise this aim, the research strategy comprised two stages. Representing the first stage of an embedded case study (Yin, 1994), and providing the context in which subsequent research would be located, the Wakefield District's strategic approach to community involvement, and the influences of national policy upon it, was examined. This stage constituted an analysis of key community involvement policy and strategy documents and in-depth qualitative interviews with organisational representatives central to this process. The final stage, and the second part of the embedded case study, selected a community group operating at the neighbourhood level with the aim of exploring the potential influences of community involvement upon health. Alternatively, the research can be defined according to the level of analyses; the local authority level response to the national policy agenda and secondly, the neighbourhood or community level. Figure 4.1 below illustrates the stages of research.

Investigation at each of these levels enables analysis of the translation of involvement policy into practice at the level of the community. Although the two stages can be viewed as distinct pieces of research, it is their culmination that ultimately realises the

thesis aim. It should be noted that as the policy supporting the implementation of the community involvement processes refers almost exclusively to England, the term national here relates to England only.

Figure 4.1 The Research Stages



Reflecting this, research questions were devised to guide research at each level. The objectives set out within Chapter One represent the primary question addressed at each stage of the research; these are presented and delineated below.

1. ***How has national policy and legislation influenced community involvement processes at the local authority level?***
   a. *How is community involvement defined within related documentation at both a national and local authority level?*
   b. *How is community involvement defined in practice?*

2. ***Is community involvement important for health and well being?***
   a. *What are the outcomes of community involvement?*
   b. *Are the outcomes potentially determinants of health?*
   c. *How do community activists perceive their own health?*
   d. *What are the perceived influences on health?*

3. ***Is social capital important in understanding the relationship between community involvement and health?***

a. *Can the Wakefield District approach to community involvement shape stocks of social capital?*

b. *What factors determine social capital development?*

c. *Are different factors important for different forms of social capital?*

d. *Is social capital a necessary resource to produce health promoting outcomes?*

4.3. Stage 1: The Wakefield District Community Involvement Framework

With a population of over 315,000 (Census, 2001), the Wakefield District is one of five metropolitan districts in West Yorkshire and includes the main population centres of Wakefield City, Ossett and Horbury in the north west; the five towns of Normanton, Castleford, Pontefract, Featherstone and Knottingley in the north east; the rural communities in the central part of the District; and Hemsworth, South Elmsall, South Kirkby and Upton in the south east. It should be noted that hereafter, all towns and villages will be referred to by an assigned pseudonym.

In the last twenty years, the local economy has undergone a dramatic restructuring with the decline of coal mining and other traditional industries. In 1981, 17,000 people were employed in the mining industry in the District, twenty years later this was reduced to under 500 (HAZ, 1999). Like many coalmining areas, it was the speed of the closures that proved to be as damaging as the job losses themselves, with the local skill base not easily transferable to other industries (ibid). Today, the local economy is experiencing growth within distribution, transport, finance and public sectors (Wakefield First and WMDC, 2003). However, the District remains characterised by a low wage, low skill economy with the highest proportion of low skilled workers in West Yorkshire (Lee et al, 2002). Like many local authority areas though, this masks a more complex picture of relative decline and affluence. Many of the towns and villages in South and East of the District were dependent upon, and often built up around, traditional industries, particularly coal mining and manufacturing. Housing in these areas is generally of low value relative to the rest of the District, with low demand becoming an increasing issue (Lee et al, 2002). In contrast, Lee et al report that the North and West of the District, as house prices in Leeds continue to increase, are experiencing a population increase. Table 4.1 below contains the key deprivation statistics for the District.

Table 4.1: Wakefield District Index of Multiple Deprivation Statistics (Source: DETR, 2000)

Domain	No. of Wards in Most Deprived Bands in England		National Rank of Wards (Out of 8,414, where 1 is the most deprived)
	10%	20%	
Income	1	12	2218
Employment	6	13	1753
Health	10	15	1411
Education, Skills and Training	7	10	2422
Housing	0	1	3502
Access to services	0	0	4519
Child Poverty	1	10	2390
Overall IMD	5	13	1994

Table 4.1 illustrates the significant health deprivation across the Wakefield District, indeed eight out of the ten most health deprived wards in West Yorkshire, a sub-region which includes both Bradford and Leeds, fall within the District (Robinson et al, 2003). It is perhaps unsurprising that the Wakefield District was awarded Health Action Zone status in 1999. Despite this pattern of deprivation, Lee et al (2002) argue that Wakefield does not experience the same intensity of social and economic problems as in other parts of Yorkshire, such as Bradford, Barnsley and Leeds. Instead, it has been found to have 'pockets' of deprivation throughout. Therefore, the Wakefield District can be characterised as an area subjected to substantial, but differential, deprivation. The value of the analysis enabled by Bourdieu's (1997) theory of capital is thus clear in this context. For Bourdieu, the volume of capital possessed is determined by the ability to translate one form into another. In the Wakefield District, the statistics suggest that access to economic and cultural capital will be limited in some communities, and it therefore follows that there will be unequal access to social forms.

4.3.1. A Qualitative Case Study

At this analytical stage, the local authority area operates as a large-scale case, where a case study is defined as an inquiry that "investigates a contemporary phenomenon within its real life context" (Yin, 1994, p13). Given the argument made here that analysis of context is essential to advancement of understanding of the relationship between involvement and health, a case study was considered the most appropriate research strategy. Furthermore, the complexity of the analysis across different

geographic layers necessitated the establishment of clear boundaries in which to locate the investigation. The case study approach utilised here represents what Yin describes as an embedded case. An embedded case study involves the selection of a single case, in this instance the Wakefield District local authority area, which holds more than one unit of analysis and attention is given to these sub-units. In the second stage of the research strategy, analysis will focus upon a community group operating within a distinct area of the Wakefield District, or sub-unit, thus constituting an embedded case study. Involvement at this level functions within the framework provided by strategic interpretations of involvement; understanding this strategic approach was identified as essential in determining the local context in which involvement processes are implemented.

The national policy agenda, as reviewed in Chapter Two, placed increasing emphasis upon strengthening communities as a means to achieve development and tackle inequalities. Legislation introduced within the Local Government Act 2000 and subsequent guidance required local authorities to secure the involvement of their communities within decision making structures. Involvement in this context was presented as a potentially empowering process (e.g. DETR, 2000a) and thus represented a key component of action to achieve strengthened communities. As such, the Wakefield Metropolitan District Council, alongside its partners, was required to develop a new framework to support this involvement. The interpretation of the new requirements to involve communities has potentially important implications for the formation of social capital. In establishing new relationships between local government and their communities, there are clear opportunities to enhance stocks of social capital (see Chapter Three, Section 3.2.4 for further discussion).

The objective of this research stage was therefore to determine how community involvement processes had been defined and implemented within the Wakefield District. The Local Government Act and associated policies required the introduction of a new community strategy and local neighbourhood renewal strategy. These documents present the overarching framework in which all actions to improve quality of life are undertaken. Additionally, both strategies present formal definitions of community involvement, reflecting the importance assigned to the participation of communities within their development (e.g. DETR, 2000b; see Chapter Two, Section

2.2.1 for further discussion). Therefore, analysis of the two strategy documents, and associated subsidiary publications, represented the first component of this research stage. It is useful at this point to report that the original aims and objectives of this thesis centred upon involvement of the community and voluntary sectors within the development of the local authority's community strategy. However, with the publication of the community strategy delayed until October 2003 (the research process began in 2002), the timescale of the research programme prevented such a focus. As such, the research emphasis shifted to the broader community involvement mechanisms developed with the continued evolution of the local authority.

The documents analysed represent the formal response to the national legislation and guidance. As Lowndes and Leach have argued, "formal statements set out the basic parameters for action... but 'rules in use' may vary considerable from 'rules in form'" (2004, p561). That is, the definitions set out within formal policy are not necessarily synonymous with the interpretations held by individual actors. Therefore, a complete analysis of the Wakefield District's community involvement framework required examination of the definitions held by individual actors central to the implementation of the new approach. Interest here focused upon the informal structure underpinning involvement, and as such, individual interpretations were explored within qualitative interviews.

4.3.2. In-depth Qualitative Interviews

The Interviewees

Individual interviews were conducted with representatives of organisations and agencies identified as central to community involvement processes. The identification process was enabled by the preliminary and documentary analysis phases; therefore, the majority of the interviewees were already familiar with the research prior to the invitation to participate. Each interview was informed of the aim of this thesis and the purpose of the interview was explained as an exploration of their views and experiences of involvement processes within the Wakefield District. An information sheet (see Appendix One), which formally presented the invitation to participate, and consent form (see Appendix Two) were then provided. Having met with many of the participants previously, all but one was happy to be interviewed. In the latter instance, it was suggested that it would be more appropriate to interview a colleague, a suggestion which was of course accepted. In total eleven interviews were conducted with

representatives from local organisations including Wakefield Metropolitan District Council, Primary Care Trusts and local voluntary bodies. The average length of each interview was fifty minutes, with the shortest interview being thirty eight minutes and the longest one hour and ten minutes.

Development of the Interview Schedule

An interview schedule consisting of a series of open-ended questions and related prompts was originally developed to ensure that the research objectives were addressed while maintaining a degree of flexibility and development of the interviewee's ideas (Denscombe, 1998). As all interviewees contributed to the development of the Wakefield District's new strategic framework, exploring their interpretations of involvement was considered essential in understanding the translation of national policy into practice. The guide, which can be found in Appendix Three, addressed their role within community involvement, experiences and understandings of related structures, interpretation of involvement and related terms. Finally, in exploring the values assigned to involvement, ideas of potential links with health and well being were also invited.

The guide was developed after completion of analysis of documents, and key themes emerging from this stage were incorporated. Utilising the terminology and principles from documents such as the Wakefield District community strategy ensured that interviews were relevant to the local context. For example, "community engagement is described as a guiding principle within the community strategy. How do you think community engagement in this sense is best defined?" In contrast, other questions were framed in response to the terminology utilised by individual interviewees. The questions were developed with the assistance of a member of the supervision team who has local knowledge of community planning and involvement. This also presented the opportunity to conduct a pilot interview and thus for further refinement of the interview schedule.

In practice, it was found that the existence of pre-formulated questions inhibited ability to actively listen (Wengraf, 2001) to the interviewee, an essential component of in-depth interviewing. It became clear that when they were nearing the completion of their discourse, I began to think of the next question rather than continue to actively listen. Therefore, the semi-structured questions were largely abandoned and reformulated as

themes to include within the interview. Reflecting this amended approach, a more discursive approach to interviewing evolved throughout the data collection as it became clear that prior relationships with the participants made it impossible to assume a position of a naïve observer. Although my opinion was never offered voluntarily, where it was requested it was given. This was found to improve rapport within the researcher/researched relationship and thus, served to provide a richer response than would have been obtained through further questioning alone. This approach reflects a rejection of the demand for the interviewer to remain detached from the discussion and thus maintain a position of objectivity throughout. Given that every researcher brings to the research setting their own set of world views, regardless of whether or not these are acknowledged, such objectivity is not possible. Instead, by embracing values and beliefs, the reliability of the data is perceived to increase (see section 4.6.1 for further discussion).

Prompting was another key technique used within the interview process to elicit the depth of response required. Kvale (1996) suggested questioning techniques to evoke further response to an issue were adhered to here; in some instances I responded to an interviewee's answer with a nod or repetition of significant words, in others more explicit prompts were used, such as 'why do you think that?' or 'can you give me an example?' These techniques proved effective in eliciting further response.

4.4. Stage 2: Exploring at the Neighbourhood Level - An Embedded Case Study

Investigation at this level represents the second phase of the embedded case study. Through the identification of appropriate sub-units within the Wakefield District, exploration of the relationship between community involvement and health was shifted to the neighbourhood level. Consideration was given to ongoing debate on the meaningfulness of geographical communities to the everyday experiences of individuals (e.g. SEU, 2001) during the selection of a sub-unit. However it was deemed essential that the area selected was relevant to the political context of Wakefield District. Selecting a community group from one ward, ensured both of these factors were satisfied.

Community groups were identified as a necessary unit of analysis given the social capital related objectives of the thesis. This approach enabled exploration of the relationship between community involvement and health amongst individuals formally involved in local activities. This approach is in contrast to much of previous social capital research that largely dismisses formal involvement as being irrelevant to modern community life (for example, Campbell et al, 1999). However, according to Putnam, formal involvement, or civic engagement, is the most efficient at generating social capital. Without an in-depth analysis of the health experiences of individuals whose involvement goes beyond the informal level, much of the central tenets of social capital theory remain unexamined. Furthermore, through focusing upon formal involvement, there was potential for the investigation of all three forms of social capital. Given the current emphasis upon increasing levels of involvement in policy discourse, research in this area is even more pertinent. The selection of community groups as a unit of analysis allowed interaction with community involvement structures to be examined from the neighbourhood level through to the local authority level.

4.4.1. Case Selection

Recent research has shown the Wakefield District to experience pockets of deprivation (Lee et al, 2002). It has been suggested that as social capital exerts a positive influence upon health through mediating against the effects of poverty (Kawachi and Kennedy, 1997) and thus disproportionately beneficial to areas experiencing deprivation, it was concluded that such areas should be included within the embedded case study stage to enable exploration of this assertion. Furthermore, this enabled investigation of several issues of contention within the literature. Firstly, Putnam's presentation of social capital is suggestive of a virtuous circle of development, in which social capital stocks are needed in the first instance to maintain the resource. Thus, those areas historically lacking social capital are assumed unable to generate the resource. Secondly, the work of Campbell and Gillies (2001) provided a cautious indication that socio-economic resources influence access to social capital. This finding demonstrates the interdependencies between the different forms of capital, as proposed by Bourdieu (1997), and provides further support for the model of health presented in Chapter Two (see Figure 2.1). In this sense, effective health interventions undertake action across the wide ranging health determinants and therefore, increasing levels of social capital alone are suggested as insufficient in achieving improved well being. Thus, the selection of

an area experiencing deprivation was likely to determine the importance of wider structural factors in shaping access to social capital.

'Hillwood' represents a sub-unit of the Wakefield District and it is from this town that the community group was drawn. To maximise investigation of social capital forms, a group likely to develop differential levels of each form was identified as a key selection criterion. Obtaining a greater contextual knowledge of the 'Hillwood' guided the selection process further.

'Hillwood'

'Hillwood' is one of the principal towns in the District and is a major settlement on the eastern side of West Yorkshire. The town and its surrounding area have been worked extensively for coal; as a result each of its wards has been designated as a pit village (ODPM, 2003). Although undergoing significant economic transformations after the demise of the mining and chemical industries in the area, 'Hillwood' has been identified as having much growth potential (Wakefield First and WMDC, 2003). In the duration of the research, substantial investment was observed, such as the reclamation of one of the biggest brownfield sites in Britain and subsequent large scale commercial developments.

According to the Index of Multiple Deprivation (DETR, 2000), several of the Town's wards are amongst the most deprived in the District. Lee et al's (2002) analysis identified 'Hillwood' as one of three major concentrations of deprivation within the District with two of the town's wards being considered a 'health hotspot'. Reflecting this, the town has become the target of a range of funding programmes. 'Hillwood', like many areas, has become a patchwork quilt of area based initiatives with their boundaries incorporating only some parts of the town. For example, the town has been in receipt of two rounds of Single Regeneration Budget (SRB) and one Sure Start programme. The result has been to create an uneven approach to regeneration and renewal.

4.4.2. Accessing the Setting

An inevitable difficulty, and one which is common to the majority of methods, is problems with accessing the research unit. Fortunately, the nature of the PhD studentship (jointly funded by an established and recognised body within the Wakefield

District) proved constructive when negotiating access to the field. Furthermore, the period of 'immersion' in the field, within the preliminary research stage, created relationships with a range of gatekeepers throughout the Wakefield District. This, together with access to further groups facilitated by members of the supervision team, enabled the identification and selection of appropriate groups for inclusion within the embedded case study. As the supervision of the PhD was shared between Sheffield Hallam University and the Wakefield District Health Action Zone, and more recently the Eastern Wakefield Primary Care Trust, a member of the supervision team was able to share their contacts with the appropriate gatekeepers, with gatekeepers typically being community workers.

The reliance on community workers as gatekeepers proved problematic; typically, I would contact a worker to seek access to a group who would in turn then seek the permission of the group for my attendance at a future meeting. Clearly, this immediately put me in a position of dependence upon the worker; in some cases I would wait for weeks, even months, before gaining access. The departure of one community worker and a period of ill health of another significantly delayed the research process.

Having determined the activities of a substantial number of community groups within 'Hillwood', a group was identified as fulfilling the selection criteria. The 'Edgeton' Community Action Group was located on the outskirts of 'Hillwood', within the village of 'Edgeton'[1]. This village had been located out with the boundaries of funding programmes and thus had not been targeted by community development processes. The group had newly formed in an area where no group had existed previously and attempts were being made to establish links with groups in neighbouring villages. Therefore, 'Edgeton' presented an opportunity for investigation of all three forms of social capital in what was likely to be a relatively poor social capital area due to the absence of previous groups and regeneration initiatives. Furthermore, the selection of 'Edgeton' enabled direct investigation of Putnam's assertion that existing stocks of social capital are necessary for their continual renewal (2000). Following the ethical procedures adhered to in the recruitment of organisational interviewees, 'Edgeton' group members were given a copy of an information sheet (Appendix Five) and consent form (Appendix Two).

[1] 'Edgeton' is a pseudonym.

4.4.3. Qualitative Observations

As discussed within Chapter Two, social capital has been defined as the features of social relations that enable action that would not otherwise be achievable, and although largely a disputed concept, there is agreement that it inheres within relationships and networks rather than being a property of the individual members. Therefore, it was considered essential that these relationships should be directly investigated. Through observations, the means through which social capital is generated, maintained and utilised can be determined. This approach reduces the over reliance upon interview data in investigating the complexity of social capital. Although social capital is largely perceived as the features of social networks that enable co-operation and co-ordination, little research has focused upon how individuals and groups draw upon the resources of social capital available to them and ultimately how this may be important to health.

Qualitative observation has been described as,

> fundamentally naturalistic in essence; it occurs in the natural context of occurrence, among the actors who would be naturally participating in the interaction, and follows the natural stream of everyday life. As such, it enjoys the complexity of drawing the observer into the phenomenological complexity of the world, where connections, correlations and causes can be witnessed as and how they unfold" (Adler and Adler, 1994, p378).

It is a particularly effective research tool for several reasons; it allows understanding of relationships on several dimensions; describes the background to interactions; follows events as they develop over time; observes changes in behaviour; inclusion in activities and thought processes that surround interactions; and sees events as they happen (Dargie, 1998, p66).

Observational methods have largely been ignored over recent years, with qualitative studies drawing heavily upon interview data (Morse, 2003). However, as Morse argues, observational methods "reveal much that the individual cannot and may not know or they consider too trivial or extraneous to discuss, and can provide the most significant clues to fitting the puzzle together or driving the research agenda" (p155). Given the complexity of social capital, and its inevitable abstract nature to the everyday experience of a community, observational methods were identified as essential in

investigating the processes underpinning its development or, equally, inhibiting its generation.

At the neighbourhood level, the activities of the 'Edgeton' Community Action Group were observed, this involved attendance at committee group meetings, annual general meetings and open forums. Additionally, these observations revealed the group's attendance at an external structure, the 'Hillwood' Area Panel, established by WMDC in response to the new requirements to involve communities within decision making processes. The area panel represented an important means of pursuing action to the 'Edgeton' group members, and therefore, observations were extended to the monthly meetings of this structure. In addition to the incalculable number of hours spent upon the West Yorkshire public transport system, approximately thirty hours of observations of the group's involvement activities were undertaken.

Initially the fieldwork was relatively unstructured as an understanding of the structure and function of the observational fields developed. Such an approach is in line with much observational work, and more specifically the field of ethnography (Silverman, 1993; Brewer, 2000). Ethnographers generally agree that capturing particular features of the interaction, event or action is essential to developing a contextual framework in which the data can be understood. Such features include; access to the setting; the physical environment; the actors (who was present and absent, dress, manner); activities; goals; principle themes and issues; and atmosphere and feelings (Dargie, 1998; Spradley, 1980). To record these details systematically an observation 'protocol' was developed, an approach advocated by several authors (Creswell, 1998; Miles and Huberman, 1984). The protocol served not only to provide essential context in which the data could be framed, but also an aid for subsequent recall. A completed protocol is shown in Appendix Four.

As understanding increased, so too did the focus of the observations. In view of the research questions, focus was placed upon the means through which a specific issue was identified and resolved by group members. This is reflective of the central tenets of social capital; it is the features of social relationships that enable the achievement of an action. The observations also set out to identify potential mechanisms through which health may be influenced, and thus enable subsequent exploration within the

interviewing processes. This observational focus was guided by the theorised pathways between social capital and health and included, identification of actions likely to influence health outcomes, dissemination of health promoting information (Berkman and Kawachi, 2000) and, in view of the overlaps between social capital and community development, developmental outcomes such as increased perceptions of control (Stansfield, 1999).

Field notes were not recorded during the period of observation, resulting in the production of non-verbatim notes. At the outset it was considered that to openly write notes whilst engaged within the setting would lead to increased anxiety and disruptive to the action (Hammersley and Atkinson, 1983; Lofland, 1971). It is inevitable that creating notes after the event is subject to problems of recall; to reduce the effects of this process, field notes were recorded at the earliest possible opportunity after exiting from the setting, which in the majority of instances proved to be immediately after the event (the use of public transport to reach the various venues provided the ideal opportunity).

The absence of verbatim notes increases reliance upon the researcher's own perceptions (Adler and Adler, 1994). Although the use of multiple observers and subsequent inter-observer crosschecking presents a means to overcome any problems associated with this, it was considered an unrealistic option here. The nature of thesis research and the heavy demands placed upon time resources results in the impossibility of ensuring that each and every observation incident is validated by a second observer. However, it is argued that the use of systematic field notes, described above (see Appendix Four), is likely to encourage and facilitate rigorous analysis and result in improved reliability and validity (see Section 4.6.1).

4.4.4. The Role of the Researcher

The method of observation differs according to the role adopted by the researcher within the field. To a large extent, my position was predetermined. Given my demographics as a young Scot, it would have been very difficult to occupy a role other than researcher without generating suspicion. The nature of the activities under observation further prevented a role as complete participant, with all activities centring upon local issues and the means to resolve them. In this sense, living outside of the Wakefield District, I occupied a position as an outsider and was unable to participate

directly within their experiences. Utilising Gold's (1970) typology of the role of the researcher, my position can be situated between a participant-as-observer and observer-as-participant. This participant-as-observer position reflects that I actively engaged in conversations out with the formal committee meeting environment, and thus constitutes informal observations. In contrast, I made very little contribution to the discussions within the meetings themselves, and therefore undertook more formal observation with the aim to obtain insight and understanding of the experiences of the residents rather than to directly experience them. This latter position is one of observer-as-participant. However, in one respect, I occupied a position of complete participant in that I utilised public transport throughout the fieldwork period. Although the absence of a driving licence was originally perceived to be a hindrance to the field work, over time it became clear that it presented a unique opportunity to share residents' experiences of a key part of community life.

The small scale of the observational fields inevitably meant my relationship with the researched had to be managed carefully. The 'Edgeton' Community Action Group responded to my invitation to participate within the research with enthusiasm and welcomed my presence as a researcher within their group. The apparent eagerness to accommodate my research cannot be easily explained, and at times caused discomfort (for example, one member of the 'Edgeton' Community Action Group continued to thank me for attending their meetings when I had made no contribution to their activities). It was explained at the outset that participation within the research may not necessarily yield any benefits to either the group or the wider community, and the enthusiasm was therefore concluded to be reflective of the group's relative infancy. That is, the association of a researcher to the group provided an additional sense of status and purpose to their activities.

It was felt important that my appearance was managed appropriately. Although the majority of the group members dressed casually for group meetings, it was felt that I would be identified as a 'scruffy student' if I did so. But equally, an overly formal dress could have been alienating. Therefore, every period of fieldwork was preceded with a wardrobe dilemma. I felt I achieved an appropriate balance by remaining, 'smart, but casual' and was fortunate enough to be assisted by the winter months where it was the norm to leave a jacket on, thus rendering dress less of an issue.

4.4.5. In-depth Qualitative Interviews

Development of the Interview Schedule

A central and guiding influence upon the interview schedule here was the adoption of a social model of health. As stated in paragraph 4.1, this model necessitates an exploration of health from well being and quality of life perspectives rather than simply the absence of disease. More traditional approaches to health measurement, mortality and morbidity rates as favoured by the medical professions, fail to capture this interpretation, and would instead measure departures from health (Bowling, 1997). As Wilkinson describes, "death rates are often used - perhaps rather paradoxically - as measures of health because good measures of health do not exist" (1996, p55). Over recent years, Popay and Williams have presented a strong case for the use of 'lay perspectives' of health in advancing knowledge. They argue that lay perspectives are necessary to enable the development of robust and holistic explanations for patterns of health and illness in contemporary society, "lay knowledge can enhance our understanding of the relationship between social circumstances and individual behaviour" (1996, p760). However, capturing health is not easy, with being healthy only entering conscious attention when illness and other dysfunctions are encountered (Lawton, 2003).

It has been well established that self-reported general health is a powerful indicator of forthcoming problems (Idler and Benyamini, 1997; Popay and Williams, 1996) and a strong predictor of survival rates amongst those suffering from illness (Fayers and Sprangers, 2002). However, it is not free from complexity. Research has shown that when people are asked to consider their own health there is a diversity of interpretations of the concept, with some people focusing upon specific health problems and others on either general physical functioning or health behaviours (Molarius and Janson, 2002). The interpretation made by the individual is typically associated with socio-cultural context, age and gender (Kaplan and Baron-Epel, 2003), with younger generations focusing upon physical strength and fitness and older people adopting a more functional interpretation (Blaxter, 2001).

The complexity of an individual's perception of their own health has led to much research on the most effective means to elicit reports for empirical enquiries. Some researchers have reported the difficulty experienced by their participants in considering

the factors influencing their health, with such discussions being considered too abstract. East (2002), for example, explored neighbourhood residents, voluntary and professional workers perceptions of the health of their community, through two key questions; "what are the main influences on people's health?" and "are there aspects of life in Sneinton that protect or promote people's health?" Although this approach revealed that professional workers adopted an essentially medical model of health, it proved inappropriate for community groups, with residents finding it difficult to talk about health in the abstract. To obtain the depth of information required, East modified her approach and explored health from a quality of life perspective.

Alternatively, Blaxter (2001) suggested that health is best explored by asking individuals to compare their own health with that of another individual's, thus removing the discussion from the abstract. Blaxter's questioning was based upon the format, 'think of someone you know who is very healthy. What makes you call them healthy?' and 'at times people are healthier than at other times, what is it like when you are healthy?' This comparative questioning has been used with success elsewhere (Cattell, 2001) and was therefore identified as a necessary approach within the interviewing process here.

Popay and Williams (2003) own approach, consistent with their argument that experience of place contributes to understandings of health inequalities, is to ask individuals to reflect on the area in which they live. They argue "people's talk is a source not only of recapitulation or description, but also of understanding and evaluation" (ibid, p55). This evaluation, according to these authors, is intrinsically linked with individual biographies. Williams explains this further elsewhere (2003, p146), "if we are to understand the impact of social structures on health we need to comprehend both the historical, real-time processes that particular structures and locales embody; and we need to enter into the way in which these processes shape the life courses and biographies of individuals." This position reflects a growing body of literature reporting life history to be an effective means of exploring health (Blaxter, 1983; Cattell, 2001; Campbell et al, 1999), although the interpretation of a life history has been considerably loose within some investigations.

The life history approach (Plummer, 2001), with its roots in the Chicago School of sociology (Dex, 1991), demands that the research focus is studied from the perspective of the person involved (Rice and Ezzy, 1999). Campbell et al's methods come closest to a life history in its truest sense with interviews being constructed around participant's response to the initial question "please tell us the story of your life from the beginning" (1999, p166). In contrast, Cattell's life history consisted of five questions as part of a wider interview schedule. She questioned employment history, places habited, general satisfaction with life experience and a final and more specific question on health, "looking back over your life, have there been any periods when your health was particularly good?"

Given the proven effectiveness of life history techniques in evoking in-depth discussions of health and the assertion within the previous chapter of the importance of historical relationships in determining levels of involvement within processes of governance, it was deemed essential that the in-depth interviews here incorporated an exploration of historical contexts. It must be emphasised that, in accordance with the arguments raised by Popay and Williams (2003), health was explored from the perspective of the experience of place, thus incorporating wider issues of well being.

It was intended at the outset that the data obtained through observations would be used to inform the development of the interview schedules to ensure the questions were embedded within the local context and firmly removed from the abstract. The observational data reaffirmed the importance of historical relationships in structuring both actions and beliefs. For example, the 'Edgeton' Community Action Group regularly expressed their suspicion of the motives of the local authority, a belief that appeared to be based upon past experience. Subsequent actions involving the specific department under suspicion were guided by interpretations of their experiences. The observational data also informed the inclusion of other issues for discussion within the in-depth interviews, and more specifically, enabled the exploration of the concepts of social capital within the real life context of participants. For example, the 'Edgeton' group had experienced difficulty in securing a long-term tenancy agreement for a disused council house, thus suspending the group's plans to develop a community drop-in centre. This one issue incorporates the relationships between the community and the

council (linking social capital) and was suspected to implicate upon individual members subjective feelings of control.

During the development of the methodology, social capital measurement tools emerged from the Office for National Statistics (e.g. harmonised data set and the General Household Survey's social capital module) and thus their inclusion within the interview schedule was considered. The value of such tools, in general terms, represents a welcome addition to the social capital debate in that the tools provide a standardised measure of social capital and thus overcome the previous dominance of measurement by proxy (e.g. Kawachi et al, 1997). However, it has been argued here that the growing evidence of the heterogeneous nature of social capital (e.g. Baum et al, 2000) necessitates further investigation of the contextual factors giving rise to the resource. The structured nature of the questions, designed to enable quantitative analysis, presented within each of the emerging tools was concluded inappropriate in exploring the specific circumstances in the Wakefield District determining levels of social capital. Additionally, at the time of the research, the measurements only supported investigation of bonding forms and therefore neglected potentially important sources of social capital. Despite this, exploratory qualitative methods should not be interpreted as mutually exclusive from the standardised measurements; instead the two approaches are complementary. Findings from in depth qualitative investigation enable the continual refinement of standardised tools. Equally, large scale implementation of the standardised techniques can potentially determine areas with low levels of social capital, and thus identify potential case studies for future qualitative research.

The approach here then was to utilise existing social capital measurement tools as the 'bare bones' upon which to build the interview schedules, thus ensuring that no aspect of social capital was neglected. In this sense, the structured questioning within the tools was used to identify themes for exploration within the qualitative interviews. The question sets presented within the measurement tools draw upon the core tenets of social capital; perceptions of the local area; reciprocity and trust; civic and social participation; social networks and support (Walker et al, 2001; Green and Fletcher, 2003). These themes were therefore used as the 'skeleton' of the interview schedules, fleshed out by knowledge obtained through observations of specific local contexts, and of course emerging issues within the interview setting itself.

Therefore, the interview schedule was developed around three broad themes; perceptions and experiences of the local area; community involvement; and explorations of health. Eliciting a discussion of the local area also facilitated investigation of features of reciprocity and trust, and social networks and support, with neighbour relations and proximity to families generally offered as a determinant of the level of satisfaction with an area. Under each theme, a number of key topics for discussion were identified, which are set out below. These topics reflect the key areas of social capital and community involvement requiring further investigation, as identified by the literature and preceding stages of research. For example, perceptions of control have been identified as a potential pathway through which social capital may influence health (Stansfield, 1999).

Qualitative Interviews Guide

1 Perception and Experiences of the Local Area
Length of residence
Satisfaction with an area
Employment within an area
Experience of community
Relationship with neighbours (including trust)
Social support structures (including provision/receipt of help)

Exemplary Opening Questions
How long have you lived in the area?
Are you happy living here?

Exemplary Prompts
Do you know your neighbours?
Do any of your family live locally?

2 Community Work and Involvement
Extent of formal participation
Satisfaction with involvement
Group achievements
Perceptions of control over decision making process
Perceived personal changes (e.g. training courses, employment, friendships)
Experiences of local council (distinguish between elected members and officers)
Voting behaviour

Exemplary Opening Questions
How long have you been a member of 'Edgeton' Community Action Group/Woodville forum for? Why did you become a member?

Exemplary Prompts
Do you think you could have done that without [name of group]? Why do you think that is?
Are you a member of any other groups?

3 Health
Questions
How have you been feeling over the past twelve months? How does this compare with other times in your life? Compared to other people of your age, how would you describe your own health?
Has your health ever stopped you from doing anything in your life?
Are you happy with things in your life at the moment? How does this compare to other times?

Although potential influences upon health were explored throughout the interview, it was considered necessary to adhere to the wealth of research into health measurement, as discussed above. Therefore, several health related questions, as informed by Blaxter's (2001) comparative approach, were also included within the final part of the interview. This line of questioning supplemented the information obtained on health and well being from the general questioning approach, and thus developing a further list of issues to be addressed within this section of the interview was deemed unnecessary.

Given the experiences with the organisational representative interviews, a list of questions was considered inappropriate. Instead, questioning begun with a general question, such as "how long have you lived in the area?" and "do you enjoy living here?" an approach advocated by several qualitative researchers (e.g. Fontana and Frey, 1998). These questions also served to elicit interviewees' biographical associations within the area, with interviewees typically using their past as an anchor in which their present experiences could be framed and understood; thus in compliance with the life history approach. Utilising general questions also enabled investigation of health from a well being perspective. It was anticipated that such general questioning would elicit a discussion of the factors likely to influence health; this was proved to be correct with interviewees identifying factors such as crime, housing and local services as determinants of their satisfaction with an area. The knowledge obtained from the observational data served to provide a prompt to elicit further discussion.

The Interviewees

The interviewees at this stage of research included members of the 'Edgeton' Community Action Group and a ward councillor supporting the group. Membership of the 'Edgeton' group fluctuated throughout the research period, and all members present during the interviewing stage were invited to participate and therefore presented a pre-selected sample size. Only one group member declined an invitation to be interview, citing time constraints as the explanatory factor. Seven in-depth qualitative interviews were undertaken, the shortest being thirty-five minutes in length (with the councillor), to ninety-five minutes. Table 4.2 below lists the pseudonyms assigned to each of the interviewees together with their biographical details.

Table 4.2: Stage Two Interviewees: Key Characteristics

Name	**Details**
David	Sixty-seven years old. Married (to Helen). The Chair of the 'Edgeton' Community Action Group. A retired manual worker, lived in 'Hillwood' for all of his life and in 'Edgeton' for thirty eight years.
Helen	Sixty-nine years old. Married (to David). A retired council officer. Treasurer to 'Edgeton' Community Action Group. Lived in 'Hillwood' all of her life and in 'Edgeton' for thirty eight years.
Paul	Forty-nine years old. Divorced. Employed manual worker. The Deputy Chair and Project Manager of 'Edgeton' Community Action Group. Lived in 'Edgeton' all his life.
Jill	Forty years old. Married. Employed office worker. Activities organiser for 'Edgeton' Community Action Group. Lived in 'Edgeton' seventeen years.
Mary	Thirty-seven years old. Married. Employed manual worker. Activities organiser to 'Edgeton' Community Action Group. Lived in 'Edgeton' twenty three years.
Fred	Seventy-four years old. Widowed. Retired colliery worker. Committee member of 'Edgeton' Community Action Group. Lived in 'Edgeton' all his life.
Tony	Elected member for 'Edgeton'.

All interviews sought to explore the potential influence of involvement upon health, but additionally, the interview with the councillor enabled further examination of linking forms of social capital and the political context of involvement. Given that potential tensions between representative and participative forms of democracy have been identified as an unresolved issue of the national policy (Taylor, 2003), it was considered essential to determine, how, if in any way, this shaped involvement at the neighbourhood level. In addition, interviewing elected members served to complement

the investigations undertaken within the first stage of the case study; that is the organisational interviews.

