Connected Communities

A review of theories, concepts and interventions relating to community-level strengths and their impact on health and well being

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Executive Summary

This paper draws on two reviews of the relationship between strong communities and health and well being. The first is a theoretical and conceptual review of recent ideas that presuppose the existence of community relationships and indicate their potential contribution to social improvements. The second is a systematic review of community strengthening interventions that have been evaluated in terms of their impact on health and well being.

Whilst there is a wealth of concepts that describe different ways of understanding communities, and theories that could explain the production of social benefits, including health and well being, these are often portrayed relatively narrowly and uncritically. Changing relationships between citizens and the state also shape the ways in which ideas such as resilience, social capital and community organizing are interpreted in government policy.

Despite the rise in popularity of community concepts in public health, the quality of intervention evaluations is poor. In particular the transformational claims for some interventions were presented uncritically. The impact of interventions such as time-banks, community gardens and participatory arts projects on health should be investigated. However non-intervention research on how communities can best mobilise internal and external resources for health gain is also needed.

Key words

Health and well being, community, social capital, resilience, social action
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This review has two elements. The first is a scoping and consolidation of the theoretical and conceptual literature underpinning current approaches to strengthening communities and the second is a systematic review to synthesise findings from evaluations of programmes and interventions. The purpose of this dual approach was to clarify the conceptual and theoretical underpinnings of interventions and policy approaches and to examine their relationship to plausible and actual health outcomes. Finally a public/policy dialogue involving academic researchers, policy makers, practitioners and community representatives was held to discuss preliminary findings as well as experiences and ideas about the value of strengthening community approaches to health and well being. Papers relating to all aspects of this study are available as separate documents.

The focus of the first review was on concepts and theories which relate to the idea of a ‘strong’ community in some way. Underpinning all these ideas is the assumption that there is something that can be understood as ‘community’ (whether this is felt or practiced through place, common identities or shared experiences) and that its very definition implies potential resources or strengths that can provide social benefits. In this review we have explored the salience of these to health and well being, particularly in the context of related income and health inequalities. In this review we identify theories and concepts at two main levels. At the first level there are concepts that define communities and their strengths in particular ways. These include ideas about social capital, social cohesion, capability, community resilience or adaptation and resistance. At a higher level are political ideas concerning the nature of society and the production of social which presupposed the existence and value of strong communities. These include communitarianism, mutualism, localism and co-production.

Theoretical concepts in modern usage relating to community strengths were analysed by taking the historical context of the development of concepts and changes in their popularity. The diagram in figure 1 does not represent a logic model but a map of how authors have linked concepts in a more narrative way. Exploring the synergies between concepts illustrates how some have become increasingly popular since the financial crisis and recent political changes, with greater emphasis on community self-reliance and responsibility.

However, as the diagram illustrates, the community-level concept that has sustained its popularity in the field of health and well being is that of ‘social capital’, and it seems to be a concept that is popular in many ways across the political spectrum. Lynch and colleagues (2000) suggest that those on the political right see social capital as an
opportunity to argue for a withdrawal of the state from welfare and social provisions, whilst those more towards the left maintain that state support is crucial to the accumulation of social capital (Baum 1999). This division is evident also in recent differentiations between the of Big Society Conservative coalitionists, on the one side, and Good Society Blue Labourites on the other.

Social capital refers to the values that people hold and the resources that they can access, which both result in, and are the result of, collective and socially negotiated ties and relationships (Edwards et al. 2003). The central premise of social capital is that social networks are a valuable asset (Field 2003). Recent writings have extended the concept of social capital from an individual asset to a feature of communities. In contrast to the focus on individuals in the work of Bordieu (1986) and Coleman (1988), Putnam (2000) is more concerned with social capital as a feature of communities. His approach, which has also been described as communitarian (Moore et al 2005), calls attention to the notion of civic virtue, which is most powerful when embedded in a network of reciprocal social relations. Putnam is pessimistic about contemporary society, arguing that there has been a decline in civic life, associated with individualisation.

Social capital is useful because it provides one basis for understanding the qualities of different communities in a more systematic way. For example, the distinction between bonding, bridging and linking forms of social capital is helpful not only in understanding the shape of communities and how they change, but also in working with communities to...
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develop effective strategies for community regeneration. It was seen as being something that could both explain the existence of resilient and adaptive communities and the successes and failures in community organizing and social action.

There are other reasons why social capital may currently be popular in community policy discourse. It draws attention to the benefits of a form of capital which is not financial and, despite an increasing turn to mutual and co-productive relationships between citizens and the state, can be achieved with little government intervention during a time of recession, whilst also evoking nostalgic notions of community connectedness (Arneil 2007; Franklin 2007). Even where social capital is used in a way that is linked to community organizing or social action much of the literature looks at social capital-building through community organizing as a way of building resilience in the presence of adversity or austerity, rather than providing the basis for resistance to the state or wider economic inequalities (Edwards et al. 2003, Bowen, 2009).

