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The culture of community engagement from participant perspectives: implications for health visiting.

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**The culture of community engagement from participant perspectives:
implications for health visiting.**

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A thesis submitted in partial fulfilment of the requirements of
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ABSTRACT

The 'Big Society' idea proposed by David Cameron (2010a) suggests that civil society take an active role in supporting community members and promoting self-determination. To date, the processes of the public sector and professional powers have limited the ability of communities to make such changes and are a barrier to the development of community engagement (National Institute for Health and Care Excellence) (NICE) 2008). It is argued that community engagement has the potential to improve health, yet there is limited understanding about how this works (NICE 2008).

This study has taken a critical ethnographic approach to explore community engagement from the perspective of community members who are actively engaged in the process. The study explored this perspective within a community centre and involved volunteers, users and managers of the facility, exploring the concept of community and levels of engagement.

The findings, presented in three major themes of 'Volunteers', 'Community' and 'Conflict', illuminate how the culture of civil society is different from that of the public services, suggesting that social interactions nurture and sustain community members. This is in contrast to the hierarchical structures of public services and the economic focus that has been prevalent in regeneration projects.

The current Coalition Government has focused on the development of health visiting and has re-introduced the community aspect of health visiting practice (Great Britain, Department of Health 2011a). The findings of this study are timely and indicate that if health visitors are to build community capacity as envisaged then they must be sensitive to the cultures and practices of communities, and engage with communities rather than expect communities to engage with the health visiting service.

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Thank you also to my family for their patience and support in whatever I do, and to colleagues, past and present, for all their encouragement. They are all part of the process that enabled this study to progress.

Candidate's statement.

The objective of this study is to inform health visiting practice. I have been supported in this study by my supervisors, Professor Frances Gordon and Dr. Jill Aylott. This study is an individual contribution and not part of a collaborative study.

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INTRODUCTION (1).

The aim of this study was to explore community engagement from the perspective of people who are involved in community activities with a view to informing the development of the role of health visitors.

What is Community Engagement? (1.1).

Community engagement can be defined as how communities engage with each other, or how statutory services engage with communities (Richardson 2008, Minkler 2012). This study focuses on communities engaging with each other through friendship and social networks. In this respect, community engagement is seen as a grassroots process amongst community members, brought together as a result of shared interests and goals (National Institute of Clinical Excellence (NICE) 2008). When communities engage together, it is the community that determines the agenda (Minkler 2012). Community engagement provides benefits to community members that include the promotion of health, well-being and equality (NICE 2008, O'Mara-Eves et al. 2013).

The term 'community engagement' can also be used to describe the way statutory services engage with communities (Richardson 2008). When services engage with communities, it is often a top-down arrangement, in contrast to the grassroots perspective when communities engage with each other. The top-down hierarchy denotes a different power relationship with statutory services engaging according to their own agenda (The Migration

Observatory 2013). Who sets the agenda is important, because the agenda setter holds power and has the ability to determine outcomes (Minkler 2012).

A further option for community engagement is one where agencies and organisations work with communities to empower them (Minkler and Wallerstein 2012). As Obama (2012) notes, some communities, particularly in inner city areas, are disadvantaged due to factors beyond the control of community members, for example lack of employment and changes to social welfare. In such cases Obama (2012) suggests that communities need the help of organisers and agencies to help them regain some power and self-determination.

Richardson (2008) also suggests that disadvantaged communities should be supported with outside help. When support of this nature is offered, communities should still be in control, determining activities and being proactive in decision making.

Although this study is essentially about community engagement from the community perspective, it also considers how organizations and health professionals can form new relationships with communities. By understanding the culture of communities, I propose that health visitors can form better partnerships with communities, where communities have more control and that in such circumstances, health visitors can be more effective in promoting sustainable health and well-being.

Why Explore Community Engagement?(1.2).

When working as a health visitor, often in deprived inner city areas, I was frustrated by the

short-term interventionist approaches of my health visiting practice. This was a role that was increasingly determined by government policy together with health and social care professionals. The public health role of health visiting had been eroded as surveillance requirements became dominant within health visiting practice (Peckover 2002, Cowley et al. 2007). It was my perception that health visiting was providing a service that the government and health care professionals considered that individuals and communities should have, rather than finding out what communities wanted. I was conscious that clients often did not engage with the health visiting service, or only engaged when they saw a need to do so. Without engagement, health visitors cannot be effective. I felt that health visiting needed to change its perspective and become more sympathetic to the culture of communities.

I was interested in long-term sustainable public health improvements where clients and communities could take a more active role in working towards these aims. I wanted to explore how the strengths of communities could be recognised and encouraged to promote sustainable health benefits. As a lecturer of students in health visiting, I had the opportunity to reflect on how the relationship between communities and health visitors might be different.

It was the Labour policy document ‘Community Engagement to Improve Health’ (NICE 2008)¹ that captured my imagination. The document proposed that community engagement could enhance health. The idea of focusing health visiting practice on communities rather than individual interventions as a way of promoting sustainable health was encouraging. Community engagement offered health visitors an opportunity to re-focus on community work.

Politics and policies have influenced this study. With a change of government in 2010, I was concerned that the community agenda would evaporate. However the Coalition Government not only proposed that public health should be distinct from NHS treatment services but also re-energised health visiting, stating that building community capacity is a key element of health visiting practice (Great Britain, Department of Health 2010a, Great Britain, Department of Health 2011a).

Because I wanted to have a better understanding of community engagement from the perspective of communities rather than health care professionals, this study is based on a group of volunteers who support their local community by staffing a community café. As

1. Community Engagement to Improve Health (NICE 2008), was informed by a rapid review of evidence supporting the premise that community engagement could improve health as a result of communities engaging in the planning, design and delivery of health promotion and activities to address social determinants of health (NICE 2008:6). The document proposed that where health authorities had only consulted with communities on the allocation and planning of health services, this resulted in marginal improvements in health. Where communities worked in equal partnership with health care professionals and services and were delegated some powers, there were more improvements in social capital and health. A barrier to community engagement has been health professional culture and dominance. The document made a number of recommendations for further research to be conducted to fill the gaps in the evidence.

volunteers, they are actively engaged in their community. They have provided insights not only into volunteering, but also by providing new understandings about the meaning of how 'community' is created and how community members gain support through community engagement. The volunteers have also demonstrated how the culture of civil society differs from that of public health care professionals.

Summary of Chapters (1.3).

The study is arranged in eight main chapters, three of which describe and explore the findings of the study. A brief overview of each of the eight chapters is summarized below.

The first chapter considers the policies that have shaped health care, from New Labour through to the Coalition Government. It includes attempts to increase community engagement with health and welfare services and contextualizes community engagement within a changing welfare sector. This chapter also considers the development of health visiting; this is a contested role and one that has changed over time (Cowley et al. 2013). Community work and public health promotion are well-established within the health visiting service, however in recent times health visiting practice has been restricted to one-to-one work with families centered around surveillance and safeguarding (Great Britain, Department of Health 2001a, Lowe 2007, Cowley et al. 2007, Hoskins 2009). This is despite health visitors being acknowledged as Specialist Community Public Health Nurses (SCPHN) (Nursing and Midwifery Council 2004, Great Britain, Department of Health

2012a). Recent government policies have re-resourced health visitors and promoted their role in community engagement.

Chapter 2, the literature review, starts by critically examining the medical model of health that in many respects has created a barrier to the development of community engagement. The review then moves on to examine the social model of public health. This chapter provides support for community engagement by exploring the influence of community, social capital and equality on health. It also considers how different models of community engagement can hinder or help self-determination and community action.

The two following chapters explore the methodology and methods used, providing the perspective and the process of the study. As this study explores culture and, ultimately, power, a critical ethnographic approach was selected. Data was collected through unstructured and semi-structured interviews and through observation. These were then thematically analysed.

The next 3 chapters cover the three themes that emerged from the findings: Volunteering, Community and Conflict are each split into sub-themes and are illustrated through excerpts of interviews, observations, vignettes and reflections.

The final, discussion chapter explores the implications of the findings in contemporary health care and proposes how health visitors may adapt a model of community engagement that will help communities to promote sustainable public health.

Challenges (1.4).

This study has presented some difficulties, in particular the speed of policy change and the subsequent changes in health visiting practice. A range of perspectives was observed at the study site as a result of a regeneration programme in the area. These were compounded as a result of the economic climate during the period of data collection. However, these difficulties only reflect the complexities of the current interplay between community life, health care practices and political agendas that are occurring nationally.

Contribution (1.5).

This study adds to a growing understanding of the contribution that community engagement has on public health. By challenging current views and understanding, the study's purpose was to seek insights into being able to recommend how health visitors can change their practice so they are able to form more meaningful relationships with clients and communities with the aim of promoting public health. The study's unique contribution is that it explores community engagement from the perspective of those lay people who are actively engaged in the process, and then uses this information to consider how health visitors can both effectively engage with communities and also support communities in the process of engagement.

BACKGROUND (2).

Why Politics Matter in the Development of Health and Community Engagement (2.1).

This chapter looks at how government policies change the environment in which community engagement and health visiting have to function. The chapter explores common themes between the policies of the New Labour Government and the Coalition Government of Conservatives and Liberal Democrats. Each has looked at the relationship between the state and civil society. Both Labour and Coalition governments have expanded the range of providers of health care and also looked at the relationship between health care services and those that promote public health.

This chapter also looks at the history of health visiting, compares it with two other examples of health visiting services in Denmark and New Zealand and considers how government policy is currently driving health visiting practice in England.

At the heart of policy of both the Labour and the Coalition Governments is a drive to alter the role of government and, in particular, the relationship between the state and non- state, public services and civil society. A range of government policies aim to involve individuals and communities in the decision-making process (Great Britain, Department of Health 2006, Great Britain, Department of Communities and Local Government 2008). As individuals and communities become more engaged in the decision-making process, the

services delivered, the role of professionals, and the relationship between the client and professional will all change.

New Labour and the Coalition Government have both combined neo-liberal and social principles in an attempt to find a middle ground in politics and a way forward in tackling contemporary issues such as global markets and social inequality. Such combinations of policies have caused tensions and contradictions that will be explored in the context of community engagement.

Tension occurs as policies are put into practice. There are distinctions made between treatment services which react to ill health in the individual, and public health services that have traditionally focused on the protection and promotion of the health of the public. Elites and professionals translate policies in ways that maintain their position and dominance. Professional power will be considered and how it has formed a barrier to community engagement.

Jenson (2009:203) states that 'politics matter in the history of public health', recognising that the political philosophy of the government is reflected in the policies it produces. Jenson proposes that public health measures developed by Liberal governments, those that provided clean water and sewage systems, did not interfere with the behaviour or liberties of individuals, principles that Liberals supported, but also principles that the population increasingly demanded (Jenson 2009). In contrast, socialism has traditionally considered that the state has an important role in providing for and, to some extent, determining the

roles and freedoms of the individual. It was a Labour government, for example, that introduced smoke-free legislation (Bauld 2011).

'New' Labour (2.2)

This study, conceived in 2009, was influenced by the policies of New Labour. The Blair government looked to the middle ground of politics, between the Labour left and Conservative right, proposing a new 'Third Way' (Giddens 2010). The politics of the Blair government retained some neo-liberal principles of the previous Conservative government. Neo-liberal principles include, for example, minimal government, a free market economy, economic individualism, acceptance of inequality and autonomous civil society (Giddens 1998). New Labour looked to neo-liberal principles promoting markets in health care and individual personal responsibility (Giddens 1998, Porter and Coles 2011). At the same time, the Blair government promoted some socialist principles around community, equality and social justice (Baggot 2007).

Socialism developed within the working classes, and in response to industrialization, capitalism and oppression. Initially socialists were reactionary, but as a result of an association with a political movement that brought about not only better living and working conditions, also began to be associated with promoting social rather than economic benefits (Heywood 2003). The strength of socialism was built on community and the collective (Heywood 2003). Socialism views humans as social beings who work together to obtain common goals. It is this collective action, working towards the good of society, that has

provided power and benefit to individual members. It is a sense of community and working together in cooperation that naturally places community engagement within a socialist perspective.

It was proposed, by the Labour Government, that involving communities in the problems that they faced was not only more democratic, but would also be more effective (Rotheroe and Miller 2008). There was an attempt to re-engage with community and with local governance (Powell and Geoghegan 2004). The Labour Government promoted citizen engagement, the development of a civil society, and neighborhood renewal. There were attempts to reduce poverty, enhance access to education and, as Ledwith notes, ‘a preoccupation with regeneration projects’ (Ledwith 2005:17). It is claimed, however, that many such projects were inefficient and ineffective due to a flawed and limited understanding of inequality and injustice (Ledwith 2005).

Although outwardly promoting community and equality, the neo-liberal intentions of the government limited their socialist ideals. While the Labour Government under the leadership of Tony Blair made provision for equality of opportunity, for example the opportunity to work, it did not strive for equality of outcome. Labour did not intend altering the status quo (Malin, Wilmot, Manthorpe 2002).

Baggot (2007) suggests that the Blair mixture of socialist and neo-liberal politics produced his own form of Communitarianism. Communitarianism proposes that to maintain a civil society, the individual can expect some benefits from being a member of society, for

example a social life and involvement in decision making. With benefits come responsibilities that the individual owes to the community (Etzioni 1998). Tam (1998) proposes that Communitarianism is not a mixture of traditional political philosophies, but rather a new philosophy creating inclusive communities where responsibilities and power are shared. Communitarianism represents a desire for a change from traditional politics, and it 'takes into account local ways of knowing in order to mobilise individual responsibility' (Blackshaw 2010:131). Drawing on the work of Bauman (2000), Blackshaw (2010) is critical of Communitarianism suggesting that its supporters have a rosy view of a community, a view that may never have existed for many and one that does not translate to the multicultural society of today.

There has been a movement to involve patients and public in health service delivery since 1974 when Community Health Councils were established (Ellins 2012). The Health and Social Care Act of 2001 (Section 11), introduced by the Labour Government, placed a legal requirement on NHS Strategic Health Authorities and Trusts to involve patients in the development of services (Great Britain 2001). Patient and Public Involvement Forums (PPI) were developed in 2003. PPI Forums were later replaced by Local Involvement Networks (LINKs) created under the Local Government and Public Involvement Act 2007 (Great Britain 2001, Great Britain 2007, Tritter and Koivusalo 2013). The Local Government and Public Involvement in Health Act (Great Britain 2007) required health care commissioners to engage with LINKs when commissioning decisions were made. This initiative encouraged local communities to engage with health care trusts in the commissioning of services to ensure that services were not only commissioned based on

health needs, but also in line with what local people wanted. Despite a desire by politicians to involve service users in commissioning decisions in practice, the membership of LINKs was self-selected and did not necessarily represent local community interests (Martin 2009).

Derek Wanless (Wanless 2002, Wanless 2004) helped to re-shape health services during New Labour's time in office. Wanless proposed that health care spending should be increased, and also that the population should become more 'engaged' with health.

Wanless (2004) suggested that in the fully-engaged scenario, individuals should take more responsibility for their own health and engage in healthy behaviours. With the population engaging in health promotion, it was anticipated that the demand on health services would diminish (Hunter 2007). The 'fully-engaged' scenario reflected New Labour ambitions; citizens should be more actively involved in shaping not only their lives and wellbeing, but also health and social services within their communities (Wanless 2002, Wanless 2004, Great Britain, Department of Communities and Local Government 2008). This theme of engagement looked to the patients and public who were participants in health promotion and care, rather than passive recipients of health care.

New Labour and Local Community Health Care (2.3).

New Labour was keen to stress the importance of community (Malin, Wilmot and Manthorpe 2002). In many ways, the creation of Primary Care Trusts (PCT's) strengthened this commitment, bringing health care planning to a community level in an attempt to

respond to local health care needs. By 2005, the Labour Government, in the document 'Commissioning a Patient-Led NHS' (Great Britain, Department of Health 2005a) proposed reducing the number of PCT's in an attempt to reduce costs. Economic considerations therefore prevailed rather than a desire to plan health care around local communities.

'Transforming Community Services' (Great Britain, Department of Health 2009a) instigated further changes in the PCT's, splitting their commissioning and provider roles in an attempt to increase patient choice. Despite the focus on community health services that the PCT's appeared to provide, financial incentives built into the commissioning process of payment by productivity benefitted acute services rather than community preventative public health work (Delamothe 2008). In practice, therefore, Transforming Community Services detracted from the public health community work, including the community-focused public health work of health visitors.

Increasingly the patient and public involvement and the choice agenda became framed with a market agenda during the Blair government. Although this was not initially the voice of a consumer in an open market, it did provide a system whereby purchasers had to demonstrate that they were buying services that met the needs of consumers. The consumer voice in this process, however, was very limited. Internal markets therefore professed to cater for the client, but in practice, managers and professionals dominated decision making in health services (Barnes and Cotterell 2012).

Markets in Health Care (2.4).

Internal markets had been created in the health sector by the Thatcher government during the 1980's in an attempt to curb costs and increase efficiency. However, these were not true markets with open competition that produced winners and losers. Malin, Wilmot and Manthorpe (2002) argue that some services such as health and education should not be delivered through free markets, but rather by the state. The authors take a social perspective when they suggest that the state has the ability, by controlling the economic system, to maximise the benefit for all, rather than those most able.

Labour continued to pursue a market economy in health care. Labour initially looked to the Third Sector to open up the health care market to new providers. The Third Sector enabled Labour to promote its 'Third Way' combination of neo-liberal and socialist principles as it took health care services forward (Ridley-Duff and Bull 2011). The Third Sector had a number of advantages over the state and private sector providers. The Third Sector helped to promote New Labour's apparent socialist intentions, in particular, the sector's ability to promote equity.

The inclusion of the Third Sector in health care provision offered opportunities, but also introduced tensions, particularly as the Third Sector is a complex collection of diverse organizations of different sizes, structures and goals (NCVO 2013). The Sector includes voluntary organizations, charities, associations, self-help groups and community groups together with Social Enterprises (National Audit Office 2013).

Social Enterprise (2.5).

The promotion of Social Enterprise has particular relevance to community engagement and health visiting. Initially Social Enterprise was promoted by New Labour to provide a 'Third way', an alternative which was neither public nor private provision. New Labour looked to promoting Social Enterprises in their first term of office as an opportunity to regenerate disadvantaged communities (Addicott 2011). Social Enterprises were also seen as a softer option or stepping stone between the public and private sectors as the Labour Government promoted a free market in health care (Marks and Hunter 2007). The Government defines a Social Enterprise as 'a business with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community, rather than being driven by the need to maximise profit for shareholders and owners' (Great Britain, Department for Business and Innovation Skills (2011:2).

Globally, Social Enterprises offer opportunities to reduce state intervention, decentralise services, and to empower, particularly those who are disadvantaged (Hayllar and Wettenhall 2013). Social Enterprises are associated with political interests and power struggles, of grassroots action and democratic principles (Ridley Duff and Bull 2011). Hayllar and Wettenhall (2013) note that as public (state) organizations have adopted the business practices of private companies, they have lost many of their social aspirations. In response to this gap, the authors suggest a global movement to restore a social element into health and social care through the development of Social Enterprises. Social

Enterprises are particularly interesting to health care organizations due to their potential to engage people and, as a result, increase positive health.

The Labour Government went one step further in developing Social Enterprises in the Third Sector; it facilitated the transformation of statutory community services, including the health visiting services, into Social Enterprises. Between 2005 and 2006, the Labour Government started to look at PCT's with a view to developing Social Enterprises in community health provision. There was concern around bringing new providers into the market place, therefore initiatives looked to health care professionals within the NHS to develop Social Enterprises through which they could continue to deliver health services (Marks and Hunter 2007).

New Labour and Public Health (2.6).

Social principles are conducive to a notion of public health that looks to the collective, suggesting that the actions of a community or society can produce more benefit than individuals working alone (Heywood 2003). However, New Labour's public health policies looked to the individual to take responsibility for reducing unhealthy behaviours and replacing them with healthier options. This assumes that the individual has control of the factors that cause ill health. It also ignores the wider determinants of health that the individual cannot control, such as social class and economic conditions (Hunter 2007, Wilkinson and Pickett 2009). Focusing on the individual rather than community did not help to promote community engagement.

Despite New Labour's stated desire to reduce inequality, including inequalities in health, public health was not given a high priority during their administration (Baggott 2011).

At the end of their term of office, the gap of life expectancy between the general population and those living in the most deprived areas had increased (Great Britain, Parliament, House of Commons 2010). Critics of Labour's 'Third Way' policies noted that while in office Labour spent little on public health, less than 0.5% of the NHS budget (Wanless et al. 2007). The Labour Government did not pay enough attention to the complexities of communities, or to the social determinants of health (Baggott 2011, Park and Wilding 2013). The lasting legacy of New Labour was that it was unable to substantially reduce inequality.

The Coalition Government (2.7).

During the course of this study, a coalition of Conservatives and Liberal Democrats formed a government. Traditionally Conservatives concentrate on privatization, enterprise, the individual, personal responsibility with limited state provision and a hierarchy within society (Heywood 2003, Porter and Coles 2011). Liberal Democrats are concerned with justice and fairness and the autonomy of individuals (Swift 2006, Clegg 2012).

Conservatives and Liberal Democrats look to promoting the individual rather than the collective. However, despite their traditional perspectives, coalition policies have strengthened the significance of this study.

As with New Labour who developed a ‘Third Way’, the Coalition Government has formed a new brand of political ideas that Porter and Coles (2011) refer to as ‘Cameronism’. Like New Labour, Cameronism has brought together a range of ideas that includes some traditional conservative values around entrepreneurship, but has mixed these with intentions to promote fairness and develop communities, areas that have traditionally been promoted by Liberal and Labour moderates.

The mixture of political ideologies supported by the Coalition Government plays out through the policies it produces. As with New Labour before it, the Coalition Government looks to combine neo-liberal policies with those that promote equality and a collective, civil society. The health policies of the Coalition Government demonstrate a desire to promote the private rather than the public sector in health care, yet at the same time policies have focused on public health and, in particular, the development of the Health Visiting Service (Great Britain, Department of Health 2010a Great Britain, Department of Health 2011a).

Coalition Government and Public Health (2.8).

The NHS is currently moving towards a true market economy with private companies increasingly providing health care services. The Coalition Government has, however, determined a different path for public health. In the document ‘Healthy Lives, Healthy People’ (Great Britain, Department of Health 2010a), the Government pledges a commitment to the promotion of public health. ‘Healthy Lives, Healthy People’ reflects the

findings of the Marmot review, demonstrating a commitment to look at the wider determinants of health in an attempt to improve public health (Marmot 2010a, Porter and Coles 2011). To support this strategy, the Coalition Government has a commitment to move the commissioning of most public health responsibilities from the National Health Service to Local Authorities (Great Britain, Department of Health 2010a, Porter and Coles 2011, Great Britain, Department of Health 2012b, Aylett and Donovan 2013). The rationale for this decision is that Local Authorities have more influence on the services that can influence the determinants of public health, for example housing and education (Great Britain, Department of Health 2010a, Great Britain, Department of Health 2011a, Aylett and Donovan 2013). In effect, public health is going back to the sector where it developed in the late 19th and early 20th centuries (Baly 1980).

The Coalition Government created a new body, Public Health England, to determine public health strategies nationally, while locally, the Directors of Public Health within each Local Authority are responsible for public health (Great Britain, Department of Health 2012a). The responsibilities of the Director of Public Health include reducing ill health and health inequalities (Great Britain, Department of Health 2011b). As with Health and Social Care, public health will be driven by outcomes that the Director of Public Health is accountable for (Great Britain, Department of Health 2012d). Local Authorities will be involved in commissioning rather than providing all public health services. It is anticipated that a range of providers, including those from the private and Third Sectors, will compete to deliver services.

There are concerns about public health returning to the care of Local Authorities. Before 1974 Directors of Public Health had little true power, and there is concern that this situation will re-occur (Davies 2010, Redman and Kenyon 2011). In addition there are concerns that Local Authorities will have insufficient funding to carry out public health duties, despite assurances that public health funding will be ‘ring-fenced’ (BMA 2012). Local Authorities will be able to ‘pool budgets with others funds being used for similar purposes’, thereby opening up possibilities of diluting the public health budget (Aylett and Donovan 2013:7). Although the NHS and Public Health are under two different national organizations, there is concern that local Clinical Commissioning Groups (CCG’s) and GP’s will dominate Health and Wellbeing Boards, and that a (GP) practice-based, rather than geographically-based, model of commissioning will prevail (Mundle and Weaks 2011). This would lessen the opportunity to develop community-based initiatives, including community engagement, and would promote a treatment model of health (Turner et al. 2013). Although there are opportunities for the promotion of both public health and community engagement to flourish under the Health and Social Care Act (Great Britain 2012a), financial constraint within Local Authorities and the marketisation of health care is likely to inhibit their development. Hunter (2007) notes that the fragmentation of services does not enhance public health; rather, the introduction of multiple providers, together with a lack of central planning, inhibits the development of public health through collective action.

The 'Big Society' (2.9).

The 'Big Society' was David Cameron's headline idea when he came to office, an idea that looked to focus on community development and the expansion of civil society (Cameron 2010a). There is little evidence to suggest that civil society has expanded. Although there has been an increase in volunteering, generally the Third Sector is struggling, hit by limited statutory agency funding and, arguably, the financial difficulties that have hit the poorest parts of society (Hetherington 2013). As services have been reduced, families and individuals have less ability to give, spending more time compensating for absent statutory services (Slay and Penny 2013). The Coalition Government has looked to society to provide for itself, yet as state provision and control is withdrawn, it could be argued that the ability of civil society to provide is reduced. Rather than developing community engagement, it seems that the Coalition Government's action has reduced the ability of communities to support community members, particularly in the poorest communities.

David Cameron's idea of the Big Society relies less on the state, and focuses on social responsibilities and support from the private and Third Sectors (Porter and Coles 2012). As with the previous Labour Government, the Coalition Government is attempting to mix the private, public and civil sectors to address social and economic problems (Edwards 2009). Increasingly governments are looking to society, the collective, to provide mutual support (Edwards 2009).

Turner et al. (2013:275) notes the ‘disappointing progress’ in reducing inequality in health, despite this being a key public health intention of New Labour and the Coalition Government. The authors suggest that there has not been enough concentration on the determinants of inequality, rather a preoccupation with treatment services (Turner et al. 2013). Where attempts have been made to strengthen communities by reducing inequality and promoting health, these have had limited impact. The impact of such initiatives has been reduced due to poor performance management together with a lack of available evidence to suggest what may work (Turner et al. 2013).

Yet within this challenging political and economic context, health visitors have been asked to facilitate the development of communities so that they can develop resources and resilience and become self-supporting, ultimately requiring less state intervention (Great Britain, Department of Health 2014). Health visitors have been tasked with the job of reducing health inequalities, despite the inability of successive governments to do so (Great Britain, Department of Health 2012a, Great Britain, Department of Health 2012d).

The Health Visitor Implementation Plan (Great Britain, Department of Health 2011a), introduced by the Coalition Government, requires health visitors to build stronger communities in an attempt to regenerate civil society. At the same time, health visiting practice is measured on the ability of health visitors to reduce inequality. To understand the current challenges that health visitors face, and to provide insight as to how they may tackle such challenges, I propose to look at the history of health visiting and look for answers in other health visiting services.

Health visiting (2.10)

Health visiting has had a chequered history in Britain since its creation in the voluntary sector 150 years ago. The service has been buffeted by social, political and professional pressures. At times the service has been proactive in supporting vulnerable families, and at others times it has reacted to immediate practice and political pressure. The Conservative Party, in its pre-election manifesto, brought health visiting back into the spotlight after a difficult period it experienced during the previous Labour administration (Cameron 2010a). The Coalition Government has regarded the health visiting profession as being pivotal in promoting child development and health (Great Britain, Department of Health 2010b, Great Britain, and Department of Health 2011a). The belief at the inception of the health visiting service, as it is now, is that it is important for society that children have a good start in life (Barlow et al. 2008, Laming 2009, Field, 2010, Marmot 2010a, Allan 2011, Tickell 2011, Munro 2011).

Health visitors have a long involvement in promoting public health. Health visiting developed as part of a social movement to improve public health, in particular the health of working class families. Manchester was the first city to develop health visiting services in the middle of the 19th Century. At that time Manchester, like many developing industrial towns and cities in the north of England, experienced a rapid growth in population. The housing to accommodate the population was of poor quality and in short supply leading to cramped and unhealthy conditions. Infection was the biggest public health issue due to the poor living and working conditions of the poor (Ashton and Seymour 1988). The first

health visitors gave advice about ‘hygiene, child welfare, mental health and social support’ (Baldwin 2012:2). In recognition of the impact health visitors had in reducing infant mortality rates, health visitors were employed by Manchester City Council. Similar services were developed in Glasgow and London (Baly 1980). Health visitors developed their role nationally around child health surveillance, supporting mothers and giving health advice. They not only worked *with* families but also *for* them, for example lobbying for child and maternity benefits (Hoskins 2009).

The Birth Notification Act of 1907 helped to develop a national health visiting service which involved visiting newborns and their mothers (Baly 1980, Institute of Health Visiting 2013a). The role quickly increased to cover child protection, the supervision of children living away from their parents and visiting ‘mentally defective’ children (Baly 1980).

Training for health visitors started in the London area. The Royal Sanitary Institute developed national training and voluntary registration in 1916. (Institute of Health Visiting 2013a). In 1945 health visitors were required to be registered.

When the National Health Service was introduced, the health visiting remit was extended to cover a wider age range of clients ‘from the cradle to the grave’ and with a wider strategic community role (Hoskins 2009:2). Although health visitors were still employed by local authorities, they became ‘attached’ to GP practices (Baldwin 2012). However, the wider role that health visitors developed did create tensions; should they move to a medical, personal intervention model alongside the medical practitioners, or work alongside the

medical officer of health promoting their public health role? (Baldwin 2012). The second tension was the role distinction between health visitors and social workers although the Jameson Report of 1956, which established the Council for the Education and Training of Health Visitors (CETHV), initially suggested joint training with Social Workers (Institute of Health Visiting 2013a).

The 1960's were a golden age for health visiting, in some ways reflecting the exuberance and social change of the era. The development of the CETHV (Council for the Education and Training of Health Visitors) meant that health visiting was recognized as a profession in its own right. It had its own professional body, professional register and had legal standing. The CETHV set out a training programme for health visitors which developed their scope of practice to include searching for health needs, promoting healthy behaviour, influencing health policy and promoting public health at a strategic level (Hoskins 2009, Baldwin 2012).

By the 1970's however health visiting was again under threat. When the Briggs Committee reported in 1972, it suggested that health visiting training should be of 6 months leading to a non-statutory certificate. Although this was not implemented at the time, in 2002, when the Nursing and Midwifery Council (NMC) replaced the UKCC, health visiting became a post-registration qualification rather than a professional registration (Cowley 2010a, Baldwin 2012). Health visitors are now registered nurses or midwives with the post-registration qualification of Specialist Community Public Health Nurse (SCPHN). This category also includes school nurses and nurses who specialize in sexual health.

In 2001 the public health function of health visitors was re-energized with the introduction of the 'Health Visitor Practice Development Resource Pack'. Health visitors were encouraged to develop their wider public health role at the beginning of the 21st century as part of New Labour's vision to promote civic renewal (Hoskins 2009).

The decline in health visitor status was compounded when the NHS Pay Review Agenda for Change downgraded the salary of health visitors entering the profession, with the result that less-experienced candidates applied for training (Baldwin 2012). During 2000-2010 health visiting numbers dropped. Training places were reduced by 40%, and this was compounded by the retirement of an ageing workforce (Hoskins 2009). The introduction of a skill mix meant that health visitors could be replaced by other less-qualified personnel such as nurses on staff grade and nursery nurses (McKnight 2006, Hoskins 2009). The development of Sure Start Children's Centres further questioned the role of the health visitor (Potter 2010).

The review of health visiting in 2007, 'Fit for the Future' (Lowe 2007), suggested that the role of health visitors included 'improving the health and well-being of children, families and communities' as well as 'addressing some of the key public health issues facing society today', (Lowe 2007:5). This was a tall order considering the problems the health visitor workforce faced at the time.

By 2007 Cowley et al. were lamenting the limited role that health visitors were able to undertake. Health visitors were struggling to provide even a minimal service to new parents

and vulnerable children (Cowley et al. 2007, Hoskins 2009). It was noted that health visitors were unable to provide positive health outcomes due to the lack of regular contact with families, (Cowley et al. 2007). The role of health visitors had become reactive, dealing with child protection and vulnerable children rather than one of proactively promoting public health (Cowley et al. 2007).

Evidence was mounting however about the importance of promoting health and well-being in the early years. The work by Barlow et al. (2008) when reviewing the Healthy Child Programme, the Field Review (2010) that looked at child poverty, the Allan Review (2011) and the Tickell Review (2011) all highlighted the importance of maximizing early growth and development. The Laming Review (2009) and Munro Review (2011) highlighted the importance of children's services and the role of front line staff in protecting children. These reports, together with the Marmot Review (2010a), highlighted the importance of early intervention to support the development of children and their families.

In many ways, the Health Visitor Implementation Plan introduced by the Coalition Government addresses the decline in the health visiting service that had occurred during the previous Labour Government (Great Britain, Department of Health 2011a). By returning the health visitor workforce to the staffing levels of 2000, the plan intends to establish a health visiting service that is proactively promoting health rather than only reacting to safeguarding and social issues (Great Britain, Department of Health 2011a, Cowley et al. 2007, Cowley 2010a).

Health Visiting Globally (2.11).

Health visiting services are present across Scandinavian countries including Denmark, Norway, Sweden, Greenland and Iceland (Lindhardt 2012). In Denmark, for example, the health visiting service was adopted in 1937 following a three year trial to reduce infant deaths (Lindhardt 2012, Poulsen 2013). The training for health visitors in Denmark is similar to that in Britain, with a theory and supervised practice element, however the training is of 18 months post (nurse) registration rather than 1 year as in the United Kingdom (Lindhardt 2012, VIA University College 2011).

Health visitors in Denmark have a similar role to that of health visitors in Britain in that they offer a universal service and conduct some of the same functions. The position of health visitors in Denmark was secured in 'The Health Law' (2007) (Poulsen 2013). Danish health visitors have a legal requirement to consider the demographic issues of the population and children with special needs. Although national guidelines are set, the role of the health visitor in Denmark is determined by each regional municipality. The amount of money allocated to health visiting services varies across municipalities

The health visiting service of New Zealand has been well-supported by government and the population throughout its history. The Royal New Zealand Plunket Society was established in 1907 by Dr Frederic Truby King in an attempt to improve the nutritional state of infants and young children (Plunket Organisation 2013a).

Plunket nurses have practiced free of medical influence for most of their history, unlike health visitors in the United Kingdom who have been influenced by both the medical profession and Local Authorities. Unlike other health visiting services, the Plunket society is only partly-funded by government, the remaining (50%) costs being met through voluntary donations and sponsorship (Plunket Organisation 2013a). Money raised locally, through fund-raising committees, supports local services (Plunket Organisation 2013b). The way that the Plunket organisation is funded, in part through voluntary contributions, allows the organisation some autonomy and flexibility to support local health care needs (Plunket Organisation 2013b). The society is a powerful and influential organisation that is well-supported by the public. The organisation has a stronger community focus than the British health visiting services and is much closer to the population it serves.

There are lessons that health visitors in Britain can learn today from the history of the Plunket society. The first is that financial independence can provide more flexibility and independence, therefore Social Enterprises that do promote social causes may be an effective model to develop health visiting services in Britain. The second is that health visitors can be a strong political force, a role that British health visitors have relinquished under pressure in recent years. The third lesson is that British health visitors need to work with communities through community networks, and have an understanding that their role is to support and serve the community rather than to serve professional or political interests.

The Health Visitor Implementation Plan, Moving Forward (2.12).

In detail, the Health Visiting Implementation Plan intends to increase the number of health visitors by 40% to 12,292 by March 2015 (Great Britain, Department of Health 2011a). It is estimated that 6,000 new health visitors will be trained 2011-15 (Great Britain, Department of Health 2011a). This has had implications for both institutions of Higher Education and Health Care Trusts as 50% of health visitor training is accomplished in practice under the supervision of Practice Teachers (Nursing and Midwifery Council 2004).

The Health Visitor Implementation Plan intends that health visitors will support parents who in turn will promote the physical, emotional and social development of their children (Great Britain, Department of Health 2011a). The four tier service outlined in the document details the different levels of involvement that health visitors will have with families. The first 3 sections state that all families will be offered a universal service, families who require specific support will be offered a 'Universal Plus' service, and those families with complex ongoing needs will be offered Universal Partnership Plus that involves a health visitor working within a multi-disciplinary team. The fourth section, which is most pertinent to this study, is 'Your Community'. This section involves health visitors working with services already established in neighbourhoods, such as 'Sure Start' Children's Centres but also, 'services families and communities provide for themselves', recognizing that communities have strengths and resources (Great Britain, Department of Health 2011a:6).

The Department of Health has provided substantial resources to develop health visitors so they can support the building of community capacity. This has included a web-based resource and financial support to Strategic Health Authorities to support this initiative (Northumbria University 2012, Pearson et al. 2013). A recent public health workforce consultation recognised the importance of developing communities and the SCPHN nurses' role in building 'resilience in the population', (Great Britain, Department of Health 2012c:31). Locally, I have been involved in developing and delivering short courses, 'Building Community Capacity', for practicing health visitors. Early feedback sessions from these courses indicate that there has been a range of success, some health visiting teams developing new links and networks with communities and developing services that are popular with communities. My fear that the Coalition Government would render my study obsolete was unfounded; rather my study has become more focused around the future of health visiting and informing health visitor practice around successful engagement with communities.

David Cameron's idea of the Big Society has impacted on health visiting practice as the government looks to society, the collective, to provide mutual support (Edwards 2009). Health visitors have been placed in a position to facilitate the development of communities so that they can develop resources and resilience and become self-supporting, ultimately requiring less state intervention.

It is questionable whether health visitors themselves or forces from outside the profession will determine their future. Some movements have been made to strengthen the profession from health visitors; the development of the Institute of Health Visiting (Institute of Health Visiting 2013a), launched in November 2012 with the aim of promoting health visiting practice, is one such example. Professor Sarah Cowley has conducted an extensive literature review which asks the question: ‘Why Health Visiting?’ (Cowley et al. 2013). The results of this investigation indicate that there is little evidence to suggest that health visitors have made a substantial difference to health and well-being in recent times. Health visitors have a relatively short period of time, until March 2015, to justify that they are making a difference and are having a positive impact on health outcomes. If they are unable to prove that they can make a difference to health and well-being in this period of time, then the window of opportunity to develop the profession may close.

Conclusion (2.13).

This chapter has looked at how national politics influence health care, including the organisation, funding, ethos and functioning of health care. Both Labour and the Coalition governments have sought to capture a middle ground of politics, bringing to this space a mixture of philosophies and ideas in an attempt to not only capture the public’s support, but also to tackle contemporary health and social problems. Governments try to do this within an economy that is influenced by global players. Health visiting practice has been determined not only by politicians, but also by other professions and by nursing bodies such as the Nursing and Midwifery Council (NMC). Health visiting has been highlighted

by the current Coalition Government, and tasked with extending their role of practice and, in particular, devoting more of their time and energies to working with communities. The next chapter looks at the literature that supports the notion of community, community engagement and public health with a view to gaining a better understanding of the task that health visitors face.

LITERATURE REVIEW (3).

Introduction (3.1)

The aim of this chapter is to put into context the notion of community engagement by looking at the issues that influence and shape it. ‘Community engagement’ with relation to health has frequently been used to describe how health care professionals can engage with communities. To date this has often been a top-down process, with professionals holding power and determining the engagement agenda. This study, however, looks at a less-used use of community engagement (Richardson 2008, Minkler 2012) whereby communities engage with each other. The aim of looking at community engagement from this second perspective of community participation is to get a better understanding of what it is like to be engaged in a community from the perspective of people who are engaged in the process. This study is about getting an understanding of what it is like to be a member of a community, and what the culture of that community is. An ethnographic approach has been selected for this purpose. It is by getting this insight into the living culture that has been created, that it is hoped to inform health visiting practice so that community engagement no longer is top-down, but rather, with better understanding, health visitors are able to work with and for communities from the bottom up. Critical ethnography fits with this change approach, as critical ethnography does not aim to just describe what is, but rather uses such information to bring about change.

This critical approach is used throughout the work for a number of reasons. It acknowledges inequalities in power and influence. Power and the way it is used by elites, including professionals, has to be acknowledged in the study as professionals have formed a barrier in the development of community engagement (NICE 2008). To move forward to a new way of working, this study looks to a position where communities have at least as much credibility and influence as professionals.

This chapter explores some of the fundamental issues of public health, including equality and the collective. It looks to define ‘community’ and Social Capital, and consider the health benefits that can be gained as a result of Social Capital.

Literature Search (3.2)

The starting point for this research project was to gain an insight into community engagement from the perspective of participants, so that health visitors could effectively support community engagement and promote health. The key term for my initial literature search was ‘community engagement’, and to this I added ‘health’ and also ‘public health’. I added a search using the terms ‘community’ and ‘engagement’ or ‘participation’ and ‘public health’.

The following databases were consulted during the initial literature search: Assia, International Bibliography of Social Science, Pub Med, Sociological Abstracts, Web of Science, British Humanities Index, Medline, Cochrane, National Library for Health, and

National Library of Public Health (Appendix 1: Literature Search). Limits to the searches included 'English language', and included peer-reviewed articles. Key documents were located initially through the title and then through the abstract. References lists of key articles were scrutinised in search of other relevant text. From the databases consulted, the National Library for Health produced the highest number of relevant texts.