4.5. Ethical Considerations

Codes of ethical conduct were strictly adhered to throughout, with the research procedures being subjected to a rigorous ethical and governance appraisal process. As the research participants included employees of the NHS, ethical approval was sought from the Local Research Ethics Committee (LREC) of the Wakefield District. As the key ethical guidelines of anonymity, confidentiality and informed consent were being adhered to, it was surprising to find that the approval of the research protocol was not as painless as anticipated. It appeared that the expertise of the LREC lay with large scale medical trials and that there had been less exposure to smaller scale qualitative projects. The main issue of contention was that of anonymity, of third parties in particular, with 'Hillwood' considered to be a village and difficult to prevent participants from talking to other residents about their involvement within my research. The issues raised did not appear at any point to be a direct attack on my ethical standards, but rather of qualitative research in general. Approval was given on the basis that the town from which the community group was drawn remained unnamed, but also that all participants had an opportunity to comment on their 'data'.

Thus, interviewees were forwarded a copy of the transcript of their interview. In practice, the provision of transcripts to participants proved, in some instances, problematic to manage. The majority were grateful for the transcript, some amended significant sections and one questioned the accuracy of it. In the latter case, the assurance was given that no section of the transcript would be used without prior agreement from the participant. Occasionally a section of an interview could not be transcribed due to either a quietly spoken interviewee or background noise. This section was marked 'unable to transcribe' and had the effect of making a sentence or paragraph, at times, incoherent. It is suspected that this is in part responsible for the both the participants amending of the transcripts and the questioning of its accuracy.

4.6. Data Analysis

Given that the research has been guided by a set of research questions, a purely inductive approach to analysis was originally assumed to be inappropriate. For this

reason, the framework approach, a method developed specifically for applied or policy relevant qualitative research where objectives have been set in advance was identified as a suitable analysis method (Pope et al, 2000). The data collection tends to be more structured than would be the norm for other qualitative research and the analytical process tends to be more explicit and more strongly informed by priori reasoning (Pope et al, 2000). Given the influence of social capital on the development of the methodology, such an approach was considered appropriate here.

However, initial analysis revealed that the emphasis upon social capital endangered the emergence of potentially important outcomes linking community involvement and health. Although the central aim of this thesis was to explore the relationship between community involvement and health and determine the value of social capital in advancing understandings, this does not legitimise the dismissal of alternative concepts. Indeed, the explanatory value of social capital can only be determined if its functioning is separated from related concepts, such as empowerment. Of course, this separation is not meant in the statistical sense, but rather the identification of the conceptual and operational boundaries. Thus, to enable the emergence of important constructs, a more inductive mode of analysis was sought. Equally, identifying all themes present within the data ensured that the functioning of social capital, in all its forms, was explored, and thus further refined. In doing so, this enabled determination of the theory of social capital that best captured experiences in the Wakefield District.

Grounded theory presents such a technique for both data collection and analysis, a key tenet being that the research process should be guided by the data emerging from the field. And as such, supporters typically warn against the completion of a literature review prior to entering the field and overly structured interview techniques (Charmaz, 1990) to avoid the data being clouded by preconceived hypotheses. As Glaser and Strauss describe, "it is presumptuous to assume that one begins to know the relevant categories and hypotheses until the "first days in the field" at least, are over" (1967, p34). However, this approach is inevitably incompatible with the requirements of grant applications and ethical approval processes and can only be applied in anthropologically strange environments. Much research therefore fails to utilise grounded theory in its truest sense and clearly it cannot be here.

However, since its original formulisation in the 1960s (Glaser and Strauss, 1967), it has undergone substantial transformation as researchers adopt the method to suit their own needs. For example, Charmaz (1990) has transformed Glaser and Strauss' positivistic approach into a grounded theory compatible with social constructionism. Glaser has indeed recognised the potential for grounded theory to be utilised as an "adopt and adapt" method and states that it does not necessarily have to be used in its entirety by researchers (1999, p837). The variation in grounded theory approaches has been encouraged by a divergence of thought between the original authors, who have continued to develop their ideas independently of each other. Although, Glaser and Strauss initially viewed knowledge of the literature prior to data collection negatively, Strauss and Corbin (1998) recognise its potential to enhance sensitivity to subtle nuances within the data. When a researcher has prior knowledge of the literature, particular importance must be placed upon determining if the concepts are truly emerging from the data, or are being seen because of an over familiarity with them (p49). Strauss and Corbin recognise that "analysts bring to the investigation biases, beliefs, and assumptions" (p97) and that the important issue is that this is acknowledged and recognised when informing the analysis.

Therefore, the data here has been analysed according to principles of grounded theory. Within grounded theory, data should be collected according to the principles of theoretical sampling, where the coding and analysis of data is used to guide further data collection to enable the development of the emergent theory. As such, it is not possible to select the number of groups for inclusion within the research at the outset. The criterion for judging when to stop sampling the different groups pertinent to a category is the category's theoretical saturation, meaning that no additional data are being found whereby the categories properties can be developed. Given that approximate numbers of participants were required to satisfy ethical committees, theoretical sampling, as defined above, was not possible. Instead, a variant of theoretical sampling was adopted; the completion of each stage of research guided identification of appropriate research units within subsequent research stages. For example, analysis of national policy documentation enabled identification of the related local authority level documentation, which in turn, highlighted the structures to be included within the fieldwork. However, as this does not conform to Strauss and Corbin's (1998) interpretation of grounded theory, the approach to data analysis here is referred to as thematic analysis. Thematic

analysis, according to Rice and Ezzy (1999), is grounded theory without the theoretical sampling, and therefore the techniques for data analysis remain focused upon the content of the data rather than pre-determined hypotheses.

The qualitative software package NVivo was used to aid the analysis of data. Such packages are viewed, as has been argued by (Kvale, 1996), as a means to structure the interview material for further analysis and therefore the responsibility for interpretation of data is not removed from the researcher. Given the different types of data collected, a software package was considered essential to enable its effective management and organisation. As explained below, the use of NVivo enabled 'data bites' and nodes to be inserted where relationships were identified across the different data types and thus proved an invaluable tool in the analysis process.

As I transcribed each tape-recorded interview and field notes, the analysis process began at the transcribing stage. The first stage of the analysis represented a familiarisation process, in which I became 'embedded' within the data. This enabled the identification of initial themes, which were developed into higher-level conceptual categories, according to the principles advocated by Strauss and Corbin (1998), as the analysis proceeded. The data was approached with questions such as, what is happening? Why is it happening? Where is it happening? How is it happening? This is similar to what Strauss and Corbin refer to as open coding with initial codes being drawn from the data themselves, although some codes were drawn from the literature. This latter coding technique was undertaken with caution to ensure that the code was not being forced upon the data but captured the concepts emerging from it.

Comparative analysis is a technique central to both grounded and thematic analysis and was used to facilitate this process. It involves comparing events, actions and interactions for similarities and differences. Each event, idea or name was given a label that was representative or stood for a phenomenon (Strauss and Corbin, 1998). Typically, the initial analysis was conducted at the level of a sentence or paragraph to ensure that the data was not broken down to such a level that all remnants of context were removed. This ensured that attention was upon the collected data rather than preconceived assumptions (Charmaz, 1990). The codes were recorded by selecting the relevant section and inserting a node using NVivo. To stimulate thinking about each

node, memos were written simultaneously to the coding process, again within the NVivo software. Memo writing is considered a key tool within many approaches to qualitative analysis; through writing continually about the data, the researcher is encouraged to further develop thinking on what is happening within the data (Strauss and Corbin, 1998; Wengraf, 2001).

As the process of open coding advanced, and category properties were emerging, the analysis shifted towards the use of axial and selective coding. Through axial coding, the categories were further refined and developed through the completion of several tasks. As advocated by Strauss and Corbin (1998), the variation of conditions, actions and consequences associated with each category were identified to ensure that each code was fully elaborated. Through this, conceptual overlaps between categories or the need for further discrimination within a category, for example the development of sub-categories, are determined. In the latter case, a subcategory is used to delineate the specific circumstances of the categories phenomenon, for example, the when, where, why, how, and with what consequences of the occurrence. Utilising NVivo assisted this process in that it enabled the originally assigned nodes to be organised as tree nodes, with each category and sub-category representing parent and child node structures. A list of all nodes is presented within Appendix Six to illustrate this organisational action. Additionally, Appendix Seven contains data coded at selected nodes to further illustrate the analytical process. The next stage of analysis involved refining the emerging theory by reviewing the categories for consistency, and where necessary, filling in poorly developed categories and cutting back overdeveloped categories. In practice, this constituted an in-depth examination of every interesting event, remark or phenomena assigned a node in the preceding analytical stages and determining their relationship to the well-developed conceptual categories.

4.6.1. Validity and Reliability

Although there is some discussion of the appropriateness of applying the criteria of validity and reliability to qualitative research (for example, Silverman, 1993), the need for rigour and quality within qualitative research necessitates an application of modified criteria. Altheide and Johnson (1998) argue that validity within qualitative research is assured when researchers provide a reflexive account of both themselves and the process of research. As Devine and Heath (1999) argue, reflexivity does not solve any bias on the part of the researcher but it does force the researcher to be aware of any

potential bias and consider its implications upon the findings. Every attempt has been made to maintain a reflexive approach to the research, particularly within the observations and interviews with community groups where the relationships required careful management throughout the fieldwork period (see Section 4.4.4).

To ensure the reliability of observational data, the development of four sets of notes is advised; short notes made at the time; an expanded version of notes made immediately after the event; a fieldwork journal to record problems and ideas arising throughout; and finally, a provisional and continuous record of analysis and interpretation. As discussed above, note taking was considered ill advised during the observations themselves to avoid inducing suspicion and anxiety amongst the actors within the event. However, each other stage of note taking was abided to. The NVivo programme was utilised to maintain the fieldwork journal and also the ongoing analysis, which in turn guided further observations.

The piloting of the in-depth organisational representative interviews is argued to improve reliability as it reduced the likelihood of misinterpretation between the researcher and interviewee arising. The reliability of each stage of interviews was enhanced further in that they were informed by the preceding research (documentary analysis and observations).

Silverman (1993) identifies two forms of validation appropriate to qualitative research, triangulation and respondent validation, both of which have been conducted here. Triangulation refers to the collection of different forms of data to realise the research objectives, concurrent findings demonstrates the validity of the data. The utilisation of observation, interview and documentary analysis data within a qualitative case study provides triangulation here. As discussed above, the research was approved on the basis that participants were given 'their data' after transcription. In doing so, it was ensured that the data represented an accurate reflection of events and served to provide respondent validation.

4.7. Summary

The relationship between community involvement and health was explored utilising a qualitative case study methodology, with the Wakefield District representing the case,

and the 'Edgeton' Community Action Group a distinct subunit. The development of the methodology has been informed by theories of social capital, particularly that of Pierre Bourdieu and recent commentary that the resource exists in bonding, bridging and linking forms.

The District's community involvement framework was identified through an analysis of key documentation and individual qualitative interviews with organisational representatives central to the development and implementation of this framework. Completion of this first stage of research provides a context in which to embed the community level research undertaken in 'Hillwood'. A community group within this area formed the focus of the second stage and their activities and structures were observed and individual members. The culmination of these stages of research enables the relationship between community involvement and health to be explored within a political context.

Chapter Five

Community Involvement: The Wakefield District Context

5.1. Introduction

Determining how the national policy agenda, and more specifically the challenge to involve communities, has been interpreted and implemented within the Wakefield District represents one of three objectives of this thesis (see Chapter One). Determining how community involvement is defined and supported at the strategic level is an essential first step in establishing the context in which it is practiced within 'Edgeton' (the community investigated within the second stage of the case study). Equally, interpretations of involvement can shape levels of social capital, either enhancing or constraining, and this research stage enabled examination of the potential effects upon the resource.

To uncover the emerging approach to community involvement, key strategic documents were analysed and eleven interviews were conducted with senior officers from the local authority, primary care trusts and voluntary sector. As set out within Chapter Four (see Section 4.3.1), this enabled examination of the informal rules, as well as the formal, governing community involvement. Given that the documents analysed here were published within the time frame of the research, and therefore may not yet be embedded within everyday interpretations, establishing informal practice was considered pertinent. The thematic analysis of the interview and documentary data revealed four key themes; the Wakefield District infrastructure; models of involvement; the practice of involvement; and models of health. The findings are thus structured around these themes.

5.2. The Wakefield District Infrastructure

Throughout the period of research (2002 to early 2004), the infrastructure supporting the District's approach to community involvement constantly evolved. Interviewees described the changing structure and capacity of the local authority, health sector and community and voluntary sectors as a determinant of the local level response to the new requirements to involve communities. Reflecting this state of change, the relationships

between each of these sectors were reported to be developing at the time of the research. Therefore, the Wakefield District infrastructure is defined as the structure and capacity of the different sectors to implement involvement, both individually and in partnership.

It is important to note that changes to the Wakefield District infrastructure were stimulated not only by the demands of national legislation and policy but also by external recognition of the failings of the Wakefield District Metropolitan Council (WMDC). As the new policy framework emerged from the Office of the Deputy Prime Minister, and its preceding departments, the WMDC was undergoing investigations into alleged criminal conduct by members and officers. The allegations focused upon the process through which contracts were awarded, the management of the council's property assets and the receipt of hospitality (District Audit Office, 2002, pS4). Although no criminal proceedings arose from this process, the Audit Public Interest Report questioned the effectiveness of the council's governance arrangements and "inherent cultural problems" (ibid, pS3).

In 2002, these observations were supported by the results of the first comprehensive performance assessment process (see Chapter Two, Section 2.2.1), which rated the WMDC as 'poor', the lowest score on a five-point scale (excellent, good, fair, weak or poor). The council itself recognised its failings in the self assessment undertaken as part of this process and stated that,

> Wakefield has been an inward-looking, reactive authority, reliant on delivering services almost exclusively in-house, with strong service departments and weak corporate arrangements. Traditional trade union influence has contributed to the slow progress towards changing into a modern authority (WMDC, 2002, p1).

Reflecting the historical influence of trade unions, forty-five of WMDC's sixty-three councillors are Labour.

In 2002, the WMDC responded to these criticisms by restructuring its corporate management arrangements; a new Chief Executive was appointed and a new Chief Executive's Office was created. The new department incorporated a number of new senior management posts, including an Assistant Chief Executive with responsibility for the LSP, diversity and social cohesion and democratic and community engagement. In the first three months of 2003, a new Chief Executive, Deputy Chief Executive,

Assistant Chief Executive and Corporate Director were appointed. In 2004, the Audit Commission reported that "a series of far reaching changes to structures, processes and culture mean that the council is very different now compared with 2002" (2004, p4) and improved the council's CPA rating to 'fair' (Audit Commission, 2004).

In direct response to the Local Government Act 2000, the WMDC also introduced a new model of political management, a cabinet with leader, during the research period (see Chapter Two, Section 2.2.1). The new council constitution supporting these changes also legislated for the introduction of new area committee arrangements. Termed 'area panels', the new structures were to "represent the front line of the Council's machinery and helps to fulfil the representative role as champions for their community" (WMDC, 2001a, p21). At the time of the research, their legal status remained as formal statutory advisory committees, as established under the Local Government Act 1972. Although the council's constitution recognised that the recent Local Government Act 2000 allowed the devolvement of cabinet functions to these committees, they were effectively meetings of the council in public rather than public meetings (WMDC, 2001a, p21). Their principal function is described as "to facilitate openness, transparency and accountability in the conduct of Council business and to encourage access and participation by local people in the democratic process" (ibid, p22). More specifically they were to make recommendations and comments to the council on a range of issues, including; the community strategy and local area community strategies; service delivery; local community chest expenditure; and the Best Value Reviews. The local strategies were to be developed in consultation with the community and other representative organisations (ibid, p24) and within the framework provided by the District's community strategy. Reflecting these roles, area panels were envisaged as enabling local people to exert ongoing influence on local plans and programmes (Wakefield District Partnership, 2003a). Additionally, the provision of a devolved budget, the Local Community Chest, represents a pot of money available to each area panel to assist schemes or initiatives identified within these strategies (WMDC, 2001a, p25).

A total of eight area panels were in operation throughout the Wakefield District at the time of research, with each based on groupings of the twenty-one electoral wards. The 'panel' itself is composed of the ward councillors and co-opted members drawn from

organisations representative of the local community. The co-opted members are appointed via a nomination process and do not hold voting rights. The constitution sets out provision for a thirty-minute session in each area panel meeting for the public to ask questions and raise issues with the panel members (WMDC, 2001a, p26). Therefore, this presentation of area committee structures suggests that there will only be limited opportunities for interaction between the councillors and local communities. Further insight into the functioning was obtained in the second stage of research and is thus discussed further in Chapter Six (see Section 6.4.1).

External to the council, the health and voluntary sectors were also undergoing major change in the research period. The establishment of the Health Action Zone (HAZ) team in 1999 and their eventual disappearance in 2003 (see Chapter Four, Section 4.5.1) represented an important event for the evolution of the District's infrastructure. The HAZ defined community involvement as central to their approach to tackling health inequalities and established District wide structures to enable effective implementation, most notably the Community Involvement Advisory Group and Community Development Good Practice Group. The functions of these structures are discussed in more depth below. In 2003, the HAZ funding stream was mainstreamed within the newly formed Primary Care Trusts (PCTs) where much of this strategic work continued.

The voluntary sector within the Wakefield District was perceived as being under resourced and underdeveloped (e.g. Wakefield HAZ, 1999), thus efforts were undertaken to enhance its capacity; most notably, a new forum for the community and voluntary sector was established in 2002. The forum, known as Vox, is an independent organisation managed by the local council for the voluntary sector, Voluntary Action Wakefield District (VAWD). The new forum was originally established to remove the increasing pressure upon VAWD to represent the sector within decision making structures and processes, as one voluntary sector representative describes,

> The board here realised that the Chief Officers... were getting called on more and more to speak on behalf of the sector as partnership structures were growing and as there was a need for community involvement. And they recognised that an additional structure of some kind needed to be set up to facilitate that to happen.
> (Voluntary Sector Officer, OR6)

However, during the development of the forum, the national Neighbourhood Renewal Unit's community empowerment policies emerged and thus Vox assumed the function of the community empowerment network (see Chapter Two, Section 2.2.1). Consisting of members from over 160 groups and charities (Vox, 2003a), Vox aims to represent the voluntary sector, community sector and communities of interest within the LSP and the associated strategic and community planning processes in the District (Vox, 2003b, para 2.2-2.3).

The loss of the Barnardos sponsored Wakefield Community Development Project in 2004 also represents a significant event in the evolution of the District's community and voluntary sector. The project, established in 1983, created and managed the Wakefield District Community Network (WDCN), a forum with over 300 members from the community and voluntary sector. At the time of the research, the forum met four times a year and offered information, support and networking opportunities to its members. After the withdrawal of Barnardos funding, and the ongoing changes to the voluntary sector, the project formalised its structures in 2004 in order to secure further grant funding (WDCN, 2004). A constitution was developed and stated "the network is a district wide forum where people can enhance their capacity for community development and provide a platform for collective action for change by sharing and developing their knowledge and skills".

The changes throughout each of these sectors were identified by organisational representatives as an important factor in shaping the new approach to community involvement. Typically, interviewees reported a historical context of low levels of involvement, particularly by the local authority; indeed, and as reported above, WMDC assessed itself as "inward-looking and reactive" (WMDC, 2002, p1). As one health officer described,

> Wakefield doesn't have a, a strong history of engagement with the voluntary sector. Its origins and traditions are more municipalism, which precluded the voluntary as well the private sectors in the past. So it was starting from a low base.
> (Health Officer, OR11)

However, the recent changes were generally viewed by the organisational representatives as positive, with the ability to engage with communities improving.

Vox was cited as an important structure in facilitating the new approach to involvement and was considered to have "done an awful lot to provide opportunities for the voluntary and community sector to get involved with the District Partnership" (Voluntary Sector Officer, OR2). Similarly, another interviewee accredited Vox with stimulating a cultural shift in the commitment to involvement,

> I've seen big changes... I think most partnerships understand that it's not enough just too occasionally invite voluntary action and stuff. But they have to have involvement, so I think that has been a really really positive thing Vox has done. You know, it's got people onto partnerships, committees.
> (Voluntary Sector Officer, OR6)

In providing a means to secure the involvement of the community and voluntary sector within formal decision making, the introduction of Vox marked an important step in developing the organisational capacity to deliver an improved involvement process. For example, one interviewee described the previous constraints upon the community and voluntary sector,

> And there were always difficulties in Wakefield getting a good CVS established. But I do think that Vox is now resourced and funded, it has the kind of personnel that can begin to take that forward, so I'm quite optimistic about that element
> (Health Sector Officer, OR11)

The perceived importance of capacity in achieving effective involvement was not limited to the resources available to the community and voluntary sector but included constraints upon statutory organisations. The funding and resources available to the health and local authority implicated the employment of community workers on a fixed term basis, thus preventing the implementation of a co-ordinated approach. As one local authority officer described,

> Its been so ad hoc, the whole, the whole, the whole approach to community development work, you know, has been let's get someone in and you know and we can build up this group and then we'll put them on a short term contract and then once we give them targets, you know we'll move onto something else. And you know, I just don't think that's, that can never work, you know the whole short term funding, the short-term employment. And I do think there does need a strategic approach, to it.
> (Local Authority Officer, OR9)

The restructuring of the health sector enabled some action on this issue; the newly established Eastern Wakefield PCT, in continuing the HAZ's work on community involvement, employed seven permanent health and development workers. Increasing the resources available to statutory sectors was considered essential in enabling the maintenance of an effective approach to community involvement,

> And probably, the most successful thing we did was make them [community development workers] permanent posts and strategically that is incredibly important. Because, in the past it had all been done on piecemeal bits of funding, you know SRB here there and everywhere.
> (Health Officer, OR11)

Similarly, the limited budgets of the statutory sectors was identified as an important factor inhibiting the investment requirement to sustain effective involvement, as one health officer described,

> And I think for a long time, that the big statutory organisations in Wakefield that'd been strapped for cash, you know, the health service, the local authority. And when you're strapped for cash, the voluntary sector functions on short term funding bids. And then people spend the whole of last year of funding trying to find, not delivering service, but trying to find ways to carry on the service.
> (Health Officer, OR10)

Although the need for core funding of the voluntary sector was repeatedly emphasised by one sector representative, they too acknowledged the financial constraints shaping local authority action,

> But I also think it does mean seriously looking at at issues around funding and core funding, and the different levels of development of the sectors and all that kind of thing. And it needs looking at, we're getting very good at looking at it at a strategic level, need to start looking at some of the practicalities. And the difficulty is that none of the statutory agencies have the budgets, to do this. I mean that's the difficulty, but then on the other hand, if the strategy in the long term you have to do that then maybe you have to start finding the budgets.
> (Voluntary Sector Officer, OR6)

However, the move towards an effective involvement approach was also considered dependent upon the ability of the community and voluntary sector to adapt to the changing policy environment. In particular, local authority officers observed that the Wakefield District was composed of a number of small towns, each with a distinctive identity and thus, the challenge was "to get all these people working together for the

benefit of the whole district" (Local Authority Officer, OR3). Similarly, a second interviewee reported that,

> There was a strong local identity there... So there was a good community sort of spirit it seemed. Unfortunately, it was very much very local, I mean people in say * [*town name*] hated people in * [*town name*] which is next door or * [*town name*].
> (Local Authority Officer, OR4)

This interpretation of local communities resonates with current social capital debates; the strong sense of community suggests the existence of high levels of bonding forms of social capital in the absence of bridging forms between diverse communities. For Narayan (1999), such stocks of social capital serve to enhance existing social stratifications. In the Wakefield District, local authority officers did not utilise social capital terminology, but it did appear that related constructs were drawn upon to describe how cohesion could be generated. As described by a local authority officer (OR4), "if you want sustainable communities... in Wakefield that essentially means, people from * [*town name*] getting on with people from * [*town name*] and so on and so forth."

Change within the community and voluntary sector was also advocated by interviewees beyond the local authority, for example a voluntary sector officer (OR6) stated, "there's also got to be a huge amount of cultural change in the voluntary and community sector." For other interviewees, action was required at a more structural level, namely the deprivation experienced by the District's communities. In this context, deprivation was identified as a constraint upon communities to respond to the new opportunities for involvement, "it's really easy to talk about engaging the community, but a lot of our community have got a long way to go before they are at the point where they can be engaged" (Health Sector Officer, OR10).

The data presented thus far demonstrate the extent of change underway, and still required, within the Wakefield District. In general, these changes were viewed as positive; however, they were not without their critics. In particular, the relationship between Vox and VAWD, the District's council for the voluntary sector, emerged as a point of confusion for interviewees outside the voluntary sector. For example, "I think it is very uncoordinated, and I think in terms of the sort of VAWD Vox structure, that's

very confusing, and I, in my opinion has been ill thought out and is probably over bureaucratic"(local authority officer, OR9). The experiences of communities in interpreting these new structures were explored in the second stage of research and are reported in Chapter Six, Section 6.4.2.

The ongoing development within each of these sectors inevitably influenced the relationships between them and, indeed, interviewees reported the evolution of partnership working within the District. Local authority officers in particular emphasised WMDC's awareness that it must engage with other service providers to overcome its self-defined inward looking culture (see above for further discussion), "the only way the council is really going to sort itself out is to work better with its partners, and to engage more with its citizens in terms of what it's there to achieve" (local authority officer, OR4). Equally, the perceived increase in commitment to partnership working was shared by representatives out with the local authority,

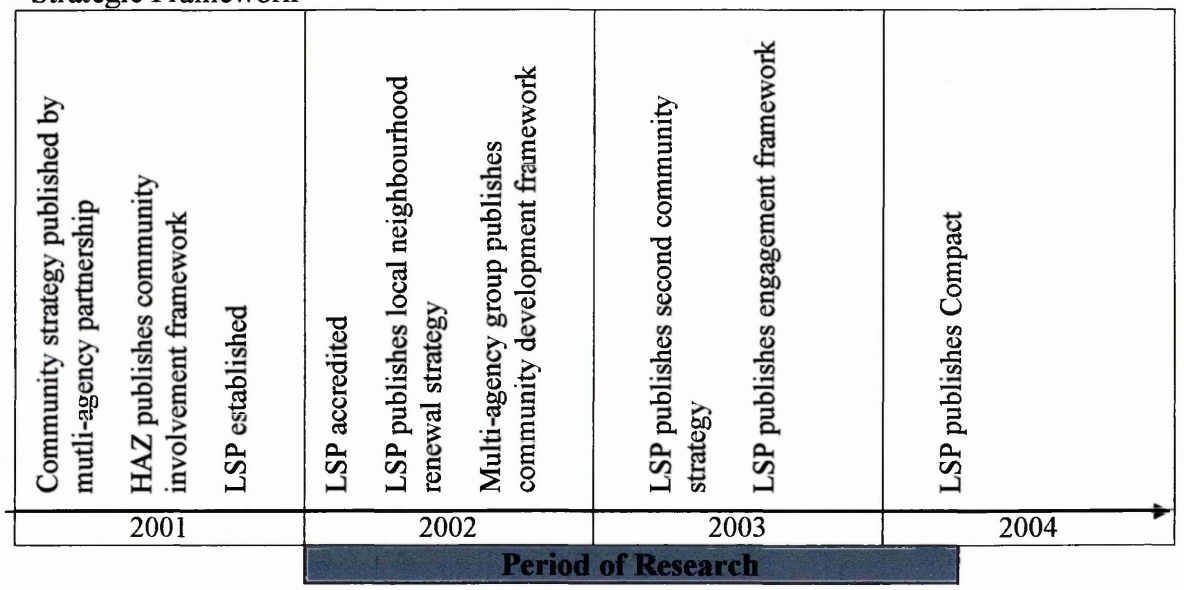
> I think there was a general within Wakefield a general desire to change and do things differently to the way in which things had been done in the past, and therefore as a consequence of that, all the players have been keen to take account of that in developing this new relationship between the partners on the Wakefield District Partnership and the communities within Wakefield District. (Voluntary Sector Officer, OR5)

Opportunities to work in partnership were enhanced by the creation of the new local strategic partnership (LSP). This structure, as set out within government guidance (see Chapter Two, Section 2.2.1 for further discussion), is responsible for the development of the District's community strategy and local neighbourhood renewal strategy. In doing so, it is central to the involvement approach. The creation of the LSP, together with the wider changes reported here, altered the capacity of the Wakefield District to involve its communities within decision making processes. Therefore, although there has reportedly been a historically low level of community involvement within the Wakefield District, structures now appear to be in place to remove previous constraints and thus reverse this trend. Reflecting this, a new strategic framework for community involvement emerged during the time frame of the research and Section 5.2.1 draws upon the interview and documentary data to identify its principle components.

5.2.1. The Involvement Strategic Framework

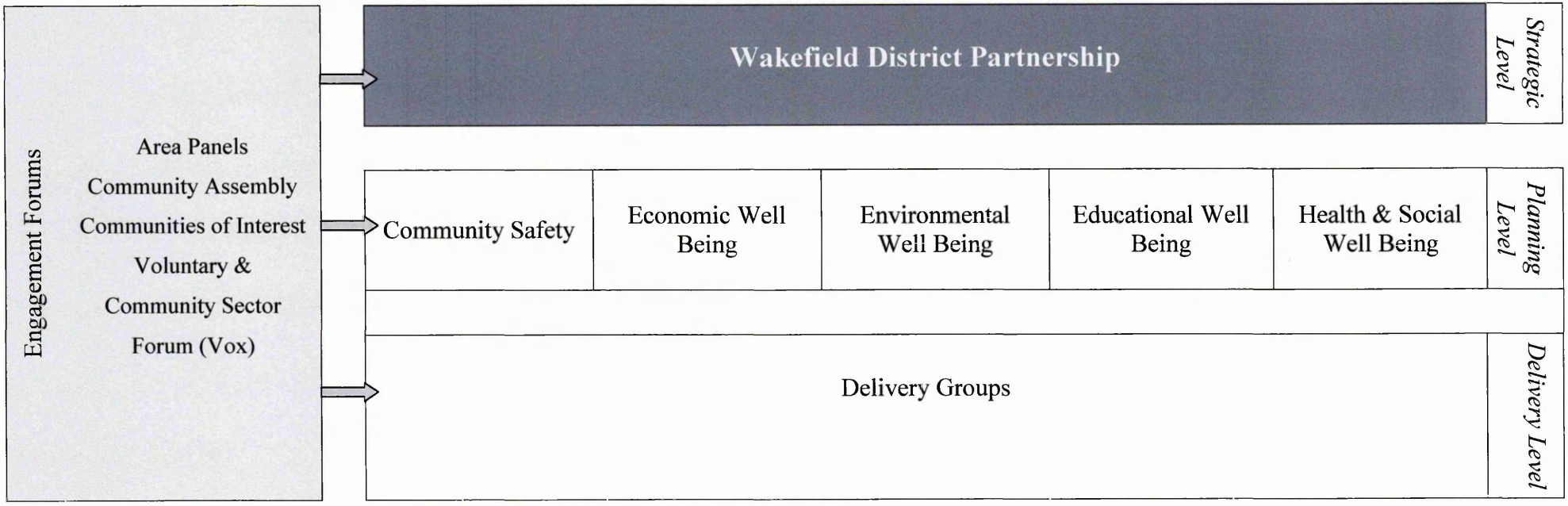
The involvement strategic framework is composed of several key structures and documents, as defined by both national policy and the local response to it. It includes the LSP, community strategy, local neighbourhood renewal strategy and the District's engagement framework. Descriptions of these were obtained in the first instance from an analysis of the relevant documentation; perceptions and interpretations were then explored in the interview process. Figure 5.1 below presents a timeline of the development and publication of the structures and documents incorporated within this framework.

Figure 5.1: A Timeline of the Development of the Wakefield District Involvement Strategic Framework



The Local Strategic Partnership was formally accredited in 2002 and named the Wakefield District Partnership. As set out within government guidance (e.g. DETR, 2001b), it functions as the overarching multi-sector strategic partnership body within the local authority area. As the Wakefield District is one of eighty-eight local authorities eligible for neighbourhood renewal funding, establishing a LSP was a necessary action to secure the monies (see Chapter Two, Section 2.2.1 for further discussion). At the time of research, the LSP consisted of a board, five thematic partnerships and delivery groups. Chief and senior officer representatives from the District's key service providers, including WMDC (councillors and officers), PCTs and the police, the voluntary, community and business sectors, all hold membership of the Partnership Board. The board is responsible for guiding the strategic direction of the

Figure 5.2: Wakefield District Partnership Structure



LSP, most notably through the development of the community strategy and local neighbourhood renewal strategy.

As shown in Figure 5.2 above, the second 'layer' of the LSP is comprised of five thematic partnerships and, as implied by their title, address specific issues and services.

The five issues are defined by the challenges set out within the District's community strategy; community safety; economic well being; environmental well being; educational well being; and health and social well being (WMDC, 2003a). The thematic partnerships are therefore responsible for co-ordinating action against each of these challenges, through the development of Joint Action Plans, and their delivery is guided by the third 'layer' of the LSP (Wakefield District Partnership, 2004a). The functioning of the LSP is supported by a series of working groups, including; officer co-ordination; multi-agency information; strategic funding; and community engagement. Involvement within the LSP structure is enabled by a range of engagement forums, as shown in Figure 5.2, including Vox, area panels, the community assembly and communities of interest (Wakefield District Partnership, 2004a). Throughout the period of research the structure of the LSP evolved reflecting the development of strategic objectives and realisation of its aims in rationalising existing partnerships and the description given here represents the state of evolution at the end of 2004.

As the LSP developed, action was undertaken to formalise the relationship between the different partners, and in particular, the role of the community and voluntary sector. This process included the publication of a local compact in January 2004 (Wakefield District Partnership, 2004b). The need for a compact was originally identified within the LSP's 2003 action plan as a means to set out an agreed way of working between the organisations on the LSP and the community and voluntary sectors (Wakefield District LSP, 2002a). *The Wakefield District Compact* is itself a short document that sets out principles for partnership working, which aim "to provide a framework for enhancing the relationship between these sectors, encouraging common approaches and systems" (Wakefield District Partnership, 2004b, p2). The principles identified include;

remaining citizen focused; being open and accountable; treating each partner as an equal; building trust and respect; being inclusive and encouraging diversity; recognition of the innovative role of the voluntary and community sectors; and recognition of this sector's support and capacity building needs. In addition to these principles, the compact presents a statement on the resources required by the community and voluntary sectors to enable their participation within partnerships,

> These resources should include sustainable long term funding, which allow the voluntary and community sectors to remain innovative and flexible. The partners support the voluntary and community sectors commitment to accountability, and the application of good practice in the use and administration of public funds (Wakefield District Partnership, 2004, p4).

This statement reflects the views of the interviewees', particularly those representatives of the voluntary sector, that the capacity of the sector must be addressed to ensure sustainability and thus enable effective involvement.