Most of these concepts are portrayed relatively narrowly, uncritically accepting notions of community as positive and overlooking potentially negative aspects of community life (Muntaner et al, 2008). In addition, the concept of social capital focuses attention on the positive consequences of sociability while putting aside its less attractive features e.g. exclusion of outsiders, excess claims on group members, and restrictions on individual freedoms such as demands for conformity (Portes 1998; Bowen 2009). Navarro (2002) suggests that Putnam’s communitarian approach to social capital has omitted power and politics; instead the emphasis is on ability to compete for resources, enhanced by the networks of which the individual is part. Navarro also critiques Putnam’s lack of awareness that the absence of togetherness may be rooted in the existence of capitalism and competitiveness and their adverse effects in alienating and atomizing citizens, ignoring the issues of inequality and the exercise of power (Edwards et al. 2003, Bowen, 2009).

A frequently cited article in relation to social capital and public health is by (Kawachi et al. 1997), who argued that high levels of social capital lessen the impact of income inequality on the health of populations. The paper draws heavily on Putnam’s communitarian approach - focused on civic engagement, norms of reciprocity and trust – whilst the network definitions of Coleman and Bourdieu are marginalised (Moore 2005). Communitarianism has been critiqued in recent years for its failure to provide a satisfactory answer to ‘the disintegration of social bonds in advanced societies’ and suggesting ‘a one-dimensional world in which communities are blessed with a cohesion that is neither chosen, intended, nor lived by the people who produce them’ (Bowring 1997:97) yet this approach has had a meteoric rise in public health rhetoric.

To see how ideas about social capital and related concepts and theories have shaped empirical research on interventions a systematic review was conducted to investigate the effectiveness of community strengthening interventions on health and wellbeing, Community interventions were defined as forms of social action and co-operation as well as programmes and interventions that are informed by theories and concepts of community. “Community” was conceived of in a broad sense and not confined to geographical area. We therefore included communities of interest, identity and
institutional settings such as schools. To be included, an intervention must have demonstrated some element of strengthening relationships, bonds or ties between people within a community which impacted on health outcomes. This meant that many “community-based” health interventions were excluded, as they were essentially clinical interventions being delivered in specific locality.

The search returned more than 7000 references. Titles and abstracts were screened for relevance, and those obviously outside the scope of the review were excluded. The researchers used a strategy of ‘if in doubt, leave it in’. Full texts of all remaining inclusions were obtained, screened by two researchers for relevance, and then distributed to the research team for critical appraisal and data extraction.
Many papers were excluded because they were descriptions of projects with little data on how efforts to strengthen or empower communities led to health or well being outcomes. However, critical appraisals highlighted some problems in the papers that were included, including lack of clarity in the definition of outcomes, too much information on processes, disconnection between theory and findings, lack of attention to the contexts in which interventions were located, and lack of attention to wider aspects of social and economic forces that shape the take up of interventions.

Finally, papers rarely reflected negative impacts. This may due to the way in which evaluations are funded. If interventions and evaluations share the same funding source then there may be a reluctance to throw doubt over an investment, or of the way in which an intervention has been commissioned.

In terms of the activities that the selected papers described these included community gardens, timebanks, digital inclusion projects, sports and arts interventions, environmental change projects and peer support interventions. There were others that aimed to develop a diversity of activities aimed at facilitating peer or neighbourhood relationships in ways that were acceptable to the people involved.

In developing a more conceptual overview of the interventions four ‘ideal types’ have been identified (Weber 1949). The following are useful categories for making sense of different kinds of interventions but does not mean that all interventions fit neatly into one category or another. These interventions are presented in the form of a two by two axis: interventions aimed at a specific group of individuals (communities of practice) versus those aimed at a ‘neighbourhood’ or place (geographic community) and those which either affirm peoples’ sense of belonging or identity or those which involve a transformation of capacities, power or resources for those groups of individuals or places.

The term ‘transformation’ was used in a number of interventions to indicate some kind of dramatic change in personal or collective capacities, powers, or resources. However some of these might be thought better as affirmation where the benefits relate to the personal rewards of social support or friendship. Whilst these changes may for the individuals themselves be personally transformative the types of transformation claimed in some of the interventions refer to the acquisition of social or political power. However whilst some of these papers make bold claims to more radical changes in the dynamics of structural power relationships (Williams and Labonte 2003, Morsillo and Prilleltensky 2007, Kegler et al 2008, Hamilton and Flanagan 2007, Itzhaky and York 2002) little evidence or argument is provided to support that view.