I consulted a range of web sites using the key term of 'community engagement'. Searches were conducted on the following web sites during the initial literature search: Association of Public Health Observatories, East Midlands Public Health Observatory, National Institute for Health Research, Yorkshire Forward, The Joseph Rowntree Foundation, Kings Fund, the Nuffield Trust and the Improvement and Development Agency for Local Government. The Joseph Rowntree Foundation was found to be a good source of relevant text.

As the study developed, I identified key issues such as 'social capital'. On each of these issues, further searches were conducted using 'social capital' and later 'social capital' and 'health'. A range of web sites was consulted, including the Department of Health.

The document 'Community engagement to improve health', (NICE 2008) was in many ways the starting point of my search. I read the rapid reviews of the literature that supported 'Community engagement to improve health', (NICE 2008). The review of the literature conducted by Popay et al. (2007) focusing on community engagement and the wider determinants of health concluded that although disadvantaged communities could benefit

from community engagement, there was less evidence that the most disadvantaged communities had. A second review by Swainston and Summerbell (2008) looked at the literature supporting the effectiveness of community engagement on health promotion and highlighted the difficulty of reviewing community engagement initiatives when each had different aims, design and, where documented, outcomes. In conclusion, the evidence to support community engagement as a tool to improve health was limited and patchy (NICE 2008).

As I extended my literature search of 'Community engagement' I obtained results in a range of fields, particularly associated with education. However, there was limited literature relating to community engagement and health, and less concerning community engagement and public health. An article describing the SEAL project in the Gorbals district of Glasgow was key to my understanding of the role of health visitors in community engagement (Taylor 2006). It demonstrated that even in the most deprived communities, community engagement could have a positive impact on health and well-being of community members (Taylor 2006). This article gave me a better understanding of the role that health visitors could develop in promotion of health through community engagement.

As my literature search on community engagement and health progressed, two themes emerged. Firstly, there was little consensus about the concept of 'community engagement'. Secondly, documents produced by the Department of Health (Great Britain) considered community engagement from a top down approach, in effect, how could the NHS get

communities to engage with it rather than how could health services engage with communities.

The Australian Department of Health, and in particular work conducted by Gregory (2008) supported the proposition of 'Community engagement to improve health', (NICE 2008) but stated, as did NICE (2008) that professionals were a barrier to community engagement. Gregory (2008) suggested that statutory services should adapt to what the consumer of services required, rather than service users adapting to service requirements, the opposite to the top down approach to community engagement that statutory services in Great Britain had promoted.

I started to look beyond documents produced by the state to get a different perspective. It was when reviewing reports supported by the Third Sector that I started to obtain a different view. Skidmore, Bound and Lownsborough (2006), in a report published by the Joseph Rowntree Foundation, provided an insight into the strategies deployed by statutory services when engaging with ethnic communities. The report suggested that, as a result of engaging with leaders of communities, minority voices, and these included women, were unheard. Richardson (2008) gave a different perspective of community engagement, suggesting that it could mean communities engaging with each other. It is worth noting that these two reports were not produced directly by community members.

Following the comments by NICE (2008) and Gregory (2008) who both suggested that professionals presented a barrier to the development of community engagement, I reviewed the literature on 'power'. Luke's (2005) 'Radical' views of power, illustrated how those

without power are surreptitiously oppressed by the illusion that they have choices. Further research led me to consider how critical theory and the critical perspective of power could be harnessed to study and promote community engagement from the bottom up rather than from the top down approach.

As the study progressed it altered focus. As a new political alliance gained power there was a resurgence to reduce health inequality (Great Britain, Department of Health 2012d). A study by O' Mara-Eves et al. (2013) suggested that community engagement promoted health equality, evidence lacking in the NICE report of 2008. It was becoming increasingly evident to me that if substantial health improvements were to be made, communities needed to be able to make changes to the factors that affected their lives from the bottom up.

The Perspective (3.3)

The bottom-up or grassroots perspective is initiated by communities rather than professionals or statutory agencies. It involves communities responding and taking collective action to change issues that concern them. The agenda and the mode of action are established by the community rather than by a government agency (Minkler 2012). Richardson (2008: 1) defines a 'community self-help activity' as 'informal groups of people, acting on a voluntary basis, working together to solve common problems by taking action themselves and with others.' The 'others' noted by Richardson can be statutory services. If statutory services are to support grassroots community activities, then they need to work in a different way to that in which most have been initiated. When supporting

community activities, statutory agencies may, for example, have the role of helping communities to develop skills to achieve goals. The goals in such situations should be set by communities; it is their agenda, and should not be the agenda of the agencies involved (Powell and Geoghegan 2004, Minkler 2012, RCGP 2013).

Statutory agencies, as a result of government directives and professional bodies, have traditionally worked in a top-down manner, whereby the agenda is set nationally through policy and, to a lesser extent, through professional organisations. This top-down approach has not been successful in creating improvements in health and wellbeing on several levels. In particular, the top-down approach has done little to address the needs of the diverse communities, which is common to the United States of America and Britain and increasingly an issue across the European Union (The Migration Observatory 2013).

Health and social inequalities persist nationally as well as globally, compromising any pursuit of a fair and just society (WHO 2008a, Wilkinson and Pickett 2009, Marmot 2010a). As Minkler (2012) notes, non-white Americans experience worse health and die younger than the white majority, yet it is estimated that in the middle of the decade, non-whites will exceed the number of whites within the North American population. The growth in the non-white population in North America has not generally been matched in their power and influence. Minkler (2012) suggests that resources are allocated on the basis of power, those with power having the ability to allocate resources not necessarily on need or merit, but at their discretion.

The Medical Model of Health (3.4).

The World Health Organization (WHO) defines 'Health' as a positive state and not just the absence of disease (WHO 1948). In Britain, health is often associated with the National Health Service, because according to Ashton and Seymour (1988:1), the British public has held a common belief that improvements in health have come about as a result of 'scientific medicine.'

The scientific biomedical model of health has dominated western societies for the last 200 years. It reflects the culture and beliefs of society during that period, which were based on scientific, positivist principles (Giddens 2009, Nettleton 2013). The scientific model works on the principle that facts are discovered in the world, a world that is recognised through the senses of an individual (Turner 1995). There is an assumption of cause and effect, and that one truth can be established. Once 'truth' has been discovered, it is generalised. The biomedical model does not recognise the relationship between mind and body, nor does it take into account the social and environmental factors that impact on health. The patient is seen as an object, not a unique individual (Illich 1975). The model assumes that the patient is a victim who has acquired a disease by chance and who will, upon diagnosis, become a passive recipient of treatment (Wade and Halligan 2004). This assumed passivity of the patient has enabled health care professionals to develop and retain their professional power.

Professional power, particularly in the medical profession, has defined health and illness, normal and deviant, and has dominated health care (Turner 1995). Treatment services have

been established and promoted, rather than public health initiatives (Rayner and Lang 2013).

Despite this power base, there is a growing awareness of the limitations of the biomedical model of health from within as well as from outside the medical profession (McKeown 1979, Blakemore 1998, Giddens 2009, Wilkinson and Pickett 2009, Marmot 2010a). The biomedical model does not recognise the patient's circumstances, their experience of ill health, or their views (Turner 1995, Giddens 2009). Although attempts have been made to medicalise mental illness, disability, chronic illness and childbirth, the medical model's desire for treatment and a conclusion of 'wellness' or 'normality' is unrealistic and unachievable in many cases (Nettleton 2013). The growing cost of treatment, together with mounting questions regarding the effectiveness of such treatment, some of which is harmful to the patient, questions the sustainability of this model (Illich 1975, Hunter 2007, Wilkinson and Pickett 2009, Nettleton 2013). In particular, medical knowledge has reduced peoples' ability and confidence to acknowledge their vulnerabilities and look for their own solutions (Illich 1975, Nettleton 2013).

Recently, there have been a number of reports that have highlighted the failings of health care professionals and health care providers, and these have dented the public's trust (Francis 2013, Keogh 2013). Professionals are identified through their expert knowledge, and such exclusivity of knowledge has enabled them to retain power. This source of power, however, is threatened as more sources of information are available to the public. Trotter

and Morgan (2006), for example, found that 55% of patients attending an outpatient's clinic had accessed the internet for health advice.

Although there is a popular belief that the NHS and health care professionals are responsible for improvements in health, the evidence suggests that it is factors and policies beyond the NHS that have the biggest impact on mortality and morbidity. Factors beyond the NHS which promote health and wellbeing include education, employment, equality of income and opportunity, together with the level of cohesiveness within society (Blakemore 1998, Wilkinson and Pickett 2009, Marmot 2010a). However, health care spending within the NHS has focused on what makes people ill rather than what makes them healthy (Hertzman and Siddiqi 2009, Jenson 2009).

There has been a movement, therefore, not only for the public to be more engaged in health care, but also in the design and delivery of health care. Rotheroe and Miller (2008) suggest that if patients and the public are going to be more involved in the design and production of health services and become more proactive, then not only do users need to change their role, but (importantly) so do professionals, a move that they as yet have been reluctant to take.

The Social Model of Health (3.5).

The social model of health describes the impact of social factors which influence health together with the lived experiences of the individual. It acknowledges the individual within

a social context, and how the individual social circumstances impact on their perception of health and illness (Nettleton 2013). It explains the relationship between social class, morbidity and mortality rates, and acknowledges that individuals, particularly in deprived social circumstances, are limited in the choices they can make regarding their behaviour and circumstances (Giddens 2009).

The vision of health used in this study looks to the social model of health. Rather than looking at health care, which has concentrated on looking at illness that has already occurred, it looks towards promoting positive health and wellbeing in society and within communities (WHO 1978, Baly 1980, WHO 1986, Baggott 2007, Chan 2008).

Public Health (3.6).

Public health is based on a collective principle. It requires actions of society for the good of that society (Acheson 1988). Minkler (2013) suggests that the worldview of those engaged in promoting public health also looks to promoting fairness and social justice. Public health strategies are not without tensions, in particular the potential for the reduction of individual liberty, yet public health aims to reduce inequalities and therefore has benefit for all those who engage with the principle (Wilkinson and Pickett 2009, McGuire 2010).

Where successes in public health have historically been led by local and national policies, for example to provide clean water and clean air, there has long been a recognition that greater wealth has been linked with better health (Orme et al. 2007). The populations of

wealthier countries have generally had better health than those with a low Gross National Product (GNP) (Wilkinson and Pickett 2009).

When looking at health statistics within countries and even within localities, there are large disparities in health outcomes. As Marmot notes, there are inequalities in health in Britain today, with almost 20 years difference in the life expectancy between the richest and poorest areas (Marmot 2010a). Despite Britain's apparent wealth, as measured by GNP, there are areas of Britain where the inhabitants achieve the same life expectancy as inhabitants as Thailand or Belize, countries with low GNP's and no national health service (Marmot 2010a:37). International studies note that where there is the greatest inequality within a country, for example in the UK and USA, there are more health and social problems (Wilkinson and Pickett 2009).

Inequality affects not only the life span, but also the quality of life. It reduces spending power, opportunities in life, and opportunities to live a healthier life (Marmot 2010a). As Marmot notes, inequality limits people's choices and the ability to control their lives (Marmot 2010a). It is unfair. 'Social justice is a matter of life or death. It affects the way people live, their consequent chance of illness and their risk of premature death' (Marmot 2010b:28).

Inequality of opportunity does not just affect the individual but, by the nature of their circumstances, it also affects the community in which that individual lives. Poorer deprived areas do not have as many resources. These areas often have poor housing and lack green

spaces (Marmot 2010a). The social resources, social networks and support mechanisms, in other words the Social Capital within deprived communities, tend to be weaker and less well-developed (Collins 2004).

Public health measures have gone beyond just ‘looking upstream’, where governments introduce policies to prevent illness; rather, it is about how society wants to conduct itself. Rayner and Lang (2012:3) state that public health is about ‘humanity’, a shared existence that determines the quality of our lives. In many societies today, including the United States of America and Britain, the experience of health and illness is different for different sections of society (Wilkinson and Pickett 2009, WHO 2013).

Equal Societies (3.7).

Wilkinson and Pickett (2009) suggest that when societies are more equal, then health improves for all. Chile, Costa Rica, South Korea and Taiwan have been able to provide better mortality outcomes than those achieved by the United States, despite their limited resources (McGuire 2010). Although McGuire acknowledges that there is not one solution to improve public health, as the economic and cultural factors in each country are different, there are three elements that have been proved across countries to improve public health: these are equality, democracy and spending on social welfare (McGuire 2010).

Democracy simply means that people rule and are politically equal, for example they all have one vote (Held 2006). Democracy gives people access to information which helps

them to make informed choices at a local and national level. It enables people to take control over their own lives; it can empower them to build skills and social capacity. Democracy can build healthier societies and, ironically, wealthier ones (McGuire 2010, Marmot 2010a, Wilkinson and Pickett 2009).

It is too simplistic to state that democracy is a panacea that can eradicate all inequalities. Many developed democracies, such as the United States of America, have high levels of poverty and inequality within its society. In contrast, neighbouring Canada has less poverty and inequality (Brady 2009). Brady argues that it is the power held in institutions within societies that perpetuates inequality. When looking to democracy to enhance equality, it is therefore important to look not only at how people are involved in making decisions at a national macro level when they vote for national leaders, but also how they are able to influence decisions at a micro level, the decisions that influence their lived environment and their day-to-day lives.

The NHS currently has a minimum impact on public health, although primary health services, social services and education can enhance public health (McGuire 2010). Welfare policies and those that promote equality require political motivation and leadership (WHO 1986). Political motivation is not always derived from a desire to improve the situation of the public, but often derived out of self-interest (McGuire 2010, Wilkinson and Pickett 2009). The choice agenda that denotes liberal or centre ground politics has not reduced health inequalities, rather extended choice for those who already have choices. It has done

little to extend real choice for those who are disadvantaged. In addition, the pursuit of individual choice limits the benefits of the collective (Green, Ross and Mirozoev 2006).

The WHO (2008), when considering issues of global and national inequalities in health, looks to the wider determinants of health rather than health care services to improve health. Increasingly it looks to the causes of ill health, considering not only social class gradients, but also the economic and political structures within a country which perpetuate inequalities (WHO 2008, Minkler 2012). The WHO suggests that inequalities in health are not necessarily due to a lack of resources in a country, such as health services, but rather that sections of the population, those who are poor, have difficulty accessing such resources. The poor are often powerless.

Wallace (2008) suggests that it is imbalances in power, due to the retention of power by those institutions which hold power, which perpetuate inequalities. Inequalities in health and opportunity say something about a society; they state that some people are valued more than others. The right to health is a basic human right. The Universal Declaration of Human Rights, Article 25 states that 'Everyone has the right to a standard of living adequate for health and wellbeing' (United Nations 1948). While inequalities remain, social justice is compromised.

The WHO (2008) suggests that community engagement and participation will enhance equality, through a process of building community capacity and developing Social Capital. The expectation is that communities and individuals will become empowered so that they

are in a position to make decisions about their lives and alter the factors that will influence their health.

Social Capital (3.8).

Social Capital is a term used by Hanifan in 1916, but the concept was described during the late 19th Century by Tocqueville and Durkheim who described the support and a feeling of trust that individuals could gain as a result of cohesive social networks (Halpern 2005).

Features of Social Capital include civic engagement, norms of reciprocity, trust and co-operation (Kawachi et al. 1997). Kawachi states that ‘Social Capital’ is a public good created as a by-product of social relationships’ (Kawachi et al. 1997:1495).

Commentators suggest that Social Capital in communities has generally diminished and as a result social inequality has increased (Putnam 2000). Although Putman noted the decline of Social Capital in America, particularly as measured in the membership of formal associations, there is evidence that informal networks have grown (Halpern 2005). As society has changed, so has the type of group that individuals wish to join.

Cowley (2010b:72) questions the motives of politicians who promote Social Capital, proposing that they are avoiding the development of policies to reduce inequalities. Cowley (2010b) suggests that politicians blame the ill and the poor for their lack of ‘neighbourliness’.

Critics point to the lack of clarity of the definitions of Social Capital, suggesting that it draws on established social theories. A further criticism is that the proposed benefits of Social Capital may in fact be due to other factors. Individuals with mental illness and chronic health problems, for example, tend to have poor social networks; it could equally be the case that the debilitating effects of illness have reduced their social encounters (Halpern 2005).

Social Capital can have negative effects, for example people may be excluded from networks and support (Putnam 2000). Inclusive communities can be restrictive and intolerant (Putnam 2000). Social Capital often reinforces social stratification, as people bond with others who are 'like us'. In addition, social networks may encourage behaviours associated with poor health, such as smoking and drug misuse (Islam et al. 2006).

Despite the controversy, Social Capital does have measurable and positive outcomes for participants (Cowley 2010b, Islam et al. 2006). Having trust in those around you is a key component of Social Capital and it can be consistently measured (Halpern 2005, Islam et al. 2006). Trust is important in making people feel safe, it helps people to flourish and helps society to function more effectively. Social Capital is associated with improvements in economic growth, education, and health (Halpern 2005). It is an important resource: 'It provides a source of resilience, a buffer against the risks of poor health' ... 'it is critical to physical and mental wellbeing' (Marmot 2010b: 24). It is the improvements in health that come about as a result of Social Capital that are of particular interest to this study.

Social Capital and Health (3.9).

At its crudest level, there is a link between Social Capital and mortality rates (Kawachi et al. 1999). This could be attributed to inequalities in social standing; however, the effect of Social Capital on improved health is still present when income is taken into account (Kawachi et al. 1999).

Petrou and Kupek (2008), in their study involving over 13,000 participants in the Health Survey for England 2003, found out that where there were low levels of trust, reciprocity, support and civic participation, there was, correspondingly, poor levels of health.

Even when the individual has few social networks, there is some evidence that living in an area where there are high levels of Social Capital has health benefits (Kawachi et al. 1999, Poder 2010). A literature review that looked at Social Capital and health carried out by Islam et al. (2006) concluded that regardless of study design or the level of egalitarianism within a country, a link between high levels of Social Capital and positive health was found. The authors state that in countries where there are high levels of public spending and a developed civil society, conditions found in Nordic countries for example, Social Capital and trust flourish (Halpern 2005, Islam et al. 2006).

Civil societies are not an alternative to public provision of services, rather the two go hand-in-hand. This is a pertinent observation in a political climate that seeks to develop Social

Capital and a civil society as an alternative to public spending (Great Britain, HM Treasury 2010).

The effects of Social Capital on health can be measured and described at three levels: micro, meso and macro (Kawachi et al. 1997, Halpern 2005). Halpern notes that ‘the most powerful health impacts appear to arise from the most intimate relationships -micro-level bonding Social Capital’, (Halpern 2005:112). It is therefore the quality of relationships that are important rather than the number of different relationships. If someone cares about you and supports you at this micro-community level, your mental and physical health improves and you are less likely to die prematurely (Halpern 2005, Kawachi et al. 1997). Supportive relationships can help reduce both physical and mental illness, for example confiding in friends improves the immune system (Halpern 2005). If you become ill, then the support that the micro community can offer helps you to recover better. Where there are high levels of trust, death from strokes and cancer are reduced (Kawachi et al. 1997).

When levels of Social Capital are poor, for example in areas of unemployment and poverty, there is a concentration of a double negative effect: the effect of poverty and the effect of inequality leading to mistrust. As Kawachi et al. (1997: 1495) state, ‘as income inequality increases, so does the level of social mistrust, which in turn is associated with increased mortality rates.’ The combined effects of inequality and mistrust place too much pressure on the social and support networks within deprived communities. Communities stop investing in Social Capital (Kawachi et al. 1997, Halpern 2005).

Community (3.10).

Parker suggests that humans elect to live communally (Parker 2007). Despite the longevity of the term 'community', it continues to be difficult to define (Lister 2010). Community has associations with goodness, something desirable, and can be described as 'local', 'altruistic' and involving co-operation (Clay 2007, Parker 2007:23).

Blackshaw (2010) notes that 'community' has become a prefix for many public services, for example community health services. He suggests that politicians particularly like to use the word 'community' as it has positive and local connotations. The increased usage of the word 'community' is, however, matched by the increased amount of uncertainty over what the word represents (Blackshaw 2010).

Communities are often associated with, for example, geographical locations, a village or neighbourhood. As a health visitor I had a caseload determined by a geographical area, or bound by the geographical boundaries of GP practice (Watkins and Cousins 2010).

Although health visitors now work in bigger teams that have corporate caseloads, there remains a notion that they work within communities (Lowe 2007).

Blackshaw (2010) suggests that in a consumer society that promotes individualization, people still seek a sense of belonging. He suggests, however, that their relationship with 'community' is now different. People are more likely to choose the community or communities they engage with, their level of engagement, and how long they wish to stay

within a community (Blackshaw 2010). Communities are only ‘kept alive’ for as long as members deem them to be worthwhile (Blackshaw 2010:15). Bauman (2000) makes reference to the liquidity of modern life and ‘liquid’ communities. Liquid communities, suggests Bauman, are a reflection of economic, social and cultural factors, and are not static or permanent. Individuals are no longer members of just one community, but several. Within communities members have some things in common with each other, but they also have their differences (Holloway and Tordes 2006). Within multi-faceted lives, people have different identities which can be represented in the different communities they join (Blackshaw 2010). The NICE (2008) report has a broad definition of community which includes people who share characteristics such as location, race and occupation, but also people with shared interests, such as the users of a service. Individuals are thus more likely to be part of a community when they have shared interests with other members of that community (Blackshaw 2010, NICE 2008). Communities defined by a shared interest rather than a shared location are more representative of how people live in communities today (Brunt 2001, Skidmore, Bound and Lownsborough 2006, NICE 2008).

Community Engagement (3.11).

Community engagement can be used to describe statutory organizations engaging with communities, or communities engaging with each other. While the first option usually denotes a top-down relationship, communities engage with each other through a grassroots or bottom-up approach.

Community Engagement Bottom-Up (3.12).

The bottom-up perspective of community engagement is one where communities work together to change their situation. An example of community engagement and development is the Public Initiative for the Prevention of Suicide and Self-Harm (PIPS) project (Northern Ireland, Department of Social Development 2012). This project was initiated by individuals who discovered that there was little support from statutory services following the suicide of a family member. Bereaved families came together to develop support services, including an information pack, and a base from which to operate and weekly support sessions. As the project developed, funding and training was secured. PIPS was recognised as providing the best practice for bereaved families following suicide. As a result, PIPS was able to influence government policy and health service delivery. This demonstrates that when communities of interest come together and are empowered, they can make changes.

Volunteering and the Voluntary Sector (3.13)

Volunteers are a key to the success of bottom-up community activities, such as the PIPS project. Volunteers can be viewed as people who work without payment or altruistically. An alternative view is that volunteering is a ‘mutually beneficial exchange’ whereby volunteers not only give, but also benefit from, the experience (Paine, Hill, Rochester 2010:8). A belief in civic life and trusting others increases volunteering (Brown and Ferris

2007). While the motivation for volunteering can be viewed on an individual level, there are demographic differences in the patterns of volunteering.

Sweden and the United States of America have high levels of volunteering while Japan, Poland and Spain have low levels (Hackl, Halla, Pruckner 2012). Where public expenditure is high, levels of volunteering tends to be lower. Democratization, and consensus with the government, reduces volunteering, while economic stability and high employment levels raises it (Hackl, Halla, Pruckner 2012).

When considering community engagement, the state and civil society, it is also important to consider the impact of the voluntary sector in this equation. In some respects the voluntary sector has bridged a gap between the state and communities. The Third Sector is generally more flexible and innovative and can often deliver outcomes that statutory agencies find difficult to achieve (National Audit Office 2013). In these respects the Third Sector has advantages over statutory services in developing community engagement. Voluntary organizations often address particular social goals, and where profits are made these are used to promote welfare and enhance social good (Ridley-Duff and Bull 2011).

New Labour saw the potential of the Voluntary Sector which it promoted through the Voluntary Service Unit within the Home Office. The Office of the Third Sector provided funding, as did the National Lottery (Alcock 2010). The Government reviewed The Charities Act 2006 (Addicott 2011) so that charitable status was more clearly defined. Charitable purpose as defined by The Charities Act includes ‘the advancement of health or the saving of lives’ and ‘the advancement of citizenship or community development’ (Great

Britain, The Charities Act 2006 Section 1, Clause 2(2), Ridley Duff and Bull 2011). Yet while acknowledging the advantages of the Voluntary Sector, the government changed the nature of some voluntary agencies by encouraging them towards mainstream providers of health care.

Community Engagement and Health (3.14).

There is evidence that when people and communities become actively involved in decision making about what influences their daily lives, their health can be enhanced (Collins 2004, Wanless 2004, NICE 2008).

The Labour Government looked towards community engagement as a process by which public health, together with active citizenship, could be promoted. Through the Department of Health, the Labour Government commissioned evidence that supported the link between community engagement and health. The subsequent report, 'Community Engagement to Improve Health' (NICE 2008), concluded that there were substantial gaps in the evidence linking community engagement with health improvements.

Twelve substantial gaps were identified in the evidence supporting community engagement and health improvement (NICE 2008). Gaps included a lack of information about how community engagement can improve health. The last of the twelve areas identified by NICE as requiring further research stated that 'there is little information on what it is like to participate in community engagement initiatives at any level' (NICE 2008:88). This statement forms the basis of this study.

Although there is little known about the experience of community engagement from the people engaged in the process from a bottom-up perspective, there is an understanding of the barriers that limit and prevent community engagement. Some barriers are due to the communities' lack of experience, knowledge or willingness to engage; however, many are due to health care professionals and statutory organizations and, in particular, their misuse of power (Gregory 2007, Popay et al. 2007, NICE 2008, Eversole 2011). Health care professionals limit community engagement as a result of 'the dominance of professional cultures and ideologies in imposing their structure and solutions on communities' (NICE 2008:18).

Health care professionals are educated, and practice in the treatment of ill health rather than the promotion of good health, the realisation of which could render their knowledge and skills redundant. Ellins (2012) suggests that professionals value their expert knowledge above that of the knowledge that the public holds. Their preference for professional knowledge is despite a growing awareness within the care professionals that the predominant model of health care, that which is treatment-based, is unsustainable, as many health problems are of a chronic nature with no quick fix (Hunter 2007, Nettleton 2013). However, forming relationships with clients and communities based on equality and trust could diminish the power of health care professionals, and therefore has been avoided. This is despite government initiatives and the potential of community engagement to promote sustainable health (Arnstein 1969, Baylis, Kenny and Sherwin 2008 Ellins (2012).

Barriers are created for communities when professionals use technical terms and prioritise scientific knowledge rather than consumer views (Gregory 2007). Health care professionals are reluctant to engage with communities when they are busy, as they are reluctant to invest their time when they are not sure of the outcomes (Gregory 2007). As Gregory (2008) notes, community engagement is a mindset. Health care professionals do not always have the knowledge, understanding or the skills to develop their practice to enhance community engagement.

Community Engagement – Top-Down (3.15).

Traditionally health services have engaged with communities on a very superficial level that has been tokenistic. It has seldom involved partnership working between services and communities. An example of this approach is illustrated in the ‘Community Engagement Toolkit’ that asks the question: ‘What do we want to know from the public?’, rather than, for example, ‘How can we work in partnership with the public?’ (NHS Centre for Involvement 2008b:1).

Despite the wide range of possibilities that the PCT’s had at their disposal to engage with patients and the public, few options were used (Ellins 2012). A survey carried out by the Picker Institute found that PCT’s tended to consult patients and the public using four methods: public meetings, formal consultations, focus groups and surveys (Chisholm et al. 2007). These methods only allow patients and service users a chance to voice their views. Such views are not necessarily used in the decision-making process. As Ellins (2012:200)

notes, although some movement has been made towards patient-centered care, the NHS still has a very ‘paternalistic’ approach to service users. A study looking at patient engagement in GP practices suggests that only 40% of surgeries support patient participation groups, and only for as long as patients are not too critical (Parsons et al. 2010).

Skidmore, Bound and Lownsborough (2006) suggest that health services tend to select with whom they work from within the community. Statutory agencies tend to work with elites, for example the leaders of community and religious organizations. The authors note that once an individual member of the public engages in consultation with one service, they are more likely to be approached by another service and asked for their opinion. This process of selection excludes those with less power in the community, for example women and minority groups. As a result, the needs of such groups are not represented. It is suggested that only a small percentage of the public may want to engage with service initiatives (Skidmore, Bound and Lownsborough 2006). If this is the case, then those members of the public who do work with statutory services should, from a democratic perspective, represent the wishes of their whole community.

The Ladder of Citizen Participation (Arnstein 1969) (Appendix 2: Arnstein’s Ladder of Citizen Participation), which was initially used to describe citizens’ participation in the planning process of the built environment, has also been used to describe engagement and public health (Ashton and Seymour 1988).

Arnstein's eight stage ladder of citizen participation has at its base 'manipulation', whereby there is no real participation; rather, individuals are advised. At level four of Arnstein's ladder is 'consultation'. The public are asked their opinions at this level, but there are no assurances that these will be taken into account, therefore participation at level four is still tokenistic. It is only in the top three stages or rungs of Arnstein's ladder where citizens have meaningful participation: when they work in partnership with statutory organizations, when power is delegated to them or where they take full control (Arnstein 1969). As health organizations typically engage with communities towards the lower end of Arnstein's scale, they do not give any power to communities, rather they retain power.

Rodgers (2005) explains how consultation with communities often works in practice. Rodgers cites an example of where the Scottish Government, keen to reduce inequalities, consulted a community that suffered from high levels of social deprivation. Attendance at public consultation meetings was poor; however, those members of the community who attended believed that a provision of baby massage support would be beneficial to them. Because there was little evidence to support the health benefits of baby massage, the service was not provided. The views of the community members who engaged with the consultation were not acted upon, and community members were not empowered (Rodgers 2005).

In a parallel to the recommendations made by Wanless (2002, 2004) suggesting that individuals should become engaged with their own health and health services, the Australian Health Service looked to engage with consumers (patients and clients) to

promote positive health (Gregory 2008). Australian reports acknowledged that health service providers needed to become more sensitive to the needs of those consumers to facilitate that engagement (Gregory 2008).

Kramer picks up this theme, i.e. that the patient or client is a customer, when discussing the introduction and implementation of 'World Class Commissioning' (Great Britain, Department of Health 2007a, Kramer 2008). World Class Commissioning aimed to engage individuals and communities in the decisions made about the commissioning of local health services (Great Britain, Department of Health 2007a, Kramer 2008). This required commissioners to engage with local people in a meaningful way. Kramer suggested that successful community engagement in the commissioning process could benefit health care delivery in two ways: in the first instance, commissioners would have a better understanding of the health needs and requirements of the local population, and secondly, by providing services suited to the local communities, 'customers' would be more likely to engage with the services provided (Kramer 2008).

Skidmore Bound and Lownsborough (2006) suggest that statutory services should work with existing community structures in a way that is acceptable to the community concerned. To do this, commissioners and professionals need a better understanding of the structure and complexities of communities. As Hills (2004) notes, communities should not be seen as a 'thing' or an 'entity', but should be recognised as being complex, and having 'shifting power relations' (Hills 2004:90). Statutory services do need to change their approach to community engagement and empowerment, as it is only when communities and individuals

have the opportunities and power to change their lives that improvements in their health and wellbeing can take place (Ashton and Seymour 1988).

Community Engagement, Community Development and Building Community Capacity(3.16).

Community development grew from the middle class philanthropic movement of the Victorian age that was designed to help the poor (Ledwith 2005, Mackereth 2006). By the 1950's there was an understanding that it was important for communities to initiate and be proactive in the process, or at least be helped to help themselves (Mackereth 2006).

Community development, like health visiting, had a golden age in the 1960's and 70's. The development of civil rights and the women's liberation movement reflected societies' developing dissatisfaction at inequality and injustice in society. The work of Paulo Freire challenged the status quo and encouraged ordinary people, through education and critical thinking, to examine their situation, and then take action to improve it (Mackereth 2006).

A Labour Government developed Community Development Projects as a response to social unrest at the end of the 1960's (Ledwith 2005). Community workers were in a difficult position; they encouraged communities to challenge government services, yet they were employed by the state (Ledwith 2005). Ledwith notes that community development can be viewed from two perspectives: the pluralist agenda, which suggests that due to the different power bases in society only small changes are possible, and the radical perspective that aims to improve social justice (Ledwith 2005). Henderson (2007) suggests a model of

‘community practice’, whereby a community practitioner stimulates change by promoting community action and active citizenship. Critical community practice, based on critical theory, aims to empower disadvantaged groups and enhance social justice (Butcher 2007). Hills (2008), with reference to the work of Scott and Weston (1998), suggests that when community development seeks to empower communities, a radical or political model seeks to address ‘equality, justice and human rights’ through changes to health policy. It is suggested, therefore, that communities should not be passive because to bring about change, they must use their power.

Power (3.17).

Morriss (2006) distinguishes between ‘power to’ and ‘power over’. ‘Power to’ is an ability or capacity to affect outcomes, whereas ‘power over’ is a relationship in which A has power over B (Morriss 2006).

Lukes’ (2005) theory of power concentrates on ‘power over’ and consists of three different dimensions or views of power. In a one-dimensional view of power, A has power over B to the point where A can influence B to do something that they would not have otherwise done. This involves a conflict of interest, as B is persuaded to do something that they would rather not do.

In the two-dimensional view of power, A ‘gives’ B apparent choice, giving an impression that B is involved in the decision-making process. However, in the two-dimensional view A

determines and limits the choices that B has. Lukes (2005:111) refers to this as ‘agenda control’. B can only make a choice within the limitations that A has set, limitations that do not threaten the power of A. An example of this would be for A, the doctor, to offer B, the patient, a choice of three hospitals in which they could have an identical operation, in contrast to asking the patient what kind of treatment they would like or where in Europe they would like to have such treatment. In the two-dimensional view described by Lukes (2005), B is unable to make a free choice regarding their care, rather A dictates the choices. In this two-dimensional view of power, A retains power but gives the impression that B has choices, and by doing so reduces the risk of conflict. The two-dimensional view of power can be related to the current choice agenda in the NHS where choice is limited (Robertson and Thorlby 2008). In the two-dimensional view, A creates barriers and limits the expectations of B.

Lukes’ third dimension of power acknowledges factors that influence choice, noting that only when the public has a range of information is it able to make meaningful decisions (Lukes 2005, Dyson and Brown 2006). This does not mean that people are able to make any decision that they would like, as there are still limitations and barriers, but at least they are aware of the factors that influence the choices that they make.

Morriss (2002) and Butcher (2007) distinguish ‘power over’ from ‘power with’ with regards to community empowerment. ‘Power over’ suggests domination backed by authority. ‘Power with’ is about conflict resolution so that shared goals can be achieved. It involves dialogue so that both parties have a better understanding of the other’s way of

seeing things. The consequence of ‘power with’ is for both parties to move forward and initiate change.

Morriss (2002), in a critique of Lukes, suggests that if people are powerless because they live in a particular society where they do not have power, it is society which is wrong and should change, not the people who have power. This has implications for community engagement and contemporary public health as to obtain equality of health, equality of power and opportunity within society is required.

It seems unlikely that any government in office would promote destabilization of the status quo, yet the empowerment of communities does offer opportunities including improvements in health and wellbeing, democratic renewal and the development of a civil society (Powell and Geoghegan 2004, Collins 2004, NICE 2008, Eversole 2011). Community empowerment, as noted above, can result in the enhancement or even replacement of some statutory services.

Research questions resulting from the literature review (3.18).

‘Community Engagement to Improve Health’ (NICE 2008) noted that there were substantial gaps in the evidence linking community engagement to long- term health goals. In particular, which components or level of community engagement was most effective, how community engagement improved health and what was the perspective of participants, community members, on community engagement. NICE (2008) recommended that further

research was required into community engagement in the following areas: the development of robust research to look at the effect of community engagement on health: evaluation of area based initiatives to look at addressing the wider determinants of health: and more research to gain an understanding of community members' experience of community engagement. The last of these was the basis of this study. Despite wide- ranging recommendations for further research suggested in the document 'Community Engagement to Improve Health' (NICE 2008), a review of the literature raised further questions.

Firstly the review highlighted the lack of consensus about what was meant by community, particularly from community members perspectives. In contemporary society individuals chose to join communities, these choices being based on location or interest (Bauman 2000, Blackshaw 2010). The lack of clarity of the concept of community led me to ask question of recipients about how they viewed 'their' community. In addition, I was curious to find out what motivated people to give up their time to support their community.

There was substantial evidence in the literature that there were benefits to the individual as a result of community participation, in particular benefits to health. What was less apparent was how this process worked, particularly as the evidence was substantially gained through quantitative methods. How community engagement promotes health from the participants perspective was not in the design of this study, however insights into this question were obtained.

Barriers to community engagement was a theme in the literature from the United Kingdom and Australia. Barriers can occur due to factors within the community; however the literature suggested that most barriers to community engagement are as a result of government and professional bodies. There appears to be a reluctance to share power with communities and members of the public, yet without such power, civil society will have difficulty reaching a situation where communities are self- sustaining in the promotion of the health and well-being of members. Insights into the professional's perspective of community engagement and professional views on the threats and opportunities community engagement offers are vital if there is to be a mind-shift amongst professionals to a position where they positively encourage proactive community membership and, as a result of community engagement, the promotion of public health. However, asking questions of health care professionals was not within the remit of this study, because this study is based on the perspective of community members.

Swainston and Summerbell (2008), in their rapid review of the literature supporting the effectiveness of community engagement on health promotion, noted that the projects they reviewed had different aims and design making generalization difficult. However, the literature suggests that communities are different. A further question for the researcher is, therefore: how is it possible to gain information from one project to inform future projects and policy development?

A constant theme resulting from the literature search into public health suggested that equality in society is required to make real public health improvements. There was less

literature to indicate how inequality was played out at a local level from the participant's point of view. Although this was not a question I asked of participants, their comments and discussions did reveal how inequality of power was acted out in the local community.

The literature provided a range of perspectives about community engagement. While government documents looked at community engagement from a top-down perspective, literature generated by the Third Sector, together with case studies, provided a different view. While health benefits appear to be promoted through communities engaging with each other, the literature suggests that the best health can be obtained when both civil societies and the state work together. A final question remains, therefore, how statutory agencies, and health visitors in particular, can engage with communities and help communities engage with each other?

Conclusion (3.19).

This chapter has reviewed some of the literature which indicates that to progress public health there needs to be action beyond statutory health and welfare services. Governments globally have looked to engage with individuals and communities so that they are more involved in service provision, make better use of services and are more responsible for enhancing their health. Evidence suggests that engagement within communities, particularly where there are high levels of Social Capital, provides health benefits. Governments have increasingly looked to communities to provide support for the individual as the provision of services through the public sector declines. Efforts to enhance

community engagement have met with obstacles, as the culture of health services and health professionals is to retain rather than to relinquish power.

There are different perspectives of community development. One view of community development is that only small changes can be made due to the power structures within society. At the opposite end of this spectrum is that community development needs to challenge the holders of power to bring about change. The following chapter looks at the theoretical perspective and methodologies that define the critical perspective, a perspective that supports radical change.

METHODOLOGY (4)

Introduction (4.1)

Previous chapters have demonstrated how political and professional power has determined the shape of health care, and limited the development of public health and community engagement. This chapter will look at the theories and methods that can inform how this position may be changed, in the light of the Health Visitor Implementation Plan that calls for health visitors to engage with communities and promote public health (Great Britain, Department of Health 2011a).

The chapter considers a critical perspective, and in particular critical theory. The main objective of critical theory is to critically examine power relationships within societies and, through the development of an alternative vision, bring about change. A number of theorists and perspectives will be examined to explore the critical approach and its potential. The work of Marx, Habermas, Foucault, Durkheim and Tocqueville will be explored and contrasted in relation to their theories of power, community and the public and civil spheres of community life.

This critical perspective questions the authority of knowledge created and promoted by elites. In the last two decades, such knowledge has frequently been as a result of a positivistic and scientific approach that has looked to discovering an objective truth (Crotty 1998). As Crotty (1998:16) notes, scientific knowledge 'is just a particular form of

constructed knowledge designed to serve a particular purpose.’ This thesis looks towards a naturalistic approach that acknowledges that there is not one, but many truths and realities.

From the critical theorist perspective, there is a precedent for knowledge to be generated and owned by the public rather than by elites. While Marcuse was critical of the way positivism dominated knowledge and understanding in society, Habermas criticised the use of a positivist approach when looking at social sciences, suggesting that such an approach only produced facts rather than values or meanings (Lessnoff 1999). Pawson (2006) reflected this view when suggesting that taking a positivistic approach reduced the richness and diversity of the findings to simplistic outcomes.

Understanding and meaning in this study has been created through the use of an ethnographic approach. Rather than a passive study, a critical ethnographic approach has been adopted. The critical approach has not been used to change the consciousness of the subjects studied, but rather, by gaining an understanding of their world view, the study aims to inform and change the way that health visitors practice. In particular, the study aims to inform the way in which health visitors develop relationships and work with communities.

Critical Theory (4.2).

A critical approach has helped to explain some of the phenomena encountered on the study, in particular, the power and influence of health care professionals who have dominated

health care, and the position of volunteers within an organisation who have little power (Illich 1974).

The critical approach is characterised by a range of ideals. It focuses on power relationships within societies and looks at how these are perpetuated. In particular, it addresses the inequalities of power. Power is often in the hands of those with wealth and information. By controlling information and knowledge, elites can retain power. The knowledge of elites, including the medical profession, has generally been generated through a positivistic, scientific method which promotes the discovery of one truth. The critical approach is opposed to positivist methods, suggesting that these are not value-free (How 2003).