The compact was published towards the end of the data collection period and therefore, determining the impact upon working practice was not possible. However, organisational representatives' perceptions of the document indicated that there was some confusion over its purpose. A voluntary sector officer (OR6) described the compact as, "the compact isn't about the relationships in the LSP though, the compact is going to be about individual groups and how they relate to statutory agencies." In contrast, a local authority officer expressed his concern that it was not directly linked to the community strategy,

> So I wanted, whatever agreement we set up with the voluntary sector there must be, must be related to the community strategy, because if the voluntary community sector for instance want to take on responsibility to deliver some more services, it's got to be through that mechanism, through the community strategy. Its alright having a compact saying we're going to improve relationships between the voluntary sector and the statutory sector, and you can say why, well, because we want to get on better, why do you want to want to get on better, well essentially what it comes down to is, its that we want to deliver a better service to people in this District.
> (Local Authority Officer, OR4)

In addition to the compact, and again in compliance with national guidance, a protocol specifying joint working arrangements between the LSP and Vox was being developed

at the time of the research (2002 to 2004); unfortunately, however, it was not published. Nevertheless, it was possible to ascertain the issues that were considered necessary for inclusion in the protocol within the organisational interviews. A local authority officer described the importance of the document in determining the involvement of the community and voluntary sectors within the LSP,

> It's essentially about how the partnership and the community empowerment network relate to each other. If you include, include, roles and responsibilities, clarity about roles and responsibilities, what community empowerment network is there to do. And what the LSP is there to do in relation to each other. It includes issues around membership and how people become members of VOX, and how VOX members come onto the LSP.
> (Local Authority Officer, OR4)

For representatives of the voluntary sector, the protocol was perceived as fundamental in setting out the LSP's commitment towards involvement,

> In that protocol obviously be looking at ways in which first of all they actually include and involve the community empowerment network in policy development of decision making the way in which they proactively promote the community empowerment network across the District. They, another issue that has to be addressed is there's a requirement in the national guidance for them to I think the word is to undertake to maintain the sustainability of the community empowerment network, should funding cease from neighbourhood renewal unit as well. So, in terms of guaranteeing the future and the future role of the network within the District.
> (Voluntary Sector Officer, OR5)

There was some optimism amongst the organisational representatives interviewed that the development of these partnership agreements would alleviate the tensions that had persisted throughout the early stages of partnership working. Despite the establishment of the LSP, the scope and pace of the changes did not always exert a positive effect upon the relationships between the different sectors. For example, representatives of both the voluntary and health sectors were critical of several events that had taken place under the auspices of partnership. One example of this was the action planning undertaken as part of the development of the District's community strategy. The experiences of different sector representatives indicated that the purpose of the process had been misunderstood at the early stages of partnership working. As one local authority officer described,

> They've been critical of it, but I think mainly because they haven't quite understood what we're trying to do at this first stage which was to put down the things that we are doing now, they're more concerned about the things that we're not doing which is the next stage.
> (Local Authority Officer, OR4)

In contrast, health and voluntary sector officers interpreted the outcome of the process as a dismissal of their input,

> Similarly when the group [thematic partnership] were asked to develop actions, highlight priorities and develop action plans. The Group spent one and a half full days doing that piece of work only to find that it was rejected and [laughs] priorities were highlighted elsewhere. They were sent back to us and said now can you develop action plans around these.
> (Health Officer, OR1)

It is unfortunate that the time frame in which this research was undertaken did not allow the necessary investigation of the evolution of these relationships. It is therefore undetermined if these divergences are reflective of the relative infancy of the LSP or a more fundamental failing of partnership working in the District.

As stated above, the LSP has been assigned responsibility (DETR, 2000a, 2001b) for the development of a District wide community strategy, a document which sets out the overarching approach to improving well being. Thus, the community strategy determines the formal parameters (see Chapter Four, Section 4.3.1) for any approach to community involvement. Work began on developing a community strategy in 2001 and in May of this year, the document, *Wakefield Community Strategy: An Invitation to Contribute*, was published (WMDC, 2001b). As implied by the title, this document was intended to represent the starting point of the future development of the community strategy (WMDC, 2001b, p34). However, the final community strategy was not published until March 2003. During the period of the research, it was clear that involvement within the process of developing a community strategy could no longer form the focus of the thesis. Its publication had been delayed by the extensive changes taking place within the WMDC, most notably the introduction of a new corporate management structure. As one local authority officer described,

> When we started looking at the community strategy it was about two years ago, the difficulty was that we had the draft community strategy in 2001, we didn't have the capacity or will to take it further than a draft stage. And that, you

> know, *until* we got some new staff in, some new, had some new leadership in this year.
> (Local Authority Officer, OR4).

After the new posts within the council had been filled, the community strategy was produced with remarkable speed. In compliance with government guidance (DETR, 2000a), it set out a long-term vision for the area, stating that in twenty-five years time the district will be a place,

> Moving forward motivated by pride and its heritage; where our people look after themselves and each other so that they are safe and healthy, having the skills and confidence to take more control over their lives; with places that are attractive to live, learn, work and invest in and where our diverse towns and villages work together to promote the well being of the whole of the District; where together with the younger people of the District we will ensure that the work we do now will stand the test of time (Wakefield District Partnership, 2003a, p7).

The strategy's three underpinning principles, community engagement, community cohesion and sustainability, are reflected within this vision. Each of these principles are explored in turn to enable further analysis of the District's emerging community involvement framework.

The effective engagement of communities, and other key stakeholders, is defined as central to the success of the community strategy's delivery (Wakefield District Partnership, 2003a, p32). As acknowledged elsewhere, (e.g. Campbell and Jovchelovitch, 2000; DETR, 1997; Skinner, 1997; Taylor, 2000), *Fast Forward* emphasises the importance of utilising the valuable resource of local knowledge, stating that "workable local solutions depend on local knowledge" (Wakefield District Partnership, 2003a, p32). In resonating with government policy (e.g. NRU, 2003a), community engagement is defined within the strategy as integral to the rebuilding of civic pride and responsibility. It is of interest, within the context of the thesis objectives, that the Wakefield District Partnership chose to frame discussions within the concept of 'community engagement' rather than alternative terminology, such as involvement or participation. However, *Fast Forward* does little other than provide an overview of the principle; a subsequent publication, *The Engagement Framework* (Wakefield District Partnership, 2003b), provides further insight into the interpretation of the challenge to involve communities and is returned to in greater depth below.

Community cohesion, the second principle of the community strategy (Wakefield District Partnership, 2003a), is described as lying "at the heart of what makes a safe and strong community and includes the notions of equality, inclusion and diversity" (p34). Within this interpretation, cohesion is synonymous with a sense of belonging, both at the community and District levels and thus mirrors the presentation of cohesion within national policy (e.g. NRU, 2003a). Reflecting the long-term vision underpinning the community strategy, sustainability was defined as the third principle (Wakefield District Partnership, 2003a). The definition presented within the strategy, states, "it means we need to consider the overall economic, educational, environmental and social impacts of our actions and it means we need to look at dealing more with the causes of problems rather than just the symptoms of the problems themselves" (ibid, p35). Such a definition is conducive to a holistic approach to public health, an issue that is returned to in Section 5.4 below.

As reported above, the challenges identified within the community strategy define the action undertaken by the LSP and are defined as, feeling and being safer, looking after ourselves, developing a dynamic local economy, investing in our people and improving our places (Wakefield District Partnership, 2003a, p11). Essentially, these centre upon crime and safety, health, education, the economy and the environment. The priorities within each challenge are listed in full in Table 5.1 below.

Table 5.1: The Community Strategy's Challenge Priorities
(Source *Fast Forward,* Wakefield District Partnership, 2003a).

Challenge	**Priorities**
Feeling and being safer	• Creating a safer environment • Reducing and preventing crime • Assisting vulnerable groups and the victims of crime • Diverting people away from crime • Reducing the fear of crime and providing reassurance
Looking after Ourselves	• Modernising and integrating a range of NHS and Social Care Services • Developing modern and dependable Social and Health Care Services in the Community • Preventing avoidable ill health through public health programmes • Reducing health inequalities between communities • Tackling domestic violence • Promoting the health and social well being of young people • Development a strategic approach to Supporting People

Challenge	Priorities
Developing a dynamic local economy	• Encouraging investment and enterprise in the District and the development of clusters of economic development • Promoting and marketing a new image of the District • The urban renaissance of Wakefield City • Reconnecting the coalfield communities in the South East • The Five Towns Initiative
Investing in our People	• Access to early years education and childcare • Raising standards of achievement in pre-16 education • Raising aspirations in 16-19 education • Encourage involvement in post 19 education • Developing cultural activities and informal learning • Raising skills through community development
Improving our Places	• Promoting and maintaining a clean and attractive environment • Improving transport choice and make it easier to get around • Improving the range and quality of cultural and leisure opportunities across the District

Given that the community strategy provides the overarching framework for improving quality of life within the Wakefield District, it represents an important component within the local public health approach. As such, the implications of the challenges and priorities listed in Table 5.1 are examined further within Section 5.4 below.

In addition to the community strategy, the LSP holds responsibility for the development of a local neighbourhood renewal strategy (LNRS). This duty reflects the identification of the District as one of the eighty-eight most deprived local authority areas in England and its subsequent receipt of neighbourhood renewal funding. The LNRS, in relation to the community strategy, presents a more targeted approach to tackling inequalities within the Wakefield District. The LNRS, *Local Action to Build Stronger Communities* was published in March 2002 (Wakefield District LSP, 2002b), and therefore prior to the publication of the community strategy (Wakefield District Partnership, 2003a). In contrast to the community strategy, which was led by the local authority, the process of developing the LNRS was co-ordinated by the Health Action Zone on behalf of the LSP. The LNRS identifies jobs, crime, education, health, housing and the environment as the key issues to tackle, thus echoing the challenges set out within the community strategy. The actions identified against each issue are developed around the government's own targets for neighbourhood renewal.

Given that the District's Health Action Zone (HAZ) led the development of the LNRS, it is useful at this point to describe the HAZ's approach to provide the LNRS with the required context. Reflecting the national guidelines, inequalities were central to the HAZ; it aimed "to work in partnership to improve the health of the people in Wakefield and District, to reduce inequalities, and improve health and social care by integrating and modernising services" (Wakefield HAZ, 1999, p8). Health was interpreted as a state of well-being and subsequently, action across a wide range of social, economic and environmental factors was deemed essential. A commitment to community involvement was at the centre of the HAZ approach (and demonstrated by their joint funding of this thesis). Following a mapping exercise of existing community involvement mechanisms and structures, the HAZ published the document *Getting People Involved* in 2001 (Wakefield District HAZ). *Getting People Involved* was described as an important first step in developing a framework for involvement activities throughout the District (p1). In doing so, it presented a model for community involvement shown in Figure 5.3 below. Involvement was defined as

> Finding ways in which people feel they are an essential part of a decision making process, and that their involvement makes a real difference to what is decided. It is a continuous process with long term as well as short-term goals. If people have never been involved before, they will need information and support to get involved in a meaningful way (Wakefield District HAZ, 2001, p9).

Figure 5.3: The Wakefield HAZ Model of Involvement (HAZ, 2001, p9)

CONSULTATION			**INVOLVEMENT**
Community Based work	*Community as advisers*	*Community as joint planners*	*Community as initiators & planners*
One-off consultation with service users led by the agency providing the service, aims to obtain feedback.	Agency seeks the views of the community on a given set of priorities or initiatives.	Community involved in decision making from the outset.	Enabling and empowering the community to identify & achieve their own goals and plans.

Consultation was differentiated from involvement, in that it focused solely upon obtaining input on a given issue, typically in a single event. Each level of involvement was described as having different objectives and the higher the level, the greater the empowerment of communities. At the centre of this model was the proposition that community development is key in underpinning both citizen and community

involvement. That is, the HAZ's use of the term community involvement implicitly incorporated a process of community development. Indeed, the values of community involvement presented within the framework are those developed by the Standing Conference for Community Development (SCCD, 2001, see Chapter Three, Table 3.1). Community development was defined as

> The process of enabling people, particularly those who have been excluded in the past, to come to a common understanding about the issues that concern them and to develop common action to tackle those issues. It is a process which particularly focuses on people experiencing inequalities and helps them to find their voice (Wakefield District Health Action Zone, 2001, p11).

The significance of community development within the HAZ model reflected an awareness of the failure of previous involvement efforts to involve sections of the community less "easy" to reach (ibid, p11). Community development was thus perceived as an important tool in tackling inequalities.

Reflecting this, community involvement features strongly within the LNRS, which states that there is a need to increase opportunities for involvement within decision-making structures within the District, "we know that the quality of community involvement has not always been good and that local people have been let down by inconsistent, fragmented and confusing processes that have not led to significant change" (Wakefield District Local Strategic Partnership, 2002b, p16). Like the HAZ's wider approach, the LNRS presents community involvement as underpinned by community development (ibid, p18). However, the LNRS does not provide a full presentation of its interpretation of community involvement, rather it identifies the development of a District wide community involvement and development strategies as a key action for the LSP (ibid, p18). In 2003, this action was realised with the publication of the *Engagement Framework* (Wakefield District Partnership, 2003b). However, the *Engagement Framework* builds upon the model of involvement presented within the community strategy rather than the LNRS. Furthermore, the *Engagement Framework* presents a policy for the involvement of all local stakeholders (ibid, p7) and defines engagement as "a process of dialogue that leads to a decision" (ibid, p4). It continues that the use of 'dialogue' "implies an ongoing exchange of views and information, rather than a one-off event. Dialogue means two or more parties listening to and taking account of one another's views" (ibid). Community development, involvement,

consultation and participation are described as different elements of the engagement process; thus engagement is used to encompass all of these terms (ibid, p9).

The model of engagement presented within the framework is based upon Wilcox's model of participation (1994; see Chapter Three, Section 3.4). Like Wilcox's model, and as shown in Figure 5.4 below, the Wakefield District Partnership define five levels of engagement.

Figure 5.4: Wakefield District Partnership Model of Engagement (adapted from *Engagement Framework*, 2003b, p9)

Level of Engagement		
	5. Development	Enabling stakeholders to develop and carry out their own plans. Includes empowering communities and capacity building, leading to communities governing themselves rather than being governed.
	4. Acting Together	Deciding together and acting together with a sharing of that responsibility.
	3. Involvement	Working together and accepting other people's ideas, decisions made on the basis of jointly identified options. Stakeholders do not have full responsibility for decisions made.
	2. Consultation & Learning	Includes researching needs, attitudes and priorities to inform the decision making process. It does not involve partnership working.
	1. Information Giving	Providing stakeholders with information and knowledge to ensure that they are able to make informed choices. Participants should receive feedback after this engagement.

The *Engagement Framework* sets out nine principles, described as being drawn from evidence of good practice, to guide its implementation. The principles emphasise the importance of meaningful, appropriate engagement that is fit for purpose, recognising that the different levels require differing levels of commitment from the groups being engaged (Wakefield District Partnership, 2003b, p11). Although not described as community development, it continues, "engagement should be based on a recognition that many individuals, groups, and communities experience social exclusion and require pro-active development and outreach to facilitate their involvement" (ibid). Similarly, it states that accessibility issues must also be considered, ensuring that the necessary facilities and support is provided to meet any additional needs. In Chapter Three (see Section 3.4), it was established that levels of involvement are differentiated by the

degree of devolution. The *Engagement Framework* does not explicitly discuss power differentials, but does state that an organisation carrying out any engagement activity must be committed to "improving communication, generating stakeholder involvement, engagement and active citizenship" (Wakefield District Partnership, 2003b, p11). In doing so, the approach appears to represent a commitment beyond tokenistic levels of engagement.

In considering the value of engagement, the *Engagement Framework* states "local people can be empowered to define the vision for their own community leading to a sense of ownership and pride" (Wakefield District Partnership, 2003b, p12). Again, this suggests that there is an awareness of community development processes and the need to include them within any effective involvement activities. In Chapter Three (see Section 3.4.2), it was reported that community development has been suggested as an important means of creating local stocks of social capital (e.g. Putnam, 2000). Although social capital is not explicitly referred to within the document, community engagement is described as improving relationships and trust within organisations (Wakefield District Partnership, 2003b, p14), features central to any theory of social capital.

As reported above, a range of working groups form part of the formal LSP structure; the *Engagement Framework* sets out plans to establish a new community engagement group to ensure co-ordination and consistency. Prior to the establishment of this group, a Community Development Good Practice Group and Community Involvement Advisory Group, had been established as formal LSP working groups (Wakefield District Partnership, 2003c). By 2004, the community engagement group had been established and assumed LSP working group status, thus appearing to replace the previous two structures.

Nine months prior to the publication of the *Engagement Framework,* a District approach to community development had been endorsed by the LSP (Wakefield District Local Strategic Partnership, 2002c). In 2002, the Community Development Good Practice Group, initially established and facilitated by the HAZ, published *Community Development A Strategic Way Forward for Wakefield* (Perry, 2002). The document drew upon the values and principles by the Standing Conference for Community

Development (SCCD, 2001; see Chapter Three, Section 3.4.1) and therefore was embedded within an ethos of social justice. It described community development as being "about building active and sustainable communities based on social justice and mutual respect. It is about changing power structures to remove the barriers that prevent people from participating in the issues that affect their lives" (Perry, 2002, p5). Given that this strategic document was formally endorsed by the LSP in December 2002, the relationship between it and the more recent *Engagement Framework* (Wakefield District Partnership, 2003b) must be established to enable a full analysis of the emerging community involvement infrastructure.

However, discussion on the relationship between the two documents is largely absent from the *Engagement Framework*, stating simply that it complements the community development framework as "actions to support community development will not be effective without a consistent approach to the methods of engagement themselves and vice versa" (Wakefield District Partnership, 2003b, p5). Further insight into the relative standing of these documents was obtained from the interview data, where individual's interpretations of community involvement were explored. The alternative models described here resonate with the interpretations provided by the organisational representatives interviewed and are discussed further in the following section.

5.3. Models of Community Involvement

The interview data reflected the divergence present in the District wide documents in that there was an absence of a common understanding of community involvement. Local authority officers offered a model of engagement that resonated closely with that presented within the *Engagement Framework* (Wakefield District Partnership, 2003b) and drew upon the concept of different levels on a ladder of engagement. In contrast, representatives of the health and voluntary sectors, many of whom were closely involved with the development of the strategic framework for community development (Perry, 2002) and *Getting People Involved* (Wakefield District HAZ, 2001), placed community development at the centre of involvement processes. For advocates of this model, issues of power and control were essential; effective involvement was possible only when communities were enabled to acquire control over the issues that affected their lives.

The issue of community development emerged as an important defining feature of interviewees' models of involvement. For one health officer, there was a sense of frustration that a multi-agency partnership had invested time in the development of *Getting People Involved*, which was perceived as being superseded by a model of community engagement, "we had a shared understanding that community development would underpin any model of involvement. Because we were working towards what we would call a democratic model of involvement rather than a consumerist [model]"(Health Sector Officer, OR1). However, local authority officers, although acknowledging divergence in opinions, were more pragmatic about the relationship between the two models,

> And to me, it's not an important argument to argue about to be honest... I see all forms of engagement asking people and involving people in things, asking people to take some responsibility for things, is, is a form of community development in itself, by engaging people you're actually developing them. (Local Authority Officer, OR4)

Like the strategic documents, advocates of both models of community involvement acknowledged the importance of developing communities in some form. However a divergence emerges in discussions of the position assigned to community development within this process. For local authority officers, engagement on some level must be undertaken as a first step in developing both individuals and communities. That is, without establishing a relationship with communities, there is no basis upon which development can proceed. In contrast, proponents of a community involvement approach described this position as a failure to understand the conceptual underpinnings of community development. For example, a health officer stated, "I think there's a strategic lack of understanding about what the difference is between community development and community engagement, and I think community development comes *first"* (Health Officer, OR10). Those adhering to this model argued that engagement alone would succeed only in securing the input of those communities already in possession of the necessary skills and knowledge. As this health officer described, "you run the risk of bring out the usual suspects to everything" (Health Officer, OR10). Similarly, another health officer stated that,

> It does not include any means of actually working out in the communities to ensure that the skills are developed out there so that a wider group of people can feed in. So effectively what that means is that you only get the articulate if you

like or the noisy if you want to call him Mr Angry, which is not really what we were about and it was most certainly not what was agreed in those two former groups.
(Health Officer, OR1)

For these interviewees, and representatives of the voluntary sector, it was essential that the wider community is equipped with the necessary skills and knowledge to become involved; for example,

> And at the same time in order to be involved and engaged with the process the people who are being asked to have a *say* need to have the *knowledge and understanding* of *what's* being asked of them in terms of what are the changes about, what impact will they have on them, what impact they will have on their community, and that takes time to acquire that knowledge and understanding.
> (Voluntary Sector Officer, OR5)

A key issue, particularly for the health officers, was that the starting point of any involvement process is determined by the stage of development of the community,

> So it struck me that what we needed to do was to take a long-term view, to take a view of engagement in people starting where they are, with their perceptions of the problems. And that lots of people we were coming into contact with weren't at a stage where you get into a community involvement. But you had to help them to move from there to a point where you could actually get involvement.
> (Health Officer, OR11)

For proponents of a model of engagement, an emphasis upon community development was viewed with caution. One local authority interviewees expressed concern that the term had paternalistic connotations,

> I actually try not to use the word community development because its, I think it's slightly paternalistic. And that there's no doubt that some community however you define them do desperately need developing, but I'm thinking that in the days when the phrase was coined, you know in the late 1960s, early 70s, you've probably researched all these, you know John Bennington's community development pilots which took place in the late 60s and early 70s. I think the world has moved on a lot now, and I think people are, have the potential capacity to take much more control over what happens to them, because you know, technology has changed, different, different attitudes towards work, and senses of community and things like that.
> (Local Authority Officer, OR3)

Although the two models described by the interviewees diverge on the role of community development, there was consensus that the ability, or capacity, of communities to be involved was an issue that had to be tackled in any approach. All interviewees stated that it could not be assumed that all communities possessed the capacity to respond to the increasing opportunities for involvement. For example, "do local people have the skills and have they got the, the time to spend on, things that they've traditionally donned as the, as the property of the local state" (Local Authority Officer, OR2). Similarly,

> I think in some ways, we do have to build the capacity to engage. And, you know, there's all sorts of ways in which some of the traditional approaches to engagement just didn't work because people didn't have the skills and the ability, and that could have been time and all sorts of other things to actually engage. (Local Authority Officer, OR7)

The use of capacity was not restricted to the skills and knowledge held by communities, it was also used to describe the material resources possessed. A voluntary sector officer emphasised the sustainability of funding as a determinant of involvement, "you can't expect groups to turn round to say well our voice needs to be x if they're struggling with payment for heating and lighting. Or whatever, or what they're worried about is their funding" (Voluntary Sector Officer, OR8).

The complexity of the issue was further revealed by the definition of capacity as an outcome of community involvement as well as a prerequisite, "newer community groups are very, you can see how community groups go from having that initial annoyance, that argument with the local authority, to now learning how to play the game if you like" (Voluntary Sector Officer, OR2). Similarly, personal development was cited as an important outcome of community involvement by a representative of the voluntary sector, "the effects on the individuals have been confidence, the skills that people can get, the belief and hope in themselves that might lead onto a better job or going onto college" (Voluntary Sector Officer, OR6). A range of other potential involvement outcomes were also described by interviewees and these are discussed within the presentation of the fourth theme to emerge from the data, models of health.

Capacity was related to a second key descriptor used within interviewees' interpretations of involvement, control and influence. Representatives from all sectors

emphasised the importance of communities being enabled to exert an influence upon both decision making processes and the wider issues that determine their quality of life. For one voluntary sector officer, this was "what involvement means, it means communities being able to not just to say what they want but also to be able to have elements of control over what they want" (Voluntary Sector Officer, OR6). Another interviewee stated that inviting communities to meetings did not constitute involvement, instead "the real question is who tends to go those meetings and how representative they are of those communities and what influence they actually have on the decision making process" (Voluntary Sector Officer, OR2).

The concepts of control and influence were also applied to the role of statutory organisations and particularly their willingness to devolve responsibility to the community and voluntary sectors. One health officer perceived statutory organisations as cautious to provide the community and voluntary sector with the resources required to deliver services,

> *Because it's public money* and I can see how people are worried about losing control of public money. There is a fair amount of probity in the procedures of the council and the PCT, so you know, you can answer for it. If you give it away, then I, might do something terrible with it, like do something useful.
> (Health Sector Officer, OR10)

Although interviewees recognised the importance of enabling communities to exert control and influence within any involvement process, it was emphasised that the communities themselves should determine the level of control. That is, involvement opportunities should be presented as a choice rather than as an obligation. Despite the emphasis within national policy upon communities delivering services, organisational representatives questioned the enthusiasm amongst this sector to assume such responsibility, for example,

> I don't think it's just a question of skills and capacity, it's also a question of inclination. That actually most people don't want to do stuff like, they want us to do it but they want us to do it better. And they want to be able to hold us to account better for what we do.
> (Local Authority Officer, OR3)

> It [national policy] tends to assume that a *lot* of people, a lot of like community people in the community want to be *really* involved in what the council does or

> what other organisations do. *And*, to the extent that they want to take control more, more want to take control of things happening in their area, actually *run things* and do things. *I think that* is a bit over optimistic that. I think a lot of people, *do* want to know about what's happening in their area, want to know why certain things are happening, and probably quite a few people want to have a say, a more direct say about what's happening in their area. I think as go further down the line in terms of taking over sort of responsibility, that dwindles down to a very small *number* of people."
> (Local Authority Officer, OR4)

A voluntary sector officer also emphasised the importance of individual groups determining the level of control assigned,

> The first is *how* much do we or don't we want to be delivering as a statutory, body. And I think that's a decision only individual groups can make. But I'm not sure that our level of knowledge is high enough for all of us to be able to make informed decisions. *Do we* want to be holding contracts for delivery of statutory services and everything that goes with that.
> (Voluntary Sector Officer, OR6)

The emphasis upon choice in any approach to involvement resonates with a further descriptor utilised by interviewees, particularly those advocating an engagement model, which is termed here ladders and levels. Organisational representatives favouring this model did not offer a single definition of engagement; instead they perceived it as a number of different events and processes that constituted a ladder of engagement. For example, "the engagement ladder, where, at its most basic it's giving information, at its most developed it's actually involvement and giving over control, to others, to communities for instance. We see that as the full width of engagement" (Local Authority Officer, OR4). And similarly,

> At the lower levels the information giving level it's the council or somebody who's actually making the decision, and at consultation level it is too, although you know consultation implies a predisposition to change on the basis of what people tell you. Moving up to as I say, the highest level of the hierarchy where the council and the public sector partners are actually operating in a support mode to the people making the decisions. They have the money to do that.
> (Local Authority Officer, OR3)

It is this interpretation that resonates most closely with that presented within the *Engagement Framework* (Wakefield District Partnership, 2003b).

5.4. Models of Health

The aim of this thesis is to determine the relationship between community involvement and health. Reflecting this, it is of interest to determine if the models of health emerging from documentary and interview data sources acknowledge the breadth of health determinants. Such models of health could be indicative of potential support for community involvement as a tool for public health. As described above, the overarching strategic framework for the Wakefield District is set out within the community strategy, *Fast Forward* (Wakefield District Partnership, 2003a), within this key document, health is discussed within the challenge of 'looking after ourselves'. 'Looking after ourselves' is described as "not simply dealing with disease and infirmity but aiming for improving physical, psychological and social well being. To do this we also need to provide opportunities for education, employment and decent affordable housing" (Wakefield District Partnership, 2003a, p16); however, this seemingly social model is largely absent in the identified priorities (see Table 5.1 above). For example, preventing avoidable ill health through public health programmes is based upon a narrow medical model, "avoidable ill health can be caused by lifestyle factors such as diet, smoking and inactivity... We will continue to invest in 'stop smoking' services and initiatives that tackle drug and alcohol misuse" (ibid, p18). Previous research (Burrows et al, 1995) has demonstrated the interaction between determinants of health (see Chapter Two, Section 2.1) and the subsequent ineffectiveness of lifestyle based interventions. Thus, the value of the actions proposed within the community strategy in the absence of simultaneous efforts to tackle socio-economic factors is unclear. The importance of the medical model in informing the community strategy is reasserted by the identified outcome measures, which include; a reduction in limiting long-term illness; reduced mortality rates; and reduced teenage conception rates.

However, the priority 'reducing health inequalities between communities' offers an alternative interpretation of health; "emphasis on dealing with inequalities will be given to services that promote healthy lifestyles and a community development approach to the needs of people living in the most deprived communities" (ibid, p18). Therefore, it is concluded that the model of health presented within the District's community strategy lacks consistency and clarity. The interview data provides further insight into the predominant model of health utilised by organisations central to the involvement process.

In general, interviewees did not explicitly express a preference for either a medical or social model of health, but there was a clear awareness of the complex relationship between social, economic and environmental factors and health. For example,

> I recognised that housing has a, has an impact on absolutely everything, you know, if you're cramped you're not going to be doing your homework and you're not going to get a quality education and you know its going to affect your life chances in the future. And you know health is like that, you can draw a scatter diagram, and everything impacts on everything has an implication for health as well.
> (Local Authority Officer, OR9)

> We've got thousands and thousands of people on sickness benefit or invalidity benefit, or, you know that's a big impact in terms of the business of the District, in terms of involving people in further education, all sorts of things. So, it's very much a holistic view of things, its concentration on looking at some of the determinants of health and it's about how we can then link it into, effectively link into the action plans of the other agencies.
> (Local Authority Officer, OR4)

Further support for a social model of health was revealed by the outcomes of involvement identified by interviewees. Here, organisational representatives drew upon the features of community that have been positively linked with health. For example, a voluntary sector officer perceived involvement as overcoming social exclusion,

> One of the other big things that we know is the loss of isolation for individuals who get involved in groups because you then have a social circle you've got places to be, you've got things to do, you've got that feeling of importance of well being and I'm sure there must be research which shows how all that then connects back to people's health.
> (Voluntary Sector Officer, OR6)

Involvement was also attributed with facilitating a sense of belonging within communities,

> And, I think you know, giving people that sense of belonging within their community which is something that you get from involvement in the community and voluntary sector activities. A feeling that you can influence what happens in the local area, all those kind of things impact upon the way you feel and upon the health of the local communities.
> (Local Authority Officer, OR7)

Therefore, a strong community was perceived by organisational representatives as enabling a sense of control and influence to be developed. This personal development was commonly identified as a key outcome of involvement, as a health officer (OR8) described, "because if you get people starting to think for themselves, doing things, they get a better respect for themselves, and actually aim a bit higher. And move forward that way you know." Similarly, a local authority officer stated,

> Whether it be, making the streets cleaner, providing a kids play area. You know supporting a luncheon club, whatever. They've all got an impact on people's quality of life and a knock on effect for peoples sort of, self-esteem and feel good factor, and in turn you know their sort of their health.
> (Local Authority Officer, OR9)

The improved perception of control and influence facilitated by involvement processes was in turn considered important in stimulating more instrumental outcomes,

> I mean suppose to take to its extreme in terms of building individuals' capacities capacity and self-belief and encouraging people to get involved in there then, you know, take that one step further and get accredited for some of their activity they do within the community. And you know, sort of knock on effect of it in terms of access to employment and getting people out of poverty.
> (Local Authority Officer, OR9)

Therefore, it is evident that despite the reluctance by local authority interviewees to embrace community development, they drew upon many of the key tenets of the process in describing the value of their model of engagement (see Chapter Three, Section 3.4.1). However, some interviewees expressed concern that a sole focus upon enhancing the number of social networks within an area would fail to address the structural roots of multiple deprivation, "it needs the commitment to broader involvement, definitely. Otherwise it won't be, it won't tackle the inequalities agenda unless they do that" (Health Officer, OR1). For this interviewee, a commitment to broader involvement incorporates a community development perspective and the concept of social capital was drawn upon to illustrate this point further,

> So any model of social capital that's only about what I call you know wartime spirit make do and mend, you know we'll all get together. But without ever tackling any of this deeper structural inequalities in health will only be a partial model.
> (Health Officer, OR1)

5.5. Conclusion

The evidence presented here suggests that there have been historically low levels of community involvement in the Wakefield District. Both documentary and interview sources highlight the paternalistic culture and absence of resources, of both the community and voluntary sectors and statutory organisations, as the key determinants of previous involvement levels. That is, the capacity of these sectors to implement a co-ordinated and strategic approach to community involvement had been constrained. The programme of research was located in a period of rapid change across the District, with action being undertaken to overcome these constraints. It is these changes that define the new strategic framework for community involvement.

Theoretical approaches to community involvement have emphasised the need to harness the valuable resources held within communities, namely the in-depth knowledge of local areas (e.g. Skinner, 1997, Taylor, 2000). This appears to have been recognised within the Wakefield District. Interviewees highlighted the changes taking place across all sectors, perceiving them to be, in general, positive. The role of Vox in addressing the underdevelopment of the community and voluntary sector, and in turn, facilitating involvement within decision making process, was cited as an integral component of the shift in culture. Vox, the District's community empowerment network, represents a key local level response to the neighbourhood renewal programme.

Also in response to the national agenda, a community strategy and local neighbourhood renewal strategy were produced within the period of research. These documents set out the strategic context in which the new approach to community involvement will be implemented; the *Engagement Framework* emerged as a subsidiary document to these overarching strategies. The three documents were published under the auspices of the newly formed Local Strategic Partnership, the Wakefield District Partnership. The interviews with organisational representatives were conducted soon after the formal accreditation of the LSP; it is perhaps unsurprising then that there was some criticism of partnership working. There was evidence that organisational representatives had interpreted the purpose of actions, such as the development of the local compact and the action planning process, inconsistently. As a result, some interviewees expressed a sense of frustration. This did not detract however from a general optimism surrounding the ongoing changes within the Wakefield District.

In considering the predominant model of involvement informing the strategic approach within the District, the influence of David Wilcox's ladder of participation is evident (Wilcox, 1994). Wilcox's ladder has been used directly in the development of the *Engagement Framework* (Wakefield District Partnership, 2003b). Wilcox proposes that there are five levels of participation, each of which hold value when implemented appropriately. Although favouring the term engagement, the *Engagement Framework* essentially reiterates much of Wilcox's model.

Within a discussion of the values of engagement, it is of interest that the concept of empowerment is utilised. Although no definition of empowerment is given, its presentation implies that it is perceived as a process enabling local people to develop the skills and knowledge required to exercise control over the issues that affect their lives. The term empowerment, in general, did not feature in interviewees' discussions of involvement, and where it did, its use was inconsistent. A health and voluntary officer both interpreted empowerment as synonymous with community development, but a local authority officer contradicted the statement made within the community strategy; this interviewee dismissed a process of empowerment as "too ambitious" for much of engagement.

The relationship between the *Engagement Framework* and the earlier produced community development strategy (Perry, 2002) was dealt with in a single statement (Wakefield District Partnership, 2003b, p5) and failed to adequately address the position of community development within the new approach. The perceived value of community development processes also emerged as an unresolved issue within the interview data. As stated above, the local authority officers interviewed reiterated the model of engagement presented in the Wakefield District Partnership document, with other interviewees advocating an approach to community involvement that incorporated a community development perspective. It should be noted that the majority of the advocates of this latter approach had been involved in the development of both *Getting People Involved* (HAZ, 2001) and *Community Development A Strategic Way Forward* (Perry, 2002). Issues of control and power were central to this approach to community involvement and thus resonated with the Standing Conference for Community Development's definition of community development (2001). The control and power

required to influence the issues that affected the lives of communities was described as being achieved only through a development process.

The two models of involvement converge on the issues of capacity and choice. These findings suggest that the government's enthusiasm for community involvement must be tempered by the reality of communities; it is not a given that they possess the capacity or the desire to participate within decision making processes. For the organisational representatives interviewed here, it is important that involvement is presented to communities as an opportunity rather than an obligation. The emphasis upon capacity by local authority officers does however highlight a contradiction within the engagement model. This model states that development occurs as a result of the engagement process; it is unclear however, how the initial act of engagement occurs if the community does not possess the required skills and knowledge.

The approach to community development within the Wakefield District's engagement model is unclear, with both key strategies and interviewees' reporting a divergence in the importance assigned to the process. A model of involvement underpinned by community development, as proposed by both the HAZ and Perry's (2002) strategic approach, presents an opportunity to tackle the determinants of health. Within this context, community development addresses the issues, such as poor skills or unemployment, that have previously rendered individuals and communities powerless to control the factors determining their quality of life. An effective tool for public health recognises the interdependent nature of determinants of health and such an approach would appear to represent such a tool. Despite the lack of clarity surrounding the continued strategic support for community development, the interviewees typically drew upon a socio-economic model of health when discussing the potential outcomes of involvement processes. Although interviewees did not necessarily explicitly adhere to such a model, they did express an awareness of the relationship between the determinants of health. It has not been determined however, how the engagement framework would tackle the root causes of ill health.