Figure 3 is a summary of the kind of health outcomes that were reported alongside different types of intervention and the theories that were thought to underpin these changes. Little reference was made to theories other than those associated with social capital (Michael et al 2008, Saldivar-Tanaka and Krasney 2004, Seyfang 2003, Smith et
al 2010, Sememza et al 2007, Griffiths 2009, Hopkins 2007), community organizing (USA) (Michael et al 2008 London et al 2010, Milligan 2004, Saldivar-Tanaka and Krasney 2004, Itzhaky and York) or community health assets - often linked to salutogenesis (Batt-Rawden and Tellnes 2005. Kegler et al 2008, Seyfang 2003, Letcher and Perlow 2009, Milligan 2004, Saldivar-Tanaka 2004). In terms of higher level political ideas, which presuppose ideas about the value and use of community strengths in the production of social goods, co-production was the only term that was used and in relationship to Timebanking. There was a surprising lack of evaluation of Timebanks given their theoretical basis and claims to support individual and neighbourhood level health and well being (Letcher and Perlow 2009, Seyfang 2003)

**Figure 3: mechanisms and health outcomes**

![Figure 3](image1.png)

Figure 4 highlights the strength of evidence for interventions in these domains. The strongest evidence (possibly because these interventions are the easiest to evaluate) is
for interventions that aim bring together a group of people, who share a common experience or characteristic, for friendship or support. In some of these interventions health benefits were also associated with feeling more closely and positively attached to the local neighbourhood (Seyfang 2003, London 2009, Saldivar-Tanaka and Krasney 2004, Lakin and Mahoney 2006, Teig et al 2009). However participation could be experienced as stressful, and the creation of new groups as excluding for others (London et al 2010, Milligan 2004, Teig et al 2009).

**Figure Four: strength of evidence**

Neighbourhood level interventions provided weaker evidence that the social fabric had changed in ways that improved the health of residents. Whilst evidence was often drawn just from people actively engaged in these interventions (and not residents who were not involved but stood to benefit) there was some evidence that interventions such as community gardens, and environmental regeneration projects which involved local people in their design saw overall improvements in mental health.

The weakest evidence was for transformative interventions. Whilst there was some evidence that, in particular, arts and digital inclusion interventions could facilitate new
learning and new ways of framing or communicating personal troubles as public issues, there was little evidence that these transformative moments were sustained in the long term. Though it could be argued that neighbourhood interventions protect residents from the worst effects of income deprivation in terms of health, and this is certainly important, there is no evidence that they pull neighbourhoods out of poverty.

However, this failure to find evidence for transformative interventions could be due to the nature of ‘interventions’ themselves. Indeed, the idea of a ‘transformative intervention’, may be a contradiction in terms. This is perhaps the implication in a paper by Crossley (2001) about a Health Authority funded HIV intervention for an ‘empowerment forum’ for gay men in the North-West of England. Instead of recreating the gay pride activism of the late 1980’s early 1990’s, this health promotion intervention was perceived by some stigmatizing and humiliating and ‘just another attempt to get us to stick condoms on our willies’.

To conclude community strengthening interventions do not have strong evidence base, although there is a long tradition of community health development initiatives. The reasons may include: the complexity and timing of evaluations to understand how complex changes in community relationships affect health and well being outcomes over time, lack of commitment or resource to evaluate interventions of this kind and the point that some forms of community organizing are a response to particular situations and research opportunities have been missed.

Recommendations:

- Mixed methods research and evaluation is needed on place making interventions such as community gardens, timebanks and participatory arts interventions and how different models may facilitate health and well being benefits for people who are engaged and not engaged.
- Research on community strengthening interventions should be attentive to the distribution of effects. Research needs to illuminate the processes of exclusion as well as inclusion through community level interventions.
- Research needs to better integrate theory and empirical research and situate an understanding of inventions within wider policy, political and economic contexts. There are a wealth of community related concepts and theories that are not fully utilized and developed in empirical research.
- In terms of non-intervention research innovative research designs are needed to identify how policy makers can better understand, and respond to, the needs and aspirations of communities.
- Researchers need to work with communities to assess how they can best mobilise internal and external resources (and connections) for health gain.
References and external links

References:


**Links to project reports and documents:**


Full review references, technical reports and references will be available at: [http://www.cisce.cardiff.ac.uk/en/content/cms/cisce-projects/completed-research](http://www.cisce.cardiff.ac.uk/en/content/cms/cisce-projects/completed-research)
The Connected Communities

Connected Communities is a cross-Council Programme being led by the AHRC in partnership with the EPSRC, ESRC, MRC and NERC and a range of external partners. The current vision for the Programme is:

“to mobilise the potential for increasingly inter-connected, culturally diverse, communities to enhance participation, prosperity, sustainability, health & well-being by better connecting research, stakeholders and communities.”

Further details about the Programme can be found on the AHRC’s Connected Communities web pages at:

www.ahrc.ac.uk/FundingOpportunities/Pages/connectedcommunities.aspx