A critical approach involves a purposeful critique of what *is*, and then looks at what *could be* (How 2003). Critical theory, associated with a range of philosophers centred on the Frankfurt School, aims to promote freedom of thought throughout society, a freedom to think how things 'might be different' (Held 1980: 38). The aim of critical theory is to promote equality and justice, and enable people to free themselves of oppression. This can be achieved as a result of people reflecting on their situation and seeking new realities, new ways in which society can be organised. The critical approach is radical, it encourages change through action.

Critical theory developed from some of the ideas proposed by Marx. Layder (1994) describes how Marx looked to the history of the economic organization of society and

human activity as he believed that the past could predict the future. He suggested a two-class society in which the bourgeoisie had means and resources to produce wealth, while the proletariat only had their labour by which they could earn a living. Marx identified a conflict of interests between the two classes. He proposed that the bourgeoisie aimed to gain the greatest work from the proletariat for the least pay. Marx suggested that this exploitative relationship made workers resentful and alienated them from their work. The proletariat were trapped in their situation by the macro organization of society. He suggested that the proletariat had the ability to break away from this oppressive regime through their social activities at the level of a micro community. Marx proposed that the proletariat should rise up above the situation which society placed them in and take revolutionary action (Layder 1994). He sought a radical transformation of society into one that was more equal.

Critics of Marx suggest that he was too dogmatic and that the two-class society he described does not describe contemporary society today, where status is no longer regulated by wealth alone (Layder 1994, Calhoun et al. 2002). Communist societies have withered while, in contrast, capitalist societies have flourished. The proletariats have become wealthier and less inclined to revolt.

A general criticism of Marx is that his theories were not fully thought through to a rational conclusion (Layder 1994). Despite these criticisms, Marxist critiques of power and oppression remain valuable, particularly in societies where there are inequalities of wealth and health. As with critical theory, Marx looked at how things could be different because

he wanted to bring about change (Crotty 1998). Although critical theory developed from Marxist theories, it moved beyond these during the last century.

Critical theory is associated with the work developed by the Institute of Social Research that was founded in 1923 at the University of Frankfurt. Marcuse, Horkheimer, Habermas and Adorno are some of the leading names in the development of critical theory. They all had differing views and did not associated themselves with a particular movement (Calhoun et al. 2002, How 2003). The Frankfurt School adapted Marxist ideals and encompassed a range of theoretical perspectives. The ideas associated with the Frankfurt School of Thought were often at odds with popular culture.

It is important to position the development of critical theory within the context of the social and political culture of Germany leading up to the Second World War. The political regime was autocratic and restrictive. Many of the academics of the Frankfurt School were Jewish or sympathetic to the Jews (Lessenoff 1999).

The oppressive nature of the pre-war German administration can be illustrated by the activities of the 'medical police' as described by Weindling (1994). During the 1930's, the National Socialist German Workers' (Nazi) Party dismissed Medical Officers of (Public) Health who did not hold right wing party views. The party then enhanced the professional power of those who remained. Laws were introduced that authorised Medical Officers to oversee policies that included sterilization and 'eugenic procedures'. These 'procedures' involved the extermination of the sick together with the isolation of the Jews into ghettos

under the pretext that they presented an infection risk to the rest of the population (Weindling 1994:127). The Schutzstaffel (SS) took this one step further. Under the guise of eradicating lice and typhus, the SS undertook mass murder. Porter suggests that, in effect, Medical Officers of Health 'facilitated the Holocaust' (Weindling 1994: 127). German public health had moved, within a generation, from an innovative movement that recognised the wider determinants of health, to a deadly arm of a political movement (Weindling 1994). Public health was a tool of oppression used to promote power and enforce the ideologies of a political movement.

In the oppressive social and political atmosphere of the time it is unsurprising that critical theorists were dreaming of something better. Many members of the Frankfurt School fled to America at the onset of the Second World War. They again found themselves at odds with a culture, one that prized individual achievement rather than the collective. Marcuse remained in America after the war while Horkheimer and Adorno returned to Frankfurt where they were joined by the 'newcomer' Habermas (Lessnoff 1999, Calhoun et al. 2002).

Although scholars associated with the Frankfurt School had differing views and theories, there were common ideals that linked their work. One such area is the critical theorists' view of the production and generation of knowledge.

The Development of Knowledge and Truth (4.3).

Critical theorists rejected the positivist approach and resulting scientific knowledge, suggesting that information gathered in such a way enhanced the position of elites (Lessnoff 1999). Marcuse suggests that the positivist approach of generating knowledge is used by those in power to recreate their own vision of reality through which they maintain power. Critical theorists suggest that knowledge is used to suppress the proletariat, who are manipulated into a false consciousness. To illustrate this point, Marcuse draws attention to the advertising industry that is designed to convince the population that they need a range of goods (Lessnoff 1999).

Habermas was also opposed to positivism, suggesting that it is 'naïve and politically harmful' (Lessnoff 1999:271). He argued that the positivist approach is not value free, but equally does not take account of values. Rather than focus on the misuse of knowledge by those in power, Habermas looks to the usefulness of knowledge through society. He suggests that knowledge is generated from three distinct areas: instrumental knowledge linked to science, practical knowledge and understanding, and emancipatory knowledge. Emancipatory knowledge looks to critical self-reflection. This process, he suggests, can lead to individual liberation (Calhoun et al. 2002).

Habermas's theory of emancipatory knowledge reflects the work of Paulo Freire (Crotty 1998). Freire held a belief that humans had an affinity with each other and also with their physical environment. He proposed that the oppressed had great potential, and also a

responsibility to shape their world. Freire suggested that as a result of critically reflecting on their situation, and through the use of the individual creative imagination, the oppressed could develop a new view of their world, a new reality. He suggested that such a change would come about through the development of an individual consciousness and a shared learning. Freire's vision was to revolutionise oppressive societies, so that people became free. He advocated not only a political, but also a cultural revolution (Crotty 1998).

Habermas, Community, Civil Society and the State (4.4).

While Marxism describes a two-class society which is in conflict, Habermas acknowledges that humans live in a social world and that they seek to develop mutual understanding, a common ground or reality by which they can conduct everyday life (Crotty 1998, Lessnoff 1999). Although rejecting a Marxist two-class society based on economic principles, Habermas suggest a different dichotomy with one power base in the public sphere, the second in civil society (Habermas 2002a). Rather than the horizontal dichotomy described by Marx, where power is exerted from above, the dichotomy which Habermas suggests is vertical, with an interplay of power between the public sphere and civil society.

Habermas describes the 'public sphere' as the state involving national and local organizations and structures. In contrast, 'civil society' is characterised by a person's private life which includes the relationships between families, social networks and voluntary associations. Habermas has been critical of liberal democracies which he suggests have become increasingly authoritarian. The influence of the public sphere has

become dominant through the support of the mass media. Habermas suggests that capitalism and the state, including the welfare state, have become ever intrusive in the private lives of the citizen, making inroads into their civil, private life. As a result, civil society and community life has been eroded (How 2003).

Habermas recognises the complexity of modern societies and the relationship between the public sphere and civil society. He is not dismissive of the public sphere, suggesting that it has the ability to moderate some of the tension between universalism and individual rights (Habermas 2002a). Equally, he also notes that the civil society has a moderating effect on political power. He proposes that the law can provide the basis for resolving conflict between the public sphere and civil society, providing that citizens recognise that the law provides them with an effective method of conflict resolution. Habermas suggests that citizens will only give the law such legitimacy, and that democracy will thrive, when there is active debate between the public/political sphere and civil society (Calhoun et al. 2002). Like Marx, Habermas believes that theory itself is not enough, but that theory has the purpose of facilitating human action (Crotty 1998).

Tocqueville, Associations and Democracy (4.5)

Habermas reflects some of the ideas proposed by Tocqueville in 1840 on the balance of power between government and civil societies. Tocqueville considered the preponderance of associations in American civil society. He suggested that Americans took action, through the formation of an association. Although associations were wide-ranging in size and scope,

Tocqueville suggested that American action was focused on forming an association, the association being a statement. This is in contrast to forming an association that then takes action. To illustrate his point, Tocqueville notes that the American response to excessive drunkenness in society was to form associations that promoted the abstinence of alcohol. The formation of the association made a statement about the overconsumption of alcohol (Tocqueville 2012). Tocqueville suggested that although the English recognised the collective as a powerful change agent, it was often individuals who brought about change.

Tocqueville proposed that the collective has more power than the individual and also that the collective is a requirement of democratic societies. He suggested that the large associations or collectives can balance power, preventing governments or powerful groups such as the aristocracy from abusing power. In democracies, the collective not only protects the individual by maintaining a balance in power between civil associations and the governments, but also, in so doing protects the rights of all citizens, enhancing equality in society (Tocqueville 2012).

Tocqueville speculated on the role of government, suggesting that as individuals were removed from the production of the necessities of life, they would be less likely to form associations. This would result in the expansion of the role and influence of government. This sentiment is echoed by Habermas who suggests that the public sphere is becoming more dominant, restricting the civil society (Habermas 2002a).

Foucault, the State and Social Control (4.6)

Foucault is associated with structuralism and postmodernism. He rejected Marxism that described a downward pressure on those who have little power, by those above who are powerful (Layder 1994). Foucault suggests that power is exercised at a local level in micro communities, as a result of local personal relationships and networks that both exert power and also control their members (Barrett 1991). Foucault believes that the individual is not independent on his ideas and actions, but is bound and limited as a result of social control. He described the power of the 'gaze', whereby constant watching and surveillance influences the behaviour of individuals. The individual does not act freely, but is controlled and punished as a result of surveillance (Barrett 1991).

Peckover (2002) used Foucault's theory of disciplinary power to explain how health visitors can exert power over their clients, in a role that promoted the ideals of the state. Disciplinary power has been used by a range of organizations from prisons to the health service. It works on the principle that if people believe that they are constantly being watched, they start to adapt and regulate their behaviour (Layder 1999). People act in a way that they believe is acceptable all of the time in case they are watched for some of the time. Peckover noted that the state enabled health visitors to have universal access to infants and the private life of families through, for example, the Notification of Births Act (1907). Through surveillance, health visitors were able to modify the behaviour of clients and promote 'truths', in effect carrying out a policing function for the state.

Foucault and Habermas have different theories of power. While Foucault suggests that democracy is dependent on power relations i.e. the power relations of the micro community, Habermas states that democracy is developed through the political procedure that controls and limits power (Sintomer 1992). Foucault's theory states that power comes from below. He believes that power is an intrinsic motivating force in human relationships. One problem associated with Foucault's theory is that it does not account for collective uprisings (Sintomer 1992). Foucault adapted some of his theories in the 1980's, whereby he acknowledged the relevance of Habermas's work. Foucault distinguished between power relations that are entered into freely and the power of domination. Foucault did not see power within relationships as necessarily being a bad thing, and came to realise that legal and moral rules in society could prevent power relationships from developing into domination (Sintomer 1992).

Durkheim, Community and the Individual (4.7)

Durkheim had an opposing view to Foucault in that he believed that factors in the macro society rather than the micro community influenced individual behaviour. Within a capitalist society, the individual and individual choice is prized, yet humans are fundamentally social beings who form into collectives. Durkheim, when writing about suicide in 1897, like Putnam detected a decline in community life, leading to isolation and despair (Nisbett 1970). Durkheim suggested that the consequence of despair is an increased incidence of suicide. He demonstrated that although suicide appears to be a private individual act, it is collective social factors that generally determine the suicide rate.

Durkheim describes four types of suicide: Egotistical and Altruistic suicides that occur when individuals are not integrated into society, or when social integration throughout society is weak. Anomic suicide occurs when the regulatory powers in society are disrupted; disruption can occur when there is economic decline, but equally if there is economic boom, changing expectations and leading to unease. The final category of suicide described by Durkheim is Fatalistic, when regulation is oppressive and overbearing. If a Marxist view of power can be seen as a horizontal dichotomy, Habermas as a vertical contrasting power relationship and Foucault as micro communities exerting power, Durkheim's theory suggest that the macro community exerts power inwardly on the individual.

Durkheim believed in the collective rather than the individual. He proposed that society collectively produced knowledge and meaning, and that those collective ideas are communicated through a common language. Durkheim suggested that knowledge and truth is a collective creation (Lehmann 1993). This is in contrast to Foucault's idea of 'truth' which he suggested is produced as a result of political and economic forces, through scientific, positivistic approaches, developed in institutions and distributed selectively (Foucault 2002:210). While acknowledging that truth is produced in such a way for the promotion of capitalist elites, Foucault (2002:210) suggests that it is the role of the intellectual to develop an alternative, a 'new politics of truth' whereby truth is produced without the influence of politics and economic influences. He therefore suggests alternative epistemological and theoretical perspectives.

Although this thesis acknowledges the growing trend of individualism fuelled by a capitalist society, the work looks towards critical theory that acknowledges a collective social life. As with a critical approach, critical theory promotes naturalistic methods of the creation of knowledge that acknowledges a range of ‘truths’ and meanings as people make sense of their world within a collective social setting.

Social Construction (4.8)

As this study focuses on the development of the community and the experiences of those within the community, social constructionism was selected as the epistemology by which to view the world and develop meaning.

Constructionism takes the view that knowledge and meaning are created as a result of individuals experiencing the world (Crotty 1989). This perspective does not propose that there is one truth ‘out there’ to be discovered, nor that truth is objective and independent of human existence. Rather, constructionism takes the view that humans engage with the world and, from the perceptions they gain as a result of that encounter, they create meaning. Constructionism sits between objectivism where the ‘truth’ is external to the individual in the world ‘out there’, and subjectivism where meaning comes from the individual’s subjective experiences of the world (Crotty 1998). Social constructionism acknowledges that meanings are constructed ‘between us’ as a result of a social experience.

Kant, who proposed a constructive approach, did not deny the existence of a real world, but that knowledge of the world was limited to the individual's perceptions of it (Moses and Knutsen 2007). Contemporary ideas of social constructionism do not rely on an individual's perceptions alone to create meaning, but suggest that meaning is created within a shared social experience. The construction of meaning within a social context results in perceptions that are coloured by cultural conventions. As meaning is determined in a social setting, such meaning must be contextualised within that social environment.

Critics of social constructionism, which include those on the left and right of politics, point to the lack of one truth as being problematic. The desire for one truth, however, is an objective of positivism, not of constructionism that aims to develop meaning and understanding (Gergen 2001). Gergen does note that social constructionism has been popular with groups 'whose voices had been marginalised by science' ... 'those thwarted by existing authorities of truth' (Gergen 2001: 8). The social construct perspective has facilitated a critique of both power and established knowledge in society. It has promoted new possibilities of understanding, recognizing the validity of multiple realities (Gergen 2001). By giving credibility and authority to many rather than one reality, social justice can be enhanced as each voice is heard.

In keeping with the critical perspective, the methodological approach taken through this work is a critical ethnography. Ethnography and constructionism were selected as they both acknowledge the existence of a collective social life. It is this common social life which is under investigation. Only by understanding the world that people create, together with the

benefits and tensions created within communities, can I start to understand what community engagement is like from the participants' perspective. The study is essentially about the strengths of communities, not about the strengths of professionals. The critical perspective acknowledges the strengths of communities and values their knowledge. The critical approach has been selected because, in keeping with some Marxist principles, it acknowledges inequalities in power and the ability to make decisions between elites and the public, in this instance, professionals and the public. It is only by understanding these power inequalities that it is possible to put the study into context, to understand, for example, the barriers which have been placed (by professionals) on the development of community engagement. Critical ethnography does not just seek to describe communities or inequalities within society; it also seeks to bring about changes.

Ethnography (4.9)

Ethnographical methodology enables the researcher to gain a better understanding of the complexities of relationships within communities. The methodology not only requires the ethnographer to look inwards to the community, but also acknowledges wider theories and issues outside the community group. In an ethnographic study, the researcher becomes, to a greater or lesser extent, a participant within the social scene that is the study site. Equally, participants within the study shape the research.

'Ethnography is concerned with the study of a culture' (Holloway and Todres 2006). It sits within a naturalistic theoretical perspective, rather than the orderly 'hard' science of

positivism. Early ethnographers such as Malinowski attempted to study culture using positivist assumptions, but such an approach has been rejected as members of a culture are seen to be proactive in shaping their world (O'Reilly 2009). The purpose of ethnography is to understand that person's world.

Ethnography also relies, at times, on opportunism and luck (Fetterman 2010). Positivistic scientific criteria do not accommodate ethnographic approaches, as the situation being studied is often transient; the researcher can only capture a moment or period in time (Hammersley 1992). The transient, individual nature of the ethnography means that the study cannot be repeated either at a later date or even by the same ethnographer. This reduces the validity of the findings (Davies, 1999, Robson 1993). Van Maanen (1988:1) states that 'ethnography is a written representation of a culture'. This statement identifies a key element of ethnography that distinguishes it from a positivist perspective, that it is a representation, a view. Van Maanen (1988:7) also states that 'culture' is not a 'scientific object' but is 'created'.

The Historical Background of Ethnography (4.10).

Ethnographic study has evolved over time, reflecting the changes in society and the drivers that shape society. This ethnographic approach grew from anthropology. Early anthropologists spent little time in the field, relying on what people said rather than observe what they did (Van Maanen 1988). However, as the study of anthropology developed, researchers moved into the 'field' so that they could observe the culture of the communities

they studied. The resulting product was a detailed description of what they experienced, highlighting the uniqueness of the culture studied, and a culture that was often distinct from that of the anthropologist. Brunt (2001) suggests that few pristine or untouched communities survive today as people trade and work outside the 'tribe', therefore injecting a range of cultural influences. Early ethnography was based upon observation, although Hammersley (1992) suggests that the facts produced from such studies were not neutral as the researcher had their own perceptions, or lens, that coloured what (s)he saw.

The method of ethnography was developed in Chicago University between the late 19th to mid 20th Century, building the University's focus on developing sociology and social studies (Deegan 2001). The work was led by Burgess and Park, who promoted researchers who were open to people. Rather than visit remote Pacific islands, as for example Mead did in the 1920's and 30's, the researchers, often Doctorate students of the University, studied communities in their locality. Students were encouraged to collect a range of data, enabling them to use triangulation to check the reliability of the information. The focus of the studies looked at the social process of communities (Deegan 2001). The ethnographic studies produced from the 'Chicago School' included work focused on 'outsiders', in the context that they were people who were geographical residents of Chicago but socially different or deviant, rather than coming from outside the city (Deegan 2001, Foley 2002).

Early ethnography used mixed methods, including statistical data, and a systematic approach (Holloway and Todres 2006). Park, however, proposed that the studies should just report the facts as they were seen, suggesting that the studies should speak for themselves.

This approach was later criticised, proposing that without analysis the studies had little meaning (Blackshaw 2010). Blackshaw (2010) also notes that the work produced by the Chicago School was often pessimistic, suggesting that urbanisation had resulted in a breakdown of social attachments.

Emic and Etic (4.11).

Ethnography aims to portray the perspective of participants. Researchers have to get close to participants to understand their viewpoint, their view of the world, but not so close that only the participant's view can be seen. The participant's, or insider's, view that ethnographers pursue is the emic (Fetterman 2010). Ethnographic studies also contain the etic, the outsider's view. Ethnographers have to incorporate the emic and the etic in their final report of the study, not only reflecting ideas from their observations and experiences, but also relating this to the bigger picture, including economic forces, together with general theories (How 2003, Holloway and Todres 2006, Fetterman 2010). This study looks to both the emic and the etic, presenting a world view of those involved in community engagement, but also contextualizing their experiences within a wider social and economic context.

Ethnography Process and Product (4.12).

Ethnography is often described as a process and a product, the process being data collection and analysis, and the product being the written documentation of the process. It is difficult to separate data collection and analysis as the two are entwined. Ethnography is also an

ethos or perspective, a way of looking and thinking. Each ethnographic study is unique as the product results from the reaction of the researcher to the participants, further filtered and coloured by the researcher themselves. Bennet (2012) proposes that the nature of the ethnographic study is explorative, and as each study is determined by its perspective and context, the only way to approach an ethnological study is to do it and then explain the process used. To have any credibility, the product of the ethnographic research must be open and honest. For the study to be trustworthy, the researcher must say who they are, and justify their product. It is only through this transparency and honesty that the reader can understand the completed product, by understanding how it was created and where it is coming from.

The ethnographic story is written by the researcher, but it is not purely a description of what they see, rather the researcher is an active participant in the story that (s)he tells, both as a player and narrator. Although about the culture, the product of an ethnographic study is based on what the researcher sees, hears, and perceives. As Crotty (1998) notes, reality is developed and constructed within a social context. The story is not of one 'truth', as the researcher works in an environment of multiple realities (Geertz 1975); it is a story that (s)he tells about what (s)he perceives these realities to be.

A technique associated with ethnographic research is the production of 'thick description' that combines data collection and analysis. Thick descriptions are provided by the researcher writing detailed daily or weekly notes as a result of being in the field (Holloway and Todres 2006). The researcher can focus on events that illuminate a situation, for

example a facial expression. Although described as ‘thick description’, the notes made by ethnographers do more than describe events; they also include the researcher’s thoughts and feelings that become part of the data. Thick descriptions are usually only seen by the researcher, but as the study progresses, extracts and examples are used to support developing explanations and theories. Van Maanen (2002) splits facts and theories into first and second order concepts. Where first order concepts are facts gained from fieldwork observations, second order concepts are theories that are produced by the researcher as a result of conceptualizing and selecting facts. This study uses thick description, using vignettes to illustrate situations observed in the field, then developing explanations and theories around these. An example of this is ‘The battle of the buns’, when an observed situation is developed into an overarching theory about the differences between two cultures.

Geertz (1975) separates thick descriptions out from the activities and procedures of ethnographic research, such as keeping a diary. Thick descriptions, according to Geertz, are about thinking, and are the essence of ‘doing ethnography’ (Geertz 1975: 6). Thick descriptions are not descriptions of what is seen, but are the thoughts and interpretations of the researcher following an observation. Geertz illustrates why just the description of an observation is not enough when, for example, making the distinction between a blink of an eye and a wink. The blink of one eye and a wink are the same movement, however the researcher has to recognise and understand the significance of the wink as opposed to the blink. The thick description is therefore the writing of the researcher who has selected, contextualised and theorised what they have seen (Madden 2010). I draw on the work of

Geertz in this study, and not just describe but also select and put into context what I observed. Therefore thick descriptions, my interpretations and thoughts of what I observed have helped me to develop theories.

Thick descriptions help the researcher to select and analyse observations and extract meaning. They help the researcher to reflect on their own world view and a developing view about participants' perspectives.

To carry out an ethnography, the researcher needs to observe, record and analyse what they have seen, contextualise this within a social setting, then think and write. It is this combination of thinking and writing that produces the final product, the ethnography (Humphreys and Watson 2009).

Critical Ethnography; a Health Visiting Perspective (4.13).

As a health visitor using ethnography and a critical theory perspective, I looked towards a critical ethnography approach. Thomas states that 'the conventional ethnographer describes what is; the critical ethnographer asks what could be' (Thomas 1993:4). Thomas (1993) defines critical theory as a theory about a capitalist society, stating that critical ethnography is 'conventional ethnography with a political purpose' (Thomas 1993:4).

Critical ethnographers look at macro cultures, and they study power and control (Holloway and Todres 2006). They focus on injustice in society, and aim to change society to make it

more equal. During the 1960's, for example, critical ethnographers worked with civil rights movements, not only highlighting the situation of those who were oppressed but also by being politically active, which promoted change (Foley 2002).

Critical ethnography denotes a range of activities, and while some critical ethnographers are politically active and, for example, use their research to highlight inequalities and influence policy, others are not (Foley and Valenzuela 2005). Critical ethnographers challenge the status quo, with a view to making changes by, for example, raising awareness (Thomas 1993).

Carspecken refers to critical researchers as 'Criticalists', who 'find contemporary society to be unfair, unequal and both subtly and overtly oppressive for many people.' He continues: 'We do not like it and we want to change it' (Carspecken 1994: 7). Criticalists, note Carspecken, understand the relationship between power and knowledge.

Carspecken (1996) proposes a Five Stage Critical Qualitative Research Method (CQR) when conducting research into and explaining social action. In stages one to three, the criticalist looks at the micro community to find out what is happening in the field. In stages four and five, the researcher contextualises the micro community by looking to the 'macro', sociological and political issues which are affecting the study. By combining the micro and the macro, the criticalist has a better understanding of what is happening, and why. As O'Reilly (2009) notes, critical ethnographers look for the meanings of meanings; they

question the obvious, things which are taken for granted, and connect these to the sources of power and control within society.

While Carspecken proposes that good critical researchers should not be biased, and that they should be open to what they find rather than what they expect to find, critical researcher are not neutral (Kincheloe and McLaren 2005). They have an agenda that is political. They want to analyse power and oppression and to bring about change (O'Reilly 2009). The objective of the critical researcher is to enhance social justice.

Social justice is the aim of health visitors. It is a requirement of their public health role to reduce inequalities in society (Great Britain, Department of Health 2012a). In particular, health visitors have to prove, and produce evidence to demonstrate, that they are actively promoting a reduction in differences in life expectancy between communities by increasing the life expectancy of those in deprived communities (Great Britain, Department of Health 2012a). I propose that health visitors should not just report on what *is*, but develop the critical perspective, looking at what *could be*, and that there should be more equality in society. My stance, therefore, is that health visitors should become more proactive in promoting social justice.

Conclusion (4.14).

This chapter has explored the conceptual background of the study, including social constructionism and the critical approach. Both have been selected in an attempt to understand and challenge current health care practices and promote equality and public

health through community engagement. To bring about change, it is necessary to understand the power and oppression between different groups and look at how power ratios can be changed.

The next chapter looks at the methods used to conduct the study and some of the challenges posed, particularly the expectations of the researcher and those of participants, together with the ethical considerations of carrying out a critical ethnographic study.

METHODS (5)

Introduction (5.1)

While retaining the methodological stance detailed in the previous chapter, this chapter looks at the selection and use of techniques that enable the collection and analysis of data in a naturalistic study. The chapter looks at how these methods were used in the study site as the work progressed from a theoretical research proposal to engagement with participants within the selected community. The chapter considers the participants involved in the study and the data collection, including interviews and participant observation. This is followed by data analysis and how issues were identified and themes developed. Finally the chapter considers some of the particular ethical issues that critical ethnography poses.

Participants (5.2).

The sample was taken from one study site. The study site was a Healthy Living Centre, the Orange Centre*¹, one of several initiatives developed by the Melbrook Development Trust* (MDT), a social enterprise. The MDT was set up in collaboration with local inhabitants to develop the economic base of Melbrook* village.

The main study sample comprised 5 of the 7 volunteers who regularly supported the Orange Centre, volunteering on average for one day per week. The volunteers who supported the study were key informants as they were actively engaged in supporting

¹ All names have been changed for the purpose of this study

their community. Key informants can suggest who to interview and offer insight. Fetterman (2010) suggests that it takes time to identify key informants; however, in this study volunteers were quickly identified as key informants as they were involved in the process of community engagement.

All the volunteers who participated in the study were given pseudonyms beginning with V: Viv, Vicky, Vera, Violet, Victor. The volunteers participated in recorded interviews between one to two times. In addition, some conversations that were not recorded also contributed to the data and are embedded in the thick descriptions.

Additional participants were recruited to supplement the information given by volunteers. These participants consisted of two distinct groups. One group consisted of two managers of the Melbrook Development Trust, Sally and Steve. The second group that provided supplementary information were members of a craft group that met at the Orange Centre. The members of the craft group were not interviewed individually but contributed to a group interview on two occasions. The two craft group interviews were conducted as members busied themselves with their craft activities. Six individuals from the craft group interviews have been identified from the audio recordings, although the remaining members (5-6) could not be identified due to the number of conversations taking place between group members during the interviews. The individual craft members that were identified from the audio recording have been allocated a name commencing with C, e.g. Clara. Connie, a member of the craft group, did not contribute to the recording but has been identified by a range of participants making reference to her.

Data Collection (5.3).

A feature of ethnographic studies is fieldwork, where the researcher spends time at the site with the community upon which the study is based. The researcher participates in community activities to a greater or lesser extent as a way of gaining access to the data. Ethnography involves being with people in the same social space and participating in their lives (Davies 1999, Madden 2010). This involves participating in their activities and observing them, with the aim of obtaining insights into their actions and their views of the world (Fetterman 2010). Van Maanen (1988) suggests that while in the field, researchers ‘learn to move among strangers while holding themselves in readiness for episodes of embarrassment, affection, partial or vague revelation, deceit, confusion, isolation, warmth, adventure, concealment, pleasure, surprise’ (Van Maanen 1988:2).

Although I did not knowingly experience deceit or concealment, I can recognise all the other episodes described by Van Maanen, together with adding some of my own. I would add ‘panic’ and ‘therapy’. On my initial, pre-data collection visit to the Orange Centre I experienced delight when not only did volunteers understand the concept and benefits of community engagement, they were also willing to take part in the study. On my next two visits to the Orange Centre I felt panic and isolation as participants were reluctant to engage in the study in the way I had determined. When I think about this in retrospect, I was using a top-down approach, trying to impose my agenda on participants, in a similar way to a health visitor having an agenda when visiting clients. As I continued to visit the Centre, I started to understand the culture of the volunteers and adapt to the community I was

moving amongst. Pleasure, warmth and surprise replaced my unease. I was never a volunteer, but I was accepted. Towards the end of the study I started to feel the therapeutic benefits of sharing, of sitting and chatting in a culture and community that I had started to understand. The change in my perspective from one that was initially top-down to one where I was led by participants has helped me to understand how health visiting practice must change if it is going to engage with clients on their terms.

The time required in fieldwork is sometimes a limitation of the ethnographic approach, as traditionally ethnographers spend six months to several years living in a community (Fetterman 2010, O’Reilly 2009). Yodanis (2006), for example, spent most mornings for five months in a local coffee shop, and returned the following summer, when conducting her study that looked at the effect of class on a micro community. Such time-intensive studies are not always possible within the constraints of funded projects (Fetterman 2010).

Enough time is needed to become immersed in the culture to gain the richness of that culture. In addition, the researcher needs to become accepted and taken for granted so that their presence does not alter the social relationships within the setting (O’Reilly 2009).

When limited time is spent in the field, then particular aspects of the community experiences can be selected (O’Reilly 2009). Fetterman (2010) suggests that when only a limited length of time is available for a study then ethnographic techniques can be used, but he suggests that the study cannot be classed as an ethnographic study.

Van Maanen (2002) questions the notion about the length of time that researchers must spend in the field, suggesting that lengthy fieldwork is a 'risky' strategy producing a lot of data that is not necessarily useful (Van Maanen 2002:102). The approach Van Maanen suggests is fieldwork that looks at the facts that are present, suggesting that most facts are already known in the field and are not waiting to be 'discovered' by the researcher. Facts that the researcher gathers, therefore, are commonplace and in the everyday life of the people in the communities being studied (Rapley 2004). It is for the researcher to identify the characteristics of a community, and to go further than simply describing them, but to ask how and why.

As Geertz suggests, the 'trick' of fieldwork is, by observing what the 'natives' say and do, 'to figure out what the devil they think they are up to' (Geertz 1974: 29). Geertz also suggests that the researcher cannot completely experience things from the 'native's' point of view. However, with reference to Malinowski, Geertz suggests that the researcher does not have to be a native to recognise one (Geertz 1974). In later work Geertz argues for a focused and theoretically powerful ethnographic study, proposing a need to gain the 'concept' of a culture rather than the 'complex whole' (Geertz 2004:4). The length of time in the field is, therefore, not the measure by which to assess the quality of an ethnographic study.

My time in the field was relatively short compared to traditional ethnographic studies. I was constrained by the length of time that I had to collect data, together with the length and

frequency of visits. I was not in a position to visit the study site daily, but visited for one to two hours every couple of weeks over a four month period.

I do not doubt that if I had spent longer in the field then I would have gained more information, however as Van Maanen (2002) notes, you can have too much data. The length of the study did give me an insight into the world of those participating in community engagement. I was not there to discover new information. As I identified on my first visit to the Orange Centre, volunteers knew about community engagement, they were actively engaged in the process. It was for me to try to understand their world and apply this to changing the working practices of health visitors.

Given the transient nature of ethnographic study, and the rate of change in health care policy, long ethnographic studies are not always possible or desirable. This is an exploratory study aimed at gaining an understanding of community engagement from the perspective of participants, not to gain the ‘complex whole’ of one particular culture.

Participant Observation (5.4).

Ethnographers collect data through participant observation. O’Reilly (2009) suggests that the term ‘participant observation’ is a contradiction in terms because the researcher wants to be involved and accepted, while at the same time watching and asking questions that are not normally asked.

Hardcastle, Usher and Holmes (2006), who applied Carspecken's five stage CQR model of critical ethnography, suggested that the researcher cannot be completely passive as their presence in the field alters the situation. In addition, they found that when the researcher had a passive role, this inhibited the engagement of participants in the research process. Madden (2010) suggests that the researcher is not a passive observer, but is constantly selecting, contextualizing and linking information.

Davies (1999) proposes that participation and observation are two separate activities, as it appears that there are risks associated where researchers are participants or observers rather than developing roles which combine the two (Gold 1958).

Participation is a way of 'facilitating observation' and 'enabling meaningful discussion with informants' (Davies 1999). However, there is a concern for ethnographers who go 'native' and become so immersed in the culture that they only see the emic and not the etic (Fetterman 2010, Madden 2010). As Madden (2010) notes, ethnographers who become too immersed stop asking questions of the culture.

Gold (1958) suggests four theoretical positions for the researcher who is involved in fieldwork. The four positions span across a range, from participant at one end of the spectrum to observer at the other. The researcher who is a participant risks losing their own identity as they take on a new role, while the complete observer role is seldom deployed. I developed a role that was nearest to that described by Gold as 'observer as participant' (Gold 1958:221), involving more observing than participating. This role presents little risk

of 'going native', but it may not allow me to form a close enough relationship with participants to fully understand their world view, resulting in the possibility of misunderstanding and misrepresentation.

Volunteers made it clear from my second visit that I was not a volunteer. My role as an observer was determined by the volunteers who wanted me to see what they did.

Davis (1999) suggests that the level of participation is not a criterion for judging the success of a study, while Madden (2010) maintains that the researcher must retain some distance from participants in order to be able to tell the (ethnographic) story.

Chance (5.5).

The collection of data is not always planned in the ethnographic study, but involves some amount of chance. Van Maanen (1988) states that 'Accidents and happenstance shapes fieldworker's studies as much as planning and foresight' (Van Maanen 1988:2). Fetterman mirrors this statement and states that sometimes the research process is chaotic and depends on 'serendipity, being in the right place at the right time or the wrong time, a lot of hard work and old-fashioned luck' (Fetterman 2010:2). It was during a chance encounter that I observed a situation that gave me more insight into tensions between volunteers and managers of the Melbrook Development Trust, for example, a situation that is described in the chapter on 'Conflict'.

Interviews(5.6).

Interviewing is a key feature of data collection in ethnographic studies. Fetterman (2010) suggests that it does not matter if these are structured or unstructured; the researcher focuses on their research goals. I used unstructured interviews when interviewing volunteers and craft group members. In subsequent interviews, I clarified some of the topics raised by volunteers and craft group members on previous interviews. Semi-structured interviews were used when I interviewed Sally and Steve, managers of the Melbrook Development Trust. These interviews were used to clarify details about the development of the volunteers group at the Orange Centre and the creation of the Melbrook Development Trust (Appendix 3).

Unstructured interviews are more commonly used in ethnographic studies as they provide more detailed information which subsequently leads to the development of meaning. Questions are often targeted at a participant's actions, experiences, relationships and feelings (Holloway and Todres 2006). When unstructured interviews are used, the researcher must always make it clear that information provided by participants could be included in the research project. It was clear to participants that their contribution could be used in the research project as I asked their permission to record the interviews and use the information I collected. All interviews were digitally recorded and transcribed. Informal discussions were not digitally recorded but were recorded in field notes and reflections.

Table A: Frequency of Unstructured Interviews with Volunteers.

Volunteers were interviewed on an individual basis within the café area of the Orange Centre.

Volunteer	Number of times interviewed
Viv	1
Vicky	2
Vera	1
Violet	2
Victor	2

Table B: Frequency of Semi-Structured Interviews with Sally and Steve

Sally and Steve were interviewed individually at the offices of the Melbrook Development Trust

Manager	Number of times interviewed
Sally	1
Steve	1

Table C: Frequency of Unstructured Interviews with Craft Group Members

A group interview that was conducted in the café area of the Orange Centre whilst the groups were generally chatting and carrying out their craft activities.

Craft group members	Number of times interviewed
The group of craft group members (Number 10-11)	2

Interviews lasted between 20 minutes to over an hour. The interviews with Vicky were the longest, while Vera preferred a shorter interview. Volunteers were generally averse to long formal interviews, but instead suggested short interviews that fitted into their work patterns. As Robson (1993) notes, it is the role of the researcher to negotiate with participants to find the level and type of participation that they feel comfortable with, and generally fitting-in with their circumstances to cause the least disruption to their lives.

As the study progressed, formal interviews with volunteers were replaced by informal discussions. These were not always directly linked to the role of the volunteers or to community engagement, but formed a background to the study. Discussions and observations were documented in field notes and contributed to thick descriptions which became part of the data that was analysed.

The researcher role changed through the period of the study from formal interviewer to casual user of the study site. During this period there was a change from asking for information, to participants volunteering their time and conversation. As Davies (1999) notes, even in casual conversations the researcher is often directing conversations around the questions they want to ask. Hammersley and Atkinson (2007) suggest that it is difficult to distinguish between interviewing and conversation. I found that the distinction between the two narrowed. It is important in ethnography to build a relationship with participants to facilitate data collection (Hammersey and Atkinson 2007).

Data was also collected from a craft group who used the café at the study site where they met each week. When I asked the group if they would like to participate in the study, the craft group assented immediately and asked me to join them. I set up the digital recorder but did not have time to prepare for the interview, rather grasping the opportunity. I asked questions about the formation and function of the craft group. The subsequent recording was confused due to multiple conversations taking place around the table where the group congregated to engage in craft activities. The data was subsequently documented and key points highlighted. Although the data was presented to each craft group member the following week as a paper document in an attempt to verify the data, participants preferred that the document be read out as they conducted their craft activities. Group members verified all the data and added extra information to expand the issues that had been raised the previous week. What appeared to be simple and innocuous questions, around for example the destination of the knitted products they created, initiated personal disclosures from some members.

Grills (1998) suggests that fieldwork is often uncomfortable for both the researcher and the participants, as they ask questions of the participants' world that are not often asked. Rather than creating discomfort, the questions that were raised offered an opportunity for two members to discuss their varied experience of infant death. Asking questions did allow individuals to share information and allowed their voice to be heard. The craft group provided a valuable insight into the role and status of the volunteers, which differed from that of the craft group.

Sally and Steve, two managers of the Melbrook Development Trust, were interviewed individually at their offices, half a mile away from the Orange Centre. Semi-structured interviews were conducted (Appendix 3: Interview schedule). Sally and Steve provided information about the development of the MDT which contextualised the study site within the community, together with the economic and social dynamics of the area.

Hammersley and Atkinson (2007) suggest that interviewing is an important tool in ethnographic research and can illicit information that may be difficult to obtain through other methods. The authors suggest that interviewing alone can limit data collection in ethnographic research, but when combined with participant observations can provide a rich source of data as each technique helps to illuminate the other.

Data Analysis (5.7).

Data analysis in ethnographic studies is continuous, and requires the researcher to interact with the data throughout the study (Roper and Shapira 2000). This provides the opportunity for the researcher to collect more data to clarify and support, or challenge, developing theories.

Two methods were drawn upon to support data analysis: thematic analysis as described by Howitt (2010), and the work of Spradley (1980) who focuses on relationships and conflict within the ethnographic study.

Howitt (2010) suggests that thematic analysis is a relatively easy method to use and produces results that are readily understood. Thematic analysis produces rich descriptions rather than theory, yet can be theoretically- or content- led. Although closely linked to content analysis, the process of thematic analysis swiftly moves to abstract themes. Howitt (2010) suggests that thematic analysis consists of three basic elements: data collection and familiarization, coding, and the identification of themes. Although Howitt breaks down these elements into six steps that start with data collection and end with report writing, these steps reflect the use of thematic analysis which includes going back and rechecking codes and themes and qualifying them with the data.

Spradley's work helped me to consider and identify issues of power and conflict within the study site. Spradley (1980) suggests that when involved in an ethnographic study, the researcher can look at overarching or universal cultural themes. He suggests six themes aimed at helping the ethnographer to understand power and relationships within the study. These themes are: social conflict, types of conflict, contradictory information, informal social control, interpersonal relationships, and problem solving. Spradley expands on each theme; contradictory information, for example, can include the difference between what an individual says and does. The category of problem solving helps to identify cultures by the particular problems a culture faces, and how solutions are sought through the use of culturally-based knowledge. Volunteers in this study faced problems, and they developed their own solutions to overcome them. Power and conflict influences the whole of the current study.

I familiarised myself with the data by reading and re-reading the field notes and interview transcripts. I then looked for issues arising from the data. NVivo helped to initially analyse the data and isolate issues. NVivo was also used to check the data and improve the quality of the analysis, ensuring that all the data was analysed and that the primary data matched the emerging theories (Howitt 2010). The initial issues identified by NVivo are listed below:

Table D. Issues Identified from Initial NVivo Facilitated Analysis

Wellbeing
Social
Friend
Feeling
Helping
Sharing
Community
Family
Board Member
Multi-Volunteer
Time Volunteering
Problems
Volunteering
Business
Volunteering Paid
Work
Conflict
NHS
Enterprise
Local (or not)

In the initial analysis ‘Volunteering’ was the biggest category, having the biggest number of references (56). While volunteers discussed issues about ‘Volunteering’ and ‘Business’ for example, the craft group discussed issues around ‘Friendship’ and ‘Sharing’ (Appendix 9: Issues Identified from Participant Groups).