In responding to the imperatives of national policy, a new strategic approach to community involvement has been adopted within the Wakefield District. This in turn has influenced the structures and opportunities for communities to participate within

decision making processes. It is the practice of community involvement that forms the focus of Chapter Six.

Chapter Six

Community Involvement in Practice and the 'Edgeton' Community Action Group

6.1. Introduction

Chapter Five presented the findings from interview and documentary data sources and revealed the Wakefield District's emerging strategic approach to community involvement. It is within this context that local communities are involved in the different levels of decision-making. Here, findings from both observations of involvement structures and interviews with those involved are reported. The method of data analysis enabled the emerging themes to determine the development of theories. This approach to analysis reflects the aim of this thesis, to explore the relationship between community involvement and health, and establish the utility of social capital in advancing understandings of any relationships. To establish the value of social capital as an explanatory concept within this relationship, the conceptual boundaries between alternative constructs must be determined (see Chapter Four, Section 4.6). As such, the thematic analysis led to the identification of key themes emerging from the data and this chapter is structured around these. As set out within the thesis methodology, this stage of research focused upon the activities of a community level involvement structure in 'Hillwood', the 'Edgeton' Community Action Group; the findings emerging from both the interview and observational data are reported here.

6.2. The 'Edgeton' Community Action Group: An Overview

In 2001, a Primary Care Trust health and development worker facilitated the formation of the 'Edgeton' Community Action Group. This employee was one of the seven new permanent workers identified by organisational representatives as providing statutory sectors with an increased capacity to develop the community and voluntary sector (see Chapter Five, Section 5.2 for further discussion). A neighbourhood renewal research project into local needs identified residents willing to form a community group. With the help of the PCT worker, these individuals became the founding members of the 'Edgeton' Community Action Group. At the beginning of the fieldwork period, October 2002, the

group held monthly evening meetings in a local sports club and later relocated to a local authority owned bungalow in the village. Securing the use of the bungalow had been a long process and was recognised as a key stage in the development of the group, who felt that the previous absence of a base had hindered their activities. The bungalow, alongside neighbouring properties, had been vacant for several years prior to the group's occupancy. Several months into the tenancy of the bungalow, the group explored the possibility of securing funding to undertake renovation work perceived as necessary for the continuing development of the group. The group wished to undertake structural work to the bungalow, which consisted of a bathroom, kitchen, living room and bedroom, and knock down the adjoining wall between the living room and bedroom to create a larger, and more usable, space for their activities. However, approval of the funding application required an extended tenancy agreement, which the group did not hold. The previously empty neighbouring bungalows subsequently being inhabited perpetuated the perceived vulnerability of the group in occupying the bungalow. The absence of a permanent base remained an important issue throughout the period of research.

The 'Edgeton' group aimed to address the issues of concern of both its members and the wider community. The monthly meetings, although rarely structured by an agenda, generally adhered to the following format; agreement of the notes of the previous meeting; discussion of any action arising from the notes; and discussion of any emerging issues. Typically, all issues would focus upon 'Edgeton's' perceived problems and needs. During the fieldwork period, efforts focused largely upon traffic calming measures, play park facilities, planning applications and the demolition of housing. Action was primarily undertaken in one of three ways; attendance at the WMDC's local area panel meetings; ad hoc correspondence with the WMDC and other statutory bodies; and finally, in conjunction with the local ward councillor. The group also published and distributed a newsletter to 'Edgeton' residents and, in the latter stages of the research, established a mother and toddler's group and open bingo sessions. It should be noted that for a number of personal reasons, the support of the health and development worker was largely absent in the latter half of the research period.

The observational and interview data revealed that, as implied by the group's name, all

members were concerned with the removal of the perceived problems within 'Edgeton'. The residents' motivation to take action stemmed from their interpretations of the historical experience of living in 'Edgeton'; by tackling local problems, it was hoped that the romanticised memories of the past would be recreated. As such, the concept of community emerged as a strong theme within the 'Edgeton' data.

6.3. The Community

Given the centrality of the 'community' within the thesis objectives, the interview process elicited interpretations and descriptions of the local community. However, utilising a direct line of questioning about the experienced sense of belonging to a community was ineffective. Interviewees' responses lacked depth, indicating that this concept is relatively futile in the context of everyday life. For example, the response "this is a community" (Mary*[1]) was typical when questioned, "do you feel that you belong to any kind of community?" Instead, indirect questioning of concrete experiences of neighbourhood life revealed the importance of features of the 'community' to resident's experience of 'Edgeton'.

The interview and observational data revealed that there was no consensual interpretation of the community; instead, a range of concepts drawing upon the principles of exclusion and inclusion emerged as important descriptors. Utilising terminology emerging from the data, these have been labelled, 'everybody knows everybody', 'closed doors' and 'them and us', each of which was intrinsically linked with the historical experience of the community and contemporary experiences were embedded within a romanticised view of the past. The significance of the historical experience of the community has been reported elsewhere, (e.g. Campbell and Gillies, 2001) and reaffirms the importance of including a life history approach within investigations of this type. Typically, the comparative interpretation led residents to conclude that there had been a process of decline in all aspects of community life, such as neighbourliness and local facilities. This decline was attributed to several factors, including; the eradication of traditional industries, most notably the closure of coal mines, housing allocations and other actions undertaken by the local authority.

[1] Please note that all names have been replaced with pseudonyms, this is indicated throughout with an *.

Residents of 'Edgeton' recalled a time at which 'everybody knew everybody' and described how this sense of neighbourliness had eroded over time. As Mary* described,

> When I first moved down here, you couldn't of asked for a better place to move. It were lovely, you know, everybody knew everybody. They were all friendly, now you're lucky to go down the road and get a grunt out of somebody.
> Mary*

Helen* felt that this erosion had directly affected the local community, "well when we first came there was a, a much more community feeling than what there is now." The statement that 'everybody knows everybody' indicates that the existence of social relationships, in some form, between neighbours was previously a characteristic of the 'Edgeton' community. However, despite their reported erosion, it emerged from the interview data that the decline in these relationships was not evenly distributed throughout 'Edgeton'. Instead, group members felt that a sense of neighbourliness had remained between the long-term residents of the area. For example, Mary* reported that,

> Everybody knows me round here, I hope they think I'm a good person so I know that. I can go out, "hey up* [name] are you alright", you know. Because they've got to know me over the years, it's just these ones that come in that don't know you, you've got to be wary of them because you don't know who they are.

Fred* too felt that his relationships within 'Edgeton' were restricted to the longer term residents, "I know the old people who have lived here since the houses have been built. There's a quite a lot come, come into the village who I just don't know."

Relationships of this type, that is links between the residents of 'Edgeton', are a potential source of bonding forms of social capital. As described in Chapter Three, Section 3.2.4, bonding social capital reflects a strong cohesiveness within a group or community (Harpham et al, 2002). However, it is the features of social relations, such as trust and reciprocity (e.g. Putnam, 2000) that determine the development of social capital. Evidence emerged from the interview data to suggest that the relationships between residents represented bonding forms of social capital, with interviewees' perceiving relationships to be characterised by a willingness to help one another during times of need.

> Its like everybody knows each other round here, and if they've got a problem then they'll go and share it, if you've got a problem you'll go to share it with one your next door neighbour or a friend down the road you know. They're quite friendly you know, they'll talk to anybody in respect of, if they know you.
> Mary*

Similarly, David* asserted that reciprocity was not as predominant as it once was and recalled a time when "everybody mucked in" to help one another, although he believed that the normative structure remained for it to be rebuilt.

> *Would you say it's the kind of place where you would help out your neighbours if they needed help?*
>
> It was yes, it was. I think it could be again you know, it, Yorkshire people are Yorkshire people you know, its a trait, alright collieries have gone, that way of life's gone, it were a society, they looked after their own they policed their own, I mean you left your back doors open and that and people come in they could have a meal, you know.
> David*

As illustrated by this extract, the mining industry was considered synonymous with the close knitted community of the past. One local councillor described the centrality of the unions in determining the normative structure of communities, "the NUM was a community. You had a problem, your problem was everybody's problem, solidarity was absolutely tremendous." The impact of pit closures upon mining communities has been subjected to substantive investigation throughout the past two decades and the finding reported here that a sense of community declined alongside the mining industry resonates with previous research (e.g. Warwick and Littlejohn, 1992).

The data presented thus far reveals that these bonding relationships within 'Edgeton' were restricted to long-term residents and had not been extended to newer residents. Instead, interviewees expressed suspicion of newer inhabitants, labelling them as the troublemakers in the area and alleged that their arrival within the area was associated with the area's decline.

> *So what's changed then? Why do you think there's suddenly not as much demand*

[for housing]?

> People that they put in, into properties. I mean council put anybody into these properties and not bat an eyelid 'cos they don't have to live round here. It's like these flats over there, you see allsorts walks of life, you know in the flats. And I've got sit there twenty-four hours a day, stop in house to watch them.
> Mary*

For Mary*, the local authority's allocation of housing to "drunks and druggies" led to 'Edgeton' becoming stigmatised as a bad area, "it has got a really bad reputation for that. So we're trying to clean it up and the councils putting more people in that's going to knock 'Edgeton' back." Although less critical, Fred* expressed a similar sentiment, "as changes have come thick and fast, not entirely good, but a lot of good has come out of it, but, especially these things that they've built here, the maisonettes and that, they've brought a lot of people undesirable people into village." Mary's frustration at the perceived role of the local authority in the area's decline is clear and the negative perception of housing allocations served to facilitate a general distrust of the local authority. These perceptions were shared by other group members and several described 'Edgeton' as "forgotten" (Fred*; Paul*), with the local authority opting to house "undesirables" (Fred*) within the area rather than embarking upon a process of regeneration. The following statements illustrate the strength of the anger and frustration directed towards the local authority.

> But we've had anything, thieves, you name it we've had it, the council moved them in, you know what I mean. And they moved bad troublemakers out of other areas to clean other areas up and it's a known fact and they've moved them into 'Edgeton'. You know, move them into 'Edgeton' they'll deal with them down there or let them fester down there with the rest of them... And that's how I feel and a lot of people in 'Edgeton' have felt it, that they've used it as a big dumping ground for everything that you can name to throw into 'Edgeton' they've thrown it in 'Edgeton'.
> Paul*

> At one time people used to queue, they used to queue to get into 'Edgeton'. To live in 'Edgeton'. That's how good it was, and I'm being serious. They used to queue. As soon as a house were empty they were straight up "can I live in 'Edgeton'? Can I live in 'Edgeton'?" They're queuing to get out now. They're queuing to get out of the place. There's a lot of people wanting to get out and get out. There's only the hardliners in respect us we know it can change that's stopping. And as soon as people are going out now we find that we've seen a change as well in the council's attitude is, 'Edgeton' now is a forgotten village.
> Paul*

Given these negative perceptions of newer residents, it is unsurprising that social relations have not extended beyond the longer-term residents of 'Edgeton'. As such, there was a clear division between 'them and us' within the interviewees' descriptions of the local area, with them being the newer inhabitants and us those with lengthy connections to 'Edgeton'. All the interviewees had lived in 'Edgeton' for a minimum of seventeen years (see Table 4.2 for further details of length of residence), and given their negative perception of the newer residents, they were not motivated to form any relationship within them and instead tended "to shy away" (Mary*). The arrival of new people within the area, those unfamiliar with the historical context of the social norms regulating behaviour within the area, were therefore excluded from what the interviewees' identified as the 'Edgeton' community.

> I mean everybody knows everybody's business, you know, it is quite a friendly little village, but, I personally, I tend I can go out and talk to, stop you in the street and it wouldn't bother me. Husband's saying, "Mary* you don't talk to people like that, you don't know who they are." A lot of them do, "you alright" even if they don't know you. You still think, "yeah you?" But you don't share your problems with the outsiders. I know that sounds horrible putting it as an outsider but they are outsiders to people that have lived in area for years.
> Mary*

It has been suggested elsewhere that bonding forms of social capital can legitimise the exclusion of non-group members (PIU, 2002). The findings reported here support this assertion, the bonding relationships between long-term residents have served to exclude newer residents and thus deny them access to the potentially valuable social capital resource. Instead, the arrival of new people into 'Edgeton' was perceived by the interviewees to threaten the stability of the area's social structure.

Closed Doors

A contradictory theme also emerged from the 'Edgeton' data, one of 'closed doors'. As interviewees perceived the bonding relationships between residents to decline, they described the community as being one increasingly characterised by people going home at night and secluding themselves from their neighbours; this phenomenon was labelled as 'closed doors'. Again, memories of the historical sense of the 'Edgeton' community informed the interviewees' statements of seclusion. For example, Jill* stated, "I think it's a

community where people come home from work, shut their doors lock it, shut the curtains and sit in and that's it. Its not one of those, we don't have street parties like we used to when I were a kid." Residents associated the observed seclusion with a perceived decline in the area's amenities; "we haven't a post office, we haven't a doctors, we've nothing" (Fred*). More specifically, it was recognised that there was no longer any building accessible to the whole community, "we did have a heart of 'Edgeton' with the old club but its derelict now, it used to be a meeting place for everybody to go into. But we haven't got one now" (Mary*). Baum and Palmer (2002) have labelled such physical spaces as 'opportunity structures', as they found them to be essential in shaping access to social capital. In 'Edgeton', it is clear that the interviewees perceived the lack of opportunity structures as an inhibitor to the development of strong bonding relationships within the area.

The interview data reveal that the removal of these amenities represented a further source of anger and frustration for the residents, as Paul* described,

> We used to have beautiful park. We used to have a beautiful cricket field, with bowling greens. We used to have a church, we used to have a little village school. And everything's just gone, they've just took everything, it seems as though. Its like a rat nibbling at a biscuit, it slowly nibbles away and nibbles away until somebody realises that there's hardly any of it left.
> Paul*

The interviewees identified the local council as the main perpetrator, "that was taken off us the village hall. That was taken off us, the council sold it, that's another thing the councils sold" (Paul*). Embedded within this perception, and related to the earlier assertion that 'Edgeton' was a forgotten village, was the belief that 'Edgeton' received relatively less investment than neighbouring areas, "we want to, a bigger slice of the pie like everyone else is getting" (Paul*). This perception served to generate further frustration at the policies of the local authority. The relationship held between members of the 'Edgeton' Community Action Group and Wakefield Metropolitan District Council is explored in more depth in Section 6.4 below.

Fear of Crime

Previous research has shown that fear of crime can create seclusion; Campbell and Gillies (2001) reported that if people are afraid to leave their homes, then they are less likely to participate in community life. However, fear of crime emerged from the data as a complex theme and was not as one-dimensional as implied by previous investigations. The visibility of both crime and anti-social behaviour was a common theme, Jill* and Fred* both reported that they had both recently been the victims of crime. Both incidents involved their personal property, "I've been broke into since them two [blocks of flats] were knocked down" (Fred*) and Jill's* cars had been vandalised. However, despite being victims of crime, when asked directly about their perceived personal safety in the village, any fear was dismissed,

> I feel safe yeah, I mean I've got a family who, comes down, ex rugby players, yeah I feel quite safe. The police have just been and put me all locks on the windows and back door and everything you know.
> Fred*

The perception of available support enabled Fred* to dismiss any fear of crime, and provides a practical example of the buffering model of social support (Cohen, 2003). Within this model, the availability of social support, a resource derived from social networks, equips an individual with an enhanced coping strategy when faced with a stressor (see Chapter Three, Section 3.1 for further discussion of the buffering model). For Fred*, the belief that his family could be relied upon deterred any fear of crime. However, social support did not alter the interviewees' concerns that their actions within 'Edgeton' would render them a target for criminal attacks. Interviewees reported that a previous member of the group had encountered threatening behaviour after becoming involved within a neighbourhood watch scheme. This incident led the group members to exert caution when tackling anti-social, and more generally, criminal behaviour, to avoid being labelled a "grass" (Mary*).

Fred* believed that his involvement within the community group may have already led to his victimisation. On arrival at Fred's* home to undertake his interview, he pointed to a broken window, which he alleged had been broken with a pellet gun,

Can you think of anything that's changed for you personally since you've been a member of 'Edgeton' Community Action Group?

> No I don't think so, apart from one or two little incidents same as I've told you about, the window and that. I think that could be a reason why.
> Fred*

Area Satisfaction

The results presented thus far portray 'Edgeton' as an area in decline with divisions amongst residents. It is perhaps unsurprising then that interviewees reported their dissatisfaction with the area and all focused upon the negative changes that had taken place. The reported decline was integral to interviewees' perceptions of the local area, for example, and as reported above, Paul* described 'Edgeton' as a "dumping ground". Despite this, there was typically a simultaneous statement that they would not consider leaving the village, "there's, just a lot of things going off that I've not been happy with, but, you live with them. I've no real intentions of moving as such (Jill*). Instead, the anger at the perceived decline served as the motivating factor for involvement and there was a strong desire to reverse the situation.

> The paint work might be a bit scrubby on some of the outside, but I think once you take all the dirt and the grime away and polish it up, it can sparkle can this village. There's some really good people here, but it's getting back out of that woodwork. That's going to be the hardest thing to get the confidence back up again.
> Paul*

The formation of the 'Edgeton' Community Action Group was identified as key within this process. Paul* described his belief that by regaining control over the factors that determine quality of life within 'Edgeton', the seclusion would be eradicated,

> And that's when you stand up and you know be counted, or that's when we're starting to stand up and be counted. And that's people are now hopefully are opening the doors and windows and coming back out in the community.
> Paul*

It is therefore evident that the interviewees perceived collective action as central in tackling the problems facing the 'Edgeton' community, and in doing so, legitimise the government's

focus on the community as a means to overcome the problems of deprived areas (e.g. Social Exclusion Unit, 2001). Further exploration of the function and structure of the 'Edgeton' Community Action Group, the network at this centre of this research stage, reveals how action was achieved. These issues are explored further in Section 6.4 below.

6.4. The 'Edgeton' Networks

The results thus far suggest that the networks operating both within and out with 'Edgeton' are complex. Section 6.2 above provided an overview of the 'Edgeton' Community Action Group, here, the observational and interview data will be drawn upon to illuminate how this structure functioned.

6.4.1. Bonding, Bridging and Linking Relationships

The group was defined as a formal network in that it was a constituted body with a defined membership of approximately twelve people, although this figure fluctuated throughout the fieldwork period. As all members were residents of 'Edgeton', the group's activities provided an opportunity to shape the bonding forms of social capital within 'Edgeton'. The potential development of bridging and linking forms was also apparent given the group's embeddedness within a range of external formal and informal networks. The informal connections included relationships with friends, family, neighbours and work colleagues, and the formal, membership and attendance at involvement structures.

In addition to the formal structure of the group provided by the constitution, the observations of the meetings revealed that an informal structure also regulated the member's roles. The majority of members assumed a range of additional roles, from fundraising to liaison with external structures, which appeared to be largely determined by individual preferences. Jill* and Mary* for example, assumed responsibility for the operation of a mother and toddler group within the recently acquired bungalow, an activity undertaken with little or no involvement from the other group members. Other members chose to attend events in 'Hillwood' and the wider area, such as the council's area panel and police forums, and would feedback the proceedings of these meetings to the group. Several of those attending these meetings were members of the local labour party. More specifically, group members accepted responsibility for individual issues of local concern.

For example; Paul* was campaigning for the development of play facilities within the area; Catherine* focused on road safety issues; and Clive* was anxious to prevent further industrial development of the area. Their progress in achieving resolution was reported and discussed at the monthly committee meetings.

The delegation of responsibilities within the group enabled simultaneous action on a greater number of issues. That is, the individual members would address a specific issue, but draw upon the group's resources to secure the desired outcome. For example, it was evident that some group members had developed an expertise on particular issues and were aware of the actions required to achieve resolution. This expertise then became a valuable resource to the group, as Mary* described;

> You know when you hear people in the group saying, "well, I've rung this section, and another well I've had to ring this section", you know, you tend to keep it stored up and think right, well Paul* has dealt with them before, so I'll go to Paul* because he knows who to speak to and who not to speak to.
> Mary*

For other interviewees, it was not the provision of support from the group that enabled action to be undertaken, but the very existence of the community action group. It was perceived that the group provided legitimacy to the issues concerning 'Edgeton' residents; 'Edgeton' now had a stronger voice, thus forcing organisations to listen to their expressed needs, "because we fight as a group, the council listen to a group rather than to one single person" (Mary*). Indeed, the group members stated that some recent outcomes would not have been achieved in the absence of the 'Edgeton' Community Action Group. An example of this, and one that formed a strong focus of the action group, was the demolition of blocks of flats within the centre of the village. This local authority owned housing was perceived by the interviewees to be the root cause of the area's problems in that its residents were the newer inhabitants of 'Edgeton' labelled the troublemakers (see Section 6.3 above). Their demolition had long been the goal of the residents interviewed and during the research period, three of the five blocks were razed to the ground. The following extract summarises the group's perception of their role in this outcome,

> For years and years and years that's all 'Edgeton' had wanted to see these flats come

> down to make it look tidy and you know try and better 'Edgeton'. Now I think if we didn't have the community meetings and the committee group up and running I think we might have been waiting a little bit longer. We actually did push for them to come down which the council did do.
> Mary*

However, it should be stated that some more sceptical members of the group were more cautious in attributing their demolition directly to their actions; instead, they identified the building of luxury housing nearby as the principal catalyst. Despite this, the data suggest that the 'Edgeton' Community Action Group had some degree of success in securing outcomes that would not have been possible, or having taken considerably longer, in the absence of the network. This demonstrates how social capital can function as a community level resource; the residents formed a network based upon bonding relationships and secured a collective goal.

In other instances, the group mobilised resources from other networks, both formal and informal to enable the realisation of goals. Given the range of issues tackled by the group, the involvement of external bodies was frequently required. As such, representatives of external organisations would attend the monthly meetings upon the invitation of the committee members. During the fieldwork period, council officers and members, police officers, funding body representatives and members of other community groups all attended meetings. Thus the 'Edgeton' Community Action Group constituted a bonding level structure embedded within broader bridging and linking networks.

Although the attendance of two ward councillors was observed, one in particular was regularly present and represented an important source of linking social capital, where linking social capital refers to the relations that exist across power differentials (Woolcock, 2001). This councillor fulfilled three principal roles within the group's structure, signposting, monitoring and conflict resolution. Typically, when a new issue emerged, the group members would embark upon a lengthy discussion but fail to identify any solutions. When present, the local councillor would intervene with practical steps forward and direct the group towards an appropriate course of action. The following extract from the observational data illustrate this signposting role,

> After some discussion of the speed limit on the road under question and alternative control measures, * (*local councillor*) suggested that a list of the issues were prepared and sent to the Highways Agency, along with an invitation to attend a committee meeting.
> 'Edgeton' Community Action Group, Observation 1

The above extract illustrates how the councillor shared his knowledge of road safety with the community group to enable action to be undertaken. In other instances, the support of the councillor was sought in progressing action already underway. For example, the application for use of a local authority property as a centre for the group was a lengthy process and was a source of frustration for the group members. The absence of a base was perceived by the group to hinder their progress and their meetings were held in a local sports club. The original application for the property had been supported by a health and development worker, and in recognising the frustration of the group members, this worker requested the support of the local councillor in securing the use of the property. The councillor accepted this monitoring role. Here, the 'Edgeton' group sought to mobilise the influence held by the councillor within the local authority to secure their objective.

During times of conflict, the councillor would also adopt a more diplomatic stance; Section 6.3 above revealed that there was a common perception amongst the group members that neighbouring areas received a greater proportion of investment than 'Edgeton'. The following extract from field notes demonstrates the group members' anger and frustration at this perception,

> Elsie* commented that neighbouring community appeared to be getting all the new facilities and was now a thriving little community. She acknowledged that there were two small shops in the area, but didn't understand why there was not more.
>
> The Chair referred to new development plans which would merge the two areas, he was angry that all the facilities would be in neighbouring community rather than between them. The Councillor and Jill* disputed this. The Councillor invited the group to view the site and the plans to resolve any issues they may have.
> ('Edgeton' Community Action Group Observation 1)

In addition to taking steps to resolve this conflict, this extract also further demonstrates the councillor's signposting role. Therefore, the councillor performed three important functions within the 'Edgeton' Community Action Group structure, equipping the group

with a resource that would not have been available to them in his absence. More broadly, the councillor's role broadly conformed to the government's vision of community leadership (see Chapter Two, Section 2.2.1 for a description). It is important to emphasise that the identification of the ward councillor as an additional source of social capital would not have been elicited with the use of interview data alone and reinforces the need for observational methods to be incorporated within any investigation of social capital.

Additionally, and often at the recommendation of this councillor, relationships with other external structures were utilised in the pursuit of action. Upon identification of an issue, the group would discuss the next steps. In the majority of cases it was not possible for the group to act independently (e.g. the demolition of housing) and the appropriate organisation was identified. Where no course of action was formulated, the group member commonly raised the issue at the 'Hillwood' Area Panel, which emerged from the observational data as an important linking relationship for the 'Edgeton' Community Action Group. Each of the District's eight area panels incorporated a thirty-minute question and answer session in which members of the public were able to submit a question to the panel of local councillors and co-opted members. This session was perceived by the group members as an opportunity to raise issues of local concern. The following extract from field notes of one area panel meeting illustrates this point,

> Paul* produced a series of A4 photos of a local wood and presented them to the panel. Although they were never distributed to the 'public' I did catch a glimpse of one showing an abandoned car. Paul* explained that they had originally raised the issue in January and had been told it would be dealt with. They were now concerned that it looked like chemical drums had been dumped in the areas. A local councillor later approach Paul* and stated that the situation would be dealt with that week.
> 'Hillwood' Area Panel, Field Notes

Paul*, in providing a regular update on the area panel at the 'Edgeton' Community Action Group's monthly meeting, informed the group of the action that was taken in response to his attendance.

> He was told initially that it [the removal of cars and hazardous materials] would be resolved by the neighbourhood action teams, however, he informed them that the

> situation had initially been reported in January. Paul* described how during the meeting, * (*local councillor*) had approached him and told him something would be done that week. Within days, he received a phone call from the Area Panel officer and was informed that the cars were to be removed and they were that week. Although the chemicals were still there, they had applied for permission to move the chemicals and they should be removed within the next few weeks.
> 'Edgeton' Community Action Group Observation

The 'Hillwood' Area Panel also served to enhance the transmission of information within 'Edgeton'. The group members who attended the panel meetings "come back with some useful information you know. * *(Neighbouring estate)* just got this and you know, you know, they come back with information that we could possibly benefit from" (Mary*). For other interviewees, the information obtained at the panel meetings served to educate them on the procedures of the local authority, as David described,

> Well it's made us aware of what they're doing to a degree, but they are, it's only what they want to tell us, or like what points we bring up that we want to discuss at future meetings. It's only that with getting involved here with group that I've got involved with these meetings you know, different ones like. Up to then I was quite ignorant of what councillors do, because as I say I wouldn't go to one of the meetings Wakefield or something like that, only when it concerned us in this area.
> David*

This extract from the interview data also suggests that involvement within the 'Edgeton' Community Action Group has generated an interest in the broader issues affecting the district. According to Putnam (e.g. 2000), involvement within organisations such as the 'Edgeton' group fosters civic mindedness; this finding provides some support for this assertion.

Thus far, it is evident that the area panel represented a source of linking social capital for the 'Edgeton' group. The observations also revealed that the structure further supported the functioning of the group through the provision of grant funding. This funding was invested within the costs of running and maintaining the activities of the group. It should be noted that the group did not access any other sources of funding throughout the second stage of research (2002-2003).

The 'Edgeton' Community Action Group's external networks extended beyond the area

panel and incorporated several other bodies; their extensiveness is best illustrated by the series of events induced by the demolition of the local authority owned flats within the centre of the village. As reported in Section 6.3, the absence of opportunity structures within 'Edgeton' was a source of frustration for the group members and the vacant land created by the demolition of the flats presented an opportunity to address the issue. The group members felt strongly that the site should be utilised by the whole community and favoured the building of a community centre for "everybody to go... to have another heart of 'Edgeton'" (Mary*). It was hoped that a new building would provide a space where people "can bob in and just find somebody to talk to if they want" (Helen*) and "somewhere for people to collect" (David*).

Securing the use of the land inevitably necessitated the involvement of a diverse range of groups, this process was initiated midway through the fieldwork period. The group recognised the importance of engaging the wider community in this process and achieved this primarily through public meetings, which were held infrequently in a local sports club. In the public meetings observed, two councillors, housing officers and between ten and twenty residents (in addition to the committee members) attended. Within these meetings, the residents of 'Edgeton' were enabled to raise any issues of concern with the councillors and officers and were updated on the activities of the community action group. In discussing the specific issue of the newly vacated site, the councillors both adopted a signposting role and encouraged the residents of 'Edgeton' to devise a strategy for future development.

> One councillor stated that it was important that the residents propose what they want to happen to the land. The council should not be deciding what happens... A second councillor said that they shouldn't dwell on this [rehousing of tenants], they had achieved something in getting the flats demolished and now needed to focus on what was going to be put in their place.
> 'Edgeton' Community Action Group [2], Field Notes Extract

Also on the advice of one councillor, the group members undertook a small-scale survey of the residents of 'Edgeton' to establish the level of support for a new community centre. At the end of the research period, the 'Edgeton' Community Action Group had yet to submit any formal strategy to WMDC but were continuing to work closely with them and the

wider community to identify a way forward.

In addition to the formal involvement of the wider community within the public meetings, informal links were also maintained. The group member's kin relationships were mobilised to achieve a variety of outcomes, from the redecoration of the bungalow, "that were my hubby, he's done it...he's done must of decorating and putting carpets down and things" (Jill*) to providing ad hoc support for the mothers and toddlers group. Section 6.3 above reported that bonding relationships existed between the long term residents of 'Edgeton'; the interview and observational data reveal that residents outside of the formal group structure drew upon the knowledge and expertise of the members when information was sought or a problem was faced. Paul* described his visits to the local pub as resembling a councillor's surgery and Mary* stated that she was often approached in the street by residents.

> When they know that you're on committee group you know, and they've got a problem, it's like "hoy Mary* I just want a word with you." In one week I got about fifteen people pulling me over, it were like, oh my God what have I let myself in for.
> Mary*

Fred* reported similar experiences and commented that people found it easier to approach the committee members rather than invest time in attending a meeting.

> You'll get people though asking, "when are these blocks of flats coming down?" You know, and when this and when that. They won't go to a meeting but they'll ask you things like that.
> Fred*

Therefore, the group represented a resource that could be drawn upon by the wider members of the 'Edgeton' community. That is, the value inherent with the 'Edgeton' Community Action Group was not restricted to the individual network members but instead had been transformed into a community level resource. The interviewees' expressed a willingness to provide assistance wherever possible, however there was no evidence that this resource was extended to the newer residents of 'Edgeton'. Section 6.3 established that there was a division between the residents of 'Edgeton'. A growing body of evidence

suggests that social capital is not a homogenous resource providing equality of access to all community members; instead access is moderated by factors such as age and socio-economic status (Baum et al, 2000; Campbell and Gillies, 2001; Baum and Palmer, 2002). The data presented suggest that length of residence is a further variable determining access to social capital.

Within 'Edgeton' then, bonding social capital was only available to longer-term residents; however, bridging relationships between the 'Edgeton' group and a community group operating in a neighbouring area were being developed during the research period. For Narayan (1999), bridging social capital is generated by the formation of cross cutting ties between diverse individuals or groups. Although the characteristics of the two groups were similar, with the neighbouring area also being a traditional mining village, the links are defined as bridging forms because of the interpreted differences between the two groups. That is, the relatively advanced state of development of the neighbouring group led the 'Edgeton' residents to perceive its members as distinctly different to them. The health and development worker and local councillor actively encouraged the 'Edgeton' group to establish links with an established group in a nearby village. For the councillor such links would enable the groups to "learn from one another" (local councillor). During the research period, the chair of the community group in question attended an 'Edgeton' committee meeting to offer advice and support. In the meeting, the chair provided the 'Edgeton' group with information on sources of funding and on the model of management adopted by their group. The interview data reveal that several members of the 'Edgeton' Community Action Group were eager to embark on further information sharing between the two groups. The reasons for not actively pursuing this related to a broader issue for the 'Edgeton' group, one of resources. A common theme to emerge from both data sources was that the individual members perceived their ability to develop as constrained by the limited time available to them to undertake their activist role. This issue is returned to in greater depth in Section 6.5 below.

6.4.2. Healthy Relationships?

The data presented thus far presents the relationships held by the 'Edgeton' Community Action Group and organisations both within and external to the area in a positive light, that

is, their presence produced important outcomes within 'Edgeton'. However, although these relationships served to secure the group's goals, they simultaneously represented a source of frustration and anger for the group members. The 'Edgeton' Community Action Group formed in order to redress the perceived decline in the area and as the findings presented in Section 6.3 describe, WMDC was perceived as a key perpetrator in this decline. Despite the formation of relationships with the council throughout the period of research, their presence did not eradicate the interviewees' deep-rooted distrust of them. Although Mary* recognised that the councillors "do try and tend to get involved quite a lot" this was largely an exception to the majority opinion. Instead, the interviewees questioned the council's commitment to supporting community groups. As David* claimed "council take it on board like 'cos its making them look good. But at end of day nowts really done, you know, everybody's, there's a lot of hot wind going around and no action at the end of day." For David*, the large, and relatively unchallenged, Labour majority in the area had enabled the local authority to dismiss external influence.

> I don't think they've altered, that's my feeling like, that you get lip service, they're still only doing things they're forced to do, because that's what government want 'em to do, latest topic whatever. Whatever press is pushing they'll do someit about, whether its reckless drivers or dirty streets, they'll do it just to shut press up, and they're still steeped in their old ways. And they've been in power too long, been Labour around here as long ever since I was born.
> David*

Similarly, Paul* perceived the council as an obstacle to the group's attempts to achieve change in 'Edgeton'.

> But it's so frustrating, it's so frustrating that you know that you want people, you can help them, if the council'd just turn round and listen, just turn round and listen, but they won't. They listen, but only with one ear... They get paid for coming to those meetings, you get paid for being a councillor, and that's why people have voted for you to put you into power to give us our fighting, to be our right hand to punch, at the government, at the hierarchies. But they don't, because once they get voted on, they're all sat there as you've seen them at the area panel. All they do is just go, just smirk, no matter what you say, you could say look Saddam Hussein and one of his goonies has got a bomb a 'Edgeton', and they'd sit there and say well whose departments that. I'm sorry, but that's, it comes across to me that way, they just sit there because they've got to sit there.
> Paul*

It should be emphasised that the 'Edgeton' Community Action Group had been in operation for approximately eighteen months at the time the research was undertaken. As such the relationships with external organisations were only just being established. Social capital theory states that it is the features of social relations, such as trust and reciprocity, that enable collective action. In 'Edgeton', it is evident that these norms have yet to be developed but the relationships appear to still function to realise the collective goals.

In attempting to further understand this negativity towards the local authority, the interviews were conducted recently after the group discovered that they were unable to secure funding to modify the bungalow they used as their centre in the absence of a long-term tenancy agreement with the local authority. These modifications were perceived by the group as essential to the development of their activities.

> And we had trouble with obtaining the bungalow, I mean we were waiting about eighteen month or more before we got it. And we thought we were going to start doing something. The Coal board were going to allow us the money, and then of course the council then said, "oh no, they wouldn't guarantee that we could have the bungalow for five year." So we couldn't have the money. So to me it isn't big enough to do a lot in it. You're fighting a losing battle.
> Helen*

It should be noted that contrary to the implication of this quote, the observational data reveal that the Coalfields Regeneration Trust application was never submitted. However, it is the interviewees' interpretation of events that inevitably shape the relationships with the local authority, thus, this remains an important finding. The issues presented here refer to the control and influence held by the 'Edgeton' Community Action Group, a third dominant theme to emerge from the data. This theme is discussed further in Section 6.5 below.