A second analysis of all the data took place, in which the data was read and re-read to clarify the themes and connections within the data. As I re-read the data, the process moved from the numerical counting of occurrences of issues to looking at relationships and contradictions in the data. Volunteering, although frequently mentioned, did not include the complexities or depth of the data that emerged around community and conflict during the second analysis of the data.

As Van Maanen (2002) notes, data analysis is more than counting the number of times that something happens, it is about selecting and interpreting facts. Exact narrative can be important and may highlight key issues, although if analysis is no more than documenting the frequency of content, meaning is lost to the point that the analysis can be misleading (Pope, Mays and Popay 2007). Fetterman (2010) describes analysis as the way by which the ethnographer finds a way or path through the 'forest of data' to produce theory (Fetterman 2010:93). He suggests that the analysis is a test of the ethnographer's ability to think.

As a result of the analysis of the data, three themes were isolated: Volunteering, Community and Conflict. From each theme, sub-themes were identified that provided explanations and meanings (Diagram 1, Thematic Analysis). In turn, the understanding gained through the development of themes and sub-themes led to the writing of the ethnographic report.

Criticism of thematic analysis includes lack of transparency and rigour and the use of only sections of data when constructing themes. Howitt (2010) suggests the use of criteria to enhance the quality and validity of thematic analysis. The quality criteria suggested by Howitt cover each stage of the analysis and involve analysis of all the data, and cross-checking the final story against the original data. The use of NVivo for initial analysis helped to ensure that all the data was used when identifying initial issues in the data. Subsequent reading and re-reading enabled the linking of issues, and created a deeper understanding of the complexities within community life.

Ethnography and Validity (5.8).

Validity, credibility and trustworthiness can be obtained through naturalistic methods if the researcher demonstrates the transparency of the research process, including details of how decisions are made (Robson 1993). Ethnographic studies can use triangulation to verify data (Fetterman 2010), though rather than verify the facts through a number of sources, the ethnographer can collect data on a number of occasions from the same individual and observe over a period of time to verify the validity of the findings (Lathlean 2006).

An issue regarding the validity of the ethnographic study is, according to Davies, ‘the degree to which ethnographers can know anything other than that which expresses their personal standpoint and experiences’ (Davies 1999:85). The ethnographic study has no value if it is unable to capture the emic, the perspective and the world view of the participants, which will be different from that of the researcher. My world view as a health

care professional was different from that of the volunteers. The different views of health care professionals and patients, for example, have been explored by Purtilo and Haddad (2007) who describe how the views and stories of health care professionals and patients are worlds apart. To try to identify and reconcile how my view may influence my perceptions and interpretation of the data, I turned to reflexivity.

Reflexivity (5.9).

All ethnographers' views and subsequent interpretations are coloured by their previous experiences, their culture, beliefs and desires. The researcher actively creates a reality both in the process of collecting data and also in their subsequent writing. Reflexivity is the researchers' awareness of their perspective, and the way they use it to shape the process and product of their research.

Critical ethnographers have to be particularly clear about how their critical position has an impact on their research, and then make this position clear to the reader. It is only through such transparency that their studies have meaning. Critical ethnographers use reflexivity to achieve this transparency. They are conscious of their perspective, and ask how their position alters the way they see, react, interpret data, and write their study (O' Reilly 2009).

Hertz suggests that reflexivity is a proactive and creative process, describing it as 'an ongoing conversation about experiences while simultaneously living in the moment' (Hertz 1997: viii). Researchers make their perspective clear to the reader by adding their thoughts

and feelings to their narrative (Hertz 1997, Charmaz 2005). If the ethnographer ignores the influence that they have on the study, the end product is flawed as the findings are misrepresented (Fetterman 2010). Bennett (2012) suggests that the use of reflexivity in the ethnographic study helps to demonstrate the complexity of the process.

Critics of the reflexive approach suggest that the resulting ethnographies can be subjective, confessional or autobiographical (Foley 2002). Rather than suggest that these are negative outcomes, Foley acknowledges that ethnographies are to some extent subjective. In addition he notes that by writing about feelings and emotions in a non- academic style, the ethnographer becomes more vulnerable. It is through reflexivity, however, that Foley believes that ethnographers become more objective. The reflexive ethnographer has to step outside of him or herself and examine the situation that they have encountered, their relationships with participants and their resulting emotions, in an objective way (Foley 2002).

As Madden notes, 'reflexivity is not really about 'you the ethnographer'; it's still about them, the participants' (Madden 2010:23). The critical ethnographer's study is about the participants, but their situation is contextualised within the power relationships throughout society.

Foley suggests that by making critical ethnography reflexive it is more readable and accessible to a wider audience. The reflective ethnographer is able to 'tell stories that ordinary people will actually find more believable and useful' and, as a result, make it

easier for 'ordinary people to develop a critical literacy' (Foley 2002:487). The use of reflexivity therefore helps the critical ethnographer to achieve their aims of promoting social justice, by enhancing the distribution of knowledge beyond elitist groups.

Initially I found it very difficult to step outside my health visitor / academic persona and stand back to observe how this affected my observations and thoughts. It made me feel very vulnerable and uncomfortable. Yet it was only by going through this process that I was able to understand the world of the volunteers, the world of people who had previously been beyond my own professional experiences. I had to adopt a different writing style, and discuss feelings rather than facts. It was this process of identification and understanding that gave me an insight not only into the ethnographic study, but also into the relationship between professionals and communities.

The researcher must be able to make their own decisions and judgements, but crucially, be able to explain and defend them. Judgements have to be made in the field regarding ethics and, in particular, the protection of participants and consent.

Ethical Governance (5.10).

Ethical principles and procedures are applied to the research process to protect the individual (World Medical Association 2008). This research project did not involve NHS patients, staff or volunteers, and therefore ethical approval was not required through the NHS Research Ethics Committee (Great Britain, Department of Health 2005b, Economic

and Social Research Council 2005, NHS National Research Ethics Service 2007). Ethical approval was gained from the University Research Ethics Committee (July-September 2009). During the course of the study, when changes in the consent process were required to be made to accommodate participants, an amendment to the process of ensuring consent was sought and agreed by the committee. Written agreement was gained from the host organisation funding the lifestyle centre and supporting the volunteers, allowing the research to take place.

Ethical Dilemmas of Critical Ethnography (5.11).

Ethnographic research presents particular ethical considerations for the ethnographer. Ethical approval has only a small part to play in the safety and wellbeing of participants (Madden 2010). The critical ethnographer cannot rely on the rigid procedures associated with obtaining ethical approval to protect participants, but must constantly, with the aid of ethical principles, make decisions with the aim of ‘doing what is right by one’s participants’ (Madden 2010:89). It is the integrity of the researcher and the quality of the decisions that they make which provides protection of participants (Robson 1993).

There are two particular examples that illustrate how ethical decisions had to be justified during the course of the study. Both of these examples concern the issue of consent. One required amendments to the process by which consent was obtained (NHS National Research Ethics Service 2007); the second was not covered by formal ethical processes, but required decisions by the researcher to ensure that ethical principles were upheld.

The initial research proposal included a two-phase approach to data collection. Phase one centred on a focus group with volunteers. The purpose of the focus group was to encourage participation and explore key themes and issues (Hansen 2006). It was also anticipated that the focus group would provide suggestions for the recruitment of appropriate supporters to the study through a process of 'snowballing' (Low 2007). An information sheet and consent form (Appendix 7: Information Sheet, Appendix 8: Consent Form), together with an invitation to join a focus group, was distributed, through the host organisation, to volunteers (NHS National Research Ethics Service 2007).

Only one volunteer responded to the invitation to take part in a focus group and arrived with a completed consent form on the allotted day. This initial meeting became a one-to-one interview, with a further volunteer, at the request of the participant, sitting and watching. On further discussion with other volunteers they made it clear that they were happy to be involved in the study, but did not want to get involved in paperwork. They were willing to participate but not to sign anything.

An amendment from the University Research Ethics Committee was obtained to allow consent to be gained verbally from participants. Participants were verbally informed of the contents of the information sheet and consent form at the beginning of digitally-recorded interviews, and with the agreement of the participant, ensured that consent to be interviewed was recorded. Four volunteers were willing to be interviewed under these conditions. As Murphy and Dingwell (2001) note, rigid principles and procedures hinder

and de-sensitise the researcher to the ethics and protection of participants, increasing them to risk of harm. In particular, the authors suggest that signed consent forms may jeopardise the confidentiality of participants in a small study or setting as these make participants more identifiable.

One further volunteer was willing to give information informally but did not want to be part of the research project, and a further volunteer declined. Both felt that they had little to offer as the newest volunteer recruits. Both volunteers were information-rich and offered interesting perspectives. The two volunteers who did not consent to participate in the study are not referred to directly, though it is difficult to exclude them from the thoughts and ideas that shaped the project as they were part of the scene that was played out in the field.

The ethnographic researcher has little control over who enters and leaves the area of their study, including who they observe and the background voices that they record (Craig and Cook 2007). While interviewing a participant, a second volunteer joined the conversation. The voice recording ceased and the situation explained. The second volunteer agreed that the information already recorded could be used, and offered further information. In the public space which the study site provided, background conversations and comments were often present on digital recordings. In such situations it is not always possible for the researcher to have the opportunity to request consent, or even to identify the source of the voices. As Murphy and Dingwall note (2001), the ethics of consent in ethnographic research is not as clear as overt and covert, resulting from the fluidity of the research

environment. The authors suggest that it is ‘impractical to seek consent from everyone involved’ (Murphy and Dingwall 2001: 342).

The issue of consent was also raised with a user of the centre who had learning difficulties. This individual, who will be referred to as Connie, attended the centre with a supporter, a worker at the home where she lived. Volunteers made frequent references to Connie who they highlighted as benefiting from attending the study site. Chance conversations between Connie, her supporter and researcher were a common feature of fieldtrips as Connie’s preferred seat was near to the café counter and the tables that volunteers frequented during their breaks. This seating area was strategically useful for discussions with volunteers during their daily routine.

In an early encounter, the supporter suggested that Connie might participate in the research study. As Connie had learning difficulties, her ability to make informed decisions had to be considered (Great Britain, Department of Health 2005b). During fieldtrips to the study site Connie was observed making choices, for example, selecting the food that she purchased, therefore the principle that Connie had the capacity to give consent was followed (Great Britain Department of Health 2001b, Great Britain 2005).

In response to the invitation to participate in the study, Connie shook her head vigorously, indicating that she did not want to be involved. The invitation was not pursued as Connie had made an informed decision. The supporter of Connie offered to participate in the study. This may have presented an opportunity to gain information about Connie. However, as

Connie had indicated that she did not want to be interviewed, the offer of participation made by Connie's supporter was not followed up and Connie's decision was respected.

In retrospect, Connie could have been provided with more information in different ways and on more occasions to ensure that she was able to make an informed decision about participating in the research project (Steel 2001). However, the Mental Capacity Act (Great Britain 2005) states that decisions must be respected, regardless of the information on which the decision was made (Great Britain 2005). The ethical decision made was to protect the autonomy of Connie, respecting her capacity to make a decision and her liberty to do so (Beauchamp and Childress 2009).

Madden (2010) suggests that researchers should consider what is best for participants, researcher and the ethnographic study. On a number of occasions, volunteers and managers had stated that Connie's wellbeing had improved as a result of attending the study site, in particular her ability to communicate and socially interact had improved. It could have promoted the validity of data collected from volunteers and supporters if Connie had verified these statements as without her verification the statements were the observations and perceptions of others. The wishes of Connie were given a higher priority than the research data as the wellbeing of participants in a research study is paramount. As Madden (2010: 91) states, no piece of data is 'worth more' than 'the comfort of participants.'

As this study is a critical ethnography, it aspires to change a situation. The study did not propose to change the situation of the key participants, the volunteers (although potential

and perhaps unforeseen impacts of the study on participants must be acknowledged) but rather to inform and change health care practice.

Ferdinand et al. (2007) propose that the critical researcher has an ethical obligation that goes beyond the consideration of the participants. To bring about change, the authors suggest, the critical researcher may have to expose unethical social and organizational practices, although this does pose risks. In the example of the 'Spy', Ferdinand et al. (2007) take the decision to undermine the manager of the organisation that they had been asked to study, preferring instead to promote the rights of the workers. Unsurprisingly, the research project was curtailed by the manager.

While Ferdinand et al.(2007) recognise that extremes of unethical practice such as corruption or illegal acts should be identified, in critical ethnographic studies it is often difficult to determine what ethically-correct behaviour actually is. While Ferdinand et al. suggest that no set of rules can be written which gives advice on every eventuality that the researcher may encounter, the researcher has to act ethically and justify their decisions.

This study also has to consider wider ethical issues, i.e. those issues related to community engagement and public health. Although community engagement is associated with striving for improved health and wellbeing (NICE 2008), it is not without risks. Individuals may suffer from stress as a result of engagement in community activities (Popay et al. 2007). It is not appropriate, therefore, to promote community engagement on the utilitarian principle (traditionally used in public health) of promoting the greatest benefit to the greatest number

of people (Holland 2007). As Rawls states, ‘in a just society the liberties of equal citizenship are taken as settled’, therefore there is no justification in the pursuit of gaining the most good for the greatest number if it involves sacrificing the liberties of individuals’ (Rawls 1973: 4).

Conclusion (5.12).

This chapter has looked at the methods used to conduct the study, and considered some of the dilemmas presented as the study moved from theory to implementation. The next short chapter introduces the study site and the participants. The following three chapters look at the findings.

INTRODUCTION TO THE FINDINGS (6).

Introduction (6.1).

The findings of this study, which used a critical ethnographic approach, are to be presented in a written narrative account. Excerpts of transcribed interviews, together with observations and vignettes are included to illustrate and exemplify the social life of the Orange Centre. The account includes descriptions together with the interpretation and analysis of events that I observed in the field. This is a personal account, and is a representation of the world view of the volunteers and users of the Orange Centre. This view is analysed in the context of wider contemporary society and government policies.

As a result of a thematic analysis, three themes were identified from the data collected at the Orange Centre; 'Volunteering', 'Community' and 'Conflict and Power'. These themes each form a chapter that in turn are split into sub-themes. The thematic framework of these three themes and twelve subthemes arose from my interpretations of the data resulting from my conversations with volunteers, supporters and craft group members, from my first meeting with volunteers in October 2009, to the end of my fieldwork in June 2010.

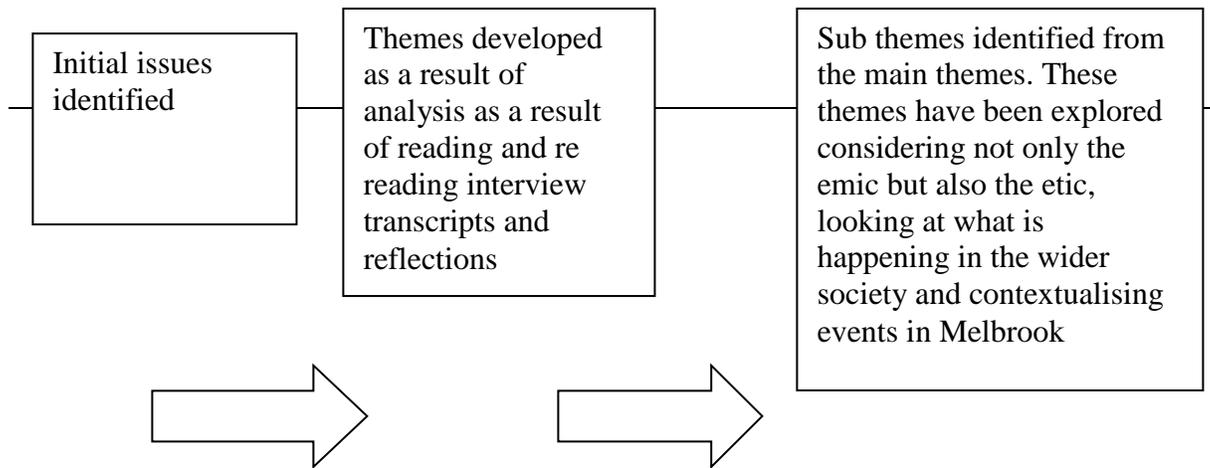
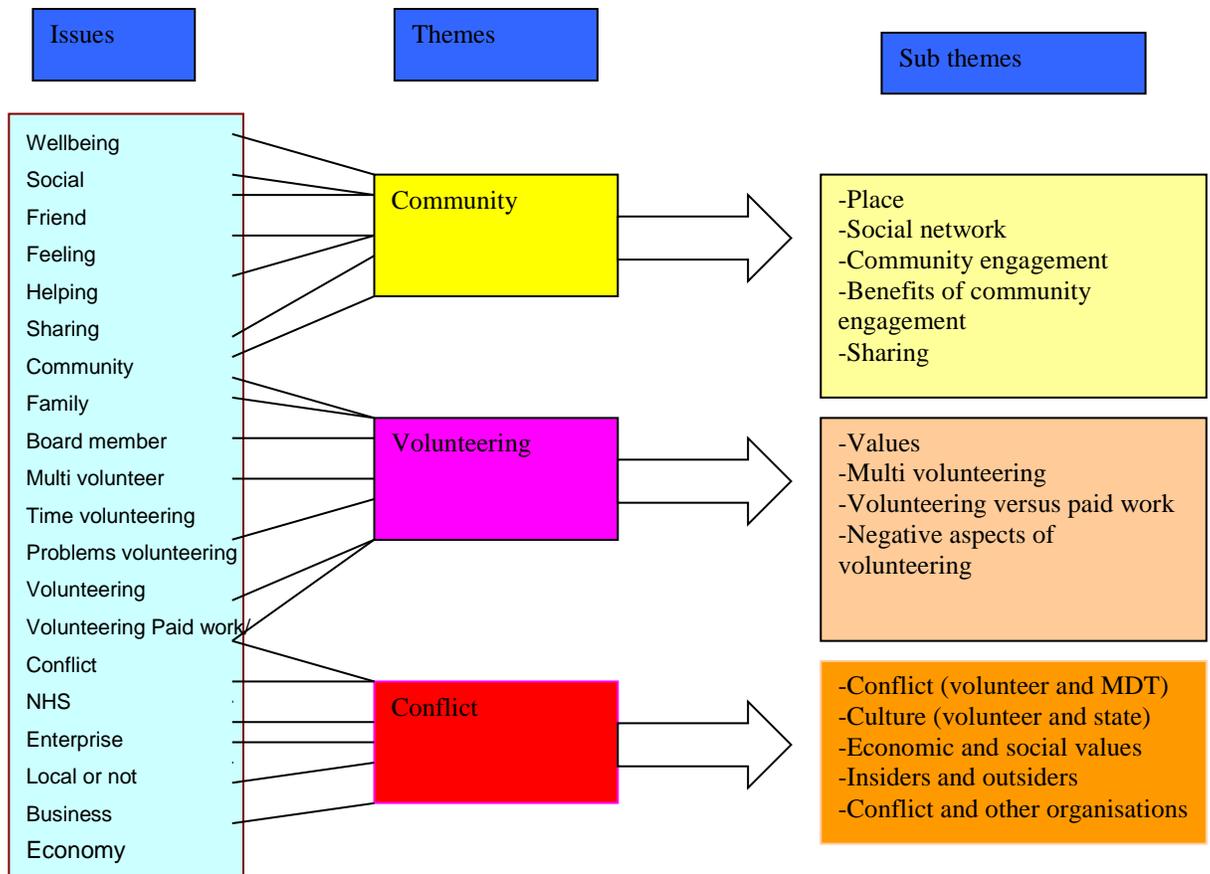


Diagram One, Thematic Framework.

This diagram shows how the list of issues identified on the initial analysis was developed into three main themes as a result of a thematic analysis. In turn, subthemes were identified in each of the three themes.

Entering The Field (6.2).

The Orange Centre is a converted church hall that stands on the brow of a hill, with the old stone church behind it. Although the church has an imposing prominence, it is not in the commercial centre of the village, but situated on one of the main roads that circulate it. Melbrook village is below the church. It comprises of brick terrace houses at its heart, with council housing and modern semidetached houses at the periphery. Latterly, the village has been surrounded by new developments, including large private housing estates, a shopping complex and light industrial units. The Orange Centre is not obvious from the road; it is set back and flanked by a high retaining wall that is topped by metal railings festooned with posters.

On entering the Orange Centre, there is a long entrance hall, with a reception area to the right. The walls advertise some of the numerous activities that take place at the centre including, for example, tai chi, mother and toddler groups, sequence dancing and after school activities. At the back of the entrance hall is a bric-a-brac stall that the volunteers organise. A door to the left leads to the café, the hub of the Orange Centre. The café is in a long, bright and airy room filled with tables and chairs. A counter runs across the far end of the room with impressive shiny equipment to make coffee situated behind the counter and a display of confectionary in a glass cabinet beside it. Two modern settees are situated in front of the counter. A spacious, well-equipped kitchen, full of stainless steel cupboards and worktops is in a room behind the counter, while a second spacious hall used for sequence

dancing is to the left. On the second floor of the Orange Centre are a range of rooms to hire, including rooms used by complementary therapists.

Volunteers busied themselves in the café; behind the counter, in the kitchen and, on occasions, sat at tables conversing with café users. Radio music played in the background, but generally conversation was the dominant sound. The café had a welcoming, happy atmosphere.

My first meeting with the volunteers was organised by Sally, one of the managers of Melbrook Development Trust. The purpose of the meeting was to discuss the possibility of the volunteers participating in the study. The volunteers, Viv, Vera, and Violet, were very friendly and welcoming. I had expected a range of people from the community. In front of me sat three smartly dressed, retired ladies. I started to discuss the study using the information sheet I had taken with me, but quickly stopped as the volunteers had a lot to say. The volunteers offered information about themselves, what they gained from volunteering, and how their work at the Centre helped people. The group understood why I wanted to capture information from people who were actively involved in their community. At the time I was pleasantly surprised that the volunteers latched onto the idea of the importance of community engagement so readily, when in the design stage of the research project it had been such a difficult concept to define and justify. In retrospect this should not have been a surprise, as community engagement, the involvement and support of their community, was something the volunteers cared about and were willing to invest their time in.

It transpired that two of the volunteers had worked in health and care and the third in financial services. Violet had been a healthcare professional who gave up work earlier than she planned and missed aspects of the work; Vera became involved in healthcare following the death of a relative. Viv had spent her working life in a business environment and was used to interacting with the public.

Vicky (together with Vera) was an active member of the Melbrook Development Trust board that made decisions about not only the Orange Centre, but the range of the Trust's activities. Vicky, who I met on my second visit to the Centre, worked part time in the public sector in a job that involved helping the public. She was a 'multi-volunteer'. Vicky was passionate about her voluntary work and was very ambitious about helping to promote the village. As well as her roles at the Orange Centre, Vicky helped to run festivals and organised the local Melbrook Village Gala.

Although in some respects volunteering seemed to be a replacement for paid work, it was also different from paid work. Both Vicky and Victor had paid work but were also volunteers. Victor had a varied career in catering and complementary therapy. He had been drawn into working at the Centre, initially by offering to help out. Volunteering work had led to a part time paid position at the Centre, but Victor continued to work as a volunteer on days he was not paid to be there. The longer I considered the difference between paid work and volunteering, the bigger the differences appeared. The differences between paid work

and unpaid work are identified and explored in the following chapter that looks at volunteering. Paid versus voluntary work is also considered in the chapter on ‘Conflict’.

Volunteers enhanced a sense of community through their work and were keen to inform me of individuals who had benefited as a result of coming together with others at the centre.

The volunteers wanted me to spend time with them observing their work and what happened at the Orange Centre. As I explored the notion of community with volunteers and service users, community seemed not to be a stable concept, but one that constantly changed.

Vicky provided an insight into the challenges associated with the activities of Melbrook Development Trust, a community regeneration project. The volunteers and supporters helped me to understand the tensions within communities and the difficulties these presented when trying to provide support for the whole of the community. Communities do not develop in a vacuum; conflicts and inequalities in power impact on communities from a micro to a macro level, and some of these will be explored in the chapter, ‘Conflict and Power’.

A consideration that links each of the three following chapters is culture: shared values, beliefs, views of the world and ways of behaving and understanding. Where volunteers and civil society have one set of values and way of behaving, statutory service and civic society have another. When the two meet there can be tensions. These tensions will be considered and, in the ‘Discussion’ chapter, together with the implications for health visiting.

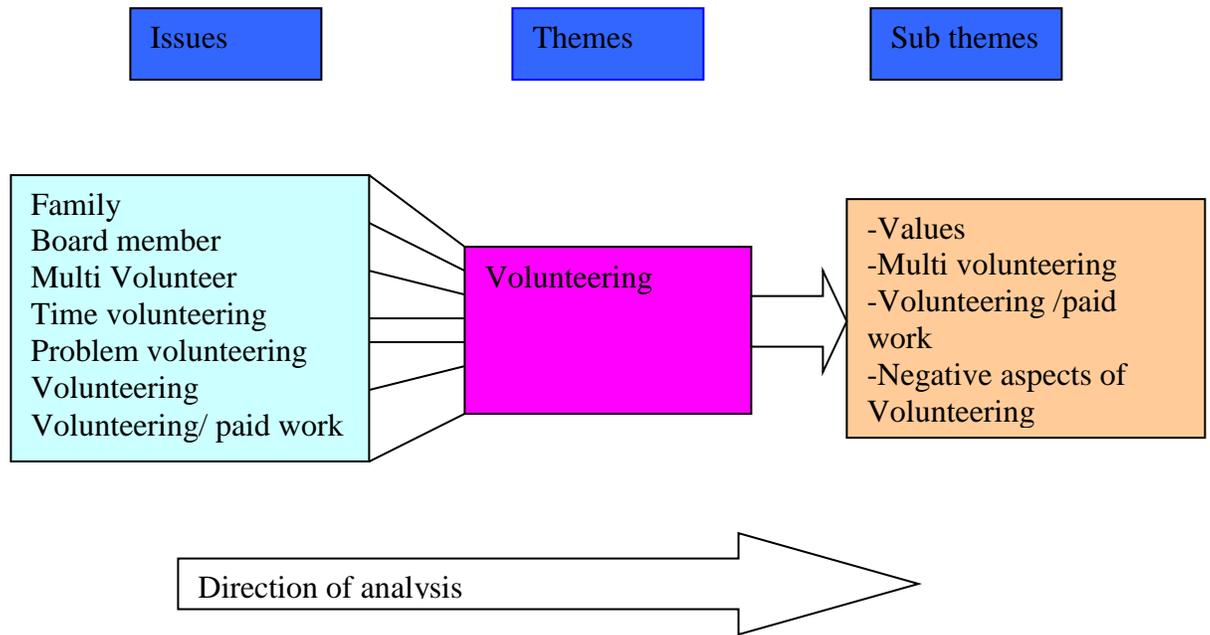
VOLUNTEERING (7)

Introduction (7.1).

Volunteers, during my initial and subsequent visits, told me about their volunteering roles, they revealed that volunteering was not a casual or occasional activity, but one that took up a lot of their time. The volunteers not only volunteered at the Orange Centre, but had several volunteering commitments with different organisations. They were involved in multiple volunteering activities. As my discussions with volunteers progressed, it became obvious that volunteers were not alone in multi-volunteering, but that other members of their families were also involved in voluntary activities. Volunteering seemed to be a way of life maintained through a personal value system, but also influenced by the community. Volunteers helped me to understand the nature of volunteering and how this differs from paid work. To understand this difference further, I looked at the professionalisation of the Third Sector to contextualise the volunteers' comments and situation into a national framework. Professionalisation of the Third Sector is discussed at the end of this chapter.

Diagram two illustrates the process of the development of this chapter, from issues raised in the field, to the development of an overarching theme on 'Volunteering', then into sub-themes that include 'Values', 'Multi-volunteering', 'Volunteering Versus Paid Work' and the Negative Aspects of Volunteering'. Each of these sub-themes will be considered in this chapter.

Diagram Two, The Process of Analysis for the Theme of ‘Volunteers’



Values (7.2).

References to family values and how these influenced the act of volunteering was interwoven through conversations with the volunteers. This suggests that the values associated with volunteering are developed and promoted within the family unit. Vera supports the link between volunteering and family values;

'I think it stems through the way I was brought up, because we were always brought up to help each other', (Vera).

The families of Viv, Vicky and Violet were involved in a range of voluntary and community activities on a regular basis. Sometimes these activities were the same as their partners and family members, for example Violet and her husband shared some voluntary activities, while Viv's husband's voluntary activities were around sport. Vicky became

involved in volunteering as a result of helping at her daughter's school. Musick and Wilson (2007) suggest that parents volunteer to support their children. In Vicky's case, she supported her daughter by supporting the school her child attended. Vicky also helped at an annual beer festival to raise money for the school of a friend's child. Vicky's family had joined her in this activity, she noted;

'My family invariably help' ... 'all my family do that now. My husband, my sister, her husband' ... 'my sister in law... and basically we just serve beer and that for three nights', (Vicky).

Vicky also informed me that her daughter had also become involved in voluntary activities.

Although families are influential in the volunteering process, caring for family members is not classed as volunteering. This classification does seem at odds with the findings that suggest that family is influential in promoting the values and habit of volunteering. The classification is also at odds with the reality that there is a growing reliance on family members to care for elderly relatives (Musick and Wilson 2007). This suggests that although the family promote volunteering, only voluntary efforts outside of the family are formally recognised.

Musick and Wilson (2007) suggest that volunteers are more likely to have particular personality types, for example they are more likely to be assertive, extrovert, conscientious and caring. The volunteers who took part in the study were assertive and determined. They had their own ideas about how they would relate to the research process and how I would

fit into their daily routine. This suggests that volunteering is a positive act of assertive individuals, rather than an activity that people drift into.

It was evident that the volunteers liked being amongst people. Violet stated;

'I had to finish work through ill health. I found I was still missing people, because people to me are very important', (Violet).

Vicky and Vera both described themselves as a, *'people person'* (Vicky and Vera). Vera notes;

'I've always been a people person; I've always enjoyed talking to people', (Vera).

Where Viv and Violet stated;

'I do love being with people', (Viv).

'I do like to spend my time with people', (Violet)

Violet liked socialising, and volunteering was a way of meeting people. She noted;

'I like it when there's more people here to help, because that gives you chance, you're not just stuck in the kitchen' ... 'You can socialize with people', (Violet).

Victor emphasised a different aspect of the person centred, caring aspect of volunteering;

'Volunteering is not just about raising money and getting the roof fixed; sometimes you're spending a lot of time with people. We had an old lady that came in yesterday, she was at the bus stop and she came in for a drink really because she was cold, and she just wanted someone to talk to. And sometimes that is what volunteering is about', (Victor).

Kearney (2008) looked at another aspect of volunteering that supports the notion that volunteering is a positive activity that people engage in for their own benefit. Although volunteering has traditionally been associated with altruism, Kearney (2008) suggests that reciprocity is an important factor. According to Cassidy et al. (2008) this works on two levels: the community and the personal. On a community level volunteering is a 'pro-social activity'; it enhances a sense of community and social participation (Vecina and Fernando 2013:39). The volunteers viewed reciprocity on a community level, suggesting that they were giving something back to their community. Violet and Viv described volunteering generally as some sort of contract;

'If you only please one person, you've done your bit', (Violet).

'I feel as though I am putting something back', (Viv).

Kearney (2008) describes reciprocity at a personal level, noting that although volunteers give of their time, they also get something back, to the point that volunteering can be seen as an act of self-interest. Volunteers in the study did gain as a result of their volunteering activities. For people that liked being with people, volunteering enabled volunteers to gain social contacts with other volunteers and café users. Volunteering added structure to their week.

Benefits experienced by the volunteer as a result of volunteering are suggested to include a positive self-image, self-esteem, and confidence, development of new skills, increased social networks and trust (Binder and Freytag 2013). Borgonovi (2008) suggested that people who are actively engaged in volunteering report better health and happiness.

Borgonovi (2008) looked to see if only well and happy people volunteered, but found a positive relationship between volunteering and health; benefits were not evident when respondents gave money or blood, or cared for friends and family. Vacina and Fernando (2013) propose that volunteering improves the physical and mental health of volunteers. They looked at volunteers in a range of organisations, accounted for variation age, and separated the role of volunteer from that of giving. They concluded that the pro-social act of volunteering gave volunteers pleasure. Meier and Stutzer (2008) suggest that the satisfaction gained from volunteering is strongest for those people who value personal development, relationships and promoting the community. Those who look to gain satisfaction from materialistic goals are less likely to gain satisfaction from volunteering.

The act of volunteering, therefore, is an end in itself for people who like being with people and helping others. It appears that for some people the activity of volunteering fulfils a need, and can be beneficial to health.

Individuals bring to and require different things from volunteering. I asked Victor what volunteers brought to volunteering and what they wanted from it. Victor suggested that volunteers were like plants: not all of them wanted to be in the sunshine. While some

wanted to be in the centre of things, others preferred to be in the shade. He suggested that some wanted feeding and nurturing, while others needed their contributions to be noted. Volunteers, therefore, need to be seen as individuals, bringing to and requiring different things from volunteering, while recognising that volunteering does satisfy a need in those who are engaged in the process.

While family values were demonstrated in the study as being influential in volunteering, the values associated with religion are also associated with voluntary action, suggest Son and Wilson (2011). However, most religions promote personal values of selflessness and the promotion of the welfare of others that is different to Kearney (2008), who suggests that the act of volunteering is one of self-interest. The act of volunteering can be seen to benefit the individual on a personal level. When members of religious organisations volunteer, this is considered to be community action rather than the actions of the individual. Chaeyoon and MacGregor (2012) suggest that religious communities should be seen as collectives, and that values of giving and supporting others should not be seen as a personal decision but rather one that is reinforced within the social group.

Many American congregations, for example, take responsibility for social and welfare activities within the community, providing sport clubs and soup kitchens (Son and Wilson 2011, Chaeyoon and MacGregor 2012). The congregation collectively takes on these responsibilities and as a result there is an expectation that members of the congregation will volunteer. Son and Wilson (2011), for example, suggested that members of religious organisations were more likely to be asked to volunteer. Most people find out about

volunteering opportunities through someone else already involved in a group or organisation (Locke 2013).

Religious beliefs played a factor in Violet's decision to volunteer. Both Violet and her husband were involved in a range of church activities, in this respect they were part of a religious community. However, Violet suggested that volunteering was linked to their Christian belief;

'I think that's part of our Christian (belief), you know, the fact that we go to church and want to do things as we would want done to ourselves', (Violet).

While the church community was influential in the volunteering activities of Violet and her husband, the act of volunteering seemed to be part of her personal belief system. However, from my conversations with Violet, it was difficult to separate individual beliefs and motivation to volunteer from a personal perspective from loyalty to the church community and property. Family values and personal beliefs were combined, and these were expressed through the church and other voluntary activities.

When looking at volunteering and religious communities it is necessary to consider that although Christianity has been the dominant religion in Britain, the number of people in Britain who consider themselves to be Christian is falling as the population becomes more diverse (Office of National Statistics 2012). In contrast, the numbers of other religious groups is increasing, in particular Muslims (Office of National Statistics 2012). Although the particular religions supported by the population of Britain are changing, it still remains

relevant to consider the religious influences on the recruitment and retention of volunteers as most religious communities promote the support of others in the wider community.

With regards to the cultural diversity in Britain today, rather than looking at the influence on religion on the levels of volunteering alone, it is also important to look at cultural influences on volunteering, as congregations tend to be racially segregated suggest Chaeyoon and MacGregor (2012).

The multicultural nature of England raises questions around community engagement and volunteering. Lukka and Paine (2008), for example, suggest that Black people are under-represented in mainstream voluntary organisations; however there is evidence of self-help and informal volunteering at a grassroots level in Black communities. The authors note that the perception of volunteering is different amongst cultures, suggesting that generally the Black population has a culture of helping each other and their community, in some respect, as an act of solidarity. As with the family, informal volunteering is not formally acknowledged. Black community members do volunteer, but their activities are not recognised. For practitioners working in communities it is important to recognise both formal and informal volunteering takes place, and to understand that there are cultural differences in the form of volunteering undertaken. However, this study suggests that people in White populations are involved in several volunteering activities that are both formal and informal.

There are instances where volunteering is aimed at particular cultural or ethnic groups. This can manifest as volunteers supporting their own ethnic or cultural groups rather than the wider community. A study by Randle and Dolnicar (2009) conducted in Australia looked at three ethnic groupings: Australian, Anglo Celtic, and Southern European. Where the first two groups looked to volunteering to advance the general community, the third group looked to supporting others with the same cultural background. The findings of this study have significance to community engagement. It is important to understand how the volunteer relates to community, the community to that they attach themselves.

The volunteers in this study were interested in supporting their own community, Melbrook. They had allegiance to Melbrook and wanted the Orange Centre, seen as a community resource, to succeed.

Steve noted that the voluntary ethic was a feature of the Melbrook community;

(Melbrook) 'is blessed with volunteers. There's actually around 42 different community groups within the village and surrounding area', (Steve).

'I think it's because of the former mining heritage culture, well former mining heritage and culture. You look after yourselves', (Steve).

Melbrook residents had a strong tradition of helping each other. This tradition was common to mining communities of South Yorkshire who shared similar life experiences that often brought tragedy and hardship to families (Bailey 2007). It was the community that helped in such circumstances, and this communal support could still be detected at Melbrook.

My perception of volunteering at the outset of this study was volunteering was a selfless act, one of philanthropy, where an individual wanted to support the welfare of another. As the study progressed however, I realised that the volunteers were involved in volunteering to satisfy their own needs. I concluded that volunteering served the volunteers in two ways. Firstly, a social need, to be with people, as expressed by Viv, Vera and Violet, and also in the case of Viv to bring structure to the day. On a second level, volunteering satisfied the volunteer's need to help and promote the welfare of others. This act gave them pleasure and a feeling of self-worth, and therefore they gained as a result of the process of giving. This was evident of the stories they told me, of people gaining benefit as a result of attending the Orange Centre. The observed progress of individuals, of the support and benefit they gained at the Centre, was, in a way, a reward for the volunteers. It demonstrated that their efforts were creating something positive.

As governments seek to promote civil society and volunteering, there needs to be an understanding of what motivates people to become engaged. People are interested in engaging and supporting their own communities and in something they are interested in, rather than indiscriminate volunteering.

The motivation to volunteer can be due to a learned behaviour associated with family beliefs and values; it is also linked to religion and culture and community (Wilson 2000, Kearney 2008). Opportunities to volunteer are associated with social contacts but determined through personal beliefs. Although volunteering appears to a selfless act, the contemporary view is that volunteering involves reciprocity, and that volunteers although

give of their time, gain substantial personal and social gains as a result of the process. This assertion was supported by the findings of the study that provided evidence to suggest that volunteers gained social contacts they desired through volunteering, and that volunteering gave them a purpose and brought structure and meaning to their lives. As well as personal motivations to volunteer, the data suggests that the volunteers were motivated by a desire to support their community.

Multi-volunteering (7.3).

It was evident on my first meeting with volunteers that volunteering took up a lot of their time. While most of the volunteers who participated in the study gave their support to the Orange Centre at least one day per week, some of the volunteers spent considerable amounts of time volunteering across different organisations in a range of roles.

My first impressions were that volunteering was a second career for the volunteers, rather than an occasional pastime. I started to consider volunteering in relation to paid employment, and began to compare and contrast volunteering and paid work.

Vicky, who worked part time, volunteered for a number of activities where she had considerable responsibility. As well as supporting Melbrook Development Trust as a member of the board and in the café, she also organised the village gala. This was a major yearly event involving the coordination of stall holders, a fairground, catering vans, and arranging insurance for an event that attracts approximately 5,000 people. She was also a

member and minute taker of a safety group that met every six weeks, and she helped to run a beer festival once a year. Although she had regular formal voluntary activities, Vicky also helped people informally as well as campaigning for single issues such as campaigning against a reduction of the local bus service;

'I took a couple of old ladies out for the day. I have a lady that rings me every day. She rings me in a morning, just to ring once so that I know she's alive. She's worried about being found, her family finding her. If I haven't heard from her by twelve o'clock I ring her to make sure she is alright.' (Vicky).

Vicky informed me that on the way to the centre an elderly resident had flagged her car down and asked for a lift. Vicky also campaigned for local services;

'When the busses went off... a gang of us get together and we were ringing here, there and everywhere and I used my phone and it cost me at least five hundred pounds for my phone bill', (Vicky).

Violet was also a multi-volunteer. When she retired from paid work due to ill health, Violet considered a number of volunteering opportunities. At the time of my visits to the Orange Centre, where she took responsibility for food preparation, Violet's volunteering activities also included;

- Weekly help at the local Luncheon club.
- As a member of the Church community Violet visited people, helped to arrange fairs, provided refreshments and arranged flower displays in the church.
- Visited a home for the elderly. Violet noted;

'Although that's fell off a bit because of circumstances', (Violet), yet she planned to visit twice over the Easter period.

In addition, Violet and her husband visited a recently bereaved relative and attended events to support other churches.

Not all of Violet's volunteering activities were formal voluntary actions in the public domain; she also spent a lot of time volunteering informally, helping individuals in the neighbourhood. Violet informed me of two instances of where she had helped individuals. These were not 'one-off' acts of kindness, but involved considerable commitment.

The first example of Violet's support of an individual member of the community was through her membership of the local choir that she attended with her husband. Violet noted;

'I take a lady there' ... 'who's recovering from cancer. We were going to give it up, have a year off. But she desperately wanted to keep going and we take her in the car and you see so we've got that commitment', (Violet).

This was an act of kindness that was not obvious to anyone other than the recipient. Violet had previously helped another member of the community, Amanda. She explained;

'I still helped a lady who had Alzheimer's because her (relative) was (abroad) and we were really her sole carers (Violet's husband) and myself. And I... you know I found that very difficult because honestly, I'd go up and she would ring me and say, I thought you were coming to see me (laugh) so although, you know I haven't got her anymore. I did miss it for a while, you know because people down (name of road) they used to say, "You know, you will wear a hole in this," (laugh)', (Violet).

Amanda was not related to Violet, it was as a result of a friendship between their two families that motivated Violet to help. Violet went on to tell me some of the changes in the

behaviour of a proud and intelligent lady as a result of Alzheimer's. Violet's reaction to this was that it;

'Obviously upset me' 'I was stressed looking after (Amanda)' 'I couldn't stop myself. You know because I know she needed me', (Violet).

Violet and Vicky both demonstrated that volunteering and helping people were a way of life, and although these activities filled up most of their time, both noted that volunteering, rather than being a career, was separate from paid employment. The values and behaviour Vicky demonstrated in her volunteering were also used in her paid job; Vicky's paid and unpaid roles overlapped but not regarding payment. She reported that her work in the public sector enabled her to recommend the Orange Centre facilities to people she met in her paid work, while people she met at the Centre asked for advice regarding her paid work role. Of her paid work she noted;

'I spend more time than perhaps my colleagues would like helping people', (Vicky).

But she also distinguished that her role as a volunteer was different from that of a paid worker;

'I couldn't be a social worker or anything like that, I'd be bringing them all home.' (Vicky).

Vicky and Violet, in the illustrations above demonstrate how members of a community provide welfare for other community members. Their voluntary work in the community was varied. They were both very committed to helping other people, spent a lot of time and energy in helping others, and at times their work was physically and emotionally draining.

Vicky and Violet demonstrated how David Cameron's notion of the 'Big Society' (Cameron 2010a) could work, in that they were involved in providing substantial support for individuals as well as providing support for the community as a whole. Despite their extensive voluntary activities, the volunteers made a definite distinction between paid work and volunteering. There were some similarities between volunteering and paid work, such as time involved and levels of personal commitment, this study, however, demonstrates that paid work and volunteering are not interchangeable.

Volunteering Versus Paid Work (7.4).

Despite New Labour and Coalition Governments' desire to develop the Third Sector, there are barriers to volunteering for both those in and out of employment. The previous Labour Government looked to the act of volunteering as a way of developing civil society and communities (Rochester, Payne, Howlett 2010). In particular they aimed to engage disadvantaged communities with the intention of improving social inclusion. However, those in deprived communities see paid work as a barrier to volunteering, and those who are unemployed are less likely to volunteer (Rochester, Payne, Howlett 2010, Locke 2013).

Successive governments have attempted to engage the unemployed in volunteering to improve social engagement and work prospects. The chance of obtaining paid work as a result of volunteering is limited; particularly for those under 25 years of age, who often lack appropriate skills (Rochester, Paine and Howlett 2010, Paine, McKay and Moro 2013).

Corden and Sainsbury (2005) dispute this view, and suggest that skills gained in volunteering prepare individuals for work.

The findings of the study suggest that there is a crossover between paid and unpaid work with regards to skills and job acquisition, but that this crossover only applies to some volunteers, and there is not a clear route between volunteering, skill acquisition and paid employment. Victor did gain paid part time work as a result of his voluntary work at the Centre, however, the others were retired or already in paid employment and were not seeking paid employment. Vicky did report that she gained skills as a result of her voluntary work, however, these were skills developed as a result of organising Melbrook Gala, rather than as a result of volunteering at the Orange Centre. Viv, Vera and Violet imported skills they had acquired elsewhere. Viv was disappointed that she could not use the management skills she acquired during her career to support the Orange Centre. Despite her suggestions to improve the administration of the centre, she resigned herself to work in the café as that was where support was required. The conclusion drawn from this study is that the skills that volunteers gain as a result of volunteering are dependent on the skills they have already and the opportunities available through their volunteering. The Orange Centre did not generally help volunteers to develop new skills; however, volunteering at the Orange Centre did help Victor to gain paid employment.

Volunteering is unlike paid work in that those who volunteer do not apply on the basis of their skill acquisition. Vicky noted;

(The) *'best volunteers are the ones who are prepared to do everything'*, (Vicky).

Some volunteers' skills sets were only suitable for particular jobs;

'We have a chap from here who's not very good on the phone'.... 'he can be off putting and very abrupt and I know he's not like that but Joe public ringing up think 'Oh I won't bother going there', so you've got to use the skills of your volunteers', (Vicky).

It was difficult to make generalisations about volunteer skill acquisition as a result of volunteering from this study, as the Melbrook Development Trust was short of money. Although there were plans to look at Food Hygiene and First Aid training for new volunteers, Sally noted that not enough attention had been paid to recognising the skills volunteers had or required;

'It probably would be good to sit down with volunteers individually on a one to one and review what they know, how it is going for them and is there anything they need, you know, and maybe look at training and that sort of thing. That should really be happening anyway but it's just getting the time to do it', (Sally).

While there was no formal training for volunteers at the Orange Centre, this does not appear too atypical. It is usual for new volunteers to get training on the job, often being taught by established volunteers suggest Haski-Leventhal and Bargel (2008). While such initiation helps to promote the culture and norms of the organisation, it does not provide the knowledge and skills that formal training provides, and can place volunteers in situations they are unprepared to deal with. In addition, it suggests that the organisation is not prepared to invest in volunteers; rather they are left to get on with the task.

I observed 'on-the-job' training of a new volunteer during my visits to the Orange Centre. The new volunteer, who did not participate in the study, was supported by Viv, Violet and Vera. Within a few weeks the new volunteer mastered the routine and tasks carried out by the volunteers, and was staffing the café counter. This was in contrast to the findings of Haski-Leventhal and Bargel (2008), who suggested in the first few weeks of volunteering new volunteers feel unskilled. As I sat at a café table with Viv watching the new volunteer setting out cups and saucers in readiness for the sequence dance class refreshment break, Viv noted, jokingly, how she felt redundant, as the new volunteer had taken over her role.

While the transfer from volunteer work to paid work is limited, full time work is also a barrier to volunteering, particularly in Britain where there is a culture of long working hours (Great Britain, Department for Communities and Local Government 2011). Part time, flexible work and self-employment offer more opportunities to volunteer suggest Rochester, Payne and Howlett (2010). Both Victor and Vicky demonstrated how part time work facilitated volunteering; they were able to fit in volunteering around their paid work.

Despite paid employment being seen as a barrier to volunteering, both New Labour and the Coalition Government, under the banner of the 'Big Society', have looked to increase the level of volunteering amongst those in employment. The motivation for this initiative has been to increase the voluntary sector with the aim of reducing state intervention in welfare services. In the case of Blair, this was to increase the range of health care providers, and although this trend has been continued by the Coalition Government, an additional driver

has been to reduce state spending on welfare services. Despite both administrations devising policies that require people to volunteer and support their communities, there has been little attention paid to how this might be realised, given the barriers to volunteering that paid work and lack of appropriate skills present. Before volunteering rates can improve, particularly amongst those in paid employment, there needs to be a better understanding of how people in work can give time to volunteering activities (Bartels, Cozzi and Mantovan 2012).

There are some international studies that have looked at volunteering for those in paid employment. Hurst (2012) for example, reported on a Canadian study that looked at employers' support for volunteering. Of those who were in employment approximately one third suggested that their employer had policies to support volunteering, while over half of the employers offered support such as flexible working hours for those wanting to volunteer in their own time (Hurst 2012). Although these initiatives appear well intentioned, they may not be as successful in encouraging volunteering as might be assumed. Rochester, Paine and Howlett (2010) suggest that when employers promote particular volunteering activities, the freedom of choice, a key element of volunteering, may become undermined (Kearney 2008).

To understand the perspectives of the volunteers with regards to paid work and volunteering, I started to ask volunteers direct questions. The distinction between paid work and volunteering is often blurred. For example, Victor was involved in both paid and unpaid work at the Orange Centre, and the roles appeared to merge;

'I do whatever needs to be done'... 'regardless of being paid or not', (Victor).

Most 'not-for-profit' organisations involve co-operation between paid and non-paid staff. However, often the choice between paid or unpaid staff is down to three issues, suggest Handy, Mook, Quarter (2008). These issues are: the productivity of volunteers (and includes their skills and reliability), the budget to train and manage volunteers, and the organisational culture – for example, is the inclusion of volunteers a key aspect of the organizational ethos? In some instances there is interchangeability of paid staff and volunteers even in situations such as hospital settings. Handy, Mook, Quarter (2008), for example, looked at a range of case studies within Canadian hospital situations where volunteers worked alongside paid staff. These ranged from hospital coffee shops, run by volunteers who then employed staff, retired Accident and Emergency staff working alongside their ex-colleagues, and volunteer information officers doing the same job as their paid counterparts. Such situations required substantial negotiations with appropriate unions, and concerns remain that volunteers will replace paid staff as organisations look to reduce their staffing costs. However, the findings of this study suggest that replacing paid staff with volunteers is not feasible given the fundamental nature of volunteering, that it is a free choice (Kearney 2008).

The key difference identified by the study, between paid employment and volunteering, was payment. Once payment was involved, then the worker was no longer free but obliged to accept particular working conditions.

The government sets out clear guidance that volunteers do not get payment for their time, although they can claim expenses (GOV UK 2013a). Although there are examples of rewards of gifts, payment would contravene current employment legislation including that of the minimum wage (Rochester, Paine and Howlett 2010). Policies were in place at the Orange Centre for the payment of expenses, although volunteers were reluctant to use this facility. Vicky, for example, had to be encouraged to claim mileage expenses for an errand she was requested to undertake. When I asked Vicky if she was ‘out of pocket’ as a result of her voluntary activities she responded laughingly;

‘Probably quite frequently’, (Vicky).

The only ‘payment’ the volunteers took was a drink from the café during their break. Steve noted;

‘Reward is never asked for, reward is never sought, but the acknowledgement is perhaps all that’s required for the individual volunteer’s personal self- esteem, that because they’re valued spurs them on’, (Steve).

Violet, Vera and Viv, who were retired from paid work made clear distinctions between paid work and volunteering. I asked Violet if volunteers should be paid, she responded;

‘I wouldn’t do it for the money you know. I think when you start doing things for money...some people tend to think, the money first, and they don’t give that commitment’, (Violet).

Violet's comment shows she was very clear that caring was not about money, but rather something you gave. She suggested that once payment was involved, that the level of caring and giving diminished. Vera's comments support this in that paid employment can diminish the capacity to give care. This is a revealing comment given recent investigation into the level of care given by healthcare professionals (Francis 2013). Vera gave up her job as a paid carer because she stated that her employer did not like her getting involved with the clients;

'I thought "well they're not telling me what I can and can't do"', (Vera).

Viv supported this theme;

'If someone pays you, they control you' ... 'once you're paid then more is expected of you because obviously you've got to. But I'm a person who if I'm doing something, no matter if I'm paid or not, I'd still be responsible, I still feel, if I'm ill I don't like letting people down', (Viv).

Vera continued about her role as a volunteer,

'Because you can pick and choose, you don't have to come if you don't want to, so to me a volunteer is somebody who really is dedicated to what they are doing', (Vera).

Viv had initially considered part-time paid work on retirement; she did not want to be paid as a volunteer. Interestingly, she noted;

'This is not what I'd do if I got paid', (Viv).

The volunteers at the Orange Centre were committed to their role. Such a commitment, as measured by the length and frequency of volunteering is often seen amongst volunteers suggest Haski-Leventhal, Bargel (2008). Commitment was defined by dedication to the role and the standard of work completed, but it did not mean that volunteers were committed to turning up every week.

During my visits to the Orange Centre a couple of volunteers were missing for several weeks due to personal circumstances. Because they were not paid and had no contractual obligation to Melbrook Development Trust, they had flexibility. Volunteers have no obligation to volunteer or turn up each week. This has implications to organisations if they consider replacing paid staff with volunteers. When I spoke to the managers of the Orange Centre about the differences between a volunteer and paid staff Sally noted;

'You become more reliant on a member of staff and there's an expectation there that that person turns up for work, whereas a volunteer. If someone volunteers and they can't make it one week that's fair enough, you know, they've got other commitments', (Sally).

Vicky, when discussing events help at the Orange Centre in an evening stated that the part-time paid staff had to lock up at the end of an evening event. She had some concern that one of the paid workers completing this task was a young single woman on her own. While it was not an ideal situation, Vicky made a clear distinction about the requirements of a paid worker and those of the volunteer;

'You couldn't really expect a volunteer to be here on their own', (Vicky).

Victor noted of volunteers;

'You don't have to do a full 8 hour slog in the kitchen, you can do an hour and tidy up the bric-a-brac table, or you can spend an hour in the garden, you don't have to do a set amount of time',(Victor).

The essential difference between paid work and volunteering, one that the volunteers in the study recognised and welcomed, was that they were not in paid employment and therefore they had no contractual agreement with an employer. They were free agents to come and go as they pleased. This is not to say they that they were not committed to the role, rather they were committed on their own terms, committed to helping others and committed to other volunteers, but not ruled by a paid employer. This is an important consideration given that Third Sector organisations are increasingly commissioned to deliver services previously delivered by the state sector. As a result, the Third Sector is applying business models to its operations. This practice is often referred to as the professionalisation of the sector.

Professionalization of the voluntary sector is changing the nature of the voluntary sector and threatening to take away one of the fundamental characteristics of volunteering; that is volunteering is an act of free will and volunteers are not constrained by contractual obligations to employers.

Volunteers do not volunteer for money; their motivation is as a result of wanting to help others, supporting their community and satisfying their own personal needs. Despite the benefits of volunteering there are some drawbacks to the role.

Negative Aspects of Volunteering (7.5).

There are negative aspects of volunteering. Some volunteering activities generally do not suit individuals. Violet had sampled a range of volunteering opportunities. Before she became a volunteer at the Orange Centre she had volunteered to support dementia sufferers and also worked with bereaved families. She found the work in both these areas upsetting and emotionally difficult, so had given up these commitments. As a volunteer she was under no obligation to continue. In contrast, Violet chose to continue her work at the Orange Centre. Despite the volunteers' apparent ease in their roles at the Orange Centre, there were tensions associated with the volunteering role.

As an observer, what surprised me was the difficult position volunteers were in. Their only support came from other volunteers. The vulnerability of the volunteers was brought home to me through the accounts of Violet and Victor (below) when they described how they tried to use their previous experience to deal with difficult situations, including the sharing of confidential information.

Volunteers provided support to café users. There appeared to be an absence of formal guidance and process to guide the volunteers with regard to confidentiality and information sharing. As a healthcare professional I am used to policies and procedures around these areas, but the volunteers had to negotiate such issues as best they could.

Violet noted that when she worked in the NHS she had a head and deputy head of department with whom she could share information and problems, together with a range of co-workers to whom she could delegate work. As Violet noted, she was able to;

'Share things and get rid of some of the stress',(Violet).

I asked Violet what she would do if someone disclosed problems to her at the Orange Centre. Although Violet talked about *'following the chain'*, (a process she was familiar with from her previous professional role) and, with permission, contacting a relative, the only support Violet mentioned that was available to her as volunteer at the Orange Centre was to discuss the situation with Viv.

Victor, who previously worked as a complementary therapist, suggested that some of the users of the Centre had health and social problems;

Just by looking at somebody sometimes you know they've got a problem'. On another occasion, 'one of the therapists might say to us, "That person needs a little bit of TLC"', (Victor).

Victor noted that when he engaged in conversation with Centre users they often disclosed their problems. I questioned Victor how the volunteer would deal with such confidences. Victor suggested that in some cases, for example if the user declared they were going to kill themselves, the volunteer would break that confidence. However, if the situation was not deemed to be serious then they would not.

It is not surprising that café users, particularly ones that were vulnerable due to social isolation and mental health issues, disclosed information to the volunteers at the Orange Centre. Volunteers generally are more likely to successfully engage with members of their community as volunteers are perceived to be more accessible than paid employees that are associated with authority and the state (Ronel et al. 2009).

Volunteers can offer something that paid and professional staff are not offering, or not perceived to offer, and are particularly successful at engaging with vulnerable individuals and marginalised groups (Ronel et al. 2009). However, while recognising the unique opportunity to provide engagement with such groups, little attention has been paid to the support volunteers need to function in this role.

The work of Faulkner and Davies (2005) is one example where the needs of volunteers were explored. The authors noted the risks posed to volunteers who offered social support to hospital patients. Volunteers were exposed to difficult emotional situations where they had limited knowledge and training to support them. Hospital volunteers valued any training they were offered to support their role (Faulkner and Davies 2005). This suggests that volunteers not only need support and guidance for their role, but are willing to undertake such training.

There was some recognition at the Orange Centre that more could be done to support the volunteers. Sally, one of the managers employed by Melbrook Development Trust and who generally oversaw the running of the Orange Centre, stated that the volunteers were a

great asset to the Orange Centre, but also recognised that Melbrook Development Trust could do more to support them;

'I just think there's a lot more we could do for the volunteers, I'm conscious that we're running around very busy and I think the (Melbrook Development Trust) needs to maybe look at their needs a bit more', (Sally).

Volunteers are not paid workers, and this study suggests that some do not want to be paid as they would rather retain the freedom of choice that unpaid voluntary status gives them. However, volunteers do require training to protect and equip them for the work that they are undertaking. It is important to consider the protection of volunteers; for their own health and well-being, for retention, but also to allow them to appropriately support work in marginalised groups. To date, volunteers do not obtain the level of training and support offered to paid employees.

Professionalisation of The Voluntary Sector (7.6).

Before leaving the theme of 'Volunteering', it is pertinent to look at volunteering in England today and to consider the etic, the influence of wider society on the emic, and the experiences of the volunteers at the Orange Centre (Fetterman 2010).

Health and welfare providers are increasingly commissioned from the Third Sector. However, it is claimed that as they take on these contracts, the features that distinguish the third from the state sector, for example their ability to engage and work closely with communities, is being undermined as a result of professionalization (Carey, Braunack-

Mayer and Barraket 2009). Professionalization occurs when the structures and procedures within an organisation become formalised (Ganesh and Mc Allum 2012). Ganesh and McAllum (2012), suggest that as the voluntary sector has taken on more state contracts to deliver services, they have had to become more efficient and accountable. While good organisational structures may help to retain volunteers, it is claimed that some practices are undermining and destroying the nature of volunteering (Rochester, Paine, and Howlett 2010).

A study carried out in Australia by Carey, Braunack- Mayer and Barraket (2009) noted that as the organisation became more bureaucratic, it became more difficult to provide individualised and diverse care. The boundaries between (paid) staff and volunteers and between the organisation and the community changed. Meetings and interactions became formalised. The authors concluded that as the organisation grew, it was able to offer more services to users, but the service on offer altered, and the ability to connect with community members lost.

Professionalisation affects volunteers moving their role from one of amateur to someone responsible for delivering a contracted service. It is suggested that volunteers' relationships with service users change when service users are defined as 'clients' rather than members of a community (Ganesh and McAllum 2012). The 'free will' element of volunteering is compromised when some volunteers are required to sign contracts, whereby they agree to abide by the rules of organisation and commit to volunteering for at least a year (Haski-

Leventhal and Bargel 2008). Yet within these changes, volunteers are often viewed as inferior to professionals and other paid workers (Powell and Geoghegan 2004).

The 'free will' characteristic of volunteering was very important to volunteers and highlighted as a key factor that distinguished volunteering from paid work. Volunteers were able to offer their services or not, and engage in activities they made a choice to engage in. Take away this key element of volunteering and the nature of the activity changes.

To attract and maintain external funding contracts, Third Sector organisations have to demonstrate cost-benefit interventions, adhere to legal and government mandatory requirements, and have increasingly adopted top-down structures (Ganesh and McAllum 2012). The number of staff employed to fulfil these obligations has increased. Paid staff in the Third Sector rose by 40% between 2001 and 2010 (NCVO 2014). It is estimated that there are now at least 1.1million people, 2.7% of the UK workforce, working in the Third Sector (NCVO 2014). The ratio of paid staff and volunteers in Third Sector organisations depends on the size, nature and the purpose of the organisation; however, paid workers can outnumber volunteers (Powell and Geoghegan 2004). Over half of paid workers in the Third Sector are employed in health and social care work, yet their wages are lower than in the public or private sector. This suggests that the Third Sector is simply replacing the state sector in form and function, while paying front line workers less.

As more paid workers are deployed in community development, volunteers have been squeezed out and marginalised. Management structures have been developed and

populated, and as a result, volunteers have been distanced from the decision-making process (Geoghegan and Powell 2004). Such reduction in volunteers' ability to be involved in decision making has considerable implications regarding the balance of power between civil society and the state.

In some respects the situation of the volunteers at the Orange Centre differs from the national picture in that volunteers are substituting for paid staff due to the financial restraints of the Orange Centre, rather than being replaced by paid staff. However, in many other respects, the volunteers are being marginalised when it comes to the running of the Orange Centre. Their voice is not dominant in the decision-making process.

The power that volunteers have reflects the power of civil society. Civil society can be an effective balance that stops the state from becoming too dominant (Habermas 2002b). However, there needs to be equality of power between civil society and the state for a balance to occur.

Volunteering is an indicator of social participation and a vibrant civil society. Reducing the power of volunteers alters the balance of power between the state and civil society.

Professionalization of the voluntary sector appears to be reducing the power of volunteers as they are squeezed out of the decision-making process. Limiting the power of volunteers seems at odds with policies that have promoted the development of the Third Sector.

However, although the state has withdrawn from some provision and governance, it still has power as, 'the rules of the game continue to be determined by the state,' (Taylor

Howard and Lever 2010:148). Therefore, the state has withdrawn from the direct provision of some health and welfare services, but has retained power over providers.

Moving beyond an English perspective to a Scandinavian view, Henriksen and Svedberg (2010) suggest that governments that wish to dominate will channel and inhibit the scope of volunteering in such a way that volunteers uphold the status quo. These statements reflect not only the situation in England today, but also the work of Lukes (2005) with regard to power. Although governments appear to relinquish power, they remain in control.

While volunteering is associated with lack of power, social activism is linked to power and change. Rather than volunteering and social activism being separate, Henriksen and Svenberg (2010) suggest that both are part of the same continuum, proposing therefore that volunteers could become more politically active. If this was to happen, and volunteers gained more power and become more politically active, this could rebalance the power balance between state and civil society (Davis- Smith 2008). However Davis- Smith (2008) suggests that volunteers can only promote democracy through their action when democratic principles are already present within society.

During my visits to the Orange Centre, the volunteers were at different stages of activism. While Violet did not want to make suggestions as she perceived that this would create more work for her, Vicky and Vera were actively involved in decision making as board members. Vicky, in particular, was frustrated by her inability to bring about change as a result of board membership. Victor was active in a different level, organising the volunteers so that

they could present their case to the management of the Orange Centre, but also encouraging the volunteers to develop strategies that helped the volunteers to get the resources they required as a result of the money raised from the bric-a-brac table. The ultimate choice that volunteers had to exercise power was through the withdrawal of their labour.

If volunteers are marginalised, through professionalization of the Third Sector, their ability to participate and make decisions at a local level is compromised, as is local democracy. Professionalization therefore brings into question the form of civil society that is being promoted through the 'Big Society' (Cameron 2010a), that to date has encouraged the growth of top-down organisations. In contrast, it is the bottom-up organisations that promote community engagement, particularly in areas of social deprivation.

Conclusion (7.7).

Volunteering has been encouraged by government with the expectation that civil society will replace some state welfare provision. Volunteers are a fundamental component of a vibrant civil society, yet despite their role in government intentions, little attention has been paid to their role or their needs.

This study demonstrates that volunteers are capable and resourceful, and that they spend a lot of time and energy supporting their community through a range of volunteering activities.

Volunteering is fundamentally different to paid employment. Although there is some overlap between paid work and volunteering with regard to some of the tasks that are undertaken, the motivation of volunteers is different from that of paid workers in that volunteers are not motivated by money. Volunteers, however, do gain benefits as a result of volunteering, including social benefits. Volunteers are not contracted to work and therefore they can choose the activities they undertake and when they volunteer. Despite the flexibility volunteering offers, volunteers are disadvantaged as they do not have the training and support offered to their paid counterparts.

Volunteering can be considered on an individual level, but also that of a collective, such as a religious organisation. The community aspect of volunteering is a motivation to volunteer, particularly when volunteers are supporting the communities of their choice.

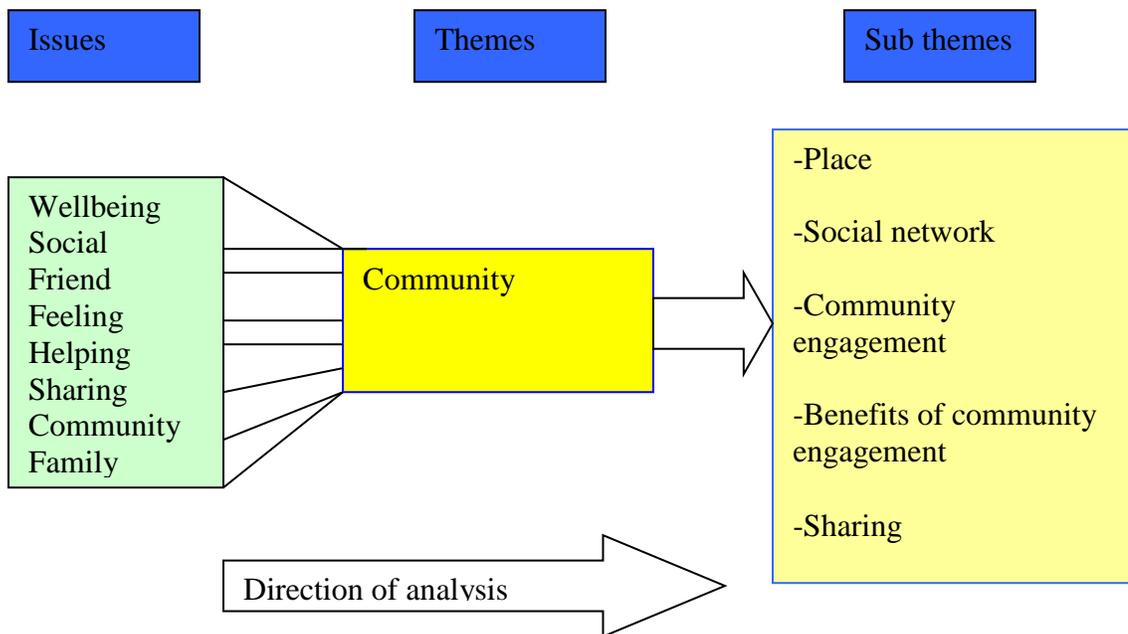
The next chapter looks at community in more depth, considering how community is defined and constructed. It also considers community engagement and the benefits of community membership.

COMMUNITY (8).

Introduction (8.1)

Community is a central theme to this study. For volunteers it was their purpose, to support their community, and the objective of their endeavours. For the craft group members and supporters, community was the focus that brought them together. Five sub-themes emerged from the findings relating to community; place, social networks, community engagement, benefits of community engagement and sharing. The concept of place will be explored and what place means to people. Social networks are described and levels of community engagement considered. The benefits of community engagement and sharing a community experience are also investigated.

Diagram 3: The process of analysis for the theme 'Community'.



Place (8.2)

Within this sub-theme emerged not one, but several views of place and how these related to community. For some, geographical place was linked to their local community, but for others, place was a somewhere where they socialised and found meaning. What became apparent was that place and community were constructed and were subjective. Individuals were emotionally attached to the community they attached themselves to.

The volunteers were local, most living in the Melbrook area throughout their adult lives. Volunteers seemed to hold a localised view of a community that was centered on the Orange Centre. Vera and Vicky had been involved in the planning of the Orange Centre, while Violet had an established relationship with the building through the church that

owned the building. Because they wanted it to succeed they volunteered to help in the day-to-day running of the Centre;

'I wanted this (Orange Centre) to succeed because a lot of people have put a lot of hard work in getting this up and running, so if it was something as little as a lack of marketing or a lack of a volunteer I just like to feel I'm doing my bit for the community, (Vicky).

Violet stated similar sentiments;

'We are very proud of this building' 'it's a community and that's what we want to be part of', (Violet).

Vera, when discussing community talked about the village. She made reference to an older generation who were set in their ways, but also new families that had moved into Melbrook.

The craft group that met in the café of the Orange Centre had a different perception of community, suggesting that it was associated with a larger geographical area than Melbrook. A craft group member (Clare) identified 'local' as extending beyond Melbrook to Melfield, an adjacent township, approximately eight miles away. To members of the craft group, 'local' appeared to refer more widely than the area immediately surrounding their home. The craft group members came from a bigger geographical area and did not have the same emotional attachments to the Orange Centre as the volunteers.

The craft group had a written statement of intent that declared the group to be ‘dedicated’, and of all abilities, that produced crafts for charitable causes in the region and overseas. In many ways they were a social group that came together to support each other. They met at the Orange Centre, but could have functioned as a group at another location. In contrast, the volunteers were location specific. Place was significant in that it represented the efforts of the community.

A traditional view of community is one tied to geographical location, such as neighborhood. Communities can be defined by a measurement in miles or walking distance from home, however such definitions are set with difficulties when trying to use standardised measurements across urban and rural communities (De Marco and De Marco (2010). While public organisations have identified communities and neighbourhoods through census material or clusters of dwellings on a map, residents define location and community differently. When individuals are asked to define their neighbourhood, the results do not correspond with official delineation, or with each other’s (Fernandez and Langhout 2014). Fernandez and Langhout (2014) suggest that this may be due to the increase of urban developments that have no community focus or amenities such as community centers or places of worship.

It is suggested that there is a trend for those who are socially mobile to have few emotional attachments to geographical place or culture, as those who aspire to be mobile look to where they are going rather where than where they are from (Lewicka 2005). In contrast, individuals from deprived areas are trapped; they are neither socially or geographically

mobile. Due to lack of resources and power, those who are living in disadvantaged communities are unable to change their situation. Bauman (2000) and Richardson (2008) suggest that disadvantaged and marginalised groups become attached to their local geographical area because no other options are available to them.

Studies over the last 40 years have challenged the perception that people move as a result of social mobility; rather people develop attachments to locations, and such emotional attachments help individuals to develop and reinforce identity, self-esteem and pride (Lewicka 2005, Lewicka 2011, Fernandez and Langhout 2014). To be attached to a place of residence, as a result of the social bonds that are developed there, is a good thing that brings psychological benefits to the individuals, including feelings of well-being and satisfaction with life (Lewicka 2005, 2011, Hipp 2010).

Cate, one of the craft group members, described the community she valued. Community to her was not the place she lived, but the area where she socialised. As the craft group members sat around the large round table engaging in their craft activities they talked about Melbrook. Cate informed the group;

'Contrary to popular belief, I don't actually live in (Melbrook)', (Cate).

A fellow craft group member responded;

'You know, I always thought you lived in (Melbrook)', (Second craft group member).

Cate responded;

'I was really pleased about that. I hate (Grimesville, where Cate lives). I always used to come to (Melbrook) you see, when there was nothing at (Grimesville) and there still isn't really. I always come to (Melbrook) so that's where I meet people and I always forget to say I come from (Grimesville)', (Cate).

In response to this disclosure, the group laughed. Allegiance to Melbrook, therefore, was not just as a result of where people live geographically, but places where people formed attachments and bonds. Lewicka (2011) suggests that attachment to place may not be where people live but where they find meaning. For some this is a second home or place of work or leisure. Where the volunteers formed an attachment to Melbrook as the place they lived and had a loyalty to, Cate had formed an attachment to, and found meaning in Melbrook because of the social attachments she was able to make there.

There are implications for health visiting in Cate's disclosure, as health visitors have associated people with their geographical community. Yet if health visitors are to engage with communities more successfully, they need to look at the communities that have meaning to people. This may be a geographical community, for example, the volunteers associated themselves with Melbrook, or it could be a different community to the place of residence.

For some people emotional attachment is not to a physical location, but to the social networks and bonds that develop in that place. It is the social networks that occur in a place that produce meaningful communities. A sense of belonging and attachment to a place is as a result of the social networks that are formed there (Lewicka 2005).

Social network (8.3)

Social networks were important to participants. They tended to be small, even within the confines of the Orange Centre there were several networks. The Orange Centre facilitated the formation of social networks as it provided a common meeting area where people could socialise. Volunteers and craft group members were keen to socialise and actively sought out opportunities to be part of a social network. Small, 'micro' networks provided support to members.

The volunteers had strong social networks as a result of living in the village. These were strengthened as a result of the friendships volunteers developed through the Orange Centre that gave them a sense of being part of a community

Victor noted that when he first lived in Melbrook, he worked some distance away and knew few people in the community. As a result of his involvement in the Orange Centre, he started to make new friends. He noted;

'I've made that many new friends and got to know the community and I'm starting to do more , you know, going out and doing other things away from here which has made it really worthwhile', (Victor).

Victor said that he was recognised in the area as a result of his work at the Centre, and that people knew his name due to the name badge he wore there. He commented;

'The worse thing is when you go shopping, everyone remembers your name, but you can't remember who they are', (Victor).

Viv had a similar story of friendships developed at the Orange Centre;

I moved here twenty-odd years ago when I was working full time, I never became part of the community' ' you go out in a morning at half-past seven and you come home at night at six. I had aged parents to look after and grandchildren and trying to juggle that and work full time, it's not easy' ' it's only since I retired and I've come here that I realise just what it's all about', (Viv).

For a community to develop, members need opportunities to meet and form relationships. (Volker, Flap and Linbenberg 2007). After she retired, and as a result of volunteering at the Orange Centre, Viv met other volunteers who lived in Melbrook, including Albert (one of the volunteers who did not take part in the study). She commented of Albert;

'He's a lovely chap' 'I've never met him (before meeting him through volunteering). He's probably lived in (Melbrook) all his life and I probably wouldn't have met him', (Viv).

Viv also talked about the members of the craft group;

'They're like old friends now', (Viv).

Then about community social life based on neighborhoods;

'You find people live different lives now'....' in the old days when they neighboured, you don't neighbour like you used to'... Life socially is different isn't it?' (Viv).

I asked Viv if the Orange Centre and volunteering helped to fill the gap left by neighbouring. Viv replied,

'Well yes', (Viv).

For Viv, physical social contact was important, meeting people face to face. During her career in paid work she enjoyed the company and stimulation of people around her and missed this when she retired. Being amongst people was important to Viv. When she complained to her husband that she felt tired after a stint at the Orange Centre, and he asked her why she continued, she replied; *'Cause I just feel part of it,' (Viv).* She felt part of the community within the Orange Centre.

The Orange Centre was important as catalyst for developing the connections between people. It helps to crystallise a sense of community. Volunteers looked to supporting the community of Melbrook – this was the objective of their voluntary work – yet I started to consider if the volunteers were themselves a community, and one that promoted a sense of community at the Orange Centre.

I asked Victor if the volunteers were a cohesive community or if they were selection individual volunteers. He noted that volunteers sometimes worked alone, sometimes in groups, attendance and commitment changing week by week, but always they were classed as '*volunteers*'.

They were more than a selection of individuals who happened to be in the same location on particular days. Tam (1998:220), from the communitarian perspective, suggest that, a 'community is no more than a group of people who have something in common that brings them together'. By this definition the volunteers could be defined as a community, in that they all supported Melbrook village, but there were other factors that identified them as a community. They were distinct from the craft group, although both volunteers and craft group members were involved in supporting others.

I asked Victor if the craft group were '*volunteers*'. He responded;

'Well I don't look at some of them as volunteers but they do a lot for charity',
(Victor).

Victor highlighted the differences between the craft group and the volunteers, stating that Orange Centre volunteers had more responsibility;

'My job is to look after people when they come in and be nice to them because they are customers. While I was part of the (craft) group that wouldn't be part of my responsibility, making drinks and looking after people', (Victor).

Violet commented on the welcoming atmosphere the volunteers worked to create;

'It's the atmosphere to the place....it is very important because you want people to come in', (Violet).

Sayer (2002), who also views community through a communitarian lens, suggests that identity and a sense of community are developed through a set of beliefs, values and understandings. The volunteers had common backgrounds in health and working with people. They not only shared a purpose, but also a set of beliefs and behaviours. These were demonstrated in the way they supported and talked about the craft group and those users of the café that had health and social problems. In essence, the volunteers were carers.

Victor suggested that society today is impersonal, but in the Orange Centre;

'In here, we know their name, we know where they live, we check on (to see if) they're alright', (Victor).

Victor talked about sitting with café users, letting them chat and get things off their chest. It was as though the volunteers had created a therapeutic community for people who wanted to drop in and participate.

On reflection, volunteers had transferred the roles and culture of their previous occupations to the role of the volunteer. In conversation, Viv and Violet noted that two craft group members failed to attend the Orange Centre for some weeks, and they wondered if anyone in the craft group knew about the well-being of absent members. They observed the well-being of café users. If a member of the craft group was upset, then one of the volunteers

would be informed. I wondered if craft group members deferred to the volunteers to take decisions, just as health care professionals define problems and tell patients ‘what they should do’ (Shircore 2014:46). Giesden (2011:173), with reference to the work of Geertz, suggests that cultural rules and ways of dealing with situations identify some individuals are seen as the “appropriate one”. Perhaps the craft group recognised the behaviours of the volunteers and assumed they were the correct ones to approach. It could be that craft group members just sought support from what they perceived as a caring community.

As a community, the volunteers offered support to each other. Victor stated that he telephoned other volunteers who were missing from the centre to check that they were alright, while Vicky noted of Victor;

‘If he weren’t here I’d not be as keen to come’, (Vicky).

Community and neighborhood are not definite, bounded areas, but are constructed. ‘Community’ is subjective rather than an objective place (Fernandez and Langhout 2014). Place is the catalyst where relationships are formed and developed, and for this reason, community members have an attachment to place. It is social networks that sustain communities.

The Orange Centre was a catalyst for the development of social networks. It helped people to join social networks as anyone could attend. Once people are in a social network it

expands their contacts and active presence within the community. Social networks help to bind people together.

Community Engagement (8.4)

Community members participate in their community to different degrees. While some are very proactive community members, others dip in. The levels of participation and community engagement will be considered in this sub-theme.

A strong sense of community encourages participation (Christens and Lin 2014).

Key features of a sense of community include; feeling part of the community, having a shared emotional connectivity with other members, and having the ability to contribute and influence. A sense of community is often a catalyst for community development, as it was for members of the Melbrook community.

Melbrook had a core of community members who were proactive and looked to improve the life of other community members. When discussing the development of Melbrook and the Melbrook Development Trust, Steve noted;

'It was a group of volunteers, people within the community who loved their community, who appreciated that there was something better to be done for former coalfield communities', (Steve).

This initial group was the driving force for looking not just what was, but what could be.

John, Fieldhouse and Liu (2011) suggest four ways members communities can influence

their community and wider society; through influencing institutions and governance at a local level as a member of a committee for example. The authors suggest that when community members volunteer to be on committees, they understand the ethical significance of their actions, that they are doing it for the benefit of the community (John, Fieldhouse, and Liu 2011).

Vicky, a volunteer and member of the Melbrook Development Trust Board, was very proactive in supporting Melbrook through a number of activities. She looked to benefit the whole of the community by:

'Helping people's future lives and future health', (Vicky).

She continued;

'I've got big ideas about the next social enterprise perhaps being a Farmer's Market or another set of allotments, because both the local allotments are very heavily subscribed and there's waiting lists. So to me there's a need there to do a third set of allotments and then they could sell cheap, healthy food to the village and obviously organic, and cheaper food and things is very prominent with the current climate', (Vicky).

Victor noted that some board members were not involved within the day-to-day running of the Orange Centre; rather they were just involved in decision -making. Of board members he stated;

'I don't really see many of them. You know you might see them an odd time' They have their meetings of a night time and then obviously they've got full time jobs. So

we're trying to do something about it. We're hoping to put up like a family tree with everybody on it', (Victor).

Where some community members were interested in organising and decision making, others preferred to contribute in other ways. Violet liked socialising and made social contacts she made at the Orange Centre. Her main work in the Centre was preparing food in the kitchen and helping in the café. When I asked her if she would like to be more involved in the organisation of the Centre she answered;

'The problem is that when you come up with ideas, you end up doing it don't you?'... 'So I think at the moment, whatever were doing here at the ladies (Craft group) and the people that come in to do the sequence dancing....that suits me fine', (Violet).

Baston, Ahmed and Tsang (2002) suggest there are four categories that motivate individuals to participate in their community. These are; egotism, altruism, collectivism and principlism. Where egotism looks to the welfare of self, altruism and collectivism look to the welfare of others. Collectivism, suggests the authors, usually results from a social problem or dilemma. The welfare state was developed as a result of social change, and the community of Melbrook acted collectively as a result of the disintegration of their economic base. Collectivism is needed to develop communities, but does bring with it the problem of exclusivity, of 'them' and 'us'. All four motivations were evident in the volunteers, who gave of their time to support their own needs along with those of the community. Violet's religious principles, and the principles to be welcoming and supportive of others, support this category.

Not all of Melbrook's community members participated in community activities at the Orange Centre. Vicky discussed a 'leaflet drop', focused on a large estate in the area, with the aim of;

'Raising awareness of this place saying it had got a café, and the therapies and what activities it had', (Vicky).

She suggested;

'We just need to get more (people) through the door and knowing about us', (Vicky).

Vera recognised that it would be desirable to engage more Melbrook residents;

'I think it could roll along a lot better if the village itself would use it, you know, get behind it, but unfortunately villagers are very strange things, villagers, they're very.....I don't know, they don't like change', (Vera).