Given the objectives of this thesis, it is of interest to note that the links with recently established involvement structures were restricted to the 'Hillwood' Area Panel. When prompted directly about their awareness of Vox, the district's community empowerment network, it emerged that the interviewees had encountered the organisation but the

experience had been a negative one. Several members of the group attended a Vox event seeking assistance with paperwork associated with their activities. Upon arrival, they discovered that such support was not available at the meeting leaving the members confused as to the purpose of Vox, "I still don't understand what Vox is" (Jill*). Similarly, David* reported confusion after attending such events, "I went to one or two of these Vox meetings, that were all going over my head." Given the relative infancy of the 'Edgeton' group, it is perhaps unsurprising that they did not fully understand the purpose of every structure within the Wakefield District. What is apparent however, is that this experience deterred the group from returning to the Vox events.

At the centre of any theory of social capital is the tenet that the existence of a network enables action that would not be achievable in its absence. If this argument is accepted, then it must be concluded that stocks of social capital reside within 'Edgeton'. Both the observational and interview data identified a number of outcomes that would not have been achieved if the 'Edgeton' Community Action Group did not exist. Drawing upon different forms of social capital enabled the range of outcomes. The resources available to the network were not restricted to its members, but instead longer-term residents of 'Edgeton' were permitted access.

6.5. Control and Influence

The findings presented thus far have highlighted the potential for membership of the 'Edgeton' Community Action Group to shape an individual's perceived levels of control and influence. As set out within Chapter Three, concepts of control and influence are central to theorised relationships between community involvement and health. This section further explores the 'Edgeton' Community Action Group's perceptions of control and influence.

For the 'Edgeton' interviewees, control was defined as the ability to get things done and influence was incorporated within this interpretation and referred specifically to the perceived ability to shape decisions and actions affecting 'Edgeton'. Using this definition, the interviewees' believed that membership of the 'Edgeton' group equipped them with increased levels of control and influence relative to that held individually; however, the

perceived levels of control and influence remained low.

There was a general sense that 'Edgeton' was now "starting to stand up and be counted" (Paul*), this was attributed to cumulative effect of collective voices, "if we didn't have this group we won't have got this done because the council won't listen to one voice, they'll listen to quite a few voices. But not just the one" (Mary*). Although the interviewees reported the increased levels of control derived from their group membership, they were generally dismissive of their achievements. With the exception of the demolition of the flats (discussed in more depth in Section 6.4 above), it was felt that the group had only achieved minor outcomes. As Jill* described,

> We've maybe not achieved a lot, nothing of, nothing big, nothing major, other than the flats have come. The rest of them have been little things like, all the burnt out cars that was in the wood and there was some abandoned chemical drums and other things. We've got the woods all tidied up and cleared away, all the old tyres.
> Jill*

As reported above, the resources available to the group were identified as a barrier to their ability to get things done in 'Edgeton'. The lack of appropriate premises, or opportunity structure, again emerged as an important factor, with the group members perceiving the size of the bungalow and their inability to modify it as inhibiting their development. Section 6.4 reported that all members of the group aimed to create a space accessible to the whole community, without it they felt unable to deliver all their objectives. As Jill* stated, "I can't [get] kids off the street though, I can't give them a youth club, just ain't got the right premises."

Several of the group members (Paul*, Catherine*, Jill* and Mary*) were all in full time employed and the retired members of the group held responsibilities for looking after grandchildren. As such, the time available to the group to undertake activities was greatly constrained. The following extract demonstrates the pressure experienced by members.

> I'm finding that it is, and it's hard, it's very hard. I mean last year I had 29 days holidays from work, and everyone of those 29 day holidays, sorry except for one weekend, and that one you don't class it as a holiday though do you, weekends, not part of your holiday. But 29 days I used going to committee meetings and meeting

local authorities.
Paul*

A further constraint identified by the interviewees was their state of knowledge and understanding of the policies and procedures involved in the resolution of local issues; "its like at nursery you've got to learn your ABC before you can read and write" (Jill*). Similarly, Paul* described the uncertainty experienced by the group when faced by some issues.

> Before I find my bullets, I make sure I know I'm going to hit my target. And there's some times I've got all my guns loaded but I can't find that target, I need that little bit of advice to find that target, to find that thing to go to, so I can find the bullets and go straight for it.
> Paul*

This extract illustrates that the culmination of the group's perceived lack of resources led to an interpreted dependence upon external organisations for support and action. Because the group felt they were unable to develop services for the local community in the absence of appropriate premises, they focused on issues such as road safety, planning applications and waste, all requiring influencing the actions and decisions undertaken by service providers. Thus successful application of influence was defined by the group members as essential to regaining control of local issues. The application of influence to external organisations, particularly the local authority, was a source of frustration for the group members. In contacting the appropriate organisation, the interviewees felt that they had pursued all courses of action available to them and they were then dependent upon this organisation to fulfil their goals. Instead of interpreting this relationship as an asset, it was perceived as a barrier, as Jill* described,

> The bit I enjoy is when somebody asks for something to be done and it's achieved. What we don't like is somebody gives us a problem and we can't achieve it because Tom, Dick and Harry's stood in front of you with all the legalities, or we just don't know where to turn for that help... At the end of the day, you can only do what you can do. If somebody stands in your way there's nothing you can do.
> Jill*

Although it was unclear if the requested actions had been refused or simply had not been

implemented at the pace desired of a community action group, it was evident that the interviewees believed that promises had been broken. As Paul* described, "they make promises but they don't fulfil" and similarly Fred* reported that "the council have come down and they tell you one thing and then nothing happens." Paul* alleged that, "we've had one big clean up, we've had one big clean up in the village, right, massive clean up and ever since then we haven't had a road sweeper round the village." As such, it was apparent that the group's accomplishments were outweighed by their perceived failure to achieve subsequent action. These issues are explored in more depth in Section 6.6 below.

6.6 The Outcomes of Community Involvement

The results presented thus far support the assertion that the 'Edgeton' Community Action Group has led to the development of social capital. However, it has not yet been determined if this outcome has the potential to influence the well being of either the individual members or the 'Edgeton' area. An ever-growing body of research has documented an association between health outcomes and stocks of social capital (e.g. Kawachi, 1997; Cattell, 2001). It therefore follows that the increased levels of social capital within 'Edgeton' can potentially influence the health of its residents. To reiterate, the aim of this thesis is to explore the relationship between community involvement and health and to determine the utility of social capital in understanding any observed relationship. Therefore, the interview and observational data was analysed to identify all outcomes of the involvement process and all identified outcomes are reported here. The emerging outcomes fell into two broad categories, those that affect the individual member with little or no consequence to the wider community (at the time of research) and secondly, outcomes that have the potential to shape life in 'Edgeton' as a whole. This finding corresponds with the theory of social capital guiding the methodology, that is, social capital is not exclusively a resource available at either the individual or collective level but instead can be mobilised at both levels (see Chapter Three, Section 3.2.4 for further discussion). Of course, in reality the observed outcomes traversed the boundaries of this simplistic categorisation; nevertheless, it serves as a useful structure for the presentation and interpretation of findings.

6.6.1. Individual Level Outcomes

It was evident that membership of the 'Edgeton' group produced both positive and negative outcomes for individual members. Utilising direct questioning within the in-depth interviews typically elicited a negative response, with group members citing the stress and frustration evoked by their involvement activities. The interview data reveal that the perceived low levels of control and influence, as reported in Section 6.5, underpinned this negativity. The group members invested significant volumes of time and effort into addressing local issues and the belief that they were unable to achieve their outcomes generated frustration, as Paul* described, "it gets so frustrating sometimes, but it gets so frustrating sometimes, I just feel like standing on top of bungalow wall thing and screaming my head off." For Mary*, not being able to get things done was a source of stress.

> Nothings really changed, apart from you do tend to get a bit stressed, but everybody does.
>
> *And what do you think is the cause of the stress?*
>
> Not getting out done.
>
> *You mean through the group or just more generally?*
>
> Well, through the group really, I know we've got a few things done within the group, but its stressful knowing that you can't get anything done... you know 'cos because we're wanting things doing to try and improve this place but you just can't get it done. So it stresses you out a bit, thinking well it doesn't seem to be going anywhere.
> Mary*

Everyday hassles and irritations are an important category of potential stressors (Steptoe, 2001); the physiological response to exposure is largely determined by the resources available to meet the psychological demand (see Chapter Three, Section 3.1 for further discussion). It has been determined here that the 'Edgeton' residents did not believe they possessed the adequate resources to respond to the demands presented to the group. Therefore, this finding suggests that the existence of the group structure is insufficient as a tool for public health without the investment of the required resources.

Despite the predominate focus upon the negative emotions arising from membership of the

'Edgeton' group; the interviewees reported that where goals had been achieved, a sense of satisfaction was generated. Fred*, who lived nearby the recently demolished housing, stated that the visibility of the group's action was a positive experience; "get satisfaction, as I say I'm the nearest to the, to these maisonettes and I've seen three knocked down and two coming, so I've got that satisfaction" (Fred*). For Mary*, no single outcome was the source of her satisfaction, but rather the belief that the 'Edgeton' group enabled action that would otherwise be unattainable.

> Satisfaction, you know from the things that we've got done. There is there is quite a bit of satisfaction there, I'm thinking, well, if we didn't have this group we won't have got this done because the council won't listen to one voice, they'll listen to quite a few voices. But not just the one. So there is a lot of satisfaction when we do get things done.
> Mary*

The interview data also revealed that membership of the 'Edgeton' group represented a source of mental stimulation, and for Jill*, this kept her "sane" after an accident resulted in a period of sick leave. Although social capital has been presented within the public health literature as a health promoting factor, Berkman (1995) has emphasised the importance of social networks in the illness recovery process. Although this has not been conclusively demonstrated here, there is evidence that membership of the group served to enhance Jill's mental well being during a period of ill health.

It was also evident that the interviewees underwent a process of personal development as result of their involvement activities. This development was presented in a number of different forms, including learning, increased levels of confidence and altered self-image. These observations resonate closely with theories of community development, a process that places empowerment and learning at its centre. This is discussed further in the presentation of each developmental outcome. The interviewees reported that as they developed an understanding of the formal procedures underpinning the governance of their area, their ability to verbalise their needs and desires to the local authority increased. Thus, they were assigned a new level of confidence in undertaking local action, as Mary* described, "yeah, I'm more confident to go and talk to the people in the council, knowing what to say, whereas before I didn't. It's really brought my confidence up by doing this

group." This change in the 'Edgeton' group members had been recognised by a local councillor, who felt that their new understanding enabled them to enter into meaningful dialogue with the local authority.

> I think as community groups are starting to learn, that we can't just dismiss things, we can't just we don't want it, because we don't want it. I'll listen to anybody whether they want it or they don't want if they give me a logical reasons why they don't want it or why they do want it. And I think that's starting to grow now and people saying, hold on a second, do you we want this, what's the benefits, what's the benefit and what's the minuses.
> Local Councillor

As described in Chapter Three, Section 3.4.1, community development refers to the process in which the barriers preventing communities to participate within the issues that determine their quality of life are removed and thus power imbalances are redressed (SCCD, 2001). In the case of 'Edgeton', the group members have become equipped with knowledge and understanding of the processes governing their area and thus have acquired enhanced abilities to converse with those already holding expertise by virtue of their employment. In addition, involvement within the 'Edgeton' group facilitated access to formal education and training, with some group members undertaking training in child protection and computer skills. The culmination of this learning process has enabled the interviewees to approach local issues with a newfound confidence. The enhanced levels of efficacy generated are indicative of an empowerment process (see Chapter Three, Section 3.1); however, the reported low level of control and influence suggests that it remains in its infancy. The group's perceived dependence upon external organisations, particularly the local authority, in securing action, reveals that the power imbalances have not yet been redressed, the anticipated outcome of empowerment.

Theories of community development state that this process of acquisition enables individuals to occupy new roles, both within and out with the group structure; evidence of this was found in 'Edgeton'. The interviewees reported the emergence of a new identity by virtue of their involvement within the 'Edgeton' Community Action Group. As described in Section 6.4.1 above, the group members reported that the residents of 'Edgeton' frequently approached them for information and advice. In addition to enhancing the

transmission of information throughout the local area, this finding reflects the group members' newly acquired role as leaders within 'Edgeton'. Mary* described how she was approached by two local women who were experiencing problems with anti-social behaviour.

> She come to me, and she were crying, she were heartbroken, she weren't getting any sleep, you know with the music, she was having hoards and hoards of people just trodding the house every two minutes... Nuisance neighbours, she asked me if I could help, and I did, I phoned the council up in the same day, you know.
> Mary*

Although the frequency with which the members were approached was occasionally cited as an annoyance, the role was readily embraced. The following extract from Paul's* interview demonstrates the enjoyment generated by their recognition as a local leader.

> They pull you up and they actually say to you, "you're part of community group, will you, can you do this? Can you get that done for us?" And I say to them, "no I can't get it done for you, I can put it forward for it to be done, but I can't actually get it done for you." You know, I wished I could, I wished I could. But it's nice to get people to pull you up and to have a moan and groan at you. You know, even though you feel sometimes you think, oh no, not again! I'm not walking down that ginnel because she pulls me up every time.
> Paul*

Putnam's theory asserts that social capital produces civic mindedness, as such voting behaviour has commonly been used as a proxy indicator for social capital (Putnam, 1993). In 'Edgeton', all residents interviewed reported that they regularly voted in both local and national elections and had always done so. It is unclear therefore, if the membership of the 'Edgeton' group enhanced levels of civic mindedness or if they joined the group because they were already civic minded. The use of voting behaviour as a proxy for social capital has been criticised elsewhere (e.g. Portes, 1998) as it serves to do little other than confuse cause and effect. The finding reported here does little to refute this argument.

As set out within the thesis methodology, each interviewee was questioned directly about perceptions of health. However, despite following proven techniques for eliciting such information (see Chapter Four, Section 4.6.4.1), questions such as "how have you been

feeling over the past twelve months?" "Compared to other people of your age, how would describe your own health?" proved relatively ineffective and responses were typically brief and lacked depth. Again (see Section 6.3), it was found that discussions of concrete life experiences, as presented here, provided richer data on an individual's health. The following extract from Helen's* interview illustrates this point,

> *So how would you describe your health with someone else of my own age?*
>
> Well I feel as though I'm a lot fitter than a lot of them. I feel that, probably do more than a lot.
> Helen*

The perceived health of the other interviewees was mixed, with only David* reporting that his health had been "brilliant" over the past twelve months, a statement that reflected his recovery in recent years from serious illness. Like Helen*, Fred* reported that he was "not so bad" and Mary* stated, "I'm fine really, nothings changed, you know with me I'm sound." In contrast, Paul* was more negative about the state of his health,

> *If you were asked to compare your own health to someone of your own age, how would you describe it?*
>
> At the present moment I think it's poor. For the simple reason is I smoke too much, I don't drink too much, but I think it's basically because I smoke too much. And I'd like to stop, I'd like to stop. But at the moment I think its poor because also I'm tired. Cos as I say, everybody thinks its, doing this work, but it does tire you, and I'm ready for a good holiday. I haven't had a holiday in six years.

Jill*, in recovering from an accident at the time of her interview, was equally negative, "I mean health at the minute is getting worse simply because I can't walk properly." As illustrated by the extracts presented here, all interviewees discussed their health in terms of their lifestyle, with smoking, drinking, diet and exercise all emerging as important determinants of perceived health. For example, in relation to other people his own age, Fred* described himself as "oh, I'm fit. I'm a member of a health club and I go three or four times a week." Such interpretations of health represent narrow medical models and exclude awareness of the potential influence of involvement activities. Similarly, given the diversity in group members' perceptions of health, little evidence on the potential influence

of community involvement in health emerges from this line of questioning. Instead, these findings reinforce the need to consider all factors impinging upon health in any analysis of this type.

An additional finding, which although is not directly related to the thesis objectives is of interest methodologically, also emerged from the data. As stated above, responses to direct questioning about health generally lacked depth, but an exception to this trend emerged where an individual had previously experienced ill health. For example, David* who had retired on medical grounds, talked more openly about the state of his health, perhaps as 'health' represented a concrete, rather than an abstract, concept to him.

6.6.2. Community Level Outcomes

It has been argued elsewhere (Berkman and Kawachi, 2000) that the ability of a network to mobilise resources for collective gain represents an important and tangible link to health. The actions of the 'Edgeton' group examined in Section 6.4 revealed that the group focused upon issues such as road safety, play areas, environmental issues (e.g. removal of abandoned vehicles and chemical drums) and the provision of a new community resource centre. Given the model of health presented in Chapter Two (see Figure 2.1), the potential influence of these issues upon the health and well being of the local population is clear. Although the group had not secured success for each of these issues at the time of the research, the functioning of the 'Edgeton' group has the potential to shape the well being of the wider area through improving and protecting local service provision.

The interview data reveal that some of the group believed their activities had stimulated a process of change within the social environment. The interviewees reported that the seclusion that had come to characterise 'Edgeton' was slowly being reversed. Membership of the 'Edgeton' group provided the interviewees with an opportunity to interact with other local residents and form new friendships. For Jill*, organising the weekly bingo sessions had introduced her to new people in 'Edgeton', and she described her eagerness to provide the older residents with assistance with daily tasks.

> Cos such as these old ladies that I've got friendly with now, I'll be able to say to *

> (*female's name*), "oh I'm going shopping on Saturday if you fancy an hour out give me a shout. You know, I'll pick you up first and we'll nip to * (*supermarket's name*)." Because they're sat at home as well doing nothing, and I don't enjoy going shopping on my home either. So, just give them a lift up and have a walk about for an hour.
> Jill*

In addition to enhancing the social networks of the group members, the continual development of the group enabled the wider population to participate within their activities. The bingo sessions, mother and toddler group and open public meetings all provided the 'Edgeton' residents with new opportunities for social interaction. Jill* described how the bingo sessions had drawn people out of their homes.

> Nothing to do in the village, this has got me out, but it hasn't just [got] me out, it's got a few of the others out. The elderly people that sit in the bungalows, there's another one that's coming next Monday, first time she'll be coming. And she just pulled up one of the members up and said, "I just sit there all week, there's nobody to see, nothing to do, and I just sit there all week watching television. And I don't get them any exercise." It, their brains just pickle.
> Jill*

As described in Section 6.3, 'Edgeton' was frequently described as a "forgotten village" with the interviewees reporting that the area had received little or no investment in local services and amenities. Paul* believed that the visibility of the group's efforts to reverse the area's decline provided the residents with a new motivation to change 'Edgeton'.

> As long as they can see that something is being done in the village and things happen the more they're coming out. And they are starting to come out and we don't want to lose that, we've started getting them coming out, it'll take a lot more longer than two year, it might take another twelve months before we even see, people, more people come.
> Paul*

It is evident therefore, that the 'Edgeton' Community Action Group has enhanced the opportunities for social interaction within the village and for some interviewees, this has reversed the perceived seclusion of its inhabitants. As reported within Chapter Three, a positive association between social integration and health date back to Durkheim's (1952) classic investigation of suicide. Here, the data presented here does not support any causal

interpretations; rather, it reveals a potential mechanism through which the 'Edgeton' group may influence health.

Thus far, the role of social capital in any relationship between involvement and health has not been discussed. The actions of the 'Edgeton' group have facilitated action, and thus indicate that stocks of social capital have been developed. However, theories of social capital state that networks, through the enhanced transmission of information, enable the development of norms of reciprocity and trust. It is these features that support collective action. These norms were only reported to exist within the 'Edgeton' community, and despite the formation of networks with external bodies, trust and reciprocity were not characteristic of these relations. Instead, the interviewees reported a persistent distrust of the local authority (see Section 6.4.3). The implications of these findings upon theories of social capital are discussed in depth in Chapter Seven.

6.7. Conclusions

The data here reveal a complex picture of community life in 'Edgeton'. The underpinning theme throughout is one of change, with group members reporting a decline in the traditional experience of community life. However, as the 'Edgeton' Community Action Group develops, it appears that some progress is being made towards reversing the exclusion and division that has come to characterise the village in recent years. As the group has developed, so too have the individual members and a process of learning and empowerment is underway. It is clear, however, that the group members perceive that their ability to develop has been constrained by the absence of resources, namely time, capacity, appropriate premises and other opportunity structures, and funding. The perceived constraints have served to hinder the development of trust within the local authority and suspicion remains the relationship's predominant characteristic.

Thus, it is evident that membership of the 'Edgeton' Community Action Group has the potential to evoke positive emotions for its participants, for the interviewees however, this outcome is tempered by the frustration generated by their perceived inability to achieve all their aims. As reported within the preceding section, this perception is underpinned by the identified lack of resources to undertake action. Therefore, establishing a network alone is

evidently insufficient in generating positive outcomes; instead, a network must be equipped with adequate resources to enable realisation of the collective aim. The resources emerging from the data as important include time, money and opportunity structures. Similarly, despite the emergence of a new strategic context for community involvement within the District, the impact at this level appeared to be limited to the 'Hillwood' Area Panel. These issues are discussed within the context of the research questions in Chapter Seven.

Chapter Seven

An Exploration of the Relationship between Community Involvement and Health: A Discussion of the Findings

7.1. Introduction

Through a programme of qualitative research, this thesis aimed to explore the relationship between community involvement and health, and in doing so, determine the utility of the concept of social capital in advancing understandings. Chapters Five and Six have presented the findings to emerge from the documentary, interview and observational sources; here, the implications of these findings for each research question are discussed.

7.2. The Influence of National Policy and Legislation upon Processes of Community Involvement within the Wakefield District

As reported within Chapter Five, the local authority, District level NHS organisations (e.g. Primary Care Groups, Primary Care Trusts and the Health Action Zone) and community and voluntary sectors all under went substantial restructuring throughout the period of research. It was widely acknowledged by interviewees from all sectors that a range of factors, such as funding and organisational capacity, had previously inhibited the effective involvement of communities within decision-making processes. From 2000 to 2003, a new strategic framework supporting the implementation of a new approach to community involvement emerged. This approach was triggered, in part, by the legislation and subsequent guidance introduced within the Local Government Act 2000. Within the Wakefield District, this led to the formation of the Local Strategic Partnership, Wakefield District Partnership, a community empowerment network (Vox), *Fast Forward*, the District's community strategy (WMDC, 2003a) and its subsidiary strategy, *Engagement Framework* (WMDC, 2003b). This strategic infrastructure was supported by a compact (Wakefield District Partnership, 2004b), which set out principles for joint working between statutory agencies and the community and voluntary sector, and area panels. In addition to the influences of the new legislation, local circumstances, such as alleged misconduct within the local authority, created an impetus for change (District Audit Office, 2002). This finding serves as a reminder of the importance of local circumstances in determining

any policy implementation.

The Local Government Act 2000 and supporting guidance (e.g. DETR, 2000) renders this strategic framework responsible for enabling the involvement of local partners, including communities, within decision-making processes. As such, new opportunities for community involvement were created within the District, including Vox and area panels, with formal links to the LSP (see Figure 5.2). The introduction of these structures inevitably shaped processes of community involvement within the Wakefield District; the exact nature of this influence is discussed further in the subsequent sections. Chapter Three identified organisational capacity as an important determinant of the effectiveness of community involvement processes. For example, if communities are consulted but their input is never utilised to shape service provision, either because of a lack of will or ability to change, then it is likely that levels of trust will be damaged (Joseph Rowntree Foundation, 2003).

7.2.1. The Formal Definitions of Community Involvement

In the Wakefield District, the strategic approach to community involvement was set out in the community strategy, *Fast Forward* (Wakefield District Partnership, 2003a) and expanded upon within the subsidiary publication, *Engagement Framework* (Wakefield District Partnership, 2003b). As implied by the title of the latter document, the District's approach drew upon the alternative concept of engagement. Reiterating the statements set out within government guidance (e.g. DETR, 2000b; 2001b), the effective engagement of communities and other stakeholders was defined as central to the success of the community strategy (Wakefield District Partnership, 2003a, p32). Again resonating with national policy, it was the local knowledge within local communities that was perceived to be a key determinant of success.

Engagement was broadly defined as incorporating the processes of community development, consultation, involvement and participation and comprised five levels; information giving; consultation and learning; involvement; acting together; and development (Wakefield District Partnership, 2003b). This approach draws heavily upon David Wilcox's (1994) model of participation, although two of the levels are relabelled. Wilcox's fifth level, supporting independent community interests is replaced with

development in the *Engagement Framework*, and the third level replaces deciding together with involvement. In doing so, the *Engagement Framework* makes the responsibilities associated with each level clear. For example, in the third level, although there is an invitation to participate within decision making, responsibility for those decisions is not shared until the fourth level of the Wakefield model, acting together. This move towards responsibilities as a key feature of the involvement continuum resonates with the Office of the Deputy Prime Minister's (2005) more recently published interpretation of involvement as a spectrum of responsibilities. In this sense, there is an expectation that communities will be prepared to make the appropriate level of commitment to the engagement process. This issue returns to the wider rights and responsibilities debate; although a social justice ethos interprets involvement as a right, rights will not be increased without an associated rise in responsibilities.

Therefore, the responsibilities at the uppermost level of the Wakefield model, development, are clear, with "communities governing themselves rather than being governed" (Wakefield District Partnership, 2003b, p9). In achieving this, the Wakefield District Partnership recognises the need to stimulate a process of empowerment. Within community development approaches (e.g. SCCD, 2001), it is empowerment that equips individuals and groups with the confidence required to fulfil new roles and assume additional responsibilities. However, the Wakefield model does not utilise the terminology of community development. As such, it is unclear how the development stage of the model will be achieved by the engagement framework alone.

In contrast, community development emerged as a defining feature of the district's approach to neighbourhood renewal. The local neighbourhood renewal strategy, *Local Action to Build Stronger Communities* (Wakefield LSP, 2002a), drew upon the district's Health Action Zone interpretation of community involvement, where any involvement process is underpinned by community development. Similarly, *Community Development: A Strategic Way Forward* (Perry, 2002), re-emphasised the importance of community development in tackling the power imbalances that prevented the involvement of individuals and communities. Despite this, it was not possible to determine the role of community development within the new strategic approach from the analysis of documents alone. As such, it was unclear whether the *Engagement Framework* (Wakefield District

Partnership, 2003b) was intended to supersede preceding approaches to involvement or build upon them. This finding thus serves to provide further justification of the collection of data from two sources (documentary and interviews) in the investigation of formal policies. The findings from the interviews with organisational representatives are explored further within Section 7.2.2 below.

7.2.2. How is community involvement defined in practice?

Although a new strategic approach to community involvement was presented within *Fast Forward* (Wakefield District Partnership, 2003a), it is not a given that this will cascade into practice. This statement is considered even more pertinent given the existence of alternative interpretations of involvement within the community strategy and local neighbourhood renewal strategy. As stated within discussions of the methodology, the formal rules are not necessarily synonymous with those guiding implementation (Lowndes and Leach, 2004; see Chapter Four, Section 4.3.1). Thus, the practical approach to involvement was investigated at three levels; firstly the interpretation of the new approach to engagement was established by the organisational representatives identified as central within its implementation; secondly observations of the new structures creating opportunities for involvement were undertaken; and finally, community activists participating within the new structures were interviewed to establish their experiences and interpretations.

Organisational Representatives and Community Involvement Interpretations

The interview data obtained from the organisational representatives revealed that the inconsistencies within the official documentation re-emerged as a divergence in the discourse utilised within the different sectors. Typically, representatives of the health and voluntary sectors, many of whom had been instrumental in the development of the strategic approach to community development and local neighbourhood renewal strategy, advocated an approach to involvement underpinned by community development. Conversely, local authority officers reiterated the central tenets of the new engagement framework within their discussions. In community development interpretations, involvement was seen as ineffective in the absence of prior community development work. Yet advocates of engagement stated that it was not possible to achieve development without first achieving some level of engagement. Theories of community development present the process as an

essential stage in equipping the powerless, or the excluded, with the skills, knowledge and confidence to participate and ultimately control the issues that determine their quality of life (e.g. SCCD, 2001). Within this interpretation, there is an assumption that the powerless have neither the ability nor desire to 'be engaged' regardless of the efforts of an external agency. Instead, the aim of community development is to enable people to reach a position where they can make an informed decision on participation within the agenda of the local strategic partnership. This does not appear to be the position adopted within the district's engagement framework.

Despite this divergence, several key descriptors of involvement were shared by all the interviewees: capacity, choice, power and control. Central to each of these descriptors was awareness that communities cannot necessarily participate within the highest levels of involvement, but instead, a range of factors determines the appropriate or preferred level. Although interviewees identified enhanced capacity as a key outcome of involvement activities, it was also considered to be an important prerequisite to the initial participation. Capacity in this sense was used broadly to incorporate the ability, skills, time and material resources possessed by communities. Although not all interviewees were advocates of community development, there was consensus that capacity was an issue. Interviewees also emphasised the need to address the capacity of organisations to undertake involvement activities. The short term nature of previous funding initiatives was cited as a key factor in inhibiting previous attempts to implement a strategic approach and an issue that must be addressed to ensure the success of the new approach.

In addition to capacity, it was recognised, particularly by voluntary and health sector interviewees, that statutory organisations must be willing to devolve power to enable the higher levels of involvement to be achieved. As such, there appeared to be a commitment to move beyond tokenistic means of involvement. Previous research has shown that in the absence of such a commitment, involvement will succeed only in damaging levels of trust between communities and local government (Joseph Rowntree Foundation, 2003).

Although the engagement framework presented increased levels of involvement as synonymous with increased responsibility, interviewees emphasised that any involvement opportunity must be presented to communities as a choice. In doing so, there appeared to

be a divergence from the national policy guiding the implementation of new approaches to community involvement. Within national policy, involvement is portrayed as a key vehicle in the regeneration of deprived areas; however interviewees expressed caution regarding the feasibility of this goal. In recognising the increasing level of responsibility associated with the engagement framework, interviewees expressed doubt that the majority would embrace the new opportunities for involvement. Instead, the Wakefield District model emphasises that the level of engagement implemented must be appropriate not only for the LSP, but also reflective of the desires of local communities.

As within any model of involvement, the underpinning theme throughout the data is control and influence. Although this is implicit in every model, discussions on this issue are largely absent within national policy documentation. As such, the national policy, which shapes implementation at the local authority level, fails to address many of the tensions inherent within involvement processes. For example, the increasing emphasis upon participative forms of democracy as a means to secure sustainable communities is dependent upon statutory organisations devolving power. The interviewees' analysis of involvement suggests that this is, at least to some extent, acknowledged within the District's approach. The discussion below will determine whether this assertion reflects practice.

In attempting to understand the divergence in interpretations of involvement, it is important to emphasise that the period of research was characterised by change, and the engagement framework only emerged within the latter stages of the fieldwork. It cannot be assumed that the publication of a new strategy will immediately override previous interpretations, as is evident from the data presented here. The partnerships within the District were newly formed and still establishing their shared goals during the research period. This is particularly evident in the reported confusion regarding the purpose of documents aiming to formalise the District's approach to involvement, such as the compact. Despite this, interviewees were positive that the existing tensions could be resolved as partnerships developed further. As such, the findings presented here cannot be taken as conclusive evidence of an inconsistent approach to involvement; instead they are representative of a District in a transient stage in the move towards a new strategic framework.

Community Involvement Structures and the 'Edgeton' Community Action Group

Largely in response to national guidance, new opportunities for community involvement were created during the research period, including membership of the LSP, Vox and area panels. The second stage of the research explored the practical implementation of these structures from the perspective of a community group within the 'Hillwood' area of the District, the 'Edgeton' Community Action Group. In doing so, the full range of the involvement spectrum was examined, from attendance at public meetings to the development of an autonomous community group.

The 'Edgeton' Community Action Group was created, with assistance from a Primary Care Trust's health and development worker, by residents of 'Edgeton' in the town of 'Hillwood'. Their aim, broadly defined, was to reverse the perceived decline in the area and secure an improved quality of life for all tenants. At the time of the research, the group was in its infancy having formed in 2002. Thus, the group presented an opportunity to establish how linkages were formed and maintained with external structures, such as the new opportunities for community involvement.

Why get involved?

Central to the 'Edgeton' group's motivation to act was a romanticised historical view of life in the village. Group members reported a perceived decline in the area, citing the removal of local amenities, decline in traditional industries and the housing allocation policy of the local authority as the contributing factors. The cumulative effect had been erosion in neighbourliness, described as characterising the village in the past, and traditional social norms had been replaced with exclusiveness. The 'Edgeton' group sought to reverse this decline by improving local services (e.g. play provision and housing) and providing new opportunities for interaction within the village. The importance of a strong historical attachment to the local area has emerged elsewhere as an important determinant of participation levels (e.g. Baum and Palmer, 2002). Similarly, Campbell and Gillies (2001) reported that romanticised views of past were commonly used as reference points for contemporary interpretations of the community. Within 'Edgeton', the perceived dissonance between historical perceptions and contemporary experiences by group members served as the catalyst to take action. Therefore, this finding demonstrates that a

social bond, in some form, with residents of 'Edgeton', was the defining characteristic of the 'Edgeton' group members' motivation to participate.

However, although the historical experience of life within 'Edgeton' served to motivate group members, it was also evident that it acted to restrict their interpretation of the composition of a 'good community'. That is, group members recalled a time when all residents knew everyone and social life centred upon the coal mines; 'Edgeton' was perceived to have become fragmented with the eradication of the mining industry and the migration of people into the area. The discourse utilised by the interviewees, such as "dumping ground" (Paul*), clearly demonstrates the negativity attached to the housing allocation policy of the local authority. The removal of the newer residents, who were incompatible from their positive interpretations of the community, therefore became synonymous with the perceived development of the village.

The Activities of the 'Edgeton' Community Action Group

In seeking action, the group members occupied defined roles that enabled several issues to be tackled simultaneously. These roles were both formally constituted, such as Chair and Treasurer, and informally developed around specific issues. The informal issue based roles proved to be particularly effective in maximising the group's ability to secure action; in adopting one issue as an individual objective, the responsible group member developed a degree of expertise in the governance of that particular issue. This expertise within the group structure then became a valuable resource available to other members seeking action on a similar issue. This information sharing is, according to Coleman (1990), a form of social capital in itself. In this sense, membership of the 'Edgeton' group has enabled individual members to draw upon the knowledge inherent within that structure, and thus avoid the resource intensive process of information acquisition. In turn, this increased the effectiveness of the 'Edgeton' group's response to local issues in that they were able to avoid the repeated investment in the development of knowledge.

One source of information utilised by the 'Edgeton' group was the 'Hillwood' area panel, one of eight local committees created as part of the wider reorganisation of the local authority's political arrangements triggered by the Local Government Act 2000. As the area panels were developed prior to the District's community strategy, they were

considered not to represent a component of new strategic approach to involvement. Instead, they were investigated here to determine the implementation of involvement processes within the Wakefield District. Nevertheless, their introduction represented a positive response to national policy; indeed, such structures were identified by the government as playing an important role within the involvement of communities (DTLR, 2001, p20). However, despite WMDC's constitution allowing for cabinet functions to be devolved to the area panels, during the period of research they were not utilised in this way; instead, they essentially functioned as council meetings in public.