There are several explanations why more of Melbrook community did not use the Orange Centre. The Centre had only been open a couple of years when I undertook the study, and was continuing to develop. Vicky noted;

'We (are) still finding us feet and been struggling to keep going more than anything and forward projecting and that', (Vicky).

A second explanation concerns the rate and level that people want to engage. The wheel of participation described by Davidson (1998) looks at different stages of participation, these are; to inform, consult, participate, and empower. Each is given equal significance in the

planning of community engagement (Kelger et al. 2009). While participation and empowerment were optimum goals, there is an understanding that these are not always possible, particularly in the short term (NICE 2008:5, Heritage and Dooris 2009). Most communities require support to go through the stages from informing to empowerment, and each community progresses at its own rate (Heritage and Dooris 2009). Individuals may want different levels of involvement, or may take longer in the process than others.

Lewin's theory of change management, developed in 1947 and quoted by Burnes (2004), together with Prochaska and DiClemente's (1983) model of change behaviour, suggest different stages of change, and while some progress through the stages rapidly, other individuals progress slowly or not at all.

A third explanation is that the Orange Centre was not fulfilling the needs of some members of the Melbrook community. Skidmore, Bound and Lownsborough (2006) suggest that some people do not participate because they feel their interests are better met elsewhere. There were many other community activities in Melbrook for the community to engage in.

Ekman and Amno (2012) distinguish passive and active disengagement. Passive disengagement means that people are not interested and leave decision making to someone else. In contrast, those who actively disengage do take an interest but do not agree with what is going on. Skidmore, Bound and Lownsborough (2006) suggest that if non-participation is a problem, then the needs of non-participants are not being met. This will be explored further in the next chapter.

As a health visitor I can understand why people want to engage in their own time at a level at which they feel comfortable. When initially they join a group, new members may want to observe and participate by joining in the activities, but as their confidence grows, some, over time, take on more responsibility of the organisation of such groups.

One of the craft group members, Caroline, explained how she came to join the group and how nervous she felt at the prospect of her first visit. She was encouraged to attend by her friend, Chelsea, who already attended the group;

'I went into the surgery one morning and popped in to see (Chelsea) and she said, Well why don't you come this morning?' I really did shake' (indicating shaking), (Caroline).

'I said you're not going home, we'll call in and tell (Caroline's husband) and tell him where you're going and I said I've got some wool with me', (Chelsea).

'Is that when you started coming here?', (Third craft group member).

'Yes, when I'm coming here. It's just that I let my husband know', (Caroline).

When working as a health visitor in an area of deprivation, a member of the team, employed as a support worker, accompanied individuals to their first meeting at groups such as toddler groups. This proved to be successful in helping young mothers to engage in a group situation. In a similar way Vicky described how a volunteer, Paula, who occasionally helped at the centre, had become involved;

'I got her to come here first of all for a fashion show, she really liked it and then took it up', (Vicky).

Vicky explained that she was unable to accompany Paula to the centre on subsequent visits due to work commitments. She continued;

'I think it took three visits for her (Paula) to come through the door herself so she came twice as far as the door and then just got the bus back again' ... 'then the third time she came she met Vera and Viv and she loved it and she's been quite a few times and she's made loads of friends and done loads of things, she's really excited and...it's just been so good for her', (Vicky).

Gilchrist (2009) notes that it takes a lot of courage to join a community group or event and often individuals attend as a result of knowing someone who is already participating.

Vicky, as a result of her volunteering activities, was at a different level of participation from Caroline or Paula. She notes;

'I think people are more knowledgeable and have got more expertise to give to an organisation now than they used to be. Certainly when I was helping out at school, going back probably 10 years ago now, there were 4 or 5 of us and we were quite strong and we all had our own strengths and skills. And previous to that I think they'd just had little old ladies that had got a couple of hours to spare to do a bit of knitting or a bit of baking and wouldn't say boo to a goose and wouldn't challenge somebody professional, like a teacher, whereas modern day now, people are quite happy to go and talk to anybody no matter who they are and not be frightened', (Vicky).

These two quotes of, Caroline and Vicky, provide examples of people at different levels of community engagement. While one requires support to engage, the second is empowered to organise substantial community activities, and is able to challenge the knowledge and authority of professionals. Gilchrist (2009) suggest that the level of social skills affect the ability to participate. Each individual makes his or her own decision about how they can

contribute to community activities; this is then influenced by other people around them. Vicky, Caroline and Paula were all gaining from and contributing to the community

Arnstein's ladder of community participation (1969) (Appendix 2: Arnstein's Ladder of Citizen Participation) looks to the empowerment of communities as being the optimum goal of participation. The examples above suggest that professionals and community members should make provision for individuals to be able to participate at each level of Arnstein's ladder. It should be for the individual to choose the level to participate at any given time. Limiting levels of participation will lead to the exclusion of some individuals.

Factors that support community engagement include places to meet, particularly those that represent a common interest, such as churches and community halls. Common meeting places create opportunities to share experiences and form relationships (Volker, Flap, Lindenberg 2007). At the end of my second meeting with the craft group, one group member was very keen for me to document that it was the Orange Centre that facilitated the meeting of the craft group, by providing accommodation, signifying the importance of a meeting place. Coming together strengthens people's sense of community (Fernandez and Langhout 2014).

Kelger et al. (2009) suggest that an organisational structure helps to support community engagement, as it helps to increase participation. The authors also state that community development endeavours to help the whole of the community, even when individuals are not engaging with the process. Skidmore, Bound and Lownsborough (2006) dispute this

idea, stating that people need to actively participate in their community to gain benefits. Active involvement in the community increases health and well-being of individuals and enhances social justice, while passive participation does not provide the same rewards (Halpern, 2005, Ledwith and Springett 2010).

People engage with their communities at different levels, the level of an individual's level of engagement changes over time. Although empowerment and self-determination is the optimum level of engagement for communities, this study demonstrates that opportunities for individuals to engage at different levels is beneficial and enhances participation. Community facilities, such as the Orange Centre support community engagement.

Benefits of Community Engagement (8.5)

Politicians and communitarians look to reciprocity, community members contributing to the community as well as benefiting from membership (Etzioni 1998). Volunteers and craft group members demonstrated how this occurred. In their own ways, people who engaged in communities helped to build social capital, and by making a contribution, obtained benefits as a result of their participation. There were several examples in the study of how community engagement enhanced the well-being of community members.

Steve and several of the volunteers made reference to Connie. Connie attended the craft group, but always sat apart from the rest of the group on one of the settees near the café counter. She attended with a supporter from the hostel where she lived. I often chatted to

Connie and her supporter. Connie always conversed with the rest of the craft group when she entered the café, telling the group where she had been and what she had been doing the previous week. Connie had a fondness for large stuffed fluffy animals such as tigers and polar bears, and these were often a focus of conversation as she would bring a different animal each week. Connie constantly knitted, as she sat and talked, occasionally getting from her seat to order food from the cafe counter or selecting wool from the large table at the other end of the café where the rest of the craft group sat and where she would have a quick chat before returning to her seat with a new ball of wool. Volunteers and Melbrook Development Trust staff spoke with pride of the progress Connie had made during the previous year whilst attending the Orange Centre;

'We have a lady here with a learning disability and she didn't like noise, she couldn't speak to anyone' (and now she) 'talks to people and she sits down and she comes up and orders food' ... 'she goes to the (craft) group now and she's doing something for other people' ... 'she started off with low esteem and now she's got high esteem because she's doing things for other people', (Victor).

Connie had benefited from the social environment of the Orange Centre, and the participation, be it at the periphery, of the craft group.

Steve noted of another individual user of the Orange Centre;

'(He) happened to come in with his sandwiches one day, we wondered who the heck he was, we sat down with him, he's now a member of the (craft group), he comes into the café, it's his home. He can't work because of the mental ill health issues that he has but he's found somewhere that cares, and perhaps that's all that's required', (Steve).

Vicky commented on how the centre had helped two other individuals;

'One chap brings his mother here (to the craft group) it may be the only time she gets out all week'... she's blind, she comes in and sits and just comes in for a chat', (Vicky).

Of a casual volunteer;

'She's tried to kill herself on a number of occasions and her doctor thinks this has been the making of her', (Vicky).

From a minimal level of participation, individuals can become more engaged in their community, as their confidence and trust grows.

On one of my visits I asked if the craft group would participate in the research process. Their response was immediate, and I hurriedly set up set up a voice recorder on the table where they sat. Craft group members explained how attending the group promoted their health and well-being;

'I've not been very well, so it's been good for me as well, to get out', (Caroline).

'If you've got a problem you can come here, and then you say it (what the problem is) then afterwards you think it doesn't matter so much', (Cate).

'It helps me feel better helping someone because I'm a basket case at the minute. I've got work problems, but coming here makes me feel better, and I try to give something back', (Clara).

It was the company and support rather than the creative activity that improved well-being of craft group members. As one member of the craft group noted;

'I mean- I'm in my flat on my own, so I don't see anybody and I'm knitting from morning until night', (Charlotte).

Charlotte stated that she liked to come to the group for companionship and that the groups felt like a family.

I spoke to the craft group on two occasions, and sat with them at the large round table they occupied at one end of the café. Initially the conversation was around their activities and how they contributed to a range of charities, but as the conversations progressed, the discussion turned to what members gained as a result of participating in the group.

After my first meeting with craft group members, I listed the main points the group members disclosed about membership of the group. I clarified these points with the group the following week. Although I had listed the points and produced a printed sheet for each of the members, as with volunteers, the group preferred to talk rather than read. This demonstrated a clash of my professional culture with that of community members. The group not only confirmed my recordings as accurate, but added detail. The main benefits the group gained as a result of sharing experiences were as follows;

- The group helps individuals within the group

- Attending the group helps to reduce the things that worry you when you are on your own.
- It is nice to share activities
- Gain companionship and friendship as a result of attending
- It is inclusive, for example all ages welcome.
- Gives a sense of achievement
- It is a creative outlet
- Reduces loneliness

Loneliness, and an ‘absence of rewarding social relationships’, can cause increased morbidity (Bolton 2012, Cacioppo 2014). A study by Cacioppo (2014), that looked at loneliness in the elderly, states that loneliness causes increased rates of depression, raised blood pressure, stress, changes in gene expression and reduced feelings of well-being. Being alone is not the cause of these symptoms; it is a feeling of isolation, not having a meaningful social contact that causes deterioration in health and well-being (Cacioppo 2014, Hams 2014). Social isolation can cause adverse mental and physical problems in all age groups. While the incidence of loneliness has remained static in the elderly population, at approximately 10% over the last 60 years, the number of people over 65 years has increased; therefore loneliness affects more people (Bolton 2012). 17% of those over 80 years report that they are lonely (Office of National Statistics 2013). People who are less socially, as well as physically, mobile are less able to form new relationships, and, as a result get left behind (Griffin 2010).

Cacioppo (2014) and his colleagues suggest a number of ways to reduce loneliness. These include; keeping in touch with family and friends, face to face contact with people as part of mutually rewarding relationships, and ‘collective connectedness’, feeling that you are part of a group (Cacioppo 2014, Hays 2014). Perry (2014) notes, that unlike individual treatment, the connections and relationships made within a group stretch beyond group encounters. This was evident in the relationships made between volunteers who met to socialise outside the confines of the Orange Centre.

Loneliness can be reduced as a result of volunteering, both as a volunteer and recipient (Griffin 2010, Great Britain, Parliament, House of Lords (2013)). While individuals can take measures to try and protect themselves from loneliness, the government looks to communities, local authorities and civil society to reduce loneliness (Bolton 2013, Great Britain, Parliament, House of Lords 2013). It is suggested that agencies should signpost individuals to suitable groups, taking into consideration the individual’s interests and strengths, together with providing support to local clubs and meeting places (Bolton 2013, Great Britain, Parliament, House of Lords 2013). In other words, facilitating and supporting community engagement.

Tetley (2012), when looking at the experiences of older people attending a luncheon club, noted that health and social care services were focused on providing support with activities of daily living, rather than social needs of club members. She found that while health and social care services offered limited support, this frequently did not match the needs and aspirations of the elderly population. The author found that it was the Third Sector that was

more flexible and knowledgeable in supporting the needs of individuals. The craft group demonstrated that they supported each other by addressing their social and emotional needs. They were fulfilling a need that statutory agencies were not.

Community engagement can provide substantial benefits for those who engage in the process. The health and well-being benefits of community engagement are starting to be recognised, however, the full potential of community engagement has not been harnessed or explored as either complementary to or as an alternative to health and welfare services currently commissioned by the state, despite evidence that suggests that state services are not addressing the needs of community members (NICE 2008, O'Mara Eves 2013).

Sharing (8.6)

Members of the craft group demonstrated how sharing problems and experiences had a beneficial effect on health and wellbeing. They demonstrated how civil society, rather than the state supported and sustained community members.

Some members of the craft group knitted garments for premature babies. Group members involved in this activity commented that knitted garments were a welcome contrast from the stark white hospital setting and that they helped to personalise the premature baby.

As the conversation progressed, two group members, generations apart, discussed their individual experiences as a result of the loss of their baby. Clara, the younger of the two

women, volunteered that she gained comfort from the knitted hat that had been on the head of her dead premature baby. She went on to talk about her loss and how helpful people had been, allowing her to grieve. One elderly lady, Clare, commented that she also had lost a baby many years ago, but that in the past, when a baby died, the baby was taken away and parents did not have chance to see it. Clare informed the group that her baby was placed in an unmarked mass grave with 12 other infants. The grieving mother did not know where the baby was buried, despite paying for the grave. Clara's experience was in contrast to Clare's, as she had experienced support and kindness from a range of organisations at the time of her loss.

I was very moved by the comments Clara and Clare made, and that they were able to share them with the group and with me who they had just met. Clare's description of her loss was particularly painful as her grief did not appear to be recognised by society at the time of her infant's death. She seemed alone in her grief, with no anchor such as a headstone that recognised the presence of her child. I did not know if Clare had discussed her loss with members of the group before. They were respectful of her story and gave her time to speak. Today, the grief associated with the loss of a baby is recognised, as is the grieving parent's need for a physical reminder of the child, such as pictures and a marked grave.

This was an instance where my professional background as a health visitor helped me to understand some of the pain both women had suffered, through my understanding of grief, but also working with families who had lost babies and young children. I would not claim to have a personal understanding of the effect the loss so clearly had on both women. As a

health care professional working with families who had lost an infant I felt incompetent, and that I was intruding on such a time of sadness, wondering if I was a reminder of the live child they had lost. Parents often feel that only other parents who have suffered the loss of a baby can have the understanding of what it is like, and therefore seek help from groups consisting of bereaved parents (SANDS 2014). Health visitors need to recognise that they may not be the best people to offer support, and those families who have a similar experience of the loss of a child can provide more appropriate support.

Conversations with and observations of volunteers and craft group members helped me to understand what community meant to participants. This was a very different view from my perspective as a health care professional. Where geographical location and boundaries have been the basis of how public bodies and professionals have determined community, community members have a different view. The concept of community from the perspective of community members is more fluid. It is not just a physical location, but rather a network of social connections and a place to which people attach meaning. A community therefore is constructed by community members. It is what people make it, and it is people who make a community.

It was made clear to me by the volunteers, on one of my early visits to the Orange Centre, that I was not a member of Melbrook community but to the neighbouring locality that had a different population. From my initial difficulty of engaging with volunteers in a manner that was appropriate to them in February of 2010, gradually, by April volunteers would choose to come and sit with me and talk about their experiences. It was during April that, as

I sat in the café having a coffee, Viv entered the room, and as she greeted me, touched my arm. The touch was very rewarding, more than a physical connection, I felt as though it was a signal of being accepted. I started to consider that I was part of the experience of community that was created within the Orange Centre. I noted in my field notes of 1st April 2010;

'The difference with the visit today is that I enjoyed it and look forward to going again. I got a 'feel good' factor from the experience, particularly in conversation with a small child, with Connie and with members of the craft group. I felt a more relaxed relationship with the volunteers'.

I made this entry because I was no longer there as a health care professional, I was at the Orange Centre as someone who was gaining benefit, of feeling uplifted, as a result of being part of a community experience. I had a glimpse of what it I like to gain social and emotional well-being from community engagement.

Not only can communities provide health and welfare provision not currently being supported by the state, communities are able to offer kinds of support that the state cannot provide. It is a shared experience that provides support and encouragement, experiences that statutory services and health care professionals cannot replicate.

Conclusion (8.7)

Gaining a better understanding of community engagement from the perspectives of community members, it appears that 'community' is a construction by people who

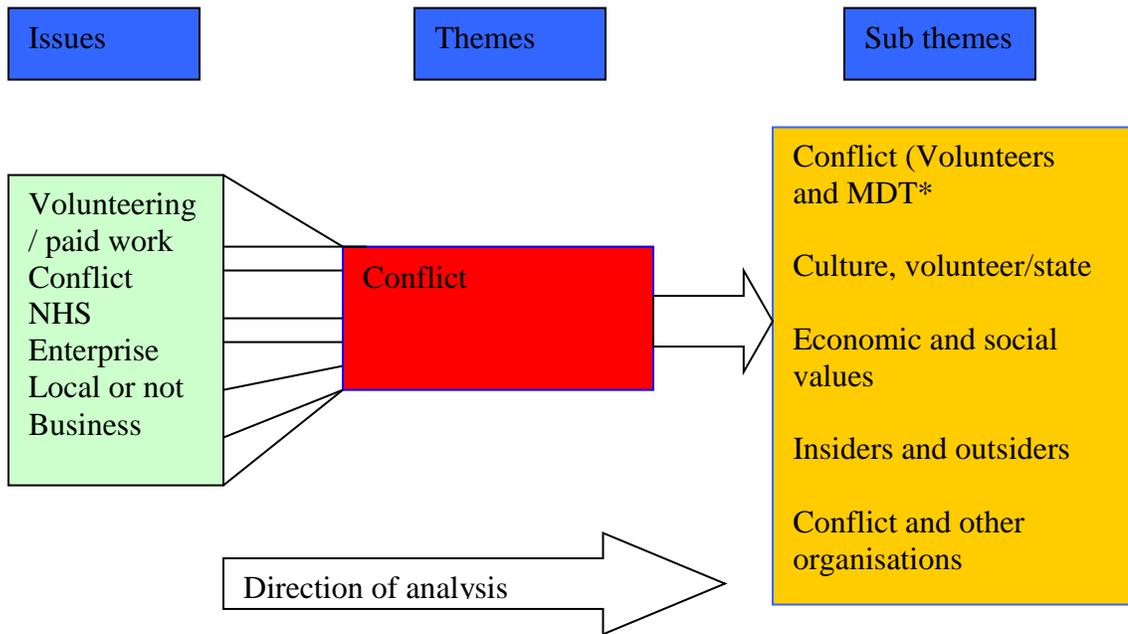
participate in the process. Community members participate in different ways and engage at different levels. Health care professionals need to develop a dialogue so they can gain a better understanding of community from the perspective of the community members. This study has enabled me to gain an understanding of how community engagement benefits those who are involved in the process. Although the study did not set out to look at the health and well-being benefits of community engagement, these were apparent in the conversations and observations I recorded. This chapter has looked at the positive benefits that community engagement can bring. The following chapter looks at the tensions and conflict that can occur both within communities and as the 'public' culture meets the culture of civil society through joint ventures of community development and economic regeneration.

CONFLICT (9)

Introduction (9.1)

The state, as it reduces welfare services, is expecting civil society to take responsibility for supporting and sustaining communities (Bellefeuille 2005, Taylor 2007). This assumes that communities are cohesive and work to common goals. This chapter illustrates the tensions and conflict within communities, from the micro-community upwards to macro-communities. It looks at how sections of communities can be in disharmony and considers the complexity of providing support for communities where there are different needs and conflicting interests. Finally, it considers the tensions created, on a practical level, when two cultures meet; the cultures of public and civil. Such tensions are exacerbated by opposing interests of social and economic benefits.

Diagram 4: The process of analysis for the theme of ‘Volunteers’



* Melbrook Development Trust

Conflict; Volunteers and Melbrook Development Trust (MDT) (9.2)

Conflict occurred between the volunteers, but in particular between the volunteers and Melbrook Development Trust. Conflict resulted from inequalities in power and influence, but also as a result of differing priorities and objectives.

The volunteers came together to support a common interest, the Orange Centre and the Melbrook community. Although this common interest binds them together in one respect,

the volunteers each have a range of different interests and views. Victor put such differences down to the age range of volunteers. Their differences, however, have practical implications;

'Older people mostly like table cloths and flowers on a table, some people like just like plain wood on a table', (Victor).

As volunteers had particular days of the week when they worked, the result was that some days there were cloths on the tables and others days not. Where there were disagreements between volunteers, sub-groups of volunteers supported each other.

Some volunteers had conflicting priorities. Vicky described the range of priorities individuals juggled as; *'got a different hat on'*. This was evident with one volunteer (Violet) who had allegiances to Melbrook Church and was keen to maintain the appearance and dignity of the Orange Centre, as the former Melbrook Church Hall.

In some ways it is difficult to make the distinction between volunteers and Melbrook Development Trust as of the five volunteers that participated in the study, two volunteers were members of the Melbrook Development Trust board (Vicky and Vera), and a third (Violet) was the wife of a board member. Yet, volunteers who had dual roles made the distinction between their role as a volunteer and that of the board member. Vicky noted that while the board made decisions about the whole Melbrook community, the work of the volunteers was local to the Orange Centre. She noted that there were few opportunities for volunteers to make decisions.

The issues the volunteers had with regard to the board of Melbrook Development Trust centred on money and power. In particular, the volunteers' lack of both. Volunteers were frustrated that they could not make decisions or purchase equipment without a decision from the Melbrook Development Trust Board and the Management Committee of the Orange Centre

Vicky noted;

'We haven't got the budget to just go out and use our initiative, money is really tight', (Vicky),

And also;

'You can't really make tons of decisions as a volunteer so it just leads to some negativity. Because we come up with some really good ideas but then can't put them into practice or they get overlooked', (Vicky).

Volunteers' inability to move on spending decisions had income generation implications.

Vicky suggested that the Orange Centre had spare capacity to rent out rooms. When furnished therapy rooms were booked, additional rooms could not be let to therapists as they did not contain appropriate equipment, in particular, a therapy couch. Volunteers were aware of this situation, but did not have the ability to purchase equipment necessary to make the rooms suitable for hire as therapy rooms. As a result, potential income was lost due to lack of appropriate resources. However, not all purchases volunteers requested were

for large sums of money, some were for very small sums. This increased the frustration of the volunteers.

The slowness of decision making by the board was a further cause of frustration to volunteers. Vicky explained how purchase decisions were delayed until the board met. Following board meetings there often followed several more stages of decision making before a purchase was agreed. As Vicky noted of one request;

'We waited nearly a year for some shelves', (Vicky).

Steve, employed by the Melbrook Development Trust, had a different view of the volunteers' power, stating that issues raised by the volunteers (at their monthly meeting with one of the managers) were fed back to the Management Committee of the Orange Centre. Steve stated that where there were no cost implications, volunteer's suggestions were implemented.

Sally, also employed by the Trust, who had more contact with the volunteers, was aware of their frustrations;

'Half the management committee aren't really actively involved in the running of the Centre and I would like to see that changed to be honest, because I think the people that are running the Centre don't always agree with members of the Management Committee about decisions. And decisions do take a long time to be made when there's a lot of people,' (Sally).

Both Victor and Vicky were frustrated of the lack of development in the Orange Centre over the previous two years. Vicky was a board member, but Victor was not. Vicky stated;

'I find it hard constantly going to meetings and we're just treading water' ... 'we had meetings where we sit around and discuss what we'd like to do as a social enterprise but nothing's got put into practice. So I do find that, as a volunteer, quite frustrating', (Vicky).

Vicky was also frustrated with the lack of progress as a board member. Of board meetings she stated;

'I feel like my time is being wasted because we're going over old ground', (Vicky).

The lack of spending power the volunteers experienced was partly as result of the financial difficulties Melbrook Development Trust faced, but also the way the money was allocated. The Orange Centre was only able to function because the volunteers gave so much of their time, supplementing a minimum input from paid staff.

The position of the volunteers with regard to the Melbrook Development Trust was in many ways a reflection of the lack of power and influence service users in the NHS experience; they were consulted, but their views could be disregarded. While Steve suggested that feeding back comments involved the volunteers in the decision-making process, in effect they had no real power or ability to make decisions. Their position, at best, was one Arnstein (1969) describes as 'placation', where volunteers were given opportunities to forward their ideas to the board, but those ideas did not influence board decisions. As the board had to make decisions that affected the whole range of Melbrook

Development Trust activities, activities including the running of a nursery and the provision of business premises for example, it could not be dominated by Orange Centre volunteers. However, it could be argued that the board should be representative of the whole of the community (Skidmore, Bound and Lownsborough 2006). From the comments of volunteers and Sally, there seemed to be a gap between the community and the board.

The volunteers were very resourceful and had introduced measures to overcome their apparent lack of power and budget. The volunteers ran a bric-a-brac stall in the entrance of the Orange Centre that helped them raise funds. Volunteers used the money raised to enhance the Centre. They did this without reference to the board. Victor gave an example of how the money was spent;

'Some chairs and tables have been donated, and we've just bought some paint to paint the chairs up and things, that's like £12-13 so that's nearly more than half of a month's raisings' (from the bric-a-brac stall income), (Victor).

Sally noted of the bric-a-brac stall,

'Well the volunteers run, which you might be aware, they run that bric-a-brac stall and that's been quite successful in bringing some money in, and the volunteers decide where the funding is going to go for. So I know some of the funding from the bric-a-brac stall has gone to pay for mirrors in the therapy rooms', (Sally).

The volunteers made decisions democratically, including how the income they raised would be spent. Each successful purchase required a vote from at least three volunteers.

Although the volunteers were managed by a member of staff from the Melbrook

Development Trust, Victor appeared to be their unofficial champion. He explained how the

volunteers took issues they wanted to discuss with the Centre manager to the shared monthly meeting. Two weeks before the volunteer/manager meeting Victor asked volunteers what issues they wanted to raise. The volunteers selected six topics they wanted to discuss at the hour-long meeting. They also decided which of the volunteers would introduce each topic.

Volunteers, therefore, had developed a form of democratic self-governance and self-determination, albeit in a minor way. They had worked around the difficulties they faced, and had created an ability to collectively make decisions that in turn had an impact on the environment of the Orange Centre. They were also attempting to make the Centre more economically viable, for example by trying to equip more therapy rooms to increase revenue, but were frustrated in their efforts.

Although the volunteers had no designated power, they could use their unique position to gain power. Without the cooperation of volunteers the Orange Centre could not stay open. They could, therefore, use their position as a volunteer to their advantage.

Victor indicated the power the volunteers held;

'It might take us longer but we achieve what we want to achieve'..... 'we still have a voice but it's like I have to say to (the volunteers), "Hold tight, we'll get what we want!'"', (Victor).

Although volunteers appeared to have no power in the decision-making process, they did have power individually, and collectively, by threatening to withhold their labour. Without the cooperation and activities of volunteers the Orange Centre could not run.

Vicky noted of the staffing at the Orange Centre;

'The only staffing is, er, two part timers, that's (A) and (B)....and if it wasn't for the volunteers it would have shut a long time ago', (Vicky).

Victor referred to the strategies used by volunteers to get some of the things they wanted as, 'people power', and that by working together they could be empowered. An example of this would be when volunteers withheld their good will by, for example, saying that no one was available to cover a certain day at the Centre, in effect holding managers of the Orange Centre to ransom.

Marx (1999) proposed that the labourer was the owner of his (or her) own labour and could decide to sell it or not. The only power the labourer had, suggested Marx, was selling or withholding their labour, as the owners of capital required labour to produce their goods. Where Marx suggested that the labourer only had power when they were in action, i.e. working as a result of selling their labour, Trade Unions and workers have exerted power and influence through the threat of and the use of withdrawal of their labour. Like many paid workers, the volunteers were powerful as a result of the threat to withhold labour. It could be argued that it would be possible to just replace volunteers who withhold their labour. Sally informed me that the Melbrook Development Trust had a good response when

they advertised for volunteers, and that new volunteers from a wide geographical area came forward; however, both Vicky and Sally noted that these volunteers did not stay.

Traditionally, workers have had more power when collectively they have threatened or actively withheld their labour. Through collective bargaining pay and working conditions have improved (Lawrence 2004). Solidarity has changed the political landscape in Britain. Action initiated by the National Union of Mineworkers brought about the collapse of the (Heath) Conservative Government for example (Lawrence 2004). In clashes between miners and the Thatcher government, it was lack of solidarity, suggests Lawrence (2004), that led to the miners' defeat. It was the outcome of this conflict that contributed to economic decline of Melbrook.

The actions of Trade Unions is an example of mustering active solidarity; but people come together collectively as a result of shared values interests and goals and to promote civil rights and social justice in other ways. Solidarity increases participation and collective action (Akkerman, Born and Torenlid 2013). It signifies cooperation, shared principles, and a common goal (Cureton 2012). Individuals involved in collective action identify with and take pride from being part of the group. They look out for the welfare of other members and take risks they might not as individuals (Cureton 2012). All these attributes make collective action more powerful than individuals working alone. By working collectively, for example by raising money through their own efforts, and by having shared goals such as wanting to improve the facilities, the volunteers were more effective in promoting change

than if they had worked independently. In the same respect, communities working together are more effective than communities that are in disharmony.

Culture, (Volunteer and the State) (9.3)

Within the theme of Conflict, a sub-theme emerged that was based on the difference of culture between the volunteers and the paid staff of Melbrook Development Trust. These tensions were due to the different priorities and world views of volunteers and managers of Melbrook Development Trust. Where volunteers valued the social life of the community, employees of Melbrook Development Trust looked to economic sustainability of the Trust.

There were tensions between the culture of the volunteers, their values, behaviour, goals and view of the world, and the culture of Melbrook Development Trust. The differences were of a philosophical nature and difficult to resolve. The differences centred on the values each placed on economic growth and social development. Where volunteers and service users of the Orange Centre valued the social aspect of regeneration activities, Sally and Steve, while acknowledging that economic and social development go hand in hand, looked to economic regeneration in the first instance. This was partly due to the restrictions associated with European Union funding that the Trust had been dependent upon. From a practical point of view, the Orange Centre, together with the trading activities of Melbrook Development Trust, could only continue for as long as they were economically viable. Therefore, the first priority for Sally and Steve was economic viability.

Sally illustrated her focus on economic viability when discussing the craft group use of Orange Centre café for their meetings. The group did not provide an income for the Centre because they did not rent a room. Sally commented on the craft group continuing to use the café;

'It may come to the stage when we have to cut back on things like that, but that's not what we're about it's a healthy living centre for the well-being of this area',
(Sally).

The difference between economic and social priorities of volunteers and employees of Melbook Development Trust can be illustrated with the pricing of confectionery at the Orange Centre. Some volunteers made buns at home and brought them to sell in the café. The buns were donated by the volunteers and therefore they could be sold relatively cheaply in the café, and the centre could still make a profit on them. When home produced buns were not available, confectionery was purchased commercially. 'Bought buns' were more expensive to obtain and had to be sold at a higher price than homemade buns for the cafe to make a profit. This resulted in inconsistencies in the price of cake and buns on sale in the Centre.

Vicky commented on the inconsistency between the price to the customer of home produced and commercially produced buns and cakes;

'Ladies bake cakes (and) donate them and sell them pretty cheap (in the Orange Centre café), and they do that for the church, but they've no overhead(s) for the church. So if we buy cakes (to sell in the café) we've got to pay back, we've got to make money. And then if you came in on Thursday and get a piece of cake at 50p, come in on a Monday and we'll charge you £1.75' ... 'I can see where she's (the

manager of the volunteers) *coming from, you need continuity. But I can see where they're (the volunteers) coming from, they're making them at home' ... 'and they don't want to be seen to be ripping people off'*, (Vicky).

Sally, who as a manager represented the organisational perspective, noted;

'I mean there's definitely a need to do a bit more co-ordination between the volunteers. I'm aware that they've got their own way of doing things, say in the café, and I suppose from a customer point of view there might be an expectation to have things done the same way. But I don't know; maybe I'm a bit too pernickety, I don't know. But I think if you're going to treat people almost like an employee you need to have the same sort of processes in place', (Sally).

Volunteers were not employees. Tensions were created because of different expectations between the volunteers and managers. A compromise was reached. Thursday was designated a 'Community day' when all the buns were home produced and sold at a 'community rate', and commercially produced confectionery at a higher cost to the customer was sold on other days.

The 'battle of the buns' reflected tensions throughout the organisation, and was symbolic of the conflict between social and economic benefits the community. While Melbrook Development Trust wanted to be economically viable, the volunteers looked to the social aspects of the Orange Centre.

The aims of the Melton Community Partnership (the initial organisation set up by the community and superseded by Melbrook Development Trust) when it was conceived in 1996, were to;

‘Improve quality of life economically, socially and environmentally for all those who live, work play and conduct a business in (Melbrook)’, (Steve).

European Funding was obtained in 2000 and the Melbrook Development Trust replaced the Melbrook Community Partnership. The nature of the community organisation changed at this point as European funding was purely to fund economic regeneration. As Steve notes, European funding was provided;

‘To create businesses, new factories, new jobs, training’, (Steve).

A number of projects were incorporated into the bid for the EU funding. The Melbrook Development Trust was set up to manage these projects, as Sally defines, to become a;

‘Trading company for the village’, (Sally).

The Orange Centre was not in the original feasibility study proposed when Melbrook Development Trust was created; rather it replaced a planned project that could not be implemented. The Orange Centre was devised as an ‘alternative’ and ‘complementary’ therapy centre so as not to lose a portion of the EU funding. The original aim of the Orange Centre was to generate income by renting consulting rooms to ‘complementary therapists’.

Although the Orange Centre was primarily conceived as an income generation project, it introduced the concept, as a healthy living centre, of producing health and social benefits as well as economic benefits. This put the Centre at odds with other Melbrook Development

Trust projects based on economic generation. Steve anticipated my question about economic and social outcomes when he posed the question;

'How can we get a social outcome when we are contracted to deliver physical outputs that are all economically based?' (Steve).

Sally noted that the plans for the Orange Centre had to be changed once it opened;

'It was originally going to be very much a therapy based centre, but we didn't have a huge uptake by therapists and that's why we sort of diversified' 'it's a multi-purpose community facility and always trying to meet the needs of local people in (the locality) whether it's looking at health promotion, helping the business sector. It's also looking at bringing community activities as well. So we're trying to address health, business, community', (Sally).

As the Centre developed, and expectations around room lettings were not fully realised, the café, designed as a facility for therapy customers, developed into the hub of the Orange Centre. Where economic benefits were not fully realised, social benefits became more prominent.

When European Union funding came to an end, Melbrook Development Trust had to change to an organisation that was self-funding. This meant refocusing their priorities and searching out new sources of income generation. In the summer of 2010, as my fieldwork was drawing to an end, Steve commented on the financial situation of Melbrook Development Trust;

'It's a struggle, the economic climate's not helped, we're about 90% sustainable at the moment and we scratch around', (Steve).

He continued;

'We are now refocused on the softer issues from being hard economic and project deliverers and merchants we are now able to focus back on our core aims to support the community', (Steve).

Both Sally and Steve wanted to support the community. Where Sally looked to a reliable regular income based on trading, Steve tended to discuss the social advantages the Orange Centre supplied. When discussing the tensions between providing social or economic benefits to community, Steve suggested that both are required;

'There is a theory that true regeneration is a mix of both social and economic, and that perhaps they should both be developed, fully embraced by the community, at the same pace', (Steve).

Sally had a more pragmatic view suggesting that the while the overarching aim was to benefit the community, this could only be achieved through a strong economic base;

'I always think social enterprise is more than profit, because you've got to set up a viable enterprise financially, but the profits get reinvested back into the community, or reinvested into the aims of the enterprise', (Sally).

Vicky recognised that the Orange Centre had to be economically viable, but only in so much that this enabled social gains to the community. Economic viability was the means to a social end. Of the Orange Centre Vicky noted;

'It doesn't have to make tons of money but it has to stabilise and be self-sufficient; we have to keep running somehow', (Vicky).

Vicky went on to discuss how the Trust had to look to things that generated money and could only support a few free groups such as the craft group and keep fit for over 50's. She noted that there were a lot of older residents in Melbrook, and told me that the trust had considered getting a van and driver to deliver prescriptions to elderly people and do a bit of shopping;

'Because that is a real community need' ... 'obviously it's not particularly profit making' ... 'but it isn't all about profit making, it's about helping people locally', (Vicky).

Two more illustrations, 'fancy coffee' and 'bacon sandwiches' demonstrate different world views and resulting tensions between community members and those employed to plan and implement regeneration projects.

Viv introduced the term 'fancy coffee', as it was one of her tasks to make a 'Latte' on the café's coffee machine. The Orange Centre invested in equipment to make 'fancy coffee' as it was anticipated that the clientele of the centre, those attending therapy sessions, would want a sophisticated and more expensive coffee.

Vicky noted;

'The idea was that if people are quite happy to pay £40 for a treatment they'd come down here and spend a couple of quid on a nice coffee' ... 'then if you were talking to your general person in the village it would be, "We're not paying it, we're not

paying £2 for a coffee, what do you think it is?” ... “We can buy a bag of tea bags for a pound!”” (Vicky).

In contrast, to therapy customers, the local community suffered from a level of economic deprivation. As local people started to use the café, then a cheaper, instant coffee was added to the menu to address a range of local budgets.

Vicky commented that the plans for a healthy café did not work in practice for similar reasons;

‘It (the café) was going to be a vegetarian and vegan café- that lasted probably two months- because we struggle now so we were certainly struggling when you were so restrictive to be vegetarian and vegan.’ (Vicky).

Victor, who had a background in catering, looked at ways of making the café more economically viable. He proposed that providing breakfasts and items such as bacon sandwiches would bring in more revenue to the Orange Centre from a ‘passing trade’. He was particularly frustrated by the lack of facilities in the kitchen of the Orange Centre café that meant that he was unable to fry food. The kitchen, was large and clean and apparently well equipped, however, it had been designed to provide ‘healthy food’ to project the ‘healthy lifestyle’ philosophy of the Centre.

Although Victor suggested that bacon could be cooked with a minimal amount of olive oil to make it ‘healthier’, without the appropriate extractor fan, this was not possible. Victor was frustrated that the philosophy on which the Centre was based, healthy living, had limited its economic potential.

In both examples, of ‘fancy coffee’ and bacon sandwiches, the aspirational ideas of the Melbrook Development Trust did not work in practice in Melbrook. Rather than looking to the local community for what they wanted, the Trust had looked at ways of attracting business from outside the community to generate money that would in turn support Melbrook community. Some of these ventures were not working, yet local people had ideas about what would work in their area. It is local people who have an expert knowledge of their community. Hull (2001), when looking at regeneration projects, noted that public bodies do not recognise the expert knowledge that community members have, or their ideas and desires.

Cornelius and Wallace (2010) propose that there are inherent tensions associated with regeneration projects, and in particular, obtaining a balance between economic and social growth. O’Hare (2010) studied a European Union funded regeneration project similar to the one at Melbrook. He suggests that the ongoing processes associated with European grants act as a barrier to local community engagement. In the cases he studied, O’Hare (2010) observed that development workers took over the responsibility for administration of the project. Community members were sidelined and became powerless in the organisation of projects that were designed to help them.

The European Commission categorises communities into two levels. Those at level two are judged to have the ability to engage with regeneration projects, while those at level one require capacity building skills to enable them to engage (O’Hare 2010). Rather than taking over responsibilities, development workers should help community members to gain the

skills they require to be fully involved in the development of their communities. Instead of empowering communities by helping them to develop skills, it appears that development workers take over.

Many regeneration projects look to improve the economic base of deprived communities, reflecting society's preoccupation with a market economy (Cornelius and Wallace 2010). This does not address the problem that economic decline also triggers a decline in the social fabric of an area. Many regeneration initiatives have failed as they are based on the physical regeneration, rather than the quality of social life of residents (Hull 2001). There is no quick fix for both social and economic decline, yet many regeneration projects have been limited in their context (Hull 2001, Cornelius and Wallace 2010). The government has funded top-down, short-term, and small-scale projects rather than looking to long-term grassroots community development (Dillon and Fanning 2012). Top-down approaches inhibit social change. Rather than empowering communities, government is 'spreading its tentacles' of control, limiting what communities can and cannot do through the restrictions associated with funding and procedural requirements (O'Hare 2010: 37).

Planners fail to ask residents what they want. Hull (2001: 301) notes the government, 'is reluctant to take the risk of backing the residents and their perceptions of what must change'. Munch (1999) led a study looking at a regeneration project in Liverpool. One resident stated; "They tell us we need professionals to come and sort us out. No we don't. We want the money so we can do it ourselves', Munch (1999:3).

My observations and discussions with the volunteers demonstrated that they were very capable, able to make decisions and had a good understanding of how money could be allocated to make the Orange Centre more profitable, yet they were not given the opportunities to take their ideas forward. Volunteers had no power in the decision-making process, only the power to withhold their labour. The report conducted by Munch (1999) was subtitled, 'It's all down to the people'. Most regeneration projects have not been left to the people, and as a result communities have not been empowered to move forward (Munch 1999, Hull 2001).

People who live in disadvantaged areas rely heavily on micro-communities, the network of friends in their locality (Hull 2001). This is often disregarded when regeneration projects are only judged on economic outcomes. It is the quality of social life, as perceived by residents, that should be monitored and used to gauge of the success of regeneration projects as this is what matters to the people who live there (Cornelius and Wallace 2010).

Although economic and social regeneration are interlinked, there has not been enough attention paid to social regeneration or the improvement of social justice within socially deprived areas (Cornelius and Wallace 2010). The findings of this study illustrate that there are different values and priorities between community members and those employed from outside the community to regenerate communities that have suffered disadvantage. While communities have a good understanding of what is required in their individual community, outside agencies and national policies have imposed priorities and practices on

communities that have substantially limited the ability of communities to effectively develop.

Insiders and Outsiders (9.4)

Although the concept of community varies amongst individuals, participants of this study illustrated the notion of insiders and outsiders. While insiders are residents of Melbrook, outsiders are people who are residents of places outside the village. The volunteers defined me as an outsider because I was not a resident of Melbrook. I lived in an adjoining postal area. Geographically, there was no distraction between Melbrook and the area where I lived as there was continuous housing between the two. As I explored insiders and outsiders, the picture became more complex and was not just based on residency. Melbrook was not one harmonious community, but contained different groups and communities within the geographical area. Cate, for example, was a member of the craft group that met at the Orange Centre but was not a resident of the village; while some residents were seen as outsiders of particular sections of Melbrook community. Within the location of Melbrook village each community group had a set of values and beliefs, and each group had loyal members. Describing and exploring 'insiders and outsiders' does help to illustrate the complexity of community life and the tensions experienced by community members. In particular, the issue of 'insiders and outsiders' had implications for the economic viability of Melbrook Development Trust that, in turn, supported the Orange Centre.

While the benefits of the Melbrook Development Trust activities were focused on Melbrook, to obtain economic viability, the village had to draw on a wider economic base;

'We're finding that people do travel to the (Orange) Centre even from (Melworth), so there is quite a broad number of users that use the Centre, and I think people from (Rochwell) as well come over to use the Centre as well because they're so close to the border. So yes it's quite widespread', (Sally).

Hull (2001) suggests that regeneration projects do not consider the wider geographical context surrounding communities. By attracting paying customers from a wider, and wealthier, geographical area, money could be transferred into Melbrook to supported community facilities such as the Orange Centre. Provision had been made to bring in such customers, for example the purchase of a 'fancy coffee' machine. However, this also meant that wealthier people benefited from Melbrook community facilities. Studies have shown that disadvantaged communities gain least from regeneration projects, whereas those who are wealthier gain most (Hull 2001, Cornelius and Wallace 2010).

Funding criteria determined the economic focus of Melbrook Development Trust activities during part of its development. Economic activities are not a bad thing, as they can be used by communities to develop community resources. An economic predominance is, however, detrimental when it inhibits and becomes a barrier to the growth of social capital.

There were tensions not only in the balance between social and economic benefits of the regeneration project, but also between the different projects run by Melbrook Development Trust. Different sections of the community had loyalties to different ventures. Vicky was

vociferous about her concerns about another project supported by Melbrook Development Trust: the local (miners' welfare) social club.

The social club at Melbrook was criticised in the local press as a result of the way it had used European Union funding during the time of the study. One of Vicky's worries was that all the projects run by Melbrook Development Trust would be tainted by the reported activities of the social club. Vicky had particular issues with the club, mainly that it had obtained 'community' funding, but in practice was exclusive to a small number of members. Vicky gave two examples to illustrate her point;

'I believe that at Christmas (the social club) paid for some bouncers on the door, someone was telling me, that there were twelve people (in the social club) on Christmas Eve, they just wanted their same core twenty people that's been there, all elderly and they wanted this money and people running round after them', (Vicky).

Vicky continued that social club members had to buy a fob so that they could gain entrance to the club. This again caused barriers to entry, enhancing the exclusiveness of the social club.

Vicky was a serial volunteer and ran many community events. Her biggest event was the annual Melbrook Gala. Events such as galas and festivals bring communities together and promote a sense of community (Payne 2013). While Vicky looked to promote a cohesive community based on common community interests, other groups used their interests to distinguish themselves from the wider Melbrook community. Vicky's relationship with the social club was particularly fraught with regard to the Gala. She noted that despite the

social club having opportunities to make extra income on the Gala day through the sale of drinks, the club wanted to charge the Gala committee for use of its toilets - toilets refurbished with 'community' funding. When Vicky contested this charge, she informed me that a representative of the social club had replied;

'Just because it's a community facility doesn't give the community the right to use it'.

This quote does seem to be a contradiction in terms, but does pose questions including, 'Who owns community facilities?' and, 'Who is eligible to use them?' At the heart of Vicky's argument is inclusivity, that community benefits should be open to all members of the community.

Community, by definition, is exclusive; some people are community members, and others are not. It is inclusivity and exclusivity that contrasts the view of Vicky and the social club management. Vicky looks to the whole of the community, while the club looks to a group within the community. Spradley and McCurdy (1990) suggest that every culture has two sides, one side of adaption, with conflict and destruction on the other.

Coal mining communities were formed as a result of an economic precedent; such communities shared an occupation and common life experiences. Towards the end of the 21st century, large private housing estates were built in the area surrounding Melbrook, together with areas devoted to light industries. The protection of a way of life and culture may have been the basis for the protection of the inclusiveness of the social club.

Crow and Maclean (2013) suggest that where there are communities based on place, conflict is more obvious. In communities based on a place, such as island communities or 'pit villages', length of residence is one indicator of being an insider, but also family connections and social networks. Crow, Allan and Summers (2001), who studied an island community, suggested that there were communities inside communities. Long-term residents referred to 'my territory' to indicate belonging, and classed themselves as insiders, as opposed to people who had moved to the island who were outsiders. The boundary between insider and outsider is fluid, for example participation in community life can help to confer insider status. Interestingly, Crow, Allan and Summers (2001) found that long standing residents did not become involved in many community activities, preferring their own social networks and interests.

Communities are made up of many interest groups based on age, sex, occupation and social class (Crow and Maclean 2013). Just because people live in the same area it does not necessarily mean that they have shared interests. Conflict between different interest groups in communities is common, particularly when shared resources are an issue, or one group has more power than another (Richardson 2008, Gilchrist 2009, Wieviorka 2013).

The fabric of the building of the Orange Centre limited activities that could take place there. As a result of the limitations of the building, groups with different interests were in competition for community resources. Volunteers had to make decisions about which community groups could use the Centre.

Vicky noted that a parent craft class had to stop meeting at the Centre as a dance class that met in the adjoining room proved too noisy for expectant parents. Vicky stated that it was a disadvantage to lose something as beneficial as a parent craft group, but equally the Centre could not afford to leave the room adjoining the parent craft group empty, particularly as the dance group had supported the Centre for a longer period. There were also soundproofing problems between therapy rooms and offices on the second floor of the building. Vicky noted that clients in hypnotherapy required complete quiet.

Rather than having to make decisions about different interest groups, Steve suggested that Melbrook Development Trust provided for all sections of the community, from the infants to the elderly:

(Melbrook Development Trust's aim) 'Is trying to improve the quality of community life, so it's trying to meet that broad spectrum, it's not just looking at one part of it , it's looking at the broader spectrum of the community. Someone mentioned it's almost like cradle to grave because we've a playgroup and baby ballet, and straight through to you know, older people come to the craft group and the sequence dance(ing)', (Steve).

Steve's comments did not reflect the reality of accommodating groups with different interests in a shared community resource.

Steve's suggestion about addressing the needs of the whole community from 'cradle to grave' made me reflect on the needs of the community with regards to health visiting practice. While health visiting has been described as offering a 'cradle to the grave' service, this proposition is difficult to justify when health visitors' work is specifically focused on

young children under five and their families (Hogg et al. 2012, Tweddell 2008). The inclusivity of health visiting is additionally challenged by increased prioritising of services. While a universal service is initially offered to all families, health visitors identify the families that will get more than a minimal service. As health visitors move towards developing capacity with communities, the opportunities to reverse this trend are available, providing this option is commissioned.

Conflict occurs when there are too few insiders, particularly when their stated aim is to represent the community. At times the objectives of the Melbrook Development Trust appeared at odds with some members of the community. The Trust had, for example, arranged the erection of a piece of art in the village that reflected Melbrook's mining heritage. A small group of community members, including Vicky, had been involved in selecting a piece of art work for the village. Vicky recalled negative comments from Melbrook residents;

'Loads of people slated that (the art work), you know the roads need doing, we need this, we need that what are they wasting their money on art work. The money could only go on an Art project, so it was either we had it or we lost it to Europe',
(Vicky).

It was difficult engaging the whole village in the activities of Melbrook Development Trust. Leaflets had been distributed to large sections of the Melbrook community giving information about the activities of the Orange Centre. The Orange Centre was situated on one of the main routes through the village, and posters had been placed around the railings of the grounds to advertise activities at the centre. Vicky did not think the message about

the Orange Centre facilities was getting to the population of Melbrook, and gave this as a reason for its limited use by local residents. Of the leaflet distributed to Melbrook residents advertising activities at the Orange Centre she said;

'They probably just threw (the leaflet) in the bin, but then they will be the first to complain you know to advertise you don't tell us what is happening, how do we know, we thought it was a church', (Vicky).

It was difficult to determine whether residents of Melbrook were not getting the message about activities at the Orange Centre, or if it was that they were not interested in what was on offer. Hull (2001), with regards to regeneration projects she studied, suggested that some residents were not aware that they were part of a project. Engaging communities and maintaining engagement does not just happen because an opportunity to engage has been created (Adamson and Bromiley 2013). The opportunities must address the needs and aspirations of community members (Skidmore, Bound Lownsborough 2006).

Vera suggested that communication was not the reason Melbrook residents made limited use of the facility, rather the reason was one of loyalty;

'A lot of the community still live in the past, they will stick to those (established) places and won't venture, because they feel as if they're betraying, you know', (Vera).

Vera suggested that newer members of the community and surrounding areas were using the Orange Centre, rather than older, established residents of Melbrook, noting that the mother and toddler group was very successful:

'The problem we had is getting people to come in. You can't literally drag them in off the streets. So we've got all these brilliant ideas and some work and some don't, you've just got to keep trying until you find what suits and what doesn't. We are getting there slowly', (Vera).

Richardson (2008) suggests that most people care about their community and want an opportunity to participate, even if they choose not to. She suggests that it is usually only a small percentage of members who are actively involved in the community activities; however it is not apathy that stops the remainder from participation, rather the limited range of opportunities that are available.

Communities are complex constructions and mean different things to different people at different times. Communities associated with place have changed over time and do not necessarily consist of people with the same life experiences or values.

Communities can be brought together through the development of networks and as a result of having shared goals (Gilchrist 2009, Miller and Ahmad 2011). Equally, communities can be pulled apart when sections of communities isolate themselves, and also when communities of interest compete for common and shared resources. Such situations result in conflict.

Conflict and Other Organisations (9.5)

Conflict not only arises within geographical communities but also between different organisations working within communities. Melbrook Development Trust worked alongside a range of local and national organisations with the aim of supporting the Melbrook community. Despite the general aim of all the organisations to help the Melbrook community, there was disagreement as to how this might be achieved, each organisation having its particular regulations and vision. An area of tension was the different priorities between the local church that owned the Orange Centre, and the Melbrook Development Trust. The local church developed the Orange Centre together with Melbrook Development Trust. Steve was positive about this shared venture with the church;

'The church doesn't normally go into businesses, so we felt that was a bit of a thing', (Steve).

Vicky, however, did note that there were some tensions as a result of the venture between church and the trust;

'There's an executive board that meet from the PCC (Church) and (Melbrook Development Trust) board from here and they've got one idea and we've got another and they don't always marry up', (Vicky).

She continued with regard to the practicalities of running the Orange Centre when the church retained a vested interest in the building;

'We try all sorts to get business in here (the Orange Centre), fashion shows and things, now a good one would probably be a psychic evening' ... 'but I don't know if the church would like that or not', (Vicky).

Sally, however, suggested that the church did not have many restrictions;

'I know some churches won't allow tai-chi in church halls, but no they're quite open', (Sally).

Developing the Orange Centre from a church hall may have limited its appeal to the local and surrounding population; however, it was the limitations of the building structure where tensions were observed.

When the concept of the Orange Centre was in the development stage, an event was held for local GP's so that they could contribute their views and ideas. Steve noted;

'There is difficulty in national health services and Primary Care Trusts accepting the concept that there is a role for complementary and alternative therapy', (Steve).

Steve reflected further that once the Orange Centre had been funded there was a difficulty engaging with GP's;

'We have found it somewhat difficult actually get into GPs' surgeries. There is perhaps reluctance there. Whether or not it's genuine on behalf of the partners in the joint GP surgeries, or whether or not it's getting past the admin within those I know not' ... 'We've stuck at it and we've made some major progress in that direction and you will see that perhaps in some of our surgeries now the activities that go on at the (Orange Centre) are actually advertised', (Steve).

Although this may seem like progress, when considering Arnstein's ladder of citizen participation, Steve is not describing the NHS and the Orange Centre working together in partnership, rather acknowledging each other's existence (Arnstein 1969). As McDonald et al. (2010) note, some professionals are reluctant to change and want to maintain control, yet government policy and consumer demand looks to new ways of working and different partnerships with patients. This study has demonstrated that some health and well-being needs can be met and sustained without medical intervention, and given the demands on the NHS such initiatives could be embraced.

Towards the end of my fieldwork, the organiser of a mental health support group approached the Orange Centre looking for a venue for the group to meet. The group had previously met at the headquarters of the Primary Care Trust that was about close due to restructuring of local NHS community services. The new venture seemed to be more in keeping with the model the Orange Centre had devised, renting a venue, but at the same time, promoting health and well-being.

Shortly after Steve informed me that the organiser of the mental health support group had approached him regarding the prospect of the Orange Centre becoming the new venue for the group, I visited the Orange Centre. The visit was unusual in that I visited later in the day than was my normal practice. I witnessed a manager of the Orange Centre (who did not participate in the study), together with some of the volunteers and Centre users discussing the prospect of the mental health support group meeting at the Orange Centre. Although I was not part of the conversation, through snippets of conversation that I could hear, the

tone of the conversation, and body language of those taking part, my impression was that the manager, volunteers and centre users were not in favour of the decision to accommodate the mental health support group at the Orange Centre. The group having the discussion acknowledged my presence and welcomed me; the tone of the conversation changed and some group members wandered off while others stayed to chat. The subject was changed.

I was surprised by the conversation I witnessed about the proposed new group, as volunteers, craft group members and Melbrook Development Trust staff had always been supportive of individual users of the Orange Centre with mental health problems. Where Steve, in an earlier discussion, had been positive about the new opportunity, the volunteers and staff at the Orange Centre did not seem as keen. Steve looked to the economic advantages of the mental health support group using the centre. Those who were regular attendees at the Orange Centre, who valued social interactions rather than economic advantages, and who had developed a social network, may have had reservations about getting to know a new group of people from outside the community of Melbrook who may have different values and goals. I did not pursue the topic as I was not invited to join the discussion that I witnessed.

Although there are a range of organisations represented within Melbrook that aim to help the community, there are tensions between the organisations. Each organisation has its own agenda, and as a result of looking to the needs of the organisation instead of looking to the needs of the community, compromise community development and community

engagement. Organisations proposing to help communities can have the effect of pulling communities apart rather than pulling them together.

Conclusion (9.6)

I collected data at the Orange Centre at a time of local and national change. While the Centre was trying to adapt to become economically sustainable, changes were occurring at a local, regional, national and European level that had financial implications on the Centre. As Sally noted, it was becoming increasingly difficult to secure funding bids. The county was going through a recession. In addition, there was a new, Coalition Government, elected in 2010 whose policies included reducing public spending while at the same time encouraging the development of a civil society. As it moved forward, Melbrook Development Trust had further challenges to face as political policies continued to shape local communities and community development projects.

Governments have looked to communities to pick up some of the activities the state took over in the 1940's when it developed a comprehensive welfare state. In addition, communities in areas of deprivation have been provided with some support to create economic growth and social capital to help them help themselves. In both these instances there has been an assumption that communities are cohesive and work together towards common goals. This study has illustrated the complexity of communities, and that rather than being one body, a community is a changing multi-dimensional construction that

incorporates tensions and conflicts. Such conflict needs to be accommodated or resolved if communities are to work together to common goals.

Each sub-theme has identified conflict at every level of the community, within sections of the community, between the volunteers and Melbrook Development Trust, and also between the Trust and other organisations. Conflict within the community can be identified when communities of interest develop within geographical communities and promote exclusivity. In addition, tensions can occur when communities with different interests share community resources. In Melbrook these conflicts and tensions were fuelled by economic consideration. Conflict that occurs between volunteers and Melbrook Development Trust was based on cultural and power differences. Where the volunteers valued a shared social experience that included enhancing social support and the building of social networks, Melbrook Development Trust prioritises economic development. Conflict between volunteers and the Melbrook Development Trust was further compounded by the volunteers' lack of power and self-determination. Conflict occurs when economic development and social development pull communities in different directions. Such conflict was not only witnessed at the Orange Centre, but is a tension that can be recognised in government policy. The next chapter argues that for communities to develop and become healthier, the social aspect of community life needs to be recognised and supported, and that communities need to be in a position to determine their own futures.

DISCUSSION (10).

Introduction (10.1).

The aim of this study is to look at community engagement from the view of participants. The study has illustrated different cultures between civil society and public services. Communities work from the bottom up; this is in contrast to public services that have hierarchical structures. The social life within communities is highly valued by those who participate. Positive social interactions support, nourish and sustain community members. However, there are tensions within communities. Communities are not necessarily cohesive or working to a common goal. Lastly, communities are unable to reach their full potential if they do not have power. When communities have the power and ability to make decisions that they can then put into action, they are capable and willing to support each other, and by doing so, promote health and well-being. This chapter explores the implications of the findings with regard to community engagement and health visiting practice.

Culture (10.2)

In many ways this study presents a microcosm of what is happening in health services, not only in Britain but in many developed countries. It illustrates the clashing of two cultures; civil society and the public sector. The volunteers are representative of civil society. The

Orange Centre provided a meeting place where social life was conducted and where individuals were supported. In contrast, the Melbrook Development Trust reflected the culture of the public sector. It was structured, business-orientated and economically focused. The culture of public sector organisations has traditionally been different from that of the Third Sector and the rest of civil society (Christensen et al. 2007). Public welfare and accountability are stated features of public organisations, yet it is political drivers and professional independence that shapes their culture (Christensen et al. 2007). When I first started to visit the Orange Centre, I took with me some of my professional culture. I wanted communication to be recorded and documented; I asked for written consent. My requirements did not fit in with the culture of the volunteers and café users. As a result, I changed and started to look at what community wanted. I started to adapt to their culture and practices.

Rather than supporting communities, professionals have been a barrier to community engagement and have tended to misuse power through controlling issues by ‘excluding communities from the engagement process’ (Popay et al. 2007:8). Professionals have legitimised power through the state and the legal system, and they also use expert knowledge as a tool by which they retain power (Brennan and Israel 2008, Longley 2012). Despite policies to develop ‘governance’ rather than ‘government’, government organisations have acted to maintain their power and influence (Gates 1999, Bellefeuille 2005). By believing that the powerful have a right to their position, those without power submit to this order. Brennan and Israel (2008: 87) state, ‘the powerless are manipulated into reconstructing their worldview in accordance to with that of the ruling elites’. Eliasoph

(2013) proposes that people who are disadvantaged in society do not participate because they are overwhelmed by those with wealth and power who have influence. They are subdued and do not speak up because they know that they cannot alter their circumstances; they feel powerless.

Confidence in professionals has been eroded over the last two decades, and the current model of the expert professional 'treating' health problems is becoming financially unsustainable (Longley 2012 Thomas 2012). King and Ross (2008) suggest that professional roles have been shaped by the culture and expectations of their profession, but also note that they are not fixed and can change. Pressures to change professional roles come from outside as well as inside a profession, and are in response to social, economic and political factors (Mc Donald et al. 2010). A current political driver looks to professionals to work in partnership with - and recognise the knowledge and expertise of - patients and clients.

Successive governments have looked to engaging with patients, client and communities more effectively as the gap between the public (civil society) and public services (the state) has become too large. This gap has resulted in public disengagement with public services and with the democratic process.

The government's desire for public engagement stretches back for more than a decade. The Labour Government, for example, proposed that the public should take more responsibility for health and be 'fully engaged' in health services (Wanless 2002, 2004). Despite an

appearance of supporting engagement, policies and practices have been governed by a top-down approach, where communities are expected to engage with the state (Powell 2011).

There has been a lack of not only engagement with public services, but the public have also disengaged with the democratic process, the perception being that governments cannot be trusted and do not represent the views of the public (Stoker 2006, Office of National Statistics 2014). To address a lack of engagement in the political process, politicians have tried to bring public services closer to civil society (Taylor 2007, Banks and Orton 2007). There is a long held expectation that as the state engages with communities, democracy will be enhanced and the health and well-being of the population will improve as a result the community's ability to make meaningful decisions (WHO 1986, Head 2007). These assumptions have been made about community engagement, yet there is a lack of knowledge and understanding about the process, particularly for the communities' perspective (NICE 2008). The findings of this study demonstrate that assumptions cannot be made about communities, and that more information about how they would like to engage with services is required if successful engagement is to take place.

For the state to engage with communities with the purpose of promoting the self-determination for communities and associated gains in public health, there needs to be a shift of power from the public sector to civil society so that communities are in a position to make meaningful decisions that affect their lives, as, to date, government policy and professional dominance have limited the scope of community engagement (NICE 2008, Walker and Longley 2012). This study demonstrated that it is not appropriate to suggest

that communities should engage with public services and fit in with their agenda, rather than public services should look at fitting in with the culture of civil society. Public services should recognise and respect that the public knows what it wants (NICE 2008).

Community Engagement and the Implications for Health Visiting (10.3).

The Health Visitor Implementation Plan (Great Britain, Department of Health 2011a) has provided the momentum and resources to expand and energise the health visiting service. A requirement of the Health Visitor Implementation Plan is that health visitors work more closely with communities and incorporate Building Community Capacity into their role, as part of their public health work (Great Britain, Department of Health 2011a).

A substantial barrier faced by health visitors, with regard to community engagement, is the contradictory nature of political agendas and policies. Health visitors have been charged with Building Community Capacity as a method of promoting health, although the evidence to support this theory is limited. (Simmonds, Reynolds and Swinburn 2011, NHS England 2014, Great Britain Department of Health /Public Health England/ NHS England/ Health Education England/ Local Government (2014). It is on their ability to provide improvements in public health outcomes that health visitors will be judged (NHS England 2014, Great Britain Department of Health /Public Health England/ NHS England/ Health Education England/ Local Government (2014).

Despite successive government's poor record of both engaging with the public and reducing inequalities, the Coalition Government has given health visitors these two tasks, with an expectation that they will succeed at both of them (Great Britain, Department of Health 2011a, Great Britain, Department of Health 2012d). Health visitors face a range of difficulties in achieving such a feat, particularly when forces outside their control determine their role and scope of practice. Factors that impact on health visiting practice include political agendas, the commissioning of health visiting services and the influence of other professional bodies. Although political agendas, for example, have buffeted health visiting practice throughout its history (Baldwin 2012), it is the sum of these factors that makes health visitors particularly vulnerable in 2015, as an election looms and as the commissioning of health visitor services moves from the NHS to Local Authorities.

It is not only factors outside health visiting that makes the professional vulnerable, but also issues within health visiting, including health visitors themselves. As NICE (2008) notes, the greatest barrier to community engagement is professionals. I can understand the professionals' reluctance to engage with communities following my own experiences at the Orange Centre. When I had to change to fit in with the culture and practices of the volunteers, I initially felt uncomfortable and vulnerable. From being in a position of control and power, I was suddenly in a situation where I was not in control and I had little influence. I was powerless. To engage with community members I had to relinquish power and work with community members on their terms. This feeling of powerlessness and vulnerability is one that health professionals will have to work through if they are to engage more effectively with communities. It will require a change of perspective to one where

health visitors do not have the only ‘right’ answers and where they will no longer control the agenda.

In an era where evidence and outcomes are the criteria by which services are judged (Great Britain, Department of Health 2012d), health visiting is in a weak position as there is neither a distinct body of knowledge attributed to health visiting as a profession nor evidence generated by or for health visitors to support health visiting practice (Baldwin 2012, Cowley et al. 2013). Many other professional roles impinge on that of health visitors, including Nursery Nurses, Social Workers, and Community Development Workers (Baldwin 2012). Even within the profession, health visitors are uncertain of their role (Machin, Machin and Pearson 2011). While their safeguarding role has been determined by a combination of legislation, social services and local social service departments, many health visitors see their core role as being one of surveillance and conducting routine development assessments (Machin, Machin and Pearson 2011). As the public health role of health visiting has been highlighted in response to government’s desire to tackle inequalities, health visitors tend to prioritise other areas of work including home visiting of individual families. Public health work with groups and communities, particularly when this does not include children aged 0-4 years, is considered, by health visitors, to be a luxury rather than part of their core role (Machin, Machin and Pearson 2011). To compound the issue, there is a lack of consistency amongst health visitors as to what constitutes public health, some believing that their surveillance work promotes public health (Machin, Machin and Pearson 2011). Health visitors lack public health promotion

skills, and recognising their lack of experiences, feel vulnerable when working in multi-discipline teams where other professional are better skilled.

By moving the commissioning of health visiting services from the NHS to Local Authorities, the Coalition Government has changed the perspective of health visiting, from that associated with a medical model of health to one that looks to a social model of health. Such changes to the structure of health care provision, reduces professional confidence in their role identity (Machin, Machin and Pearson 2011). In addition, most health visitors are firstly nurses who subsequently train to become health visitors. Although working as health visitors, they rely on their nursing experience in health visiting practice. Taking away the crux of the medical model may cause health visitors to question their professional identity. When health visitors are unsure of their role, then it is more difficult for other professionals and the public to know what they do to and engage with the health visiting service.

Although the Coalition Government states that public health is best placed in Local Authorities who have services that can address the needs of local communities (GOV. UK 2014), support for this proposal is not universal. Jolley (2011:2) notes that when public health was under the control of Local Authorities pre-1974, the standards of public health services were very variable and inconsistent as a result of ‘political interference of councils’ (Holland 2011). The union ‘UNITE’ suggested that moving the commissioning of health visiting services to Local Authorities is ‘misguided’, suggesting that the move will lead to the fragmentation of services and reduced funding for these services (UNITE 2011).

The Coalition Government has given reassurances that public health funding will be ring-fenced within Local Authority budgets, when public health funding is transferred from the NHS. The government spending review for Local Authorities 15/16 notes that there will be no reduction in public health funding (GOV. UK 2014). However, the amount of money that central government allocates to Local Authorities to fund local services is to be cut by 1.8% to 6.4% (Butler and Jowett 2011). In total, government has cut Local Authority spending by 40% since 2010 resulting in drastic cuts of staff and services (Butler and Jowett 2011). The authors suggest that such cuts in the NHS would not be tolerated by the public, it being politically safer to cut public health spending within Local Authorities rather than reduce funding of the NHS. Within the context of Local Authority cuts, public health funding and health visiting services are more vulnerable than they have been in the NHS, as what constitutes public health and consequently how public health funding is allocated is open to interpretation.

The Health Visitor Implementation Plan has provided the impetus to develop the health visiting service, by increasing the numbers of health visitors by 40% with the aim of expanding the service, for example, promoting the Building of Community Capacity (Great Britain, Department of Health 2011a). As the time span of the Health Visitor Implementation Plan comes to an end (March 2015), there are indications that there are still some issues regarding the numbers of health visitors in practice. It was only in 2014 that the decline in health visitor numbers was reversed (Community Practitioner 2015). Where some teams are fully staffed, others, particularly those based in deprived areas, remain short

of staff. Despite the national increase in health visiting numbers, each health visitor has more children on their case-load due to an increase in the birth rate. This has made it difficult to develop the scope of health visiting practice into areas such as community engagement and public health promotion, as health visiting time is predominately taken up with routine visits to individual families (Community Practitioner 2015).

Although the Coalition Government have championed health visiting services, there is no indication that such support will continue beyond 2015 regardless of which party or parties are in government. The combination of factors: government agendas, changes in commissioning and lack of professional confidence, place health visitors in a vulnerable position, given that they will be judged on their ability to improve public health outcomes and reduce health inequality (Great Britain, Department of Health 2012d).

Health visitors currently lack skills in community engagement and the promotion of public health (Beaglehole 2004, O'Mara -Eves 2013). To be effective in engaging with communities, health visitors need to have a better understanding of the perspectives of the communities they work with, and they also need to be better at sharing and delegating power (O'Mara-Eves 2013).

The World Health Organisation promoted Building Community Capacity through the Ottawa Charter, and has continued to support the principle, as it is believed to be a process by which sustainable public health can be achieved (WHO 1986). Building Community Capacity encompasses community development and empowerment of communities (WHO

1986). It looks to develop partnership working and social capital, together with enhancing the skills of those who participate (Simmons, Reynolds, Swinburn 2011). Despite the continued support of the WHO in Building Community Capacity, and the support of the Coalition Government there is little evidence to support its belief in the transformative nature of community capacity building (Simmonds, Reynolds and Swinburn 2011).

As part of the development of the health visiting service, following the release of the Health Visiting Implementation Plan (Great Britain, Department of Health 2011a), I have been involved in the development and facilitation of courses designed to support health visitors in building community capacity. This study has informed the content and approach of the courses that have been delivered across a region (previously represented by the Strategic Health Authority and now by Health Education). There is a requirement that candidates report their progress six months after completion of the course. The changes to health visiting practice, following the course, have been captured formally in the format of case studies, as well as informally. Some teams have faced difficulties in the planning and delivery of Building Community Capacity initiatives. These have been as a result of vacancies within teams, lack of resources and due to the way commissioning decisions are interpreted. However, early findings indicate that health visitors are making changes to the way they engage with communities. These changes have led to better engagement by community members in health promotion activities and health visiting services because they have looked to what communities want. To support their credibility as part of the public health workforce, it is vital that health visitors capture and record their successes in

promoting public health through community engagement and Building Community Capacity.

Local authorities have a history of involvement in community development. Local authorities in and around Melbrook were involved in community development in the late 1980's and early 1990's when the economic base of the area declined. While some projects promoted social and economic development, others looked to promote health and reduce health inequalities (Pedler et al. 1990, Healthy (City) Support Team 1993). At the time, statutory agencies supported the development of grassroots infrastructure. Local community influence on statutory services was encouraged (Healthy (City) Support Team 1993). It is this background, of grassroots activism that helped Melbrook community members come together to try and change their situation.

Contemporary community development can be directed by government agencies to improve the structure of struggling communities. Although community members are asked their views, such development activities do not engage or empower community members (Matarrita-Cascante and Brennan 2011). An alternative view of community development is one that is based on the agenda devised by the community, rather than one imposed by 'experts' (Mackereth 2006:18, Minkler 2012).

Williams (2005) notes that British policies aimed at developing communities have been based on the culture of wealthier communities, where formal self-help activities are more common. In contrast, the culture of disadvantaged communities relies on support through

small, informal networks. Head (2007) describes the different ways in which wealthier and less advantaged groups build networks and promote social capital. While advantaged communities tend to form bridging bonds that expand their social networks and resources, disadvantaged communities rely on forming local bonds within micro communities. Parkin (2010), for example, notes that however well a student in a deprived area achieves, he or she is not going to make those relationships in society that offer him or her more opportunities. In disadvantaged communities, suggests Williams (2005), it is acceptable to obtain emotional support as a one-way relationship. Community members in disadvantaged communities do not want charity. rather they prefer to reciprocate a favour (Williams 2005). Williams (2005) suggests that instead of trying to promote one model of self-help, government policy should reflect the diversity of communities. Williams (2005) suggests that in disadvantaged communities building on schemes where reciprocity is involved, for example through time banks, reflects the values of the community. There was no formal reciprocity at the Orange Centre, but the support offered and gained was emotional and social. People gave and received on an informal basis, the amount they gave and the support they received changed over time depending on their individual circumstances. My observations suggest that reciprocity is more complex than a one-way relationship, as the act of giving enhances a feeling of satisfaction and well-being in the giver as well as receiver.

Community development facilitates the building of networks that enable people to help themselves through local efforts and collective action. A 'bottom-up' approach to community development supports self-reliance and control (Matarrita -Cascante and

Brennan 2011). Bottom-up or grassroots community development supports social justice, equality, participation and education. Thomas (2012) refers to the outcome of this bottom-up community development as ‘community engagement’, where communities engage with each other. This reflects the community engagement that occurred at the Orange Centre.

Community members of Melbrook and the Orange Centre engaged with each other and obtained benefits from the process, yet they were limited by the structure and authority of Melbrook Development Trust. Volunteers had little self-determination and had to defer to the board. The only power that volunteers had was the power they created through their own initiatives; as a result of creating funds through the bric-a-brac stall, and by threatening or actually withdrawing their labour.

For health visitors to engage with communities and to facilitate the engagement of communities with each other they need to develop more skills, including those of community development workers. Traditional roles of the community development worker include ‘rescuer’, ‘provider’, and ‘moderniser’ (Toomey 2011). ‘Rescuers’ and ‘providers’ develop dependency rather than empowerment, and these roles should only be used in the short term where communities are unable to help themselves. Toomey (2011) proposes alternative roles for community developers that include ‘catalyst’, ‘facilitator’ ‘ally’ and ‘advocate’. The ‘catalyst’ helps to ignite an idea and a focus for change, possibly by challenging ideas and barriers. The advantage of ‘catalysts’ in community development is that they do not have to see a project through to the end; rather the community is empowered to continue. The ‘facilitator’ can bring people together, including marginalised

groups, where the 'ally' is a friend and supporter of the collective working as an intermediary or representative. The 'advocate' takes the role of the 'ally' into a political perspective, supporting issues that affect the community such as health inequalities (Toomey 2011). Political activism has been part of health visiting practice in the past, but has been less evident in recent times (Hoskins 2009). Although dismissed by Toomey as being responsible for creating problematic political regimes around the world, it is the role of the liberator that presents the most exciting but also the most contentious option for health visitors. The role of the liberator, as described by Freire, is to educate, raise political awareness, and motivate those who are oppressed with the aim of bringing about social change (Crotty 1998). The liberator mirrors the critical perspective, looking not at what is, but looking towards what is possible.

The critical perspective that underlies this study has helped me to explore and understand the power that professionals and the public sector holds, and how this power has been used to limit the power of communities and civil society. The public sector and professionals have retained power by promoting a belief that their knowledge is superior to that of civil society, and by limiting the ability of communities to participate in meaningful decision making (Walker and Longley 2012). Under such circumstances, engagement with the public sector has become a negative experience for communities (Powell 2011). The critical perspective has demonstrated to me how health visitors can develop their role in the future, particularly with disadvantaged and disillusioned communities, those who are oppressed, by helping them to understand the factors that limit their power and influence.

Health visitors are in a position to encourage communities to visualise how things can be different.

Tension within Communities (10.4).

Brennan and Israel (2008) suggest that community capacity and community power can be enhanced through community development. The authors note that this is not a one-off quick fix, but that support for communities should be maintained, as without a focus of collective action for collective good, power in communities may start to cluster around particular groups. In other words, the community needs professionals to act as moderators to maintain cohesiveness in the community. There is a suggestion that without the influence of professionals, clusters of power will develop, resulting in divisions within the community (Brennan and Israel 2008). Where there are powerless groups within communities, Brennan and Israel (2008), suggest these groups come together to form collective action.

The findings of this study reflect that communities did start to split into different groups, with loci of power that groups tried to strengthen and consolidate. The social club, for example, tried to exclude members of the community from the use of resources they deemed as their own. Resources were the source of conflict at Melbrook, particularly as the economic situation became more constrained.

Health visitors are in a unique situation in that, by offering a universal service, they visit all families, and therefore are in a good position to recognise individuals with particular

interests and goals (Whittaker and Browne 2014). They are in a position to bind communities together, recognise common goals, and bring people together. I would, however, question that professionals are the only people that can bring people together, as the Melbrook community initially worked collectively to bring more resources to the village. Additionally, even with tensions within the geographical community, sub-sections and different interest groups offered support to each other. My observations suggest that there will always be some tensions in a geographical community as it embraces many interest groups. Health visitors, as well as working with the whole community, could also engage with groups of interest.

Community development work involves inherent tensions and challenges (Banks and Orton 2007). It requires a good understanding of other people's points of view and perspective, while at the same time an ability to negotiate roles and boundaries (Gilchrist 2007). For health visitors, as with Local Authority community development workers, this means having dual responsibility and accountability, both to the ethos and requirements of employers, but also working on behalf of and acting as an advocate for the community. Banks and Orton (2007: 103) suggest that 'visibility' is an issue for community development workers. If community workers are highly visible, 'making their mark' in the community, then the focus is on the community worker rather than the community, and the empowerment of the community can be compromised. Yet, health visitors have to demonstrate that their interventions are having a positive impact on health (Great Britain, Department of Health 2012e). While there is some flexibility in the way outcomes are achieved at a local level, barriers are perceived to exist within the health visiting workforce.

To achieve the flexibility required to address the needs of individual communities some of these perceptions need to be challenged.

Power (10.5).

The aim of building community capacity and the ultimate goal of community engagement is to empower. Empowerment requires the movement of power from those who have it to those who do not (O'Mara-Eves 2013). Community empowerment means that communities are in a position take control and ownership of their, 'endeavours and destinies' and make meaningful decisions that affect their lives and their health (WHO 1986:1, Woodhall et al. 2010). Empowerment can also look to reducing inequality and oppression, and promoting social justice (Woodhall et al. 2010).

Woodall, Warwick-Booth and Cross (2012) argue that the nature of 'empowerment' has been lost and no longer means giving communities power to control their health, their circumstances, or their ability to reduce inequality. This statement is supported through policies that look to empower individuals, such as the Community Champions initiative (NICE 2008, Woodhall, White and South 2013). Although such programmes have been shown to empower individuals, they are less likely to bring about social change as individuals have little political power. Therefore, while policy focuses on the empowerment of individuals, government is not threatened by the reactionary potential of the collective (Woodhall et al. 2010, Meade 2012). Australian attempts to empower communities, as part of health promotion activities, have been criticised because health authorities and

professionals have monopolised agendas and terms of engagement (Kilpatrick 2009).

Policy initiatives within Australia are currently different from those in the UK, in that there is an expectation that communities will support and supplement their local health services through volunteering.

Taylor (2007) suggests that as governments continue to devolve power to local areas, there are more opportunities for communities to be more involved in the decision-making process. The evidence suggests, however, that there continues to be an imbalance of power between the state and civil society, and that the ability of civil society to influence decision making is patchy (Taylor, Howard and Lever 2010). The opportunity for collective action has been reduced as Trade Union membership has diminished (Stoker 2006). Third sector and civil society organisations provide opportunities for the collective voice to be heard. Civil society is a balance to the power of the state; however, Third Sector organisations are increasingly dominated by government funding and regulations (Habermas 2002a, Taylor, Howard and Lever 2010). For communities to be empowered they need to actively participate in the decision-making process, and with this in mind there have been attempts to move to a position where communities are actively involved and taking ownership of local health services, illustrated by slogans such as ‘Doing with us not for us’, (Kilpatrick 2009:42).

Community control (10.6).

There are limits to what professionals and governments can do alone (Thomas 2012).

Examples from around the world illustrate how citizens can be more involved in the planning and delivery of health care services and how communities can challenge the power of large healthcare related organisations. The actions of civil society have brought about change (Lupel 2006). As a result of a debts crisis, citizens in Japan became proactive in the delivery of childcare and nursing services through community and non-profit organisations when the state was no longer in a position to provide such services (Hayllar and Wettarnall 2013). Co-production, where professionals and community members work together to deliver service, is successful where communities have power (Bovaird 2007). As Bovaird (2007) notes, co-production involves risks for communities and professionals. Professionals need to trust communities, and acknowledge that they have the ability to decide what they need to do to improve their health. Hutson (2013) looked at how a deprived community in America was able to moderate the activities of large healthcare organisations. Through collective action the community was able to limit the size of new developments in their neighbourhood, while at the same time securing jobs for the local population. The growth of social enterprises in Britain, including those that employ health visitors, offer opportunities for flexible working and reaching out to minority and disadvantaged communities. However, to optimise health and social gains, community members need to be powerful within the organisation (O'Mara-Eves et al. 2013).

At the Orange Centre volunteers were not powerful within the organisation and could not influence decision making. Yet things could have been different. I do wonder what the volunteers could have achieved if they had more influence and resources. Collectively, volunteers and craft group members supported each other and other Orange Centre users

more effectively than any public service. Although I used a critical perspective in this study, it was never my intention to change the situation of volunteers, rather to observe them and participate on the periphery of the community at the Orange Centre. It is my intention, however, to change health visiting practice.

Community Engagement and Health (10.7).

The findings of this study demonstrate that community engagement promotes health. In particular, craft group members stated that engaging with other members of the community helped to reduce worry and stress. As Cate noted, talking about problems that worried her reduced her anxiety and diminished her problems. Clara recognised that the act of helping someone helped her to feel better.

There is a growing body of knowledge supporting the theory that community engagement promotes health (O'Mara Eves 2013). A systematic review carried out by O'Mara-Eves et al. (2013) to consider community engagement as an approach to reduce health inequalities, discussed three levels of engagement. The first level considered community engagement with professionals to improve services; the second level looked at partnership working between professionals and communities; while the third focused on communities collectively involved in community development to bring about change. The work of Popay et al. (2007), which supported the 2008 review of community engagement and health (NICE 2008), looked towards a utilitarian model of community engagement where the community engaged with the NHS. This model was reflective of the first level of

engagement suggested by O'Mara-Eves et al. (2013), while Arnstein's model of community participation, that supports the empowerment of communities, represented the third level (Arnstein 1969). Theoretically, in the middle of these two is Marmot's (2010a) proposal that while looking to improve the health of all members of society, those in disadvantaged communities should receive most help. This model, of progressive universalism, with additional tiered support going to those in most need, mirrors the service health visitors currently offer to families (Great Britain, Department of Health 2011a, Whittaker and Browne 2014).