Although the function of area panels appeared to be limited in terms of their position within any spectrum of involvement, with emphasis upon information giving, the 'Edgeton' data revealed the importance attached to this structure by group members. For the 'Edgeton' group, the 'Hillwood' area panel was a key mechanism in seeking action on local issues. Group members would attend the monthly meetings and question the panel (ward councillors and co-opted members) on issues such as car parking, fly tipping and the development of the 'Edgeton' area. In this sense, the area panel was utilised by the 'Edgeton' Community Action Group as an extension of councillor surgeries, that is, to tackle only issues that affected their immediate environment rather than the 'Hillwood' area as a whole. Frequently, the group's attendance resulted in a commitment from the panel to take action on the issue raised, such as fly tipping, but additionally the group were equipped with useful information on how problems had been resolved in other areas. This latter outcome of attendance served to provide further education on systems of local governance and as such, the group's understanding of service delivery and its decision making processes was further advanced. The four members who regularly attended the panel meetings would report any useful discussions back to the 'Edgeton' group's committee, further illustrating how information was shared amongst the group members.

The value attached to the area panels provides some support to Wilcox's model of participation, and also to the Wakefield District's engagement framework, which was based upon this model (see Figure 5.3). Wilcox's model (1994) aims to redress the hierarchical implications of Arnstein's ladder of participation (1969) and presents each level of involvement as a valuable process when implemented appropriately. Despite offering only limited opportunities for control and influence to attending members of the public, the

involvement structure was valued by the 'Edgeton' group members. In contrast, Vox, the District's community empowerment network and a potential source of valuable support, was not incorporated within the external networks of the 'Edgeton' group.

Vox represented a key vehicle in enabling the involvement of both individuals and groups within the LSP and as set out within national policy (NRU, 2003b), Vox held responsibility for the facilitation of community and voluntary sector representation onto the LSP. For some organisational representatives, Vox was credited with achieving major changes in the District's approach to involvement and securing a shift beyond tokenistic levels. In contrast, for some local authority officers, the relationship between Vox and the District's council for the voluntary sector (VAWD) was a source of confusion. This confusion was also evident amongst members of the 'Edgeton' Community Action Group; although criticism here did not centre upon the bureaucratic nature of Vox and VAWD, uncertainty over Vox's role was evident within the interview data. Within government guidance (e.g. DETR, 2001b; NRU, 2003b), the community empowerment network is portrayed as a key component of the local authority response to the increased requirements to involve local communities within decision making processes. In addition to appointing representatives to the LSP, the network administers funds (the single community programme) to support and develop the voluntary and community sector. However, the 'Edgeton' group's limited contact with Vox provided only a source of confusion rather than of help. As a result, there was no evidence of sustained links between Vox and the 'Edgeton' Community Action Group throughout the period of research.

In interpreting this finding, it is important to acknowledge that the 'Edgeton' group were in their infancy at the time of the research, having formed in 2001, and by their own admission, were still learning the rules of local governance. However, the confusion reported by the group member's over Vox's purpose appeared to function as a deterrent to future contact and highlights the centrality of capacity to the community sector's response to any opportunity for involvement. In the case of Vox, the 'Edgeton' group did not fully understand its function within decision making processes and discussions of the LSP itself were noticeably absent from both the interview and observational data. As such, the appointment of any 'Edgeton' group member to the LSP as a representative of the community and voluntary sector was unrealistic during the time of research. In contrast

however, and as stated above, the group members readily embraced the opportunity to attend the area panel and question ward councillors on local issues. Therefore, it appeared that during the research period, the level of involvement offered by the area panel was appropriate to the 'Edgeton' group's stage of development.

The absence of an awareness of Vox's role by the 'Edgeton' group raises questions concerning the groups that are likely to participate within the highest levels of decision making. The 'Edgeton' Community Action Group were heavily involved in activities within 'Edgeton' and in the wider 'Hillwood' area (e.g. the area panel), in this sense, the label 'usual suspects' would not be misplaced. Yet despite this, the group lacked the capacity, or in this instance the knowledge, to participate within the LSP. Although the capacity of individuals who were appointed as representatives of the LSP was not examined here, it can be concluded that they possessed enhanced knowledge, relative to the 'Edgeton' group, to enable involvement at this level. The national policy guiding the District's approach states that local government must be committed to involving the diversity of views within communities (DETR, 2000a; see Chapter Two, Section 2.2.1 for further discussion). However, given the capacity required to participate at higher levels of decision making, it is unclear how diverse communities can be represented on the LSP. Although different levels of involvement are offered within the District, is it the vision of government that only the communities rich in skills and knowledge are enabled to exercise the greatest influence in decision making? This position is clearly incompatible with the government's presentation of involvement as a key vehicle in tackling the seclusion experienced in the country's deprived areas. Instead, acceptance that only the most developed communities may experience the highest levels of involvement would appear to replicate previous failures of public health initiatives in that change is restricted to the groups already best equipped to take action (see Chapter Two, Section 2.1 for a review of this literature).

Similarly, the organisational representatives interviewed questioned the motivations of communities to participate at the levels required to achieve the government's vision. The evidence presented here suggests that the capacity of the community sector, and their choices, represent a key challenge to LSPs in achieving the level of involvement set out within government guidance. Failing to address the capacity of this sector will result in only limited involvement, with only those already equipped with the necessary skills,

knowledge and time responding to the new opportunities to participate within decision making.

It has been established therefore, that despite involvement within the area panels, the 'Edgeton' group did not possess the capacity required to participate with Vox. Given the centrality of capacity to both the data presented here and theoretical models of involvement, further examination of the 'Edgeton' group's capacity, and its development, is required. Although the formation of the 'Edgeton' group was facilitated by a health and development worker, there was no prior process of community development. Rather, the group was formed in 2001 with the single aim of improving quality of life in 'Edgeton' and any learning and empowerment processes were secondary to their involvement. The interview data revealed that the group members identified the physical environment, time and knowledge as inhibiting their ability to take action.

The absence of appropriate premises was perceived by the 'Edgeton' group as a key constraint; the bungalow allocated by the local authority for use as a community centre was reported to be too small to carry out inclusive activities. Reflecting this, a significant amount of time and energy was invested into the identification of a solution to this problem. Associated with this issue was funding; the group had failed to secure the funds necessary to either renovate the bungalow to create a better space or develop a new facility. However, it is not clear if the provision of a new community centre would alone enhance the capacity of the 'Edgeton' group. The emphasis placed upon the physical resources available to the group perhaps reflects the continued dismissal by the group of their achievements. At the time of the research, in repeatedly dismissing any achievements as only minor, there appeared to be an implicit need amongst the group members to secure high visibility outcomes. The interviewees perceived 'Edgeton' to be a 'forgotten village', describing the local authority as housing trouble makers within the area rather than choosing to invest in its development. Achieving the large scale development associated with a new community centre would represent confirmation to the group members that they could control life in 'Edgeton'.

Although the group members asserted that the area panels facilitated a learning process, they identified their limited knowledge and understanding of systems of local governance

as a further constraint on their capacity to act. The group members reported that they did not always know how to tackle every issue faced and, in these instances, advice and support was required. At the group's outset, a health and development worker was present to provide this support but a change in employment by the worker subsequently led to its removal. In the absence of this worker, this role appeared to be fulfilled, to some extent, by a ward councillor. Observations of the monthly committee meetings revealed that this councillor performed key functions within the group's structure, including signposting the group to the appropriate organisation when seeking action and the resolution of emerging areas of conflict. In addition to identifying the appropriate agency to approach in response to each issue raised, the councillor encouraged the 'Edgeton' group to establish links with external community groups operating in neighbouring areas. The councillor believed that establishing such links would enable information and advice to be shared between the groups. During the research period, there was some evidence that links were being formed, with members of groups in neighbouring villages attending 'Edgeton' committee meetings. Although these links functioned primarily as a further source of information sharing at the time of the research, there was potential for their further development into a more extensive network of support.

The actions undertaken by the councillor resonate with the role of 'community leader', the concept at the centre of the government's vision for local government (e.g. DETR, 1998). The Local Government Act 2000 provided the legislative underpinnings of the new political management structures replacing the committee systems. By reducing the time spent in committees, it was envisaged that councillors could invest increased time in their communities. The regular attendance of this councillor at the committee meetings suggests that, to some extent, this policy aim was successful within 'Edgeton'. However, it should be emphasised that the interaction between the councillor and the 'Edgeton' group was only examined after the legislative changes, thus, this conclusion is not a definitive demonstration of the effectiveness of national policy.

The third factor, time, identified by interviewees as inhibiting their capacity to act is difficult to address, either by the group itself or by an external agency. As asserted by the organisational representatives, the commitment invested in involvement activities should be a matter of choice to the individual groups or communities. Therefore, the individual group

members must make the decision, within the constraints of employment and family commitments, as to how much time to invest within the activities of the 'Edgeton' Community Action Group. This issue reflects one of wider importance to community involvement, that is, involvement within the highest levels of decision making processes demands a substantial investment of time. Given this, the groups capable of making the necessary commitment are likely to be relatively free from the demands of economic necessity. Therefore, any approach to involvement must consider the wider structural factors impinging upon the ability to participate.

For the 'Edgeton' group, any development in their capacity occurred indirectly with the progression of his/her involvement activities. Although the councillor appeared to perform a valuable function within the 'Edgeton' group, their involvement was limited to attendance at the committee and the occasional ad hoc communication out with the formal meetings. As such, the developmental function of this relationship was limited. Similarly, the health and development worker was instrumental in establishing the group's constitution and securing the use of the bungalow but involvement was restricted to the initial stages of the group's development. In this sense, the path of the 'Edgeton' Community Action Group within involvement activities resonates closely with the engagement model underpinning the District's new strategic framework. The two models of involvement advocated by the organisational representatives in the first stage of research suggested alternative processes to secure the development of communities. Within an involvement model, community development is an essential prerequisite to involvement at any level. In contrast, the engagement model emerging from the data argues that there must first be engagement at some level to facilitate a developmental process.

Although arguing that the act of involvement must first take place before any developmental process can begin, addressing the capacity of communities remains a central tenet of the engagement model. Despite this, there was no systematic investment in the capacity of the 'Edgeton' group and sources of support, such as the health and development worker and councillor, available to the group were inconsistent during the fieldwork period. The consequences of this are evident; the 'Edgeton' group's capacity to participate within the different levels of involvement was restricted and their ability to tackle the issues of local concern constrained.

The discussions thus far have demonstrated that issues of capacity and control and influence are inseparable, with capacity determining the level of control exerted upon local issues. Despite reporting that membership of the 'Edgeton' group increased the perceived level of control and influence over local issues, group members asserted that levels of control and influence remained low. The interpretation of the resources available to group members to secure action appeared to underpin this perception, which, in turn, created a subjective dependence upon external bodies to secure action. Reflecting this, the 'Edgeton' group focused on requesting action by the local authority to address issues such as fly tipping and play facilities. The response of the council was frequently interpreted as being too slow or incomplete by the group members, serving to perpetuate their perception of exerting only low levels of influence in 'Edgeton'. Where increased perceptions of control and influence were experienced, embeddedness within the 'Edgeton' group structure emerged as the defining factor, with members asserting that the collective voice of the group commanded a greater response by external bodies. However, the group's perceived dependence upon the local authority served to temper any process of empowerment.

This body of evidence reveals a complex picture of involvement; although the formation of the 'Edgeton' Community Action Group represented an opportunity to act at the uppermost level of any model of involvement, in reality the group did not possess the capacity to enable them to do so. As such, their interaction within the new opportunities for involvement in the Wakefield District was limited to attendance at the 'Hillwood' area panel. The new requirements to involve communities demands that local authorities demonstrate a commitment beyond consultation (DETR, 2000a) and it is evident that the newly formed LSP, in particular, presents an opportunity to participate within higher levels of decision making. However, the data presented here serves as a reminder that the groups and communities involved at this level are likely to be unrepresentative of the majority. Interviews with organisational representatives demonstrated an awareness of this potential tension, yet the experiences of the 'Edgeton' group suggest that much work is still required to address the capacity of the undeveloped communities. Given these findings, it is unclear how the 'Edgeton' group will be enabled to advance further through the District's engagement framework, indeed, if such levels are even desired. The concept of power and control is central to any model of involvement, it has been determined here that capacity is

key in understanding the level of control achieved. As such, any model of involvement must incorporate reference to the resources required at each level to ensure effective implementation.

7.3. Is community involvement important for health and well being?

Acceptance of any relationship between community involvement and health necessitates the adoption of a broad social model of health. Chapter Two presented Dahlgren and Whitehead's (1991) model of interdependent health determinants (see Figure 2.1). Within this framework, any theorised relationship would comprise an interaction between involvement and a range of structural and environmental (social, economic and physical) factors. As such, the simple creation of new opportunities for communities to participate within decision making would appear to be insufficient to influence health and well being alone. However, decades of research into features of the social environment suggest that participating in society is beneficial to health (e.g. Durkheim, 1952; Kawachi, 1997). Social support, collective action, social influence and access to material resources have all been identified (Berkman and Glass, 2000; Berkman and Kawachi, 2000) as potential mechanisms through which health may be influenced. In considering these mechanisms, the opportunities for interaction between involvement activities and structural determinants of health are clear. The task here, therefore, is to determine if there is any relationship between health and community involvement and to identify any potential mechanism through which an influence may be exerted. To achieve this, all outcomes of the 'Edgeton' group's involvement activities were identified and analysed. The value of social capital in informing the interpretation of these findings will be discussed in depth in Section 7.4 below.

The strategic framework in which community involvement is implemented is potentially important in shaping any relationship with health. That is, if there is support only for consultative methods of involvement, then the outcomes are likely to be very different to a more empowering process of citizen control (Arnstein, 1969), with consultation providing relatively limited opportunities for interaction with structural determinants of health. Similarly, the model of health utilised within this strategic framework will determine the level of support given to community involvement as a potential tool for public health.

Analysis of key District wide documentation revealed that the new strategic framework for community involvement presented a confused model of health. Although appearing to incorporate a broad range of health determinants, the associated actions largely target individual lifestyles. However, the organisational interviewees utilised a broad social model in their discussions, highlighting the interrelatedness between health determinants. For some interviewees, involvement presented an important means of overcoming social exclusion through increasing self-esteem and in turn, generating a sense of belonging. In this context, the interpretations of involvement echo that presented within national policy. For example, the Neighbourhood Renewal Unit (2003c) presents governance, social capital, service delivery and social inclusion as four goals of community participation. In increasing the confidence and capacity within communities, networks are established which creates cohesion (NRU, 2003a). For Berkman and Glass (2000), this represents an important means through which health can be influenced.

7.3.1. What are the outcomes of community involvement?

The observational and interview data obtained within the second stage of research revealed involvement outcomes operated at two levels; the individual and community. The processes giving rise to each outcome are examined here. As stated within Chapter Six, this categorisation serves to structure discussion rather than imply exclusivity.

Individual Level Outcomes

Directly questioning interviewees on the perceived outcomes emerging from their involvement within the 'Edgeton' group was typically met with a negative response, with members citing increased levels of stress and frustration. This negativity was embedded within the group's interpretation of their ability to tackle local issues; as discussed above, the group members believed that they were unable to act independently of external organisations and the magnitude of their achievements was largely dismissed. Therefore, the levels of investment within the 'Edgeton' group were interpreted as incommensurate with their achievements, resulting in frustration for members. The identification of negative outcomes supports research conducted elsewhere; Cattell and Herring (2002) reported that the process of securing resources and facilities represented a source of frustration for community activists. The culmination of these findings emphasises the importance of the resources, or more generally capacity, held by communities to respond to

involvement opportunities.

Although the interpreted experience of involvement within the 'Edgeton' group was largely negative, there was also evidence of membership providing individuals with satisfaction. Despite being largely dismissed, the visibility of the group's achievements represented a source of enjoyment to the interviewees. For example, the group members expressed satisfaction with their contribution to the demolition of the flats. However, the 'Edgeton' group's focus, reflecting their developmental stage, remained upon the action still required rather than their achievements to date. As a result, interpretations of their involvement experience were dominated by the factors that inhibited their actions and produced negativity.

In reporting a negative effect of involvement, we are reminded that uncritical acceptance of community involvement as a positive process, as presented within national policy, fails to capture its complexity. Instead, community involvement can be implemented at a range of levels, and the level engaged with must reflect both the capacity and choice of individual groups in commitment. In the case of 'Edgeton', the limited capacity of the group served to restrict their choices and as such, any satisfaction was secondary to the negative experiences of the group. Therefore, any process of involvement must be recognised as a complex process requiring substantial investment by both communities and local government to ensure positive outcomes.

Despite the interpreted shortcomings in the group's capacity, there was some evidence that membership of the 'Edgeton' group had stimulated a process of personal development. As reported above, the involvement activities, such as attendance at area panel meetings, facilitated the education of group members on the procedures of local governance. In addition to this informal learning process, membership of the Edgeton group stimulated entry into formal education. With the support of the health and development worker, three of the group members accessed IT and child protection training. The value of the certificates obtained through completion of these courses was clear and the achievements of the individual members were announced at the group's committee meetings.

This increased skills and knowledge enhanced the group members' ability to verbalise the

needs of 'Edgeton' and in turn, generated a new sense of confidence. This self assessed development was endorsed by the ward councillor working with the group, who reported observing changes within the capacity of its members. This increased capacity held by the group served as a catalyst for a further outcome; as the knowledge held by the group members was increasingly recognised as an available resource to the residents of 'Edgeton', their role within the village began to evolve into one of community leader. Both the interview and observational data found that group members were frequently approached by 'Edgeton' residents seeking information or action on local issues. The nature of the interaction between 'Edgeton' group members and residents ranged from questioning on the demolition dates of the flats to requests for help with dealing with anti-social behaviour. The group members appeared to embrace this role and described their willingness to provide assistance where possible.

For Bourdieu (1997) increased knowledge on a given issue represents a form of cultural capital, which can function as symbolic capital. Symbolic capital, or prestige, is developed when the enhanced knowledge is recognised and leads to an enhanced social standing. Equally, symbolic capital can improve access to cultural forms, although this interaction was not observed here. Within 'Edgeton', the increasing knowledge and ability to take action on local issues appeared to enable the group members to adopt a position of community leader within the local area. In considering this, the parallels with community development are clear; underpinning any process of community development is the removal of the barriers that have created power imbalances (SCCD, 2001). Within the context of the findings reported here, the 'Edgeton' group members had developed the skills and knowledge required to interact with the local authority to ensure that local issues were addressed. As this learning process continues, individuals are enabled to occupy new roles. Although the reported frustration at the lack of resources available to group members means that caution must be exerted when claiming any process of community development was underway within 'Edgeton', there is evidence that the 'Edgeton' group were at least beginning to embark upon this process. As determined in Section 7.2.2. above, this process occurred indirectly as a result of the involvement activities.

Empowerment represents an important concept within community involvement, particularly for advocates of community development approaches, and Chapter Two

revealed its influence upon the government's interpretation of the value of involvement. The central tenet of the concept is the process in which increased perceptions of control are developed (Tones, 1998). Within the context of the District's engagement framework, empowerment is identified as a process associated with the uppermost level, development. However, it has been established here that the 'Edgeton' group did not act at this level; instead their activities were restricted by their capacity. Again, it must be concluded that although there was evidence of increasing capacity, the empowerment process of the group remained in its infancy at the time of the research. For many commentators (e.g. Laverack and Wallerstein, 2001), empowerment is an essential process in enabling effective involvement; this argument is, in part, supported by the findings reported here. The 'Edgeton' group occupied the early stages of an empowerment process at the time of the research, as such, their involvement activities were limited to those offering only low levels of devolvement.

There was some evidence, particularly for Jill*, that the 'Edgeton' group served to provide individuals with a source of mental stimulation. At the time of her interview, Jill* was recovering from an accident and unable to work and she reported that her involvement within the 'Edgeton' group maintained her sanity. Although expressed somewhat jovially, this light hearted comment illustrates an important point, and one that has been reported elsewhere (e.g. Berkman, 1995); participation fulfils a potentially important role in the recovery from health and illness. Similarly, Cattell and Herring (2002) reported that where an illness or disability was experienced, participation provided a new sense of purpose to daily life which otherwise lacked structure and meaning. Here, involvement fulfilled this function for only one member, thus caution must be exerted over the commonality of this experience. However, in echoing findings reported elsewhere, support is given to the role of involvement in protecting mental well being.

Community Level Outcomes

The preceding discussion demonstrated the importance of information sharing to the 'Edgeton' group's ability to secure action. The interview data revealed that the extent of information sharing went beyond the members of the 'Edgeton' group and extended to village residents. In addition to formally disseminating information to the residents of 'Edgeton', through publication of a newsletter and public meetings, the group acted

informally within the village by virtue of their status as residents. By communicating the actions ongoing within the village, group members hoped that the despondency that had led to the labelling of 'Edgeton' as the 'forgotten village' would be overcome. For group members, tackling this despondency was central in reducing the social exclusion that had come to characterise the area in recent years. For Paul* in particular, demonstrating to residents that the quality of life in 'Edgeton' could be improved was an important first step in tackling exclusion.

In addition, the bingo and mother and toddler sessions organised by the 'Edgeton' group provided opportunities for increased interaction between residents. To further increase interaction, group members were eager to secure the development of a facility accessible to all residents, such as a new community centre. The importance assigned by group members to such a facility reflects the emphasis placed upon 'opportunity structures' (Baum and Palmer, 2002), or the physical environment, in supporting a sense of neighbourliness. For the 'Edgeton' group, it was not possible to recreate the interpreted historical sense of community in the absence of a communal space in which residents could interact. Despite interviewees perceiving the absence of a community centre as a constraint, it was evident that the bingo and mother and toddler sessions held within the bungalow increased the extensiveness of the social networks of the 'Edgeton' residents. As such, the formal network structure of the 'Edgeton' group had led to the subsequent creation of informal social and support networks.

More generally, the actions secured by the 'Edgeton' group represent important outcomes in their own right. All actions undertaken aimed to improve the quality of life in the village and thus were of benefit to the wider residents. These tangible outcomes included forcing local authority action on fly tipping, waste removal, play facilities and the longer term development of a community centre. Although these actions were dismissed by the group members as minor, the benefits to the village as a whole are clear.

7.3.2. Are the outcomes potentially determinants of health?

In interpreting health as a broad sense of well being, a wide range of factors are accepted as health determinants; the interaction between these factors, and the resulting inequalities, was reviewed in Chapter Two (see Figure 2.1). The preceding section identified the diverse

individual and community level outcomes to emerge from involvement processes in the Wakefield District. Utilising this model of health, the potential influence of each outcome upon well being is determined here.

Social support features within most theorised links between the social environment and health (e.g. Berkman and Glass, 2000); for example, social networks represent a source of social support to their members and have been reported to represent a health promoting resource, with some research attributing a three fold reduction in mortality rates to its provision (Kawachi and Kennedy, 1997). However, the networks investigated here, the 'Edgeton' group itself and the external links formed, did not function as a source of social support to its members during the time of the research. Instead, the support drawn from the 'Edgeton' group was specific to the resolution of local problems and there was little evidence of interaction between members beyond the formal activities of the group. In contrast, the subsequent formation of a social and support groups (bingo and mother and toddler sessions) can conceivably function in this way. Indeed it was apparent that Jill*, who was responsible for the formation of these groups, increasingly drew upon the friendships formed through the bingo sessions as a source of support. Unfortunately, these groups were formed during the latter stages of the research period and thus prevented any further exploration of this functioning.

The importance of social support to health is proposed to centre upon the stress response (Cohen, 2003), with support hypothesised as a potential 'buffer' against the effects of stressors (Steptoe, 2001). That is, exposure to a stressor does not inevitably trigger a stress response; instead the perceived availability of resources determines its interpretation and membership of a network may equip an individual with the resources required to respond to the stressor. However, the data presented here suggests that the 'Edgeton' group functioned as a stressor to individual members with stress and frustration emerging as an outcome experienced by the interviewees. The stress and frustration experienced by members reflected the perceived lack of capacity to achieve their goals and as such, the resources required to respond to the demands of involvement within the 'Edgeton' group were largely unmet.

Emphasising the complexity of any relationship between involvement and health, positive

influences on health also emerged from the data. As discussed above, for one group member in particular, involvement within the 'Edgeton' group appeared to preserve mental well being during a period of ill health. As described in Section 7.3.2, this highlights a role for involvement not only in the protection of well being but in aiding recovery from periods of ill health. Although this outcome was restricted to the experiences of one member, it was evident that involvement within the group yielded benefits for other members. In particular, membership of the 'Edgeton' group stimulated a learning process, with interviewees reporting increased knowledge obtained both informally from their involvement activities and formally from training courses. This in turn enabled the position of the group members within the local community to evolve into leaders. The adoption of this position was enabled by the 'Edgeton' residents' recognition of the increased knowledge held by group members.

Although this role remained in its infancy during the research period, its development represents a further potential health enhancing mechanism. For Wilkinson (1997), the presence of a social hierarchy is central in determining levels of income inequalities. Wilkinson argues that the interpreted position occupied within this hierarchy determines the sense of adequacy experienced by individuals, with those at the bottom perceiving only their failings (1999, p13). The anxiety generated by this social comparison is, for Wilkinson, an important determinant of health (see Chapter Three, Section 3.3 for further discussion). In this context, the adoption of a new role as leader in the local community can potentially be health promoting. That is, the 'Edgeton' group members' position within the social hierarchy is elevated, thus facilitating an increased sense of adequacy. Similarly, Berkman and Glass (2000) have identified the provision of meaningful social roles as an important health related outcome of engagement. In this sense, involvement facilitates the generation of a sense of value, belonging and attachment. However, further investigation of this developmental process is required to determine the psychological effects of the community leadership role.

The formal educational achievements obtained by group members represent a potentially important resource to individuals; with the increased qualifications conceivably being translated into improved job opportunities. During the research period, the interviewees of working age held unskilled manual occupations, thus, the new qualifications present an

opportunity to enter skilled employment and therefore potentially increase income. Level of income is one of the strongest predictors of health (e.g. Cooper et al, 1999), and any action which provides the means to increase income therefore represents a tangible link to health. The realisation of such a link is however dependent upon investment within the capacity of communities; offering involvement opportunities alone would not achieve such outcomes.

The existence of the 'Edgeton' group in itself also represented a potentially important resource for health. The group aimed to improve quality of life within 'Edgeton', and although their achievements were largely dismissed during the time of the research, their actions protected and enhanced local services. The cumulative effects of these actions served to improve both the social and physical environment in 'Edgeton'. Collective action has been theorised as one important mechanism through which social capital shapes health outcomes (Berkman and Kawachi, 2000). It has been shown here that the 'Edgeton' group drew upon the resources available to the group, namely the strengthened voice, to secure positive outcomes for the community as a whole.

The increased levels of information sharing generated by the community also represent an important resource for public health. The 'Edgeton' group informed village residents of their activities formally through the publication of a newsletter and informally through everyday interaction. Theorised links between social networks and health argue that such information channels can enhance the transmission of important health messages (Kawachi et al, 1999). During the research period, the newsletter published by the 'Edgeton' group was utilised in this way, with support groups and advice both advertised. Although it was beyond the scope of this thesis to determine if this served to alter the health related behaviour of the 'Edgeton' residents, it is clear that the newsletter represents a useful resource in communicating potentially health promoting information.

Additionally, group members reported that the transmission of information, in general, had triggered a reversal of the seclusion that had become characteristic of the community in recent years. Informing residents of the actions taken to tackle issues of local concern was described as initiating a reduction in the despondency underpinning the perception of a 'forgotten village'. The government's public health strategy, *Saving Lives: Our Healthier*

Nation (DH, 1999a), argues social networks generate a sense of pride and belonging in the community and as such, considered to be a determinant of health. More broadly, this process is synonymous with the government's interpretation of the value of involvement in tackling social exclusion. Within the context of the data presented here, the involvement activities of the 'Edgeton' group appeared to decrease the sense of hopelessness experienced by residents. Although these changes were only beginning to emerge during the research period, it is conceivable that, over time, despondency becomes replaced with the more positive characteristics central to the government's agenda.

In summary, the involvement activities of the 'Edgeton' group can potentially exert both a positive and negative influence upon both the health of its members and the wider community. Importantly, the theorised mechanisms underpinning this relationship all function through an interaction with the wider determinants of health. That is, involvement has been shown to shape access to and operation of key determinants, such as education and the environment. Therefore, the value of involvement as a tool for public health is likely to be increased when there is simultaneous investment within the social, economic and physical environment of communities.

7.3.3. Perceptions of Health

Questioning directly about perceptions of health, like direct questioning about the sense of community, proved a relatively ineffective approach, with the concept of health only appearing relevant to everyday interpretations where ill health had been experienced. In this sense, the interviewees utilised a narrow medical model of health, interpreting health as simply the absence of disease or illness. Reflecting the dominance of this model, determinants of health focused primarily upon lifestyle and individual behaviours, such as smoking and diet.

The limited responses to questioning about perceptions of health revealed that experiences of well being were mixed, perhaps reflecting the diversity of ages within the 'Edgeton' group (interviewees were aged between 40 and 70 years). Some members reported experiencing periods of ill health, while others perceived comparatively poor health due to their lifestyle. As such, this finding does not allow any conclusions to be drawn in relation to the influence of involvement upon health.

However, the data does provide some insight into the direction of any potential relationship between involvement and health. It has been suggested (e.g. Pevalin and Rose, 2003) that social capital and other measures of involvement, may be associated with health because individuals are less likely to participate within social or civic activities when experiencing ill health. Here, the mixed perceptions of health amongst individuals highly involved within community activities suggests that the relationship is likely to be more complex than suggested by Pevalin and Rose. Indeed, for Jill*, involvement proved to be an important resource in the recovery from ill health and provided a sense of structure and meaning to everyday life that would otherwise have been absent. Therefore, ill health did not prevent Jill's* involvement, rather it provided further motivation to maintain membership of the 'Edgeton' group.

Despite Jill's perception of the importance of group membership, lifestyle factors dominated the perceived determinants of health. Therefore, it is concluded that general questioning about experiences of involvement and, more broadly, the community yield richer information on potential health influences. Here, wider structural determinants, such as crime, housing and local service provision, all emerged within discussions of satisfaction within the area yet were not acknowledged by the interviewees as potential health determinants when questioned directly about perceived influences.

7.4. Is social capital important in understanding the relationship between community involvement and health?

The aim of this thesis is to determine the relationship between community involvement and health and to establish the utility of social capital in understanding any observed relationship. To enable this, it must first be determined if involvement processes within the Wakefield District have, or can potentially, influence stocks of social capital. The potential for the new strategic approach to develop social capital within the Wakefield District is clear, yet not inevitable. As Lowndes et al (2002) have shown, the creation of involvement structures will only succeed in enhancing stocks of social capital if there is a genuine commitment to involvement. As previous research has shown (Joseph Rowntree Foundation, 2003), implementing only tokenistic levels of involvement succeeds only in damaging the trust between systems of local governance and communities. Therefore,

without a genuine commitment to involving communities, positive influences upon stocks of social capital are likely to be limited.

7.4.1. How does the Wakefield District's approach to community involvement shape stocks of social capital?

Chapter Three reviewed the differing interpretations of social capital and concluded that social capital existed in three principle forms; bonding, bridging and linking. The findings presented thus far have highlighted that the activities of the 'Edgeton' group resulted in the formation of a complex network structure, both within and external to the 'Edgeton' area. In doing so, there was clear potential for the development of social capital in linking, bridging and bonding forms. As such, the research presented here represents investigation of potential sources of each form; with linking relationships shaped by the implementation of the Wakefield District's strategic framework for community involvement and the actions of the 'Edgeton' group influencing the formation of bonding and bridging forms of social capital. Reflecting this, the role of community involvement in determining stocks of each form of social capital is discussed here.

Linking Social Capital

Chapter Three established that local authorities can influence stocks of social capital through two distinct processes; creating opportunities for involvement and the provision of support to facilitate involvement. The actions of local government can therefore either enhance or constrain the development and maintenance of social capital. The first stage of the research, involving both analysis of key documents and interviewing organisational representatives, established that opportunities for involvement within the Wakefield District had increased in response to the Local Government Act 2000 and subsequent guidance. However, the data collected from both these sources revealed that the provision of support to communities was unclear.

The introduction of both the Local Strategic Partnership and area panels provided two contrasting levels of involvement available to the communities of the Wakefield District. The LSP enabled the development of sustained relationships between the community and voluntary sector and key service providers (e.g. WMDC, Primary Care Trusts, and Police) and in doing so, represented a potentially important source of social capital. Continued

involvement at this level of decision making could enable the development of trust between the members of the LSP, which in turn may underpin the actions of the LSP. However, it has been determined here that such embedded relationships (Evans, 1996) were limited to sections of the community already in possession of the required skills and knowledge and the 'Edgeton' Community Action Group did not qualify. As such, any conclusions regarding the value of the LSP as a source of social capital remain inferred from the findings of the first stage of research.

The participation of the 'Edgeton' group within the new involvement structures created in the District was restricted to the 'Hillwood' area panel. At this level, the relationships between communities and service providers diverged from those offered by the LSP. Firstly, only the local authority was represented on the panel, reflecting the status of the area panels as meetings of the council held in public. Secondly, the interaction between councillors and communities was restricted to question and answer sessions. As such, the potential formation of sustained links, or embeddedness, was limited relative to the relationships offered by the LSP. Despite this, the findings obtained from observations and interviews with the 'Edgeton' group revealed that the area panels provided an important source of information to the group members. Coleman (1990) argues that information sharing is in itself a form of social capital. For Coleman, the acquisition of information is a resource intensive process and membership of a network can reduce the required investment level. Coleman's assertion is supported by the data presented here; attendance at the area panel by some members of the 'Edgeton' group provided information and understanding on the operation of local government, which was in turn reported and shared with the group's committee. Moreover, the diversity of information presented during the area panel meetings ensured that the acquisition process of the attending 'Edgeton' group members was also enhanced. That is, they were enabled to draw upon the expertise offered by the panel members (councillors) during the question and answer sessions rather than undertake a lengthy investigative process.

Information sharing also features within Putnam's presentation of social capital; for Putnam (1993b), the transmission of information facilitated by networks of civic engagement enables the development of trust. Within this alternative presentation, information transmission enables the identification of the motives of other network members, which

over time generates trust. In the case of 'Edgeton', the group members reported suspicion rather than trust in the local authority. This distrust was embedded within the interpretation of the historical experience of life in 'Edgeton', with interviewees reporting that the local authority had systematically removed key local amenities and housed 'undesirables' within the area. Although increases in trust were not observed during the timeframe of the research, the reversal of this trend is not inconceivable. The transmission of information between the local authority and the 'Edgeton' group facilitated by the area panel may serve to provide group members with an understanding of the processes underpinning decision making. The increased transparency of decision making processes may then increase levels of trust. Equally, increasing the capacity of communities may support higher levels of involvement and thus enhance the transmission of such information. Therefore, the potential role of the area panel in generating social capital is clear, but this outcome is clearly dependent upon the local authority's commitment to transparent and accountable systems of government.

The processes in which community involvement activities are supported represents a second means through which the District's approach may influence levels of social capital. Analysis of documents and interviews with organisational represents revealed that the capacity of communities to respond to involvement opportunities was a key issue to be addressed. However, the means through which capacity would be increased lacked clarity, both within the formal presentation of the new engagement framework and the discourse utilised by representatives of different sectors. Given that the engagement framework does not endorse community development approaches, the position of this process is unclear. Instead, the support offered to the District's communities centred upon the activities of Vox, the community empowerment network. Vox was assigned responsibility for the facilitation of representation onto the LSP and as such, played an important role in extending the networks available to communities. However, findings from the second stage of research revealed that there was no interaction between the 'Edgeton' Community Action Group and Vox and the available support to the 'Edgeton' group was subsequently limited to the advice of a ward councillor. The ward councillor's role within the 'Edgeton' group was an important resource in enabling the achievement of action and this relationship represents a source of linking social capital in its own right. However, it did not increase the group's level of involvement within formal decision making processes.