O'Mara-Eves et al. (2013) concluded that community engagement can have a positive influence on health in particular, health behaviours, health consequences, self-efficacy, and perceived social support outcomes across various conditions. However, community engagement is only effective when communities work in equal partnerships with professionals or when communities are empowered to take control (O'Mara Eves et al. 2013). Where professionals and communities worked together, the success of the initiative is dependent on the amount of power delegated to communities. Interventions delivered by the community members are particularly effective, while those delivered by professionals alone the least effective (O'Mara-Eves et al. 2013). Where communities worked in partnership with professionals, interventions worked best when professionals were sensitive to the culture of the communities they worked with. The evidence suggests that health measures should incorporate community engagement, and that such measures should be targeted on disadvantaged communities (Marmot 2010a, O'Mara-Eves et al. 2013).

The studies reviewed by O'Mara Eves et al. (2013) were predominantly from North America (84%), while only 8% of studies were from the UK. This had an impact on the representation of communities as the North American studies included a higher non-white population. The studies reviewed by O'Mara Eves et al. (2013) were mainly focused single issue interventions such as drug abuse. A systematic review of community engagement with regards to health and social outcomes, completed by Milton et al. (2011) looked at the UK literature. The team concluded that community engagement had a positive impact on 'housing, crime, social capital and community empowerment', but found no evidence of improvements in health or quality of services (Milton et al. 2011:316).

Both systematic reviews note the absence of robust evaluative tools to capture the breadth of effects of community engagement (Milton et al. 2011, O'Mara-Eves et al. 2013). While this may be due to the lack of an effective evaluative tool, the problem could stem from cultural differences between public and community perceptions and values as to what constitutes a positive outcome. For, as long as politicians and health care professionals alone determine what success looks like, community views and values are not represented. If the community perspective of community engagement is to be captured, then community members should be involved in the planning and design of evaluations (O'Mara Eves et al. 2013).

Shircore and Shaw (2013) suggest that the commissioning of services needs to alter from a narrow range of outputs so that a wider range of services are provided. They suggest that the current outcomes framework limits the work of professionals who focus on meeting

targets. In contrast, service users look to health services which promote values in society such as community cohesion and a feeling of belonging. Shircore and Shaw (2013) recommend that commissioning should involve communities so that they are able to manage the problems they face.

Volunteers and craft group members demonstrated that they were capable of managing the problems they faced. The volunteers devised ways of gaining resources and power, while craft group members held events and were looking to open a joint bank account. They provided emotional and social benefits to those who participated. These had an impact on health and well-being. Such benefits, despite being recognised and valued by community members, could not be measured using public health indicators that rely on qualitative data such as infant mortality and hospital admissions for example (Public Health England 2014). This situation could change as the commissioning of public health services moves to local authorities, where a social rather than medical model of health is promoted (Great Britain 2012a, Great Britain Department of Health 2012 a, c, Buck and Gregory 2013, GOV UK 2013b, NHS England 2014).

The Public Service (Social Value Act) (Great Britain 2012a) places a responsibility on local authorities to take regard of social and economic well-being when commissioning service. To provide social value local authorities are required to look at what local citizens and communities value, and take into account their 'needs, wants, and aspirations' when commissioning service (Blume and Randle 2013:6). Commissioning in the future will look to developing active 'vibrant' communities that enhance the quality of life of community

members (Blume and Randle 2013). Local authorities are also tasked with creating inclusive communities and promoting equality. Health visitors have a role to play in this respect through the progressive universalism that offers more support to those in most need.

Community engagement needs to be specific to the needs and culture of the community (Wallerstein 2006, O'Mara-Eves 2013). One size does not fit all communities, and therefore a top-down approach alone is not effective (O'Mara-Eves et al. 2013).

Community engagement is effective when communities define their own agenda rather than having one imposed upon them (Wallerstein 2006, Minkler 2012). Communities need to be empowered if they are to have influence and bring about change. Wallerstein (2006:14) suggests that empowerment is an end in itself; in particular he promotes the development of a 'critical consciousness' within micro-communities, raising awareness about what can be different (Wallerstein 2006). While bottom-up engagement and critical awareness needs to develop at a micro level, at the macro level, there needs to be financial support for community engagement, but, crucially, the promotion of a culture which supports equality and fairness in society.

The government proposes that health visitors, a part of the public health workforce, will work to reducing health inequality; yet, as with community engagement, there are inconsistencies in government policies and practices to support this agenda (Great Britain, Department of Health 2011a, Great Britain, Department of Health 2012e). In addition, public health practitioners tend to focus on specific tasks, for example in the area of health protection, rather than looking at the bigger picture, at issues such as social justice.

Both Labour and Coalition Governments have looked for alternatives to a neoliberal capitalist economy that has promoted individualism, inequality and economic instability (Meier 2007, Powell 2011). In addition, globalisation has reduced equality, and disadvantaged groups that have less social mobility (Bauman 2000, Lewicka 2005, Bellefeuille 2005). While reducing inequality has been a policy priority, there has also been a movement to reducing welfare provision, not only in Britain, but in many developed countries around the world (Bellefeuille 2005).

Although there is a long history of giving and mutual support in the working classes, the assumption of the 'Big Society' is that those who are most disadvantaged in society have the ability to tackle the causes of the disadvantage they face (Powell 2011). Not all communities have the resources or are willing to take on this task (Murdock and Abram 1998). Evidence suggests that for inequalities to be reduced and health improved, both state and civil society must play a part in promoting an equal and healthy society (McGuire 2010). Therefore, public spending needs to increase rather than decrease. In particular, public services should offer more support to those who are disadvantaged to help reduce inequality (Marmot 2010a, O'Mara-Eves et al. 2013).

Inequality in health is a symptom of inequality in society (Marmot 2010a). The promotion of public health, therefore, is an issue of social justice, as Krieger and Birn (1998; 1603) state, 'Social justice is the foundation of public health.' The authors suggest that it was drive to promote social justice and democracy that brought about early improvements in

public health. Krieger and Birn (1998) propose that public health is about collective political and social activism that strives towards a common good rather than the neoliberal principles that have exacerbated inequality.

While not disputing that social justice is at the heart of public health, Mackie (2010) suggests that there are differences between the theory of public health and the work of public health practitioners. Public health practitioners focus on actions, and getting ‘things done’, rather than the theory behind public health – including the promotion of social justice (Mackie 2010). Mackie (2010) proposes that social justice should inform public health and the intentions and actions of public health practitioners.

Even in democratic societies not everyone experiences fairness and equality (Barker et al. 2009). To achieve fairness in society it is not enough to provide everyone with an equal universal service. Public health practitioners must take action to treat people differently, giving more support to those in greatest need, if they are to promote equality in society (Marmot 2010a, Mackie 2010). To promote a more equal society, therefore, health visitors must look to supporting disadvantaged communities by distributing their services unequally (Gostin and Powers 2006, Wilkinson and Pickett, 2009, Mackie 2010). Meier (2007) proposes that inequality of health affects the whole of society and therefore efforts should look to addressing inequalities in health for the benefit of the whole of society.

Despite liberal democracies confirming civil and political rights, in practice, inequalities remain as those in power retain their power. Once governments are elected communities

have little control over them. An alternative, suggest Barker et al. (2009), is participatory democracy where the population are more involved in collective decision making. The study demonstrated that volunteers had a well-developed democratic system of decision making. Although they had little power, they understood the power that they held and used it to their best advantage. The facilitation of participatory democracy involves extending democratic principles through society, and communication between the citizens. The internet and social media has made communication much easier, and campaigns such as those led by 38 Degrees have demonstrated how a collective voice has more influence on central government (38degrees.org). International declarations stating that health is a human right originally focused on the health of the individual. The latest generation of human rights look to the empowerment of the collective as a way of promoting public health, as individuals are unable to reduce inequality (Meier 2007).

My observations at the Orange Centre illustrated how the collective works. The collective interactions are more powerful and beneficial than individuals working alone. It demonstrated that community engagement brings benefits that individuals alone cannot experience. Community engagement and public health are linked; they are both about the collective and promoting well-being.

Moving Forward (10.8).

In 2015, health visiting will be commissioned by local authorities rather than the NHS, and with this move a change of perspective; from problem solving and illness to promoting

well-being (Great Britain 2012a, Great Britain, Department of Health 2012a, c, NHS England 2014). Well-being reflects the aspirations of the World Health Organisation (1978) Alma Ata declaration, which states that health is more than an absence of disease. Wellness looks to the positives, of assets, opportunities and choice rather than problems and limitations. Where health services have traditionally looked to treating a passive patient, wellness requires the population to be motivated and proactively engaged with the promotion of health (Wanless 2002, Wanless, 2004, Walker 2012). Well-being focuses on the quality of life and includes happiness, pleasure, self-confidence, self-esteem, feeling safe, and general satisfaction (Walker 2012). David Cameron has supported the concept and monitoring of well-being (Cameron 2010b). Currently 77% of the UK population report that they are satisfied with their lives, a satisfaction rating higher than the European average (Office of National Statistics 2014).

Local Authorities have a legal duty to promote the economic, social and environmental well-being of their areas, and have some discretion on how they promote well-being through local community strategies (Great Britain 2000, Thomas 2012).

Local Health and Well-being Boards, that consist of local councillors, GP's and members of the local community, produce Joint Health and Well-being Strategies. The priorities of these strategies include quality of life, health inequalities, and working in partnership (City Council 2013).

When health visitors are commissioned by organisations that focus on wellness rather than illness, their ability to promote public health and equality should be strengthened. As well

as opportunities that closer working relationships with local authorities bring, there are also threats, in particular a threat to the funding of health visiting services. Evidence is beginning to emerge that the ring-fencing of public health funding is being eroded and that public health funds are being used for existing Local Authority services. The number of school nurses and sexual health services has been cut, and money has been diverted to the maintenance of parks and leisure services (Lacobucci 2014). These decisions, supported by Public Health England, could be seen to demonstrate a move from a professional dominated service to one where individuals and communities have opportunities to support their own health. When health visitors are commissioned by local authorities they need to demonstrate their value in promoting well-being and equality. Their role in community engagement, community development and community empowerment is crucial in this respect.

Communities are changing; they are no longer static, based on geographical location; rather, transient communities of interest have developed and can be nurtured through health visitor support (Bauman 2000). Of particular interest to health visitors are micro-communities that offer the most emotional support to those participating (Parkin 2010). Micro-communities, based on neighbourhoods and/or interests, have the potential to promote well-being, together with improvements in physical and mental health (Halpern 2005). Health visitors must start to focus on how people define their community, or communities, they are part of, rather than relying on professionally imposed boundaries. People positively join communities of interest, and health visitors must engage with these communities (NICE 2008).

Community engagement is fundamental to health visiting practice. While building community capacity initiatives are helping health visitors to re-engage with their public health role, it is a better understanding of community engagement that will help them to achieve their ultimate goal of addressing health inequalities and promoting public health. Health visitors need to gain more skills to help them engage with communities and to help communities engage with each other. Critically, a new professional culture is required for health visitors, so that they are able to share power with communities, or let communities take power (Gilchrist 2007, Kilpatrick 2009). Where communities have power, they can take positive action to influence the factors which determine their health. Communities can provide more effective interventions than health care professionals and have a wider perspective of what health and well-being is (O'Mara-Eves et al. 2013, Shircore 2013). Health visitors need to acknowledge the strengths and knowledge of communities and be sympathetic to their culture, just as I had to learn to adapt to the culture of the volunteers. It is only by making this move that health visitors will effectively engage with communities and reach their ultimate goal of promoting public health and social justice. Finally, health visitors should adopt a critical perspective and challenge those who govern at the macro level of society. If inequality is systemic, then there needs to be pressure on governments to support policies and develop a culture of fairness and equality throughout society (Gostin and Powers 2006). Health visitors could help to challenge inequality in society as liberators and also advocates of disadvantaged communities (Toomey 2011). It is when civil society and public services work sympathetically together that most health benefits can be gained (McGuire 2010).

Reflections (10.9)

Although I initially looked at different methods to enable me to carry out this study, it was the ethnographic approach that emerged as being the one most suited to capturing the culture of a community. It helped me to distinguish a civil society from that of the professional and public. It allowed me to capture the perspective, the way of looking and thinking, the worldview of community members.

The ethnographic approach enabled me to capture the richness of a social existence, and of the meaning and importance of social encounters. It also helped me to understand the complexities and tensions within community existence. I looked inwardly to the Melbrook and the community at the Orange Centre, but also outwardly at the factors that shaped that community.

The ethnographic approach also helped me to step out of myself and distinguish my professional self from my personal. I had to look beyond the professional. The 'professional' person was a barrier that stopped me engaging with members of the community, but rather the volunteers and the craft group members communicated with me, the person. I was never one of them, but I was able to move amongst them and get a glimpse of their world. I started to view what could be; gaining confidence in the ability of communities to take control and determine their destinies, and started to look at wellness as a real possibility. I also enjoyed the warmth of the community experience.

The motivation of this study was to look at how health visitors could develop a different relationship with communities, and by doing so promote sustainable public health. This study of community engagement, of giving to and receiving from shared social existence provided the answer.

CONCLUSION (11).

This study has focused on community engagement from the perspective of community members who participate in the process, and has considered how communities engage with each other. In keeping with the critical paradigm, it has critically analysed the position of health care professionals and the state, and concluded that both have limited the development and empowerment of communities. The study has explored the benefits of community engagement on health, and considered how health visiting practice should develop to more effectively engage with communities.

While the health visiting service has defined community as a geographical place with boundaries, community participants do not have the same view (Fernandez and Langhout 2014). 'Community' is a concept constructed by those who take part in one or more communities that can be based on interest as well as place (Bauman 2000, NICE 2008). Engagement and participation can occur at different levels. This study suggests that while empowerment and self-determination may be the best options for communities, individuals may still gain from a lower level of participation and these possibilities should be made available.

The use of an ethnographic approach has helped to explore and explain fundamental issues including culture and the supportive nature of a positive communal experience. The critical perspective has highlighted the tensions and complexities within communities. It has

enabled reflection on the power of the state and professional bodies in contrast to that of civil society. The work of Habermas (2002a) was included to demonstrate how civil society and the state may form a balance to control the excesses of each other.

‘New Labour’, the Conservative party and the Coalition Government have expected communities and civil society to become more involved in the welfare of citizens and the promotion of health (Meier 2007, Powell 2011). Political philosophies and recent economic constraints have reduced state spending. With this has come an expectation that communities will be capable and willing to fill the gap, without much consideration to the feasibility of this proposition (Powell 2011).

While communities have been delegated to take the responsibility of addressing and changing the problems they face, those that occur as a result of social deprivation for example, there has been no corresponding movement of power (Walker and Longley 2012). Without power, communities are limited in the changes they can make, and as a result become disillusioned with the process (Eliasoph 2013).

State efforts to enhance community engagement have expected communities to fit in with the structure and practices of public services that are based on hierarchical, ‘top-down’ organisations (Powell 2011). This is in contrast to civil society, which is informal and personal. Community engagement in civil society is based on a bottom-up, grassroots arrangement (Richardson 2008, Minkler 2012). Communities experiencing social

deprivation work informally, supporting each other emotionally and socially in small micro-communities (Willians 2005, Head 2007).

The Third Sector has been encouraged by New Labour and by the Coalition Government to support welfare, providing services that were previously delivered by the public sector. The Third Sector has the advantage of being flexible, and has a track record of engaging with hard to reach groups that the public sector has not been able to engage (National Audit Office 2013). However, as a result of their increased reliance on government funding, the Third Sector is losing some of the features that made it unique, as it increasingly needs to comply with the contractual requirements of the state (Carey, Braunack-Mayer and Barraket 2009). In such a climate, volunteers have been sidelined, and the appeal and effectiveness of some Third Sector provision has been lost (Rochester, Paine and Howlett 2010).

As part of their intention to involve more providers in welfare provision, governments have encouraged NHS staff to develop social enterprises (Marks and Hunter 2007, Addicott 2011). Social enterprises have the potential to introduce more flexibility; however, this is dependent on commissioning (Shircore and Shaw 2013). While social enterprises may offer more opportunities to develop health visiting practice, such organisations are vulnerable to the private sector, which has more resources and experience in winning contracts (Reynolds and McKee 2012, Floyd 2012). Under the present administration, the private sector is becoming more dominant in healthcare provision, and in the future more health visitors

may be employed by the private sector, and their practice determined by the nature of the services that are commissioned by Local Authorities (Cambell 2012, Ramesh 2012).

Despite New Labour's efforts to reduce social exclusion and poverty, inequality increased during their time of office, and this trend has continued (Marmot 2010a). Social and economic inequality has a direct impact on public health (Marmot 2010a). Inequality is multi-factorial and involves not only economic inequality, but also a lack of choice and power (Morgan and Popay 2007, Wilkinson and Pickett 2009).

Health visitors, as part of the public health workforce, have been tasked with reducing inequalities in health. To do this, they must address the causes of health inequality, in particular, the lack of power within deprived communities (Great Britain, Department of Health 2012a, c, Eliasoph 2013). If health visitors adopt a critical perspective, then they can fulfil two roles; as advocates and political activists highlighting the situation of those in deprived communities, and also as liberators, helping communities to understand the forces that oppress them (Toomey 2011). For the health of the public to flourish there needs to be social justice in society (Wilkinson and Pickett 2009, Dorling 201). A fair and equitable society not only improves the lives of those who have least, it also benefits the whole of society (Wilkinson and Pickett 2009, McGuire2010).

National policies and political trends across the world are influencing the relationship between state and civil society. Many politicians search for alternatives to the neo-

liberalism that has recently been blamed for increasing inequality. However, while new opportunities are sought, the ‘marketisation’ of healthcare has persisted.

Change can bring opportunities and threats. The transfer of public health responsibilities to local authorities does provide opportunities to develop community engagement and promote public health, particularly as local authorities’ activities are based on a social model of health and have a statutory responsibility to promote social well-being in communities. The Public Service (Social Value) Act (Great Britain 2012a) requires local authorities to commission for social value; this means enhancing the quality of life of community members.

Commissioning for what people value is a change of perspective, and demonstrates a move away from state and professional dominance (Blune and Randle 2013). This study demonstrates that what people value is the company and support of other people within a community. They invest in, and benefit from, a strong and rich social existence that helps to build social capital. Volunteers and craft group members demonstrated that they were very capable of supporting other community members. They were resourceful and had ideas to develop their community.

Although there is evidence that social capital and community engagement provide substantial benefits to participants, this resource has not been fully developed or deployed by the state (Kawachi et al. 1997, Halpern 2005). There are, increasingly, examples from

around the world where civil society has developed initiatives to provide support and welfare for citizens and communities (Hayllar and Wetternall 2014).

If the vision of the 'Big Society' is to be realised then the knowledge, skills and abilities of communities will have to be acknowledged; together with a transfer of power to communities so that they are able to plan and control their destinies (Cameron 2010a).

Health visitors have been given a clear mandate to work with communities and promote public health (Great Britain, Department of Health 2011a). They have been given this task within an environment of public health services upheaval. A challenge health visitors must address is establishing a presence within that environment, and demonstrating that they can deliver positive health outcomes. Engaging with and empowering communities is one way they can do this, but must make sure that they appropriately document positive health outcomes, including improvements to well-being.

An understanding of community engagement is fundamental to health visiting practice. Health visitors need to engage with and support communities so that members are encouraged to engage with each other. To do this effectively, health visitors need to be sensitive to the culture of communities, and work to an agenda devised by the community. This study contributes to a body of knowledge that can help health visitors develop such an understanding, and shift the perspective from a professional culture to that of a community's; therefore moving from an interventionist approach to community

empowerment. By making such a change, health visitors will be in a position where they can justify their title of community public health practitioner.

METHODOLOGICAL CHALLENGES AND LIMITATIONS OF THE STUDY (12).

Limitations (12.1).

The study was conducted on a small scale with regards to the number of participants and the length of time in the field. It was conducted on one site, and reflects one community at a particular period of the development. Due to the complexities of the external environment of the study and the internal relationships of, for example, the community-based organisation that ran the study site, it is difficult to completely disengage community engagement influences with other social factors.

Selecting a position within the critical perspective was something of a juggling act. I did not intend to change the situation of the volunteers, but I did want to bring about changes in health visiting. I looked to the micro-community, but also to the influence of national politics to explain the situation of the volunteers. At times this has led to a theoretical, political orientated account rather than a descriptive or semi-fictionalised ethnography as proposed by Humphreys and Watson (2009); and has looked to the etic for answers as well as the emic (Holloway and Tordes 2006, Fetterman 2010).

My inexperience using an ethnographic approach was one of the biggest challenges. It took some time to establish my role. I personally found it difficult to sit back, relax, observe and drink in what was going on around me. This probably goes back to my professional training, where I felt as though I must be ‘doing’ something all of the time, rather than just ‘being’ and experiencing the moment. My professional background must be acknowledged as a limitation to the study, as, despite my keen desire to understand the culture of volunteers, the choice of what I saw and recorded must have been influenced by my previous experiences and ways of thinking.

Although I tried to select a ‘grassroots’ organisation that was not connected to the NHS, most of the volunteers had experience in a caring role. The volunteers formed a small sample. I anticipate that if the remaining volunteers had participated I would have gained a slightly different perspective, as their role at the centre was more varied. Connie was fascinating, and her progress was referred to by volunteers, managers and centre users. As she chose not to be interviewed, I do not have Connie’s own account, and it is possible that her increased sociability was due to factors outside the Orange Centre.

During the time I visited the Orange Centre, Melbrook Development Trust was undergoing a change of funding and focus. This had an effect on the volunteers, however, the changes reflected those taking place in the wider society. Due to the nature of its funding and accountability, Melbrook Development Trust had formal processes that may have differed from those emerging grassroots organisations. However, the situation between the volunteers and the Trust did help me to contrast the two cultures. The findings of the study

were unique to a time and place and therefore it is difficult to generalise the findings to other groups. General observations and findings, however, can be used to inform health visiting practice. This information can then be adapted to accommodate individual groups that health visitors engage with in practice.

RECOMMENDATIONS (13).

Although the Coalition Government has put a spotlight on health visiting over the last 4 years and halted the decline in health visitor numbers, this patronage is about to end and health visiting is to face a new future, as the service is to be commissioned by Local Authorities. Health visiting is again at a crossroads, and the future for the health visiting service is uncertain, providing both challenges and opportunities. To address the challenges, and make the most of the opportunities, I would suggest that health visitors need to change, and this study has demonstrated the areas in which change is required.

Firstly, health visitors need to develop a stronger professional identity. This statement seems counter intuitive at the end of a study which has suggested that it is professionals who are a barrier to community engagement. Yet without a stronger professional identity, it is difficult for other professionals, and particularly for communities to understand what health visitors can offer, and misunderstanding can occur.

There needs to be more cohesion amongst health visitors themselves as to what their role is. Public health and working with communities has not been given a high priority by health visitors in recent times due to a focus on crisis intervention and routine visits resulting from staff shortages. However both public health promotion and community engagement are long established aspects of visiting practice that have been emphasised not only by recent political agendas, but also by the title of ‘Specialist Community Public Health Nurse’

(SCPHN), placing health visiting firmly within the public health workforce (Nursing and Midwifery Council 2004, Great Britain, Department of Health 2012d).

There needs to be recognition that community engagement and public health promotion is equally as important, and potentially more beneficial in the long term, than crisis and routine intervention. As the commissioning of health visiting services moves to Local Authorities, it is imperative that health visitors recognise that the promotion of positive public health and working with communities are key aspects of their role (Great Britain, Department of Health 2011a, Great Britain, Department of Health 2012d). Moving away from a medical model and focusing on a social model of health may be unsettling for some health visitors, causing them to question their role, yet professional roles do change over time, in response to changing (health) needs together with changes in society, including the changing expectations of the public (Mc Donald et al 2010).

There is a growing awareness amongst some health professionals that ‘treatment’ services have a minimum impact on the health and well-being of the public, and that for many chronic health and social problems in today’s society, treatment by health professionals is costly and at the same time, of limited significance. A new approach is therefore required to help individuals and communities to find some of the solutions to the issues they face. It is community members who have the most insight into their individual and collective experiences.

As Gregory (2008) notes, engagement requires a mind-set, and the community should be the starting point of any community engagement activity. This philosophy needs to be central to the education of student health visitors and health visiting practice. Therefore, what is ultimately required in health visiting is a mind shift, not only from the individual to the community, from illness to wellness, but crucially, from providing to empowering. This study clearly demonstrates that communities are resourceful and resilient and can support and sustain members. Community resourcefulness has been ignored or stifled by statutory services rather than encouraged and allowed to flourish. Internationally, there has been a trend to reduce the services provided by the state. Although this has been exacerbated by the financial climate over the last 5-10 years, the movement has resulted from a growing awareness that the state cannot resolve all the issues in society, and that civil society has a vital part to play in the process of solving the problems that communities face today.

Health visitors are in a unique position in that they provide a universal service to a well population in their own communities. Unlike General Practitioners, Social Workers and District Nurses, they do not see people solely on the basis that a problem has occurred. Health visitors have the flexibility to see individual families also and to engage with communities, including communities of interest. Importantly, individuals and communities can contact health visitors directly. Health visitors form relationships with members of the community at key points in their lives, currently, as families are formed and children are growing up, when the focus is changing for many families from a working life to resources within the local community. Health visiting practice is firmly based in the community, even if this is within a notional geographical community. Health visitors have the opportunity to

build on these current opportunities and develop their public health and community development role. I would suggest that it is only when health visitors make this mind shift, from individual interventions to community support and empowerment that they can appreciate the potential of communities. By engaging with communities, health visitors have the opportunity to promote sustainable health and well-being.

To get to such a position, however, changes need to be made within health visiting. My personal experiences indicate that to work successfully with communities, health visitors need to adopt a different approach and not to think that they have all the answers. This study has illustrated that communities are best at knowing what their problems are and can also provide workable solutions. It is only by working in partnership or by empowering communities to be able to provide their own solutions that public health can become sustainably enhanced. Such a move, however, requires health visitors to relinquish some of their power. This is a big ask when health visitors are facing change within their role and commissioning, a time when they are at their most vulnerable. Health visitors however can draw on their history and look to times when they have successfully worked with and for communities.

As with communities, health visitors have within their grasp the solutions to many of the issues that they face. Health visitors work within teams and have networks within their organisation that they can draw on. Within health visiting practice, health visitors are familiar with, or are involved with, such tools as Action Learning Sets, Communities of Practice and most are involved in clinical supervision, including group supervision

(Andrew, Tolson and Ferguson, 2008, Wallbank and Hatton 2011, Machin and Pearson 2014). All these tools can assist individuals and teams through the change process. The Health Visitor Implementation Plan calls for all health visitors to be leaders and visionaries. Health visitors must grasp this role and be dominant in developing the health visiting service from within.

The training and education of the health visiting workforce have been key factors in the rolling out of the Health Visitor Implementation Plan (Great Britain, Department of Health 2011a) and should continue to be a strong feature in the development of the health visiting profession. The training and education of health visitors, for both initial training and for continual professional development, is a joint, equal, venture between clinical practice within Health Care Trusts and academic education in Institutions of Higher Education. Each area has a distinct role to play in shaping health visiting practice in the future.

Institutions of Higher Education are influential in shaping health visiting practice as higher education provides students not only with information and skill acquisition, but also promotes an ethos and perspective by which to practice. Already, leadership is a key feature in the curriculum. I propose that within this initiative there should be more advice and practical examples of how health visitors can influence not only their service, but also influence other professionals and commissioners. I strongly recommend that public health and wellness, together with community engagement and empowerment become key aspects of the health visiting curriculum to represent current trends not only in contemporary health care but particularly in the statutory legislative framework in which Local Authorities

function (Great Britain, Department of Health 2012d, Great Britain 2012b). This is the environment that health visitors will be performing in, and one in which they must provide public health outcomes.

Evidence and research, topics already covered in the health visiting curriculum, could be strengthened so that health visitors have a better understanding of not only using evidence in practice but also how they can generate evidence. Health visitors will be judged on their ability to deliver outcomes, and should be fully conversant with how they can provide evidence and different forms of evidence. Evidence to support practice has often been of a quantitative nature, for example the number of women initiating and continuing to breast feed (Great Britain, Department of Health 2012d). When looking at the quality of life however, qualitative data is informative and significant. The Family Nurse Partnership (2015), for example, has been very successful in producing qualitative data about clients' experiences. Health visitors have lessons to learn from this initiative. However I suggest that health visitors should not only be skilled in gaining data from clients, but also in helping communities to be involved in the design, collection and evaluation of community-led research. It is only when communities determine the research question, process and evaluative tool that the community perspective can be truly captured, and a better understanding of what communities value, and what enhances their quality of life, can be gained.

This study can help to inform the development of the Health Visiting (SCPHN) course at the Institute of Higher Education where I currently work as a Lecturer, when the course is

revalidated in 2016. This process of re-writing the curriculum involves not only university staff, but also stakeholders such as health visitors and managers from local Health Care Trusts together with commissioners. I recommend that community members are strongly represented in this process so they are able to inform and shape the curriculum to represent the community perspective.

Health visitors clearly require more skills, particularly in the areas of working in partnership with communities as well as working with multi-discipline teams. Health visitors need to draw on the skills of community development workers. In this, the work of Toomey (2001) can be influential in helping health visitors to understand and develop their roles as, for example advocates. To this I would add the role of liberator. Health visitors also need to develop their skills in public health work and draw on other members of the public health workforce, and the public health framework, to help develop their role (Great Britain, Department of Health 2012a). Where Institutions of Higher Education can introduce concepts, examples and specialist speakers on areas of expertise, it is for Practice Teachers in clinical practice to demonstrate how concepts can be implemented in health visiting practice.

When considering how the mind-set and practice of health visitors can be changed to one that gives a higher priority to the promotion of community well-being, it is important to recognise the influence that practicing health visitors and Practice Teachers have on the education and practice of new health visitors. Practice Teachers have shown how they can lead and influence health visiting practice by putting the Health Visitor Implementation

Plan into practice. Although there are links between Practice Teachers and Lecturers, I recommend that these links are strengthened so that one vision of health visiting is conveyed across the two elements of education. Such a vision can be strengthened through Practice Teachers and Mentor updates and continual professional education shared, by Practice Teachers and Lecturers. It can also be strengthened by formal and informal networking, for example Lecturers attending Practice Teachers' regional meetings, and showcase events held by Health Care Trusts. It can also be enhanced as a result of Practice Teachers and practicing health visitors co-teaching with lecturers within the university setting.

Health visitors need to look inwardly to address issues in their own practice and profession, (in ethnographic terms this could be associated with the principle of the emic); they also need to influence factors which impact on them from outside (the etic).

The Nursing and Midwifery Council (NMC) has demoted health visiting from a position where it was recognised on the register as an individual profession, equal to, for example, something such as (adult) nursing or midwifery, to one where it is an additional qualification for nurses or midwives (Cowley 2010a). It is essential that health visitors are represented on discussions at the NMC regarding their future. The scope of health visiting practice has been determined by successive governments. It is time that health visitors had a bigger say in their own destiny, by influencing government decisions about their profession, their practice and in particular, the service they are able to offer communities. To do this they need a stronger voice as a profession, but also representation on national working parties. Health Visitors need to make links with Local Authorities to inform their

commissioners of what they are capable of, and to secure a service that will enable them to deliver a service that enables health visitors to work with communities as well as individual families. I suggest that ‘influencing’ is a key skill that health visitor students must acquire and be assessed for during their initial training, and that this skill should be nurtured in practice through training and assessed through the appraisal process. An expectation should be developed within the health visiting profession, that health visitors influence policy at local, regional and national levels, with the aim of securing a community-orientated, health-promoting health visiting service.

There are moves to develop the voice of the health visitors. The Institute of Health Visiting has attracted government funding until March 2015 to develop a Fellowship Scheme for 150 health visitors who will become champions of the profession and influence local and national agendas (Institute of Health Visiting 2015). A body of knowledge needs to be developed to demonstrate the effect of health visitors’ work with communities and their effectiveness of promoting public health through this activity. Health Visitors need to be more prolific in the collection and dissemination of evidence, and showcase their efforts through local and regional networks, and also through national conference and publication. Regional research networks can support such a process, for example, initiatives such as the North of England Health Visitor Research Network.

As NICE (2008) noted, there are large gaps in the evidence to support community engagement and health. Although the study by O’Mara-Eves et al. (2013) demonstrated the effectiveness of involving communities in the delivery of care, and reducing health

inequality, gaps in the evidence still remain. This study has touched on how the community can support community members. I recommend that more research is conducted to find out how this can be maximised, and look at the factors that contribute to successful community engagement from the perspective of community members. Further research is required to find out what community members want from their health visiting service, and how they would like health visitors to engage with them. It is vital that health visitors learn to effectively engage with communities and that they help communities to engage with each other, as this will enhance public health and well-being and help to reduce health inequalities. Although communities have a lot to offer and can support community members without the professional help, health visitors still have a role to play in community engagement and health promotion. As McGuire (2010) notes, when civil society and statutory agencies work together, the best health benefits can be achieved.

Final word (13.1).

This study has been used to inform the education of student and practicing health visitors. I am part of local and national health visiting networks and plan to continue disseminating the findings of this study through these and through publication and presentations. It has been a joy and privilege that my research and practice have worked so closely together in tandem, each informing the other. I hope that through my endeavours I can continue to convey the importance of community engagement in health visiting practice and, as a result, not only help to shape the future of health visiting practice, but in so doing, promote public health.

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APPENDICES

APPENDIX 1: LITERATURE SEARCH.

Data bases

Data base	Search terms	Year	Number of hits
Assia	'Community' and 'Engagement' and 'Health' in title	2000-2009	Journals articles 254 Books 8 Conferences 10
Assia	'Community' and 'Engagement' and 'Public Health' in title	2005-2009	Nil
Assia	'Community' and 'Engagement' or 'Participation' and 'public health' in abstract	2005-2009	32
Pub Med	'Community engagement' in abstract	2004-2009	598
Pub Med	Community engagement' and 'Public health' in abstract	2004-2009	379
Pub Med	Community engagement 'and 'Public health' in abstract	2007-2009	331
International Bibliography of Social Science	Community engagement 'and 'Public health'		4
Sociological abstracts	Community engagement 'and 'Public health'	2005-2009	6
Web of Science	Community engagement 'and 'Public health' in title	2004-2009	3

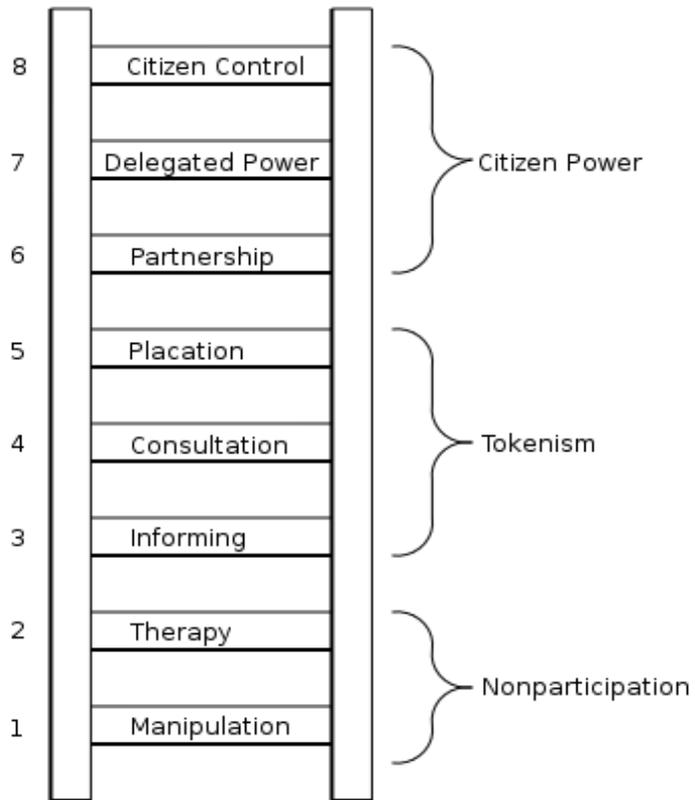
Data base	Search terms	Year	Number of hits
CINAHL Plus	Community engagement' and 'Public health'	2005-2008	10
COCHRANE	'Community engagement'		0
National Library for Health	'Community engagement', in title		Evidence 4 Guidance 1 Specialist Libraries 32
Public Health Specialist Library	'Community engagement'		Evidence 2 Guidance 2 References 10
Association of Public Health Observatories	'Community engagement'		23
East Midlands Public Health Observatory	'Community engagement'		Reports 4 Research 4 News and Events 4
National Institute for Health Research	'Community engagement and health'		200
Joseph Rowntree Foundation	'Community engagement' in title		459
Joseph Rowntree Foundation	Joseph Rowntree Foundation		254
Joseph Rowntree Foundation	Joseph Rowntree Foundation	2008	108
Nuffield Trust	'Community engagement'		0
Improvement and Development Agency for Local Government	Healthy communities		480

Web sites

Data base	Search terms	Year	Number of hits
<u>Improvement and Development Agency for Local Government</u>	<u>'Community engagement'</u>		782
<u>Improvement and Development Agency for Local Government</u>	<u>Community engagement'</u> and <u>'Public health'</u>		382

APPENDIX 2: ARNSTEIN'S LADDER OF CITIZEN PARTICIPATION(1969).

(<http://www.tandfonline.com/doi/abs/10.1080/01944366908977225>).



APPENDIX 3: INTERVIEW SCHEDULE

Schedule of question for semi structured interviews with Sally and Steve
(Managers at Melbrook Development Trust)

- How long have you been working for Melbrook Development Trust?
- What is your role in the Trust?
- How did the Melbrook Development Trust come about?
- What activities does the Trust undertake?
- Who uses the Orange Centre, people inside or outside of the village?
- How were volunteers recruited?
- How do you see the future of the volunteers?

APPENDIX 4: INFORMATION SHEET



SHARPENS YOUR THINKING

Information about the research (28.9.2009)

'A Case study considering the perspective of participants involved in community engagement'.

I would like to invite you to take part in the research study above. Before you decide if you want to take part you need to know more about the research, why it is being carried out, and what it will involve for you. Please take as long as you need consider the information below and talk to other people about the study if you wish.

The purpose of the study.

The government would like the public to become more involved on a personal and community level in decision making and public services. Examples of this involvement in the health service include more patient choice, involvement in self care and the public saying how they would like their local health services to develop. The government also thinks that it is beneficial to people when they work together as a group or community. Although policy documents aim to promote community participation, there is very little known or understood about what it is like to participate in such an activity. The aim of this project is to find out what it is like to participate from the point of view of community members who are involved in the process. It is intended that the knowledge gained from the study will help to inform community developments and health projects and support the education of health care professionals.

Why have you been invited ?

The Melbrook Development Trust was approached and the volunteer group was suggested as a possible area of study. Volunteers are active participants in the community based Lifestyle Centre. Health care professionals were not approached as they form a barrier to community engagement.

Do I have to take part?

No you do not have to take part. If you do decide to take part, you can decide how much you want to be involved in the project. If you decide to be involved, you will be asked to

sign a consent form. If you become involved then change your mind, you can withdraw at any time without giving a reason, and the information you have supplied will be taken out of the study, unless you state that you want it leaving in.

What will it involve ?

- You could take part in a (focus) group discussion to talk about what the main issues are.
- You could take part in an informal interview with the researcher
- You could help to develop the research project

The aim of the researcher is collect information at the Lifestyle centre, and at times which are convenient to you. Informal Interviews will be tape recorded and then written down. You will be able to see and make comment on the individual contributions you have made. Your contributions will remain confidential and you will not be identified in any report or publication. There is no financial benefit from taking part in the study, but the intention is that you may find the process of interest.

A case study approach has been chosen for this study as this allows the opportunity to look at a group of people, document the project within the community and provides the flexibility to collect information in different ways.

The collection of information will take place from Autumn of 2009 until the summer of 2010. This research will be approved and will be monitored by Sheffield Hallam University. If you are not happy about the way this research has been conducted, and you would like to make a complaint, you can do so to the following;

Professor Frances Gordon
Faculty of Health and Wellbeing
Robert Winston Building
Collegiate Crescent
Sheffield Hallam University, Sheffield S20 2DP

If you would like more information, please contact;

Lynn Kenyon
Telephone 0114 225 2287 ,
E mail L.Kenyon@shu.ac.uk,
or write to;

Lynn Kenyon Senior Lecturer
Faculty of Health and Wellbeing
Robert Winston Building
Collegiate Crescent
Sheffield Hallam University, Sheffield S20 2DP

APPENDIX 5: CONSENT FORM



SHARPENS YOUR THINKING

Centre number
Study number
Participant number

Consent form

Title of project; *'A Case study considering the perspective of participants involved in community engagement'*.

Name of Researcher; Lynn Kenyon

1. I confirm that I have read and understood the information sheet dated 28.9.2009 for the above study. I have had the opportunity to consider the information, ask any questions and had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason without my legal rights being affected

3. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of person taking consent

Date

Signature

One copy for participant and one for site file

APPENDIX 6: ISSUES HIGHLIGHTED FROM PARTICIPANT GROUPS

Issue	Volunteers	Supporters	Craft group
Board member	/		
Business	/	/	
Conflict	/	/	
Enterprise	/	/	
Local or not	/		
Multi volunteer	/		
Paid work/volunteer	/		
Problems with volunteering	/		
Time volunteering	/		
Volunteers	/	/	
Community	/	/	
Economy		/	
NHS		/	
Social		/	
Friend			/
Family			/
Feeling			/
Helping			/
Sharing			/
Wellbeing	/	/	