Therefore, during the time of the research, the support available to communities to respond to the new opportunities for involvement was restricted to those communities and groups already in possession of the required capacity. In the absence of further outreach work, it is difficult to envisage how the 'Edgeton' group will be able to participate within the highest levels of decision making within the District. As such, access to stocks of social capital is restricted to the most developed communities. The inequality in access to networks reported here parallels Bourdieu's theory of social capital. For Bourdieu (1997), the three forms of capital, social, economic and cultural, are interdependent and can be exchanged for one another. In the context of the findings presented here, richness in skills and knowledge enabling participation within the LSP can be equated with cultural capital, a resource that facilitates access to a potential source of social forms. For the 'Edgeton' group, their lack of cultural capital increases their dependence upon social forms and their development is dependent upon their ability to utilise the available social capital to develop increased skills and knowledge. Previous research has reported that communities must possess cultural capital to enable interaction with local government, and thus develop social capital (Butler and Robson, 2001); here however, this relationship is shown to be more complex with the stocks of cultural capital determining the nature of the interaction with local government rather than its existence.

Therefore, in the absence of increased support to the community and voluntary sector, the Wakefield District's approach to community involvement creates unequal access to potential sources of social capital. Both Putnam (1996) and Bourdieu (1997) argue that social capital is self-reinforcing and cumulative, in that the existence of the resource enables further interaction, which in turn generates more. This assertion is supported here with capital rich groups and communities drawing upon their resources to participate within the highest levels of decision making. This finding has important implications for the proposition that social capital is disproportionately beneficial within areas of deprivation; in this context, social capital is perceived to provide a means to mitigate the potentially damaging effects of life in poverty (Pevalin and Rose, 2003). The data presented here suggests that existing levels of support for involvement activities within the Wakefield District will succeed only in perpetuating existing levels of inequalities in stocks of social capital. Given time, it is possible for the 'Edgeton' group to achieve a state of development

that enables their participation within diverse involvement structures; however, the self-cumulative nature of social capital suggests that that inequity will remain.

Reporting inequalities in access to social capital supports a growing body of research that has questioned its homogeneity. For example, Baum et al (2000) reported that educational levels represented an important determinant of participation within both social and civic activities. Therefore, it is important that any efforts to increase levels of social capital acknowledge that failure to address wider structural factors will succeed only in further perpetuating inequalities in the resource. This finding is particularly important given the growing interest in social capital within public health, as evidenced by the Health Development Agency's research programme (e.g. Cooper et al, 1999). This issue is returned to and discussed in more depth in Section 7.4.3 below.

Bridging and Bonding Social Capital

The data presented in Chapter Six led to the conclusion that the activities of the 'Edgeton' group enabled the achievement of actions that would not have been possible in its absence and therefore suggested that levels of social capital had been increased. Control and influence emerged as a key theme throughout the data; despite 'Edgeton' group members reporting only low levels, the perceived ability to influence local issues had increased since the formation of the group. For Bourdieu (1997), the formation of a network of any type enables individual members to draw upon the collectively owned capital and exert a more powerful voice. Although the economic and cultural capital available to the 'Edgeton' group was limited, the culmination of individuals applying pressure to the local authority equipped the group structure with greater influence than that available separately. It was the development of this resource that enabled the 'Edgeton' group to secure action.

However, the features of interaction that are theorised to enable the development of the resource, such as trust and reciprocity, were only evident between longer term residents of 'Edgeton' and the relationships formed out with the village were not characterised by these norms. Instead, group members reported that 'Edgeton' had traditionally been characterised by high levels of bonding social capital and recalled a time when everyone knew everyone and shared their problems. However, this perception of the past served to exclude newer residents who, for the interviewees, had become synonymous with the area's

decline and interpretations of the 'Edgeton' community typically excluded the newer residents whose presence conflicted with positive perceptions of the area.

It is concluded therefore, that although bonding forms of social capital represent the relationships held within a community or group (see Figure 3.1), it does not necessarily follow that residents of single geographic area represent a single community. In contrast, the 'Edgeton' data was underpinned by a sense of division between the newer and longer term residents. This finding represents what Portes (1998) describes as the downside of social capital; higher levels of bonding social capital in the absence of other forms serve to advance only the interests of group members. The divisions within the 'Edgeton' community further highlight the heterogeneity of social capital. It was reported above that capacity levels served to shape access to linking forms, at this level, length of residency determined the availability of the resource.

The question here, however, is, did the activities of the 'Edgeton' Community Action Group extend the bonding relationships between the longer term residents? To reverse this trend, bridging relationships between the two groups of residents are required. For Narayan (1999), bridging relationships represent cross cutting ties between heterogeneous groups. Although the residents of 'Edgeton' did not necessarily differ in terms of their ethnicity, class or religion, the group members' interpretations led to a perceived divergence between themselves and the newer residents. The stage two interview data suggests that the actions of the group had succeeded in increasing levels of interaction between 'Edgeton' residents, for example, through the organisation of bingo and mother and toddler sessions. As such, the extensiveness of the network extended beyond the formal structure of involvement and fulfilled a social function. In doing so, further opportunities to increase levels of bonding social capital within the 'Edgeton' area were provided. As stated above, these groups were established in the latter stages of the research, thus preventing further investigation. Despite this, it is clear that the existence of the 'Edgeton' group generated increased opportunities for social interaction within the village. However, there was no evidence to suggest that relationships had been extended to newer residents; instead, interviewees continued to distinguish between 'them and us' in their interpreted experiences of life in 'Edgeton'. Yet, it remained the long term goal of the group to establish a community facility accessible to all. It is conceivable then, that the achievement of such a resource

may enable the development of bridging relationships.

Although there was an absence of bridging relationships within the 'Edgeton' community itself, there was evidence that the 'Edgeton' group had begun to form links with community groups in neighbouring villages. The ward councillor embedded within the group structure encouraged the development of such links to facilitate information sharing. Although these relationships remained in their infancy at the time of the research, it was evident that the 'Edgeton' group drew upon the relatively advanced skills and knowledge held by a neighbouring group. Once again emphasising the self-cumulative nature of social capital, access to this bridging source was facilitated by the linking relationships available to the group.

7.4.2. What factors determine social capital development?

The preceding discussion has shown how different forms of social capital developed and functioned within the Wakefield District. Reflecting the diversity of sources, it is clear that different forms of social capital are determined by different factors. However, given the self-cumulative nature of the resource, the diverging factors interact to determine the overall stock of social capital. It should be emphasised that the investigations of social capital conducted here have focused upon the resources created as a result of involvement activities; therefore, the factors shaping the development of the resource are those that also determine the practice of involvement within the Wakefield District. Each of these factors is discussed in more depth here.

An important finding to emerge from the 'Edgeton' data is the implicit influence of the group members' historical association with the village in shaping both perceptions of 'Edgeton' and relationships with the local authority. In the case of 'Edgeton', interpretations of previous actions undertaken by WMDC, such as removal of local amenities and housing policies, served to hinder the development of trusting relationships. Although the group worked with the local authority, and frequently acted upon the guidance of a ward councillor, the perception of WMDC remained predominantly negative. Social capital theory achieves little in assisting the interpretation of this finding; central to all definitions is the proposition that networks enable the achievement of mutually beneficial actions through the development of norms such as reciprocity and trust. Yet in

'Edgeton', the linking relationships between WMDC and the Community Action Group appear to be achieving such actions but trust in the local authority remains absent. Equally, it is inconceivable to imagine that a local authority would only act in the interests of its communities in cases where a strong bond of trust had been formed. Therefore it is clear that social capital discourse does not readily translate to linking forms of the resource and alternative interpretations are required.

Social capital at this level is governed primarily by politics; both the political agenda of the national government demanding local authorities evolve into effective community leaders and the continual pressure to secure re-election. In this sense, the vote held by members of a community represents a vital outcome for local government and the dynamics of the relationships become very different to those characterising bonding links. Yet the end result remains the same; both parties, the community group and the local authority, achieve beneficial outcomes with the local authority potentially securing votes and the community a service.

Further demonstration of the role played by the local authority in determining stocks of social capital was provided by the 'Edgeton' group's interpretation of housing allocation policies. In 'Edgeton', the migration of people into the area was associated with a decline in the neighbourliness described as once characterising the community. Research conducted elsewhere has indicated that the stability of the informal social controls regulating a community is an important determinant of social capital (Cattell, 2004). In the case of 'Edgeton', the housing allocation policies were perceived to disrupt the traditional patterns of social interaction. Subsequently, bonding social capital became the exclusive property of longer term residents and served to exclude newer inhabitants from the interpreted community. However, stability was considered to exert a negative effect upon the formation of linking forms of social capital. It has been suggested above that the electoral vote provides local authorities with the motivation to work with and for communities. For one interviewee, the large majority held by Labour councillors in the Wakefield District was perceived to legitimise a dismissal of their views. For example, David* argued that the stability of the Labour party led to a continuation of traditional approaches to governance and only tokenistic implementation of involvement. Although this interpretation was only reported by one interviewee, it necessitates consideration of the

potentially alternative functioning of different forms of social capital.

Within 'Edgeton', the historical context exerted a negative effect on linking relationships between the community group and the local authority; however, it is equally conceivable that a positive historical context would be enhancing. In this sense, support is given to Putnam's (1993b) assertion that levels of social capital are embedded within an historical context of civicness. In the Wakefield District, the organisational representatives reported the implementation of only low levels of involvement in the past. Therefore, opportunities for the formation of diverse forms of social capital were limited. Despite this, the implication of Putnam's assertion is that social capital will remain defined by history; this conclusion is not supported here. The research presented here was conducted within a two year period and the continued development of social capital therefore remains underdetermined. Instead, it is suggested that the historical context must be acknowledged in any effort to create social capital to ensure effectiveness.

Previous research has reported that fear of crime is an important determinant of social capital development (e.g. Campbell and Gillies, 2001). The rationale behind this proposition is clear; if people are afraid to go out of their homes, they are less likely to participate in local activities. In 'Edgeton', fear of crime emerged as a complex theme. The group members expressed concern that their actions would lead to an increased vulnerability to crime, indeed, Fred* felt that his home had been vandalised in response to his involvement within the 'Edgeton' Community Action Group. Yet the perceived threat to the group members evidently did not prevent their continued involvement, however, it did lead to the adoption of a cautious approach and it is unclear to what extent that this shaped the actions of the group.

However, the dominant factor determining the development of social capital, in all forms, was the capacity of the 'Edgeton' group. To restate the point, the limited skills, knowledge, time and physical resources, served to restrict the level at which the group participated and therefore the available sources of social capital. In doing so, the significance of Bourdieu's (1997) theory is clear. As concluded above, the absence of skills and knowledge increases the dependency upon social forms of capital to secure development. Additionally, the group members attached high value to the physical infrastructure supporting the social

experience of life in 'Edgeton'. For Baum and Palmer (2002) opportunity structures, or the organisation of the physical and social environment, determine both the development and subsequent access to social capital through enabling or inhibiting social interaction. The findings presented here revealed perceptions of physical space as essential in facilitating interaction between residents. Reflecting this, securing the development of a new community facility in the site previously occupied by flats became an important objective of the group during the time of research. As such, it is suggested that the generation of social capital is enhanced by simultaneous investment in the resources shaping the involvement of communities.

Thus far, discussion has focused on the factors that inhibited the development of social capital; however, it was evident that several factors served to positively influence the potential development of the resource. In particular, it has been established that one ward councillor performed a signposting role within the group structure, encouraging links with external groups. Additionally, the availability of the health and development worker when establishing the 'Edgeton' group proved instrumental in enabling the formalisation of the network. The value of both this worker and the councillor demonstrates the importance of ensuring sustainability within the infrastructure supporting the community and voluntary sector. The organisational representatives asserted that the previous development of this sector had been inhibited by the provision of only short term funding for community workers. Addressing the sustainability of this support will aid the extension of involvement opportunities beyond those sections of the community already in possession of a rich stock of skills and knowledge.

7.4.3. Is social capital a necessary resource to produce health promoting outcomes?

It has been shown that the Wakefield District's approach to involvement has shaped the development of social capital. Furthermore, Section 7.3.2 identified the mechanisms establishing a relationship between involvement and health; however, it has not yet been determined if the formation of social capital is an important factor in this relationship. A growing body of evidence (e.g. Kawachi, 1997; Cattell, 2001) has reported an association between health and social capital; the creation of social capital could therefore be indicative of improved health. Yet, the findings presented here suggest that if social capital is a critical factor in this relationship, its functioning is more complex than implied by this

simple statement. Importantly, the perceptions of health reported by 'Edgeton' group members were mixed, indicating the importance of wider health determinants relative to the newly formed resource of social capital. Secondly, the outcomes of involvement highlighted the stress and frustration generated by group membership suggesting that the formation of a network alone is insufficient as a tool for public health. Reflecting this, the formation of social capital in its different forms is a complex process and a range of factors interact to both enhance and constrain development. Incorporating these observations, the dependency of the health related outcomes upon the formation of social capital is reviewed here.

The mechanisms supporting a link between community involvement and health focused upon two principle functions; the development of resources and the subsequent facilitation of collective action. It was established that the resources available to the 'Edgeton' group defined the level of involvement and its interpreted experience. Given the limited skills, knowledge, funds and facilities available, the predominant experience was one of stress and frustration. As stated above, this finding demonstrates the significance of Bourdieu's (1997) interpretation of social capital to the practice of involvement, in that the development of the resource is shaped by the availability of economic and cultural forms of capital. The 'Edgeton' group lacked the resources to undertake action themselves, creating a perceived dependency upon external organisations to deliver and improve local services. Therefore, the formation of the 'Edgeton' group provided the necessary means to develop bonding, bridging and linking forms of social capital but the translation of this stock into other forms of capital remained in its infancy at the time of the research. Conversely, the development of social capital was constrained by the absence of other resources. Supporting this argument is the observation that membership of the 'Edgeton' group stimulated a process of learning during the research period, which in turn enabled the occupation of a new role within the 'Edgeton' area, one of community leader. Reflecting the developmental stage of the group, the increased knowledge remained insufficient to facilitate involvement within the higher levels of decision making. The findings reported here suggest that creating new opportunities for involvement, and thus social capital development, will be disproportionately beneficial to those already in possession of social capital. It is concluded then, that the outcomes of involvement are shaped by the available stocks of social capital, and importantly, their interdependency with economic and cultural

forms. As such, it is suggested here that the development of all three forms of capital may enable communities to develop increased perceptions of control and influence and thus respond to the challenges of involvement.

Collective action has been identified as the second principle mechanism through which involvement may influence health. The achievements of the 'Edgeton' group, albeit largely dismissed by the members, centred upon their ability to identify key local issues and exert pressure upon the local authority to tackle them. In response, the village experienced improved service provision and thus providing an important link to health. As concluded above, the formation of the group enabled increased levels of influence to be exerted and action would not have been possible, or at least delayed, in the absence of the group. Therefore, this action was dependent upon the ability of the community group to mobilise the social capital available within the network structure.

These conclusions support the adoption of a social model of health, such as that presented by Dahlgren and Whitehead (1991). In this context, health is determined by a wide range of interdependent factors including both individual behaviours and income. Therefore, social capital based interventions informed by Bourdieu's theory are likely to represent the most effective tool for public health. Such interventions necessitate investment in the total stock of resources possessed by communities and reject the proposition that the creation of networks alone is a sufficient tool to tackle the inequalities characterising contemporary society. This is supported by previous research that has found that although social capital is associated with health, the strength of the relationship is weaker than that between income and health (e.g. Kawachi et al, 1999).

Social capital succeeds in encapsulating a range of complex interactions and in this sense represents a useful concept in advancing understandings of the relationship between community involvement and health. The evidence reported here indicates that the functioning of this relationship is shaped by the level and form of social capital held. That is, the ability of communities to translate social capital into other resources, as defined by Bourdieu (1997), determines each of the identified outcomes. It is clear however, that many of the central tenets, as presented here, draw upon related theories of social networks and empowerment. Demands have been made to clarify the conceptual boundaries between

these concepts (e.g. Kawachi and Berkman, 2000); yet the value of social capital is provided by its ability to analyse the operation of such concepts across societal layers and, more specifically to public health debates, their interaction with determinants of health. Therefore, it is concluded that social capital is an important concept in understanding relationships between community involvement and health.

7.5. Methodological Reflections

The research has utilised a qualitative methodology to investigate the translation of involvement policy into practice. In doing so, data was collected from documentary, interview and observational sources. The value of such an approach is evident and it has been demonstrated here that each data source has served to illuminate interpretations of involvement within the Wakefield District and its implementation. However, given the complexity of the issues under investigation, the analytical constraints presented by the methodological approach must be discussed.

As with every case study, the findings presented here clearly cannot claim to be a complete presentation of involvement within the Wakefield District; instead they provide some insight into the translation of national policy to implementation at the local level and one community group's experiences of this process. To investigate every involvement activity conducted within a population over 300 000 (Census, 2001) would be an impossible task and the value of such an approach is questionable. By selecting one community group to explore how community involvement is related to health, and the political influences upon it, understanding is obtained of the complexities shaping the relationship. As such, evidence is provided of how involvement processes can operate within a specified context.

The research sought to investigate the potential for social capital to influence health and in doing so investigated only the experiences of those involved with community activities. It has been argued elsewhere that such formal relationships are no longer relevant within contemporary society (e.g. Campbell et al, 1999), however, it is such relationships that have been theorised to provide a rich source of social and economic benefits (Putnam, 2000). Failing to examine the value of formal relationships therefore prevents increased understanding of an important tenet of social capital theory. This rationale informed the selection of a community group as the focus of the research, with investigation of their

experiences serving to illuminate any potential benefits of social capital. However, the selection of such a group does not allow comparisons with individuals removed from formal engagement structures. Such comparative analysis has been undertaken by numerous researchers elsewhere (e.g. Baum and Palmer, 2002) and it was concluded unnecessary to repeat the analysis here; instead the aim has been to advance understanding of the potential mechanisms underpinning any relationship between community involvement and health. Despite this, interviewing the non-involved residents of 'Edgeton' might have enabled further insight into the developmental process of the community group.

The advantages of selecting a newly formed community group to investigate the practice of involvement within the District are clear; it enables examination of the development of networks facilitating involvement at its various levels. However, the infancy of the group equally serves to exert caution in interpreting findings. The findings presented here represent how involvement was experienced during the timeframe of the research and it remains undetermined if the suspicion of the local authority or the capacity of the 'Edgeton' group evolved over time. Instead, understanding is provided of the specific factors enhancing and constraining involvement activities at a given point of time.

Additionally, the inclusion of a second case study may have supported the formation of alternative conclusions. Although it was originally intended to utilise two cases within the second stage of the methodology, the practicalities of the research process prevented such an approach. In particular, and as described within Chapter Four, Section 4.4.2, the case was selected with the assistance of community workers, a process which proved time consuming. A second community group from the 'Hillwood' area was deemed necessary to ensure a degree of comparability in the availability of involvement opportunities. However, an appropriate group was not identified within the time frame of the research.

The inclusion of a second, more developed community group, is likely to have yielded further understanding of the processes underpinning access to the range of involvement opportunities. It was observed that the 'Edgeton' group did not possess the knowledge and understanding required to access higher levels of involvement and the research was unable to determine the necessary processes to redress this. Similarly, it is unclear if the 'Edgeton' group members' distrust of the local authority will decrease with continued involvement.

Contrasting their experiences with those of a more developed community group may have served to illuminate the evolution of such linking relationships. Furthermore, the 'Edgeton' data highlighted the potentially negative effects of involvement upon health in the absence of the appropriate resources to secure action. A more developed community group may have secured the required resources to enable the emergence of a more positive effect upon health. However, it cannot be determined if a second case study would have yielded such contrasting findings. It is argued that the depth and quality of the data drawn from investigation of the 'Edgeton' Community Action Group alone has provided a valuable advancement of understandings of the relationship between community involvement and health.

The findings presented here suggest potential mechanisms through which involvement activities may influence health. The identified mechanisms are based upon findings obtained within the two year period of the field work. Understandings of the relationship investigated here would be further advanced by the adoption of a longitudinal research design, beyond the scope of this thesis. Such an approach would enable examination of the factors shaping the ongoing developmental process and the subsequent interaction with health determinants.

In addition to these general methodological observations, it has been established that some of the data collection techniques utilised were relatively ineffective in fulfilling their aim. Most notably was the direct questioning of interviewees about experiences of the community and health, with responses lacking depth, suggesting that these concepts were too abstract to enable application to everyday life in 'Edgeton'. The thesis methodology identified the difficulties experienced elsewhere in eliciting in depth responses to subjective health questioning (e.g. East, 2002). In response to this review of the literature, techniques were adopted that have been proven to yield perceptions of health. However, general questioning on the experience of involvement and satisfaction with the local area provided the richest information on the factors shaping health and well being.

Research aiming to investigate social capital at any level must acknowledge the importance of the historical context in determining the experience of the community or group. The findings presented here support a growing body of evidence (e.g. Campbell and Gillies,

2001) that views of the past determine not only motivations to participate within local activities but also shape relationships with systems of local governance. It would perhaps be a useful exercise within any approach to community involvement to explore historical interpretations of the local area as a first step. In doing so, perceptions of decline can be established and realistic goals then be established.

It is important to also consider the influence of the researcher on the data obtained. It is conceivable that the association with the Health Action Zone influenced the findings, particularly the discourse utilised by the organisational representatives. However, the strong resonance between the themes emerging from the interview data and the key documentation analysed suggests that any influences upon the discourse were minimal. In addition to enhancing the validity of the findings reported here, this observation also serves to emphasise the strength of triangulation. In collecting data from more than one source, in this case documentary analysis and qualitative interviews, the findings have been validated. It is evident that some findings presented here, most notably the role performed by the councillor within the 'Edgeton' group, were only enabled by the use of observational techniques.

In the second stage of research, interviews and observations with the 'Edgeton' group, the potential influence of the researcher upon the data must be considered. The 'Edgeton' group was observed over a twelve month period and during this time relationships were formed with members. As such, remaining detached from the experiences of the group became difficult and frustrations were shared. However, intervention within any of the committee meetings was never offered to ensure any influence was minimised. Additionally, having reviewed the findings, it is unclear how the presence of the researcher could have shaped the interpreted experience of involvement within the 'Edgeton' group which was deeply embedded in the historical context of the community.

Observational methods were an important component of the methodology and represent a progression in research aiming to explore social capital, a concept embedded within interaction. However, the transcription of the observational data proved problematic and its format inhibited the ability for presentation within this thesis. During the initial fieldwork period, discussions at the various meetings were localised and often difficult to follow

resulting in disjointed field notes. Over time, the field notes progressed into comprehensive records of the observational event yet they were littered with identifiable passages, the removal of which was deemed to render them meaningless. Yet this does not serve to dismiss the value of this form of data collection, instead the observations revealed how the 'Edgeton' group functioned, both within their own committee system and externally within structures such as the 'Hillwood' area panel. Indeed, the observational data revealed, for example, the separation of tasks amongst the group that enabled individual members to develop relative expertise in specific issues. The individual levels of expertise represented an important resource to the group in that enhanced their ability to undertake action on a wide range of issues. Similarly, findings emerging from the observational data informed lines of questioning utilised within the interviewing process. Most importantly, the observational data enabled the experiences of the 'Edgeton' group to be placed in context. Without such data, the significance of issues emerging from the interview data, such as frustration in securing suitable premises, would not have been fully realised.

Despite this, it is apparent that the value of the observational data is not fully reflected within the presentation of findings and only a small number of field note extracts have been used. An alternative approach to recording the field notes may have enhanced the ability to easily insert the data into this thesis. Every effort was taken at the transcription stage to ensure that an accurate record of the observational event was made. This approach included the completion of an observational protocol, an example of which is shown in Appendix 4a. It is suggested that the increased use of memo writing (see Chapter Four, Section 4.6 for more details) at the transcription stage may have increased the ability to translate field notes into the presentation of findings. This technique would ensure that the field notes were explicitly built into the evolving theoretical framework at the outset rather than remaining implicit.

Increased presentation of observational data may have increased the reader's understanding of how interaction within the 'Edgeton' group led to the development of social capital. Clear extracts showing the process in which issues are identified and subsequently tackled are likely to demonstrate the value of the group structure in facilitating action. Similarly, such extracts may serve to illuminate the significance of norms in regulating the group's functioning. It is difficult to capture the complexity of social capital without such data.

Finally, social capital has informed the development and implementation of the methodology presented here. In operationalising any academic theory, there is a danger of enforcing preconceived ideas upon the findings. To avoid this, analytical techniques were chosen to enable themes to emerge from the data. As discussed in Chapter Four, Section 4.6, the thematic analysis ensured all outcomes of involvement were identified. Therefore, it is concluded that the enforcement of social capital upon the data has been minimised.

7.6. Conclusion

Recent legislation and policy has created new opportunities for communities to participate within decision making processes and the response of one local authority has been examined here. In investigating the interaction of the 'Edgeton' Community Action Group within Wakefield District involvement processes, the translation of this policy into practice has been observed and the potential influences upon health explored. The findings reported here present a complex picture of the relationship between community involvement and health. Within public health, there is often uncritical acceptance of the positive role of community involvement; however, it has been shown here that community involvement can be potentially damaging to health in the absence of the necessary resources. Reflecting this, the resources available to communities to respond to any involvement opportunity must be addressed before involvement will provide any value within public health. Social capital serves as a useful tool in encapsulating the complexity of this relationship, particularly the interpretations presented by Pierre Bourdieu (1997). For Bourdieu, social capital is shaped by the possession of other resources, namely economic and cultural capital; the experiences of the 'Edgeton' group have been shaped by their ability to develop and draw upon both these resources.

The national guidance informing the local authority's approach to community involvement emphasises the need to ensure the diversity within communities is represented in decision making (DETR, 2000a). At the time of the research, the 'Edgeton' group did not possess the necessary capacity to participate within the LSP and as such, their access to networks was limited. Although the organisational representatives emphasised the importance of individual groups and communities choosing the level of involvement they wished to

interact with, it is clear that the choices available to the 'Edgeton' group were limited by the resources available to them. In this sense, Bourdieu's (1997) assertion that access to social capital is shaped by the possession of economic and cultural forms of the resource is supported. The 'Edgeton' group lacked the skills and knowledge required to participate within higher levels of decision making, which served to restrict their access to a potential source of linking social capital. Consequently, participation at the highest levels of decision making within the Wakefield District are restricted to those sections of the community in possession of the required skills and knowledge. Reflecting this, increasing opportunities for involvement alone is an insufficient mechanism to tackle deprivation, as presented within government policy, to the contrary, such an approach is likely to perpetuate existing inequalities. Both Putnam (1996) and Bourdieu (1997) portray social capital as self-cumulative, in that the possession of the resource enables access to further sources. This feature of social capital development and maintenance has been supported here.

Equally, the heterogeneous nature of bonding and bridging forms of social capital has been demonstrated here, with access shaped by both opportunity structure and length of residence. The 'Edgeton' group members emphasised the constraints placed upon interaction between residents by the physical environment, or opportunity structures, of the village. Subsequently, the experience of the community was characterised by a sense of division between the newer and longer term residents. The provision of improved opportunities for interaction will potentially facilitate the development of bridging forms of social capital, which in turn will increase the cohesiveness of the community.

Within Chapter Three, community development was portrayed as a potential means to tackle the factors rendering communities powerless to determine the quality of their lives. Although community development would therefore appear to represent an appropriate process to ensure the involvement of communities such as 'Edgeton' within the higher levels of decision making, the findings presented here do not support any conclusions to be drawn. Instead, the position of community development within the Wakefield District's approach to involvement is unclear, with both strategic documentation and the interpretations of organisational representatives diverging on this issue. Additionally, the removal of the support of the health and development worker during the research period

prevented observation of this process within 'Edgeton'. Therefore, the potential value of community development in improving the effectiveness of involvement processes is undetermined here.

It is concluded that the process of community involvement can potentially influence health through two principle mechanisms: facilitating the development of resources and collective action. The first of these mechanisms centres upon the developmental process that generates improved access to resources essential to secure change within communities. In the context of the findings presented here, skills and knowledge are central in enabling communities to articulate their needs and identify the means to fulfil them. The learning process underpinning this development, in increasing the qualifications held, is suggested to represent a potential means of accessing improved job opportunities. This development in turn serves to address the despondency characterising their perceived exclusion. The second mechanism, collective action, highlights the role of a community group in protecting and enhancing local services. It is argued here that the development of social capital in its different forms shapes the functioning of both these mechanisms and therefore represents a valuable concept in understanding the relationship between involvement and health. Social capital, in embodying a wide range of constructs, demonstrated its utility in delineating this complex relationship.

The research also provides further understandings of the functioning of social capital. The 'Edgeton' data highlights the factors defining social capital formation and in doing so, emphasises the importance of wider community resources. Similarly, investigation of linking, bridging and bonding forms of social capital have revealed divergences between each form. In particular, linking relationships formed between the 'Edgeton' group and WMDC were not characterised by trust, a central tenet of social capital theory, but rather suspicion. Therefore, although linking relationships were found to exist between the 'Edgeton' group and the local authority, social norms were relatively unimportant to this form of social capital. Reflecting this, it is suggested that the significance of other sources, such as political motivations, to the development of social capital is explored further.

This thesis aimed to explore the relationship between community involvement and health, and in doing so, determine the utility of social capital in advancing understandings. It is

concluded that community involvement can potentially influence health through facilitating both the development of resources and collective action. However, in the absence of the necessary investment within communities, this influence is not inevitably positive. The functioning of these mechanisms is shaped by the stocks of social capital available to communities and therefore represents an important concept in understanding the relationship between involvement and health.

Chapter Eight

Conclusions and Recommendations for Further Work

The introduction of legislation and government guidance to increase opportunities for the involvement of communities within local decision making structures does not inevitably translate into increased stocks of social capital. Instead, interaction within new involvement structures is determined by the capacity of communities. Capacity in this sense refers to the level of skills, knowledge, finance and time available to communities. In the absence of associated attempts to facilitate the development of excluded sections of society, involvement at higher levels of decision making is realised only by those already in possession of the required resources. Previous research (Putnam, 2000; Lowndes et al, 2002; and Marinetto, 2003) has suggested that local government can either enhance or constrain the development of social capital. This assertion does not reflect the inequalities in access to sources of social capital. Increased opportunities for involvement are likely to succeed in enhancing the diversity of forms of social capital available to groups and communities already in possession of the resource. Importantly, it is the interaction between the different forms of capital, as proposed by Bourdieu (1997), which underpins the self-cumulative nature of social capital. Communities with relatively low levels of capital, in all its forms, are restrained from participating within the higher levels of decision making.

The processes and interventions required to remove such constraints have not been fully investigated here; instead, the research has focused upon yielding understandings of the factors that determine experiences of involvement. Therefore, further exploration of the continuing development of groups and communities, particularly in areas where there have historically been limited opportunities to enhance stocks of social capital, would advance understandings. Such research is pertinent in the current political climate where strengthening communities through involvement is advocated as a key mechanism in tackling social exclusion. In this sense, and as proposed by Pevalin and Rose (2003), social capital is perceived as potentially disproportionately beneficial to deprived communities where access to material resources is limited. Similarly, comparing the involvement experiences of communities with variable stocks of capital will enable further examination of the heterogeneous nature of social capital. That is, the process of social capital development and maintenance is likely to be determined by

the distinct social, economic and physical environment of each community. Establishing the interaction between each of these factors will provide further insight into the resources required to develop stocks of social capital in all its forms.

The volume and form of capital available to communities determines the value of involvement as a tool for public health. Community involvement can potentially influence health through two key mechanisms; the facilitation of access to or the development of resources and collective action. These mechanisms have been proposed elsewhere to represent potentially important pathways mediating a link between social capital and health (Berkman and Kawachi, 2000). However, it is concluded here that the functioning of both mechanisms is determined by the translation of social capital into cultural and economic forms. The generation of social capital facilitates a learning and development process, which in turn increases the volume of cultural capital available to the group structure. Similarly, it is the possession of cultural capital that initiates the verbalisation of needs and the subsequent pursuit of action. This supports the findings reported elsewhere (Butler and Robson, 2001) suggesting an important link between stocks of cultural capital and interaction with local government. Here, the potential of this developmental process to increase access to economic capital has only been theorised. For example, it is suggested that the increased skills and knowledge, or cultural capital possessed, may translate into improved job opportunities. Longitudinal research will provide the required empirical evidence to inform further conclusions.

Although elements of both Coleman's (1990) and Putnam's (2000) theories have been supported here, it is Bourdieu's (1997) theory of social capital that provides the greatest analytical value to discussions of community involvement and health. As concluded above, capacity shapes the volume and form of social capital available, which in turn, determines the functioning of the mechanisms linking community involvement to health. The interdependencies between economic, cultural and social forms of capital are central to Bourdieu's theory, and thus inform analysis of this relationship within a society characterised by inequalities. This conclusion has important implications for the implementation of involvement processes; the value of involvement as a tool for public health is constrained in the absence of simultaneous efforts to invest in the wider community infrastructure. Such holistic intervention is not only important within the field of public health but also to the process of democratic renewal. The simple creation of involvement structures alone is unlikely to generate increased levels of participation

among the excluded sections of society; instead it is suggests that the benefits will only be experienced by the capital rich communities. As recommended above, a comparative case study methodology is required to advance understandings. This supports Dahlgren and Whitehead's (1991) (see Figure 2.1) presentation of health determinants as interdependent layers of influence. This model suggests that the targeting of one determinant alone, in this instance, social and community networks, is ineffective in achieving improved health and well being. Therefore, Bourdieu's presentation of social capital presents a potentially valuable resource for public health.

This thesis also serves as an important reminder that a geographic area does not inevitably represent a single community. Instead, interpretations of communities are largely informed by the historical experience, with factors deviating from the romanticised perceptions of the past generating negativity and, in turn, division. In particular, the migration of people into an area appears to disturb the traditional normative structure and damage levels of cohesion. For Cattell (2004), stability within the social infrastructure is an important determinant of social capital levels and, for stocks within the community, this assertion is supported here. It is important then that the continued emphasis upon community based interventions within national policy acknowledges the diversity inherent within communities to ensure that any existing divisions are not perpetuated. Further investigation into the effects of migration upon the normative structure defining social interaction within geographic communities is necessary to advance understandings of cohesion. Such research is particularly important given the current political debate on immigration and the subsequent integration of cultural norms. The value of life history approaches in illuminating the experiences of a community have been demonstrated here and should inform the development of future research.

Although the normative structure is important to the formation and functioning of bridging and bonding forms of social capital, it is largely irrelevant to discussions of linking forms. It is concluded that the formation of relations between communities and systems of governance can generate an important resource within the context of involvement processes. However, it is undetermined if this resource is indeed social capital. The relationships formed at this interaction level were not defined by the norms characteristic of bonding and bridging networks but action was still secured. Therefore, the value of social capital in capturing the complexity of relationships between

communities and local government is unclear. Further investigation is required to identify the factors, with particular focus upon the significance of the political process, that shape linking relationships.

Despite this, it is concluded that social capital is a valuable concept in advancing understandings of the relationship between community involvement and health. Social capital is a resource shaped by the availability of cultural and economic forms of capital and the interaction between the three forms enables analysis of the complex factors that determine patterns of involvement. It has been demonstrated here that social capital alone is insufficient in facilitating access to higher levels of involvement; instead access is dependent upon the translation of social forms into cultural forms of capital. This conclusion does not necessitate an abandonment of social capital as an important resource in strengthening communities, as portrayed within contemporary interpretations, but rather suggests that its value as an explanatory concept is underpinned by its interaction with additional forms of capital.

Finally, the research conducted here has been undertaken during a period of restructuring within local government and the longer term effects of these changes can only be established by continued research. The interdependent nature of health determinants across the life span necessitates the implementation of longitudinal qualitative and quantitative research. This approach will ensure the development of a comprehensive knowledge base on the processes defining the relationship between community involvement and health. In turn, this will maximise the potential functioning of community involvement as a public health intervention.

The translation of government policy into practice has been investigated here. The methodological approach utilised documentary analysis, observational and interview techniques and thus rich data was collected. This has enabled the advancement of understandings of the complexities linking involvement and health. It has been demonstrated that the introduction of involvement structures alone is insufficient in facilitating the participation of sections of the community. In doing so, the findings provide important implications for involvement policies. It is recommended that Bourdieu's (1997) theory of social capital, rather than that of Putnam (e.g. 2000), is utilised to inform the development of approaches to involvement. Such an approach necessitates consideration of the total volume of resources available to communities to

respond to the ongoing process of democratic renewal. In the absence of the appropriate investment in communities, existing social stratifications will be increased. In a society characterised by inequalities, Bourdieu's theory represents an opportunity to develop involvement approaches into a genuinely holistic approach for public health.

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Appendix One: Research Stage One Information Sheet

Exploring the links between community involvement and development and health.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
Sheffield Hallam University are funding a postgraduate student (Lorna Ritchie) to conduct a research project. The research aims to explore the links between health and the processes of community involvement and development, within the context of the community planning process.

The research itself will be taking place throughout 2003. The project will be completed in late 2004.

Why have I been chosen?
People involved within community planning or community development processes are being invited to take part in the research. This is part of a wider research programme which involves observing some public meetings and community groups.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

The researcher will interview you on a one to one basis. The purpose of the interview is to find out how the community planning processes have been developed and implemented within the Wakefield District and your experiences of them. It aims to identify some of the ways in which the activities and organisation of community groups may have been influenced by this process.

The interviews will vary in length for each individual, as a guide, an interview is likely to last approximately one hour.

What are the possible benefits of taking part?
The research is unlikely to provide any immediate benefits and may not prove to be helpful in securing funding bids. But it will be of help to practitioners (e.g. community development workers and health promotion specialists). It will add to their understanding of how their work affects health. By doing this, communities are likely to benefit in the long run.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?
The results of the research will be used to produce a PhD thesis. It is possible that they may also be published in journal after this. A copy of the results will be available directly from the researcher in late 2004 (contact details are below). You will not be able to be identified in any publication of the results.

Contact for Further Information
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Appendix Two: Consent Form

Sheffield Hallam University

Title of Project: Exploring the links between community involvement and development and health.

Name of Researcher: Lorna Ritchie

1.	I confirm that I have read and understand the information sheet dated	
2.	I understand that my participation is voluntary and that I free to withdraw at any time without giving any reason	
3.	I confirm that I have been able to ask questions about the study and all my questions have been answered	
4.	I confirm that I have received enough information about this study	
5.	I agree to take part in the above study. I understand only information relevant to the study will be collected, and will be made anonymous	

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Please keep your copy of the consent form and the information sheet together.

Appendix Three: Research Stage One Interview Schedule

As part of an investigation into the relationship between community involvement and health, I'm interested in what opportunities exist for individuals and community groups to participate in decision making processes throughout the District. I'd like to find out your experiences of involvement within those processes and your thoughts on what involvement means.

1 Role and Responsibilities

How long have you been in your current role for?

Can you briefly describe your role?

How do you work with/involve communities? Can you give any examples?

Do you provide any support (e.g. grants/advice) to the community and voluntary sector? Can you give any examples?

2 Involvement Processes

Do you think there has been any change in the way the council now engages with its communities?

Community engagement is described as a guiding principle within the community strategy. How do you think community engagement in this sense is best defined?

The area panels are a relatively new structure, how effective do you think they have been in involving communities? *Prompt for other structures (Vox/community assembly)*

How do you think the community and voluntary sectors within the Wakefield District have responded to the new opportunities for involvement provided to them?

How much influence do you think the community and voluntary sector has in decision making?

Some people think that the community and voluntary sector within Wakefield District are relatively underdeveloped. Would you agree with this? Why do you think that is?

The government has identified a need to rebuild trust between local authorities and their citizens. How much trust do you think the council and the public? Why do you think that is?

3 Health

Do you think involvement/engagement is important? Why?

What do you think the outcomes of engagement are?

Can you think of any ways that involvement activities can influence health? Why?
How would you define health?

Appendix Four: Completed Observational Protocol

OBSERVATION NOTES		
The Event/Location	**What**	Edgeton Community Action Group
	Who	8 committee members, ward councillor (for 1hr), 2 residents, 2 representatives from the older people project. Apologies were received from 1 group member and health and development worker.
	When	11 November 2003, 7-9.20pm
	Where	Bungalow
The Focus of Observation	**Feature of Interest**	The presentation of problems and issues and identified solutions. The issues themselves. Relationships to and interactions with other groups and organisations.
	Outcomes	Advertisement of Older People's advice day.
Researcher's Role		Overt
Access		Previously approved by the committee, initially via the community development worker.
Room Layout		Seminar. Room decorated and carpeted since my last visit. A4 signs now posted on doors stating "no smoking". * (*names removed*) sat around the green garden table. The chairs were a combination of garden, deck and other folding types. Seats were placed against three of the walls in a circular arrangement.
Participants	**Dress**	Relaxed.
	Manner	Informal at times, but also angry, particularly in relation to difficulties with SRB and the WMDC.
Topics for Discussion		Older people's advice day, * (*name removed*) update.
Agenda		Yes, but only the Chair had a copy.
Nature of Discussion	**Dominant Speaker**	5 group members (names have been removed)
	Questions Directed At	* (*name removed*), and earlier on, Older People's project workers and ward councillor
	How discussions are conducted	Generally informal discussion, although some members raised their hands and awaited the Chair's indication to speak. At several points during the meeting, members of the group spoke over one another and several discussions took place at once.
Atmosphere		Tense at some points, particularly when * (*name removed*) stated she was leaving.

Appendix Five: Research Stage Two Information Sheet

Sheffield Hallam University

Exploring the links between community involvement and development and health.

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?
Sheffield Hallam University are funding a postgraduate student (Lorna Ritchie) to conduct a research project. The research aims to explore the links between health and the processes of community involvement and development.

The research itself will be taking place throughout 2003. The project will be completed in late 2004.

Why have I been chosen?
Community groups in the * (*name removed*) area of Wakefield District are being invited to take part in the research. The reason for this is to look at the possible ways in which membership within the group and participation in its activities affects health, if in any way at all.

Do I have to take part?
It is up to you along with other group members to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen to me if I take part?
There are two stages of research. The first will involve observation of some group meetings, and the second, interviews with individual members. The interviews will look at the way you see your health and find out more

about being a member of your community group. This will take place over several months in 2003. You are not been asked to undertake any additional activities or responsibilities.

What are the possible benefits of taking part?
The research is not intended to be a survey of local needs and the results may not help you to secure funding bids. But it will be of help to practitioners (e.g. community development workers and health promotion specialists). It will add to their understanding of how their work affects health. By doing this, communities themselves are likely to benefit in the long run.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will have your name and address removed so that you cannot be recognised from it.

What will happen to the results of the research study?
The results of the research will be used to produce a PhD thesis. It is possible that they may also be published in journal after this. A copy of the results will be available directly from the researcher in late 2004 (contact details are below). You will not be able to be identified in any publication of the results.

Contact for Further Information
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Appendix Six: NVivo Node Listings

Project: Organisational Interviews
NODE LISTING

Number of Nodes: 34

1 **(1) /Wakefield District Infrastructure**

2 (1 1) /Wakefield District Infrastructure/Structure and Capacity

3 (1 2) /Wakefield District Infrastructure/Organisational Change

4 (1 3) /Wakefield District Infrastructure/Bridging Relationships

5 (1 4) /Wakefield District Infrastructure/The Involvement Strategic Framework

6 (1 4 1) /Wakefield District Infrastructure/The Involvement Strategic Framework/National Policy

7 (1 4 2) /Wakefield District Infrastructure/The Involvement Strategic Framework/LSP

8 (1 4 3) /Wakefield District Infrastructure/The Involvement Strategic Framework/The Community Strategy

9 (1 4 4) /Wakefield District Infrastructure/The Involvement Strategic Framework/District Wide Involvement Policy

10 (1 4 5) /Wakefield District Infrastructure/The Involvement Strategic Framework/Partnership Agreements

11 **(2) /Models of Involvement**

12 (2 1) /Models of Involvement/Control and Influence

13 (2 2) /Models of Involvement/Ladders and Levels

14 (2 3) /Models of Involvement/Organisational Capacity

15 (2 4) /Models of Involvement/Community Capacity

16 (2 5) /Models of Involvement/Community Development

17 (2 6) /Models of Involvement/Choice

18 (2 7) /Models of Involvement/The Value of Involvement

(2 8) /Models of Involvement/Social Capital

(3) /The Practice of Involvement

(3 1) /The Practice of Involvement/Strategic and Decision Making

(3 2) /The Practice of Involvement/Linking Relationships

(3 3) /The Practice of Involvement/Fit for Purpose

(3 4) /The Practice of Involvement/Trust

(3 5) /The Practice of Involvement/Strategy Consultation

(3 6) /The Practice of Involvement/Consultation Structures

(3 8) /The Practice of Involvement/Conflict

(3 9) /The Practice of Involvement/Representative Democracy

(3 10) /The Practice of Involvement/Control and Influence

(3 11) /The Practice of Involvement/The Usual Suspects

(3 12) /The Practice of Involvement/Barriers to Effective Involvement

(4) /Models of Health

(4 1) /Models of Health/Social

(4 2) /Models of Health/Medical

Project: Community Groups
NODE LISTING

Number of Nodes: 39

1 **(1) /The Community**

2 (1 1) /The Community/Sense of Community

3 (1 2) /The Community/Reciprocity

4 (1 3) /The Community/Self Interest

5 (1 4) /The Community/Everybody Knows Everybody

6 (1 5) /The Community/Things Change

7 (1 6) /The Community/A Mining Community

8 (1 7) /The Community/Closed Doors

9 (1 8) /The Community/Them and Us

10 **(2) /Perceptions of the Local Area**

11 (2 3) /Perceptions of the Local Area/Satisfaction with the area

12 (2 4) /Perceptions of the Local Area/Physical Environment

13 (2 7) /Perceptions of the Local Area/Fear of Crime

14 (2 9) /Perceptions of the Local Area/Vertical Links

15 **(3) /Networks**

16 (3 4) /Networks/Formal Networks

17 (3 4 1) /Networks/Formal Networks/Bonding Relationships

18 (3 4 2) /Networks/Formal Networks/Linking Relationships

19 (3 4 3) /Networks/Formal Networks/Bridging Relationships

20 (3 4 4) /Networks/Formal Networks/Usual Suspects

21 **(3 6) /Networks/Informal Networks**

22 (3 6 1) /Networks/Informal Networks/Bridging Relationships

23 (3 6 3) /Networks/Informal Networks/Bonding Relationships

24 **(4) /Involvement Outcomes**

25 (4 1) /Involvement Outcomes/Stress

26 (4 2) /Involvement Outcomes/Development

27 (4 3) /Involvement Outcomes/Information Giving

28 (4 4) /Involvement Outcomes/Training

29 (4 5) /Involvement Outcomes/Fulfilment

30 (4 8) /Involvement Outcomes/Community leaders

31 (5) /Control and Influence

32 (5 1) /Control and Influence/Broken Promises

33 (5 2) /Control and Influence/Perceived Influence

34 (5 3) /Control and Influence/Learning The Rules

35 (5 4) /Control and Influence/Resources

36 (6) /Well Being

37 (6 1) /Well Being/Perceived Health

38 (7) /Voting Behaviour

39 (8) /The Researcher's Role

Project: Organisational Interviews NODE CODING REPORT

Node: /Models of Involvement/Control and Influence
Treenode address: (2 1)
Description: Control/power/influence held by communities in involvement processes.

Document 1 of 39 Ideal - Memo
Passage 1 of 1 Section 0, Para 22, 409 chars.

22: I think the world has moved on a lot now, and I think people are, have the potential capacity to take much more control over what happens to them, because you know, technology has changed, different, different attitudes towards work, and senses of community and things like that. The world is a different place and it's not about the state doing things for local people. It's about the state being supportive

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Document 2 of 39 OR 1
Passage 1 of 2 Section 0, Para 106, 666 chars.

106: If we have a model of engagement that includes development and involvement so, which means that the organisation develops structures and mechanisms for allowing people to influence what's happening in there. But it's got to move, for me it's always got to move beyond just the listening or refer to what you say with your research process, we know what you want but we are still going to do what we want. Communities have got to see action. And, it's very much linked to social action, it's the action that will bring about change. Action at the community level. At a higher political level. We need different structural changes in order to regenerate communities.

Passage 2 of 2 Section 0, Para 106, 175 chars.

106: So by getting involved, and helping people to get some counselling, set up support groups, they do start to feel better, more in control [unable to transcribe the next phrase]

Document 3 of 39 OR 2
Passage 1 of 9 Section 0, Para 57, 174 chars.

57: The real question is who tends to go those meetings and how representative they are of those communities and what influence they actually have on the decision making process

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Passage 2 of 9 Section 0, Para 73, 147 chars.

73: I think for the average person on the street though there's not really much difference, they're no better off, in terms of having some influence.

Passage 3 of 9 Section 0, Para 73, 147 chars.

73: But I don't think its really taking power down to the sort of grassroots if you think of it in those terms. I don't think it's really doing that. [9]

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[9] Internal DB: This section is referring to OR2's perceptions of recent changes in opportunities for the community and voluntary sector to become involved.

Passage 4 of 9 Section 0, Para 81, 236 chars.

81: I certainly I certainly don't think that the structures we've got in place give, have taken power away from those with power and devolved it down to community level which is perhaps an opportunity that's been missed within Wakefield.

Passage 5 of 9 Section 0, Para 85, 169 chars.

85: Well obviously central government have told them that they've got to provide mechanisms and set up structures to devolve power away from central decision making process.

Passage 6 of 9 Section 0, Para 85, 140 chars.

85: there is a genuine belief by, a number of people within the local authority and local members as well to take that, to devolve power down.

Passage 7 of 9 Section 0, Para 117, 351 chars.

117: It means allowing people to, first of all say what they feel about their own lives, through that and by that, hopefully change. If they are unhappy they are unhealthy, they don't feel, if their mental and physical health is poor, if they do get engaged they can hopefully influence and change what's going on to improve, to improve their well-being.

Passage 8 of 9 Section 0, Para 141, 558 chars.

141: A lot of it is down to individuals in the community. And I think most community projects survive with fairly, with few community activists if you like. And one of the challenges to us all is to go on that power base if you like of community groups out, I think that's the biggest challenge that we actually face to be honest. So that, what we would look to do obviously is to work with a number of people, develop their community group themselves so that they're able to cope with that strong person not being there or you know moving away or what ever.

Passage 9 of 9 Section 0, Para 141, 370 chars.

141: so that when * (*organisations name*) aren't there they've got a committee or a group who can make decisions, hopefully have some money devolved down to them from the local authority. So they can actually influence where the grass is cut and when that litter is taken away or this place not dropped. So that they're actually responsible for their particular estate or neighbourhood.

Document 4 of 39 OR 3
Passage 1 of 4 Section 0, Para 17, 650 chars.

17: So it's around how people are able to make choices in the decision making process and around them. I suppose that's it in a nutshell. Depending on who makes the decisions, so at the lower levels the information giving level it's the council or somebody who's actually making the decision, and at consultation level it is too, although you know consultation implies a predisposition to change on the basis of what people tell you. Moving up to as I say, the highest level of the hierarchy where the council and the public sector partners are actually operating in a support mode to the people making the decisions. They have the money to do that.

Passage 2 of 4 Section 0, Para 21, 205 chars.

21: So, I think that there are, probably after about a year now identify a couple of community based organisations who I would think are capable of taking ownership of the facility or programmes or whatever.

Passage 3 of 4 Section 0, Para 25, 425 chars.

25: So, I was trying to abolish them all together but we'll get them better, more fit for purpose and if the members here having been confronted with this choice decide that they are more consultative, not about delegated functions then, they're constituted properly, you know, they're not going to work as consultative bodies, so we'd have to reengineer them and and there wasn't much thought, I don't think put into the areas.

Passage 4 of 4 Section 0, Para 29, 410 chars.

29: I think the world has moved on a lot now, and I think people are, have the potential capacity to take much more control over what happens to them, because you know, technology has changed, different, different attitudes towards work, and senses of community and things like that. The world is a different place and it's not about the state doing things for local people. It's about the state being supportive.

Document 5 of 39 OR 4
Passage 1 of 3 Section 0, Para 25, 476 chars.

25: But the area panel, area panels largely I would see as being involved in developing the action plans, monitoring their delivery and reviewing them. Whether at some time in the future they may take charge, or deliver the actions themselves, I think that's something a little bit further down the line in terms, into the future. And, we've not got to that stage yet, but its something as a longer term thing as well devolved budgets to area panels is what we'd be looking at.

Passage 2 of 3 Section 0, Para 61, 744 chars.

61: It tends to assume that a lot of people, a lot of like community people in the community want to be really involved in what the council does or what other organisations do. And, to the extent that they want to take control more, more want to take control of things happening in their area, actually run things and do things. I think

that is a bit over optimistic that. I think a lot of people, do want to know about what's happening in their area, want to know why certain things are happening, and probably quite a few people want to have a say, a more direct say about what's happening in their area. I think as go further down the line in terms of taking over sort of responsibility, that dwindles down to a very small number of people.

Passage 3 of 3 Section 0, Para 73, 314 chars.

73: So I wanted, whatever agreement we set up with the voluntary sector there must be, must be related to the community strategy, because if the voluntary community sector for instance want to take on responsibility to deliver some more services, it's got to be through that mechanism, through the community strategy.

Document 6 of 39 OR 6
Passage 1 of 6 Section 0, Para 77, 483 chars.

77: And I think as part of that a light bulb starts to go on, actually there is loads more service delivery that can be done by voluntary and community groups. And, I think the process of us, having these people sitting round the table thinking purely about the needs of voluntary and community groups has been really really important. And then them going away linking that to, well actually that means we could do that bit of our work better if we, I think that is really important.

Passage 2 of 6 Section 0, Para 109, 370 chars.

109: The first is how much do we or don't we want to be delivering as a statutory, body. And I think that's a decision only individual groups can make. But I'm not sure that our level of knowledge is high enough for all of us to be able to make informed decisions. Do we want to be holding contracts for delivery of statutory services and everything that goes with that.

Passage 3 of 6 Section 0, Para 117, 756 chars.

117: In * (*place name*) there are, I don't know, 30 40 multipurpose community centres that are run by community committees, completely run by community committees. They get core funding from the council that allows them to employ a centre manager or a development worker or pay their insurance, and their heating and lighting. And then on top of that they're then contract for elderly day care for luncheon clubs. They can maybe get money for additional advice services, they can then contract a youth club with a youth service they may have scouts and brownies in there they may have contracts with the partnership for childcare. You know, so you then have the college and various other people coming in for training. But they are completely community managed.

Passage 4 of 6 Section 0, Para 117, 296 chars.

117: what we did in * *(place name)*, was deal with big agencies, for them to manage the workers but the community committees decided when they were in what specialisms they wanted, how often they went. So you know, they're controlling the actual service without having to worry about the CSL quality work.

Passage 5 of 6 Section 0, Para 133, 172 chars.

133: To me, that's what involvement means, it means communities being able to not just to say what they want but also to be able to have elements of control over what they want.

Passage 6 of 6 Section 0, Para 165, 498 chars.

165: is about that whole issue of where people feel they're able to take control. If you feel that everything is done to and you have you no say and no control and no hope you live in a crap area and all this kind of things. What the ability of feeling that actually we can have some control over that, the difference in confidence of communities which I'm pretty sure does link to making a better community, safer community, healthier community. But again its all kind of a bit intangible isn't it[4].

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[4] Internal DB: Perceived control.

Document 7 of 39 OR10
Passage 1 of 3 Section 0, Para 109, 186 chars.

109: They do know what they want, you know, and people are not quite as daft as they look are they, once you give them a bit of authority and experience they'll make very sensible decisions.

Passage 2 of 3 Section 0, Paras 123 to 125, 342 chars.

125: R I think there's talk about it, and that's a start. I think, I'm not, I'm not sure that it's really there yet.

Passage 3 of 3 Section 0, Para 125, 310 chars.

125: Because it's public money and I can see how people are worried about loosing control of public money. There is a fair amount of probity in the procedures of the council and the PCT, so you know, you can answer for it. If you give it away, then I, might do something terrible with it, like do something useful

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Document 8 of 39 OR5
Passage 1 of 1 Section 0, Para 135, 330 chars.

135: Empowerment within the context of VOX is supporting individuals through communities and groups of communities to determine, I suppose within the context of VOX, its, it is individuals, but individuals as parts of groups, communities, not individuals in isolation. To, come together to determine their future lifestyles I suppose.

Document 9 of 39 OR8
Passage 1 of 1 Section 0, Para 17, 126 chars.

17: But that's all come from the people concerned and sort of local it's actually locals that are on the board and are running it.

Document 10 of 39 OR9
Passage 1 of 5 Section 0, Para 17, 422 chars.

17: And, I think there is, a learning, gap in terms of where elected members are and where the council is within Wakefield about community development and community leadership and that's, one of the aspects that we are picking up in member training currently, our members [unable to transcribe word] community leadership and when, when its ok to step back and let, you know, communities do it for themselves and when its not.

Passage 2 of 5 Section 0, Para 25, 257 chars.

25: what funding are we delegating as well really so that there is some true local decision making instead of us just going out and finding out what people want in * (*town name*) and then saying, well you know, we're not going to bend any mainstream funding that way.

Passage 3 of 5 Section 0, Para 77, 557 chars.

77: we're talking about developing to a level where voluntary and community sector can start delivering services on behalf of you know sort of the statutory organisations. I don't think that's sort of there in many places at all. And particularly in terms of developing social firms. Again, you know the amount of effort and money that I've seen going into community groups to try and develop social firms and get them to that level where they have got an income stream, they do own sort of capital and they can start you know developing their organisation.

Passage 4 of 5 Section 0, Para 77, 770 chars.

77: I don't think people are being are being realistic about what is achievable and where we are now. And you know, what time it actually takes. And you know, I think the damage that, some external funding has actually done, you know, more than, more than good. You know and there's still not in a position where they're saying, ok, we'll pass some of the mainstream activities over to you to deliver. I can't see, I know there's a couple of good examples in Sheffield but I, you know, I've been to things nationally where, you know there was meant to be examples of good practice, sort of x y and z. But in reality, they're not, they're not projects that are actually standing on their own two feet and going from strength to strength. I think there's very, very few.

Passage 5 of 5 Section 0, Para 77, 359 chars.

77: I think, I don't think enough sort of emphasis has been paid on about on sort of community action, and actually putting some resources into delivering things on the ground. What the community want and building the individual and the organisation around that instead of, you know, giving people, you know credits for being able to type a minute or whatever.

Node: /Perceptions of the Local Area/Physical Environment
Treenode address: (2 4)

Documents in Set: All Documents

Document 1 of 38 CG1~10 18~05~04
Passage 1 of 3 Section 0, Para 209, 313 chars.

209: we haven't got a very big community centre a lot of people can't go anyway, you know, because it's so compact. We do actually hold most of our meetings in the community centre, but the big general meetings we hold it in * (*local sport's club*) which they're kind enough to give us for nought really to hold those meetings.

Passage 2 of 3 Section 0, Para 401, 1313 chars.

401: Building a community centre for everybody to go, you know. Its like, I said to you earlier, we've just, started a mother and toddler group, its going well, you know, we do want to start with the after school clubs, but, all the after school clubs round here, you know, we'd need a bigger place, so obviously, we want a bigger community centre, you know just to have another heart of Edgeton. We did have a heart of Edgeton with the old club but its derelict now, it used to be a meeting place for everybody to go into. But we haven't got one now. Well we've got bungalow, but its like, we can't have a lease on it, even though the council's let us use the bungalow, we can't have a lease on it. So we can't have computers because, we've no way in lease we can't, well, most places like BT and stuff like that the you need a lease of at least five years so you can have a telephone line. So because we can't get a telephone line, we can't have computers for the kids. So we're always held back, you know we've got a big community centre that we can call ours, and can't get kicked out off. I think it would better, I'd be a lot happier in this village to see something like that and a big park for the kids, they've had nothing round here for years, so it'll be a good thing for the kids to see the park.

Passage 3 of 3 Section 0, Para 409, 239 chars.

409: We've had one or two small pots of money, not the big pots, you know because we haven't got a five year lease on the bungalow [unable to transcribe] because we can't have a five year lease they're not willing to give us a big, big funding.

Document 2 of 38 CG1~2 24~02~04
Passage 1 of 8 Section 0, Para 77, 675 chars.

77: There's, as a group we've got a few members, but if you have a general open meeting you don't get that many people that'll come. But I think that's mainly because, the centre that we've got that we're in now it's a bungalow and it's just not big enough. So we can't get things happening, we can't do what we want to do, because we can't get a long enough lease to get the grants. Stops us from knocking walls in. So we need bigger premises and just doing the few things like mother and toddler group and the bingo sessions that we do, and are just going to start, well the bingo is anyway, just going to start getting too many people in so we can't do what we want to do.

Passage 2 of 8 Section 0, Para 77, 315 chars.

77: So we need a bigger premises to actually advertise properly to then get the community to open their eyes and see, yeah they are doing something rather than, well there's nowt going on, there's a bungalow there but they're not doing anything. It isn't that we're not its just that we can't, so we're stuck again.

Passage 3 of 8 Section 0, Para 85, 248 chars.

85: We used to have a village hall, but I don't think anyone knew how to go about using it and getting to be able to use it so that's been, that got sold off which has annoyed quite a few people. So yeah, we're just hoping to get some bigger premises.

Passage 4 of 8 Section 0, Para 101, 321 chars.

101: Yeah, its just one of the old ladies asked if we could start some bingo up because they used to go here and that shut down, they used to go there and that shut down. So they've got nowhere else to go, and I mean, the village club that's shut down that I've just mentioned, that used to do the bingo, that's shut down.

Passage 5 of 8 Section 0, Para 113, 390 chars.

113: No, there's nowhere. There used to be a café type, a motorcycle shop at the bottom of the street, they turned the showroom into a café. But every time I went past it were either empty or not even open. And I'd say it's probably the prices they were charging that people wouldn't go in, plus there's been a lot of younger ones that they're trying to get in there that's been out of work.

Passage 6 of 8 Section 0, Para 228, 454 chars.

228: Yeah, because we can't get this five year tenancy, it just means that we can't get some of the bigger grants for knocking walls out, security and stuff like that. And I think that issue is mainly because it's bungalow. It's been, it had been empty for two or three years, but so had the other two across the road. And then all of a sudden they've been taken up. And this one now is the only one that's really vacant even though we're here its vacant.

Passage 7 of 8 Section 0, Para 260, 241 chars.

260: We'll probably go back to the original place of meeting down at the local * *(local sports club)* and I don't know about the Wednesday bingo because there are too many of us, but maybe the Monday afternoon they could probably all congregate at my house.

Passage 8 of 8 Section 0, Para 392, 443 chars.

392: And I don't think they've got faith in us simply because we can't do it. And its just back to the same thing we haven't got a big enough premises to do it. So you feel as if you're letting them down. Like they want to do line dancing. Behind here in the garden might, or in the street, but this place ain't big enough. There are people out there that've got the ideas and they do know what they want, it's just not having a place to do it.

Document 3 of 38 CG1~4 02~03~04
Passage 1 of 1 Section 0, Para 272, 523 chars.

272: R No that was taken off us the village hall. That was taken off us, the council sold it, that's another thing the councils sold. It's used now for the * (*building name*) as a, a one of these do, you know when you have a do. * (*Place name*) they call it now. Its very nice inside, she's done it up beautiful inside, but, I think in deeds, I think we can still actually use it once a month [oh can you]. Yeah, to her discretion I suppose, but, by rights if it's still in the deeds we should still be able to use that as once a month.

Document 4 of 38 CG1~5 08~03~04
Passage 1 of 3 Section 0, Para 17, 421 chars.

17: Well I think we should have something whereby we could, it were big enough to do more in it. I mean you go to the other groups and they have, a kitchen so that you can provide meals or snacks or, I mean if you get the community group going you can have can have, it can be rented out for weddings, birthdays, you can hopefully try, I mean a lot of the youngsters nowadays, I don't think they know what they want either.

Passage 2 of 3 Section 0, Para 117, 78 chars.

117: But, how many children can you get to do anything in the size of the bungalow.

Passage 3 of 3 Section 0, Para 117, 348 chars.

117: you see when I were working it was heartbreaking sometimes 'cos I'd go to pensioners houses and they'd say, when you've been I shan't see another sole all day. Whereas if you have something that's fairly central that they can go to, well they can bob in and just find somebody to talk to if they want can't they. Which is I think what it needs.

Document 5 of 38 CG1~6 08~03~04
Passage 1 of 3 Section 0, Para 105, 102 chars.

105: Get a good sized community centre, although it's got to be viable, you know financially support itself.

Passage 2 of 3 Section 0, Para 105, 740 chars.

105: Somewhere for them to come, relax, play games whatever they want whatever their choice is. Wait for the buses or taxis of whatever they want, having a number of people that probably get involved that'll help them, do their shopping for them. You know, you've got a centre, once you're getting people meeting each other again, and gelling together and they start to get know what's going off in community. You know, and they start to know who's who and who aren't, and then people start to say hey don't do that, otherwise you know, we'll sort it out. And, if you've got a good community

hall, that's adaptable, you can divide it up into smaller rooms for whatever you want to do, classes or different things you know, there's allsorts,

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Passage 3 of 3 Section 0, Para 105, 415 chars.

105: somewhere for people to collect and even if they've got a bar, fair enough as long as it were controlled and weren't making trouble. Some games rooms, a place outside for toddlers to play, as well as indoors, you know have an all weather thing and if there's enough ground left as I say get youths involved get whatever they want. But they want somewhere they can go and they can afford it or its free, whichever.

Document 6 of 38 CG1~9 06~05~04
Passage 1 of 2 Section 0, Para 153, 280 chars.

153: Well I'd like to see something on this spare ground when the other two maisonettes get knocked down. I'd like to see something for the community for the old people for the children. It's a big space is that. Whether we'll get it or not I don't know. But we're pressing for it.

Passage 2 of 2 Section 0, Para 173, 247 chars.

173: Yes, I think it is people are getting interested. And some old people who used to walk up to the * (*local sports club*) to play bingo and that, I think they're getting interested. The only thing is the place isn't big enough with it being a small, bungalow.

This Node codes no other
documents in this set.

Node: /The Community/Everybody Knows Everybody
Treenode address: (1 4)
Documents in Set: All Documents

Document 1 of 38 CG1~10 18~05~04
Passage 1 of 4 Section 0, Para 101, 253 chars.

101: We're not, not anymore. When I first moved down here, you couldn't of asked for a better place to move. It were lovely, you know, everybody knew everybody. They were all friendly, now you're lucky to go down the road and get a grunt out of somebody.

Passage 2 of 4 Section 0, Para 177, 559 chars.

177: Quite safe. I've only got to take my dog (laughter). Everybody knows me round here, I hope they think I'm a good person so I know that. I can go out, "hey up * (*name removed*) are you alright?" you know. Because they've got to know me over the years, it's just these ones that come in that don't know you, you've got to be wary of them because you don't know who they are. I don't like leaving my house unattended because I'm always frightened of coming back and having it burgled. But hopefully I mean once all these flats are down I won't have to worry about it.

Passage 3 of 4 Section 0, Paras 291 to 297, 581 chars.

291: LR But asides from that, would you describe it as a place where people would help each other out?
292:
293: R Yeah.
294:
295: LR You would do.
296:
297: R Yeah. Definitely. Its like everybody knows each other round here, and if they've got a problem then they'll go and share it, if you've got a problem you'll go to share it with one your next door neighbour or a friend down the road you know. They're quite friendly you know, they'll talk to anybody in respect of, if they know you. They don't, they're quite nice people that live in Edgeton and we do open our arms, but you can't cross a Edgetoner.

Passage 4 of 4 Section 0, Para 301, 340 chars.

301: Because we've been, I won't swear, been messed on that many times with the council, you know, you just have got to be careful, simple as that. I mean everybody knows everybody's business, you know, it is quite a friendly little village, but, I personally, I tend I can go out and talk to, stop you in the street and it wouldn't bother me.

Document 2 of 38 CG1~4 02~03~04
Passage 1 of 1 Section 0, Para 36, 195 chars.

36: Obviously with it being a small mining village everybody one another, you know. If they wasn't related they was friends of the family or something like that. Everybody knew basically everybody.

Document 3 of 38 CG1~5 08~03~04
Passage 1 of 4 Section 0, Paras 35 to 37, 710 chars.

35: LR And do you know many of the people that live round about?
36:
37: R Oh yeah, I know most of them. We have a good neighbourhood situation here, because at Christmas time we all get together in one house or another. Except for them, they don't, but they have a biggish family and they're sort of all family orientated you know. And higher up, I know them all and I speak to them all. And one or two of them I could go into the houses you know, but these I could go in as well you know. More so than probably, I go round more than what * (*name removed*) does. If there's any letters or whatever to deliver usually me that gets roped into doing it. So they're all more or less used to seeing me I suppose in a way you know.

Passage 2 of 4 Section 0, Para 49, 977 chars.

49: I suppose we don't go in one another's houses a lot as such, but you can if you want. You know. I mean, when my two were little, we used to have a coffee morning up here and most of the women used to go to it. And we did it quite a lot and we'd have parties for silver jubilee and jubilee you know different things. 'Cos when lived up here at the corner they had quite a big field at side of their house. So, we had some big parties there for things like that you know. I mean at that time, I definitely knew everybody. A lot of them, when they come up here and they live further round the corner they seem to come up with the idea that they want to be on there own, you know. That always seems strange to me 'cos I lived in street of terraced houses when I were up to fifteen and everybody knew one another and you were all, you know, you were all neighbourly. Whereas, a lot of that's gone ain't it. You know, so really we're lucky that we've got what we have here.

Passage 3 of 4 Section 0, Para 77, 76 chars.

77: So, you know, it's amazing who you bump into, who still says thing you know.

Passage 4 of 4 Section 0, Para 77, 348 chars.

77: So, when we first came to Edgeton, I mean everybody knew everybody more or less. I suppose it was like where I lived anyway, I mean I lived in * (*street name*) and * (*name removed*) lived, that was * (*street name*) and you went round corner and up there and * (*name removed*) lived there. I mean you know everybody in streets round you, more than they do now. Strange isn't it.

Document 4 of 38 CG1~6 08~03~04
Passage 1 of 2 Section 0, Para 37, 575 chars.

37: It's been a good spot, and we've got on well like with farmer over road, I mean, one of sisters over there, she's godparent to my kiddies like. And neighbours have been good, we've had right good lot of neighbours over the years, not so much now from here up. But it was at one time, everybody were involved you know. If doing out like silver jubilee out like that, everybody got together. But now, well we know more of them down here, but, even then its, we're not as much in contact with them you know. But it has quietened down, I think that comes with age as well.

Passage 2 of 2 Section 0, Para 105, 763 chars.

105: I mean as you see all these houses that's been put up and built. Now they're not all just go up to * (*local facility*) or wherever they'll some nights they don't want to be driving and drinking, so if they've got something local, you're just walking down to, you get back to that old community thing. Everybody walk down the pub and back, if anyone were a bit inebriated they'd see him home, you know. Things like that, everybody helped everybody, you know and you had a good time and everybody knew everybody, and if somebody didn't come in pub they'd say where's so and so tonight. And if they didn't show up for a couple of nights they'd see why you hadn't turned up, you weren't there dead on bed for a week or two, and not being found, they went and looked for him.

Document 5 of 38 CG1~9 06~05~04
Passage 1 of 2 Section 0, Para 57, 317 chars.

57: Oh yes, entirely happy yes. Always lived in the village and think I always will. The people have changed and I just don't know a lot of people. You knew everybody you see in the old, in the old village, everybody knew everybody and now, people are coming in from different districts and you just don't know them.

Passage 2 of 2 Section 0, Para 61, 149 chars.

61: I know the old people who have lived here since the houses have been built. There's a quite a lot come, come into the village who I just don't know.

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