Social contexts and health:
a GCPH synthesis

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This report draws on a wide range of work undertaken by or commissioned by members of the Glasgow Centre for Population Health (GCPH) team and the GoWell team in collaboration with many organisations and communities. Thanks are owed to the large number of researchers, colleagues, research participants and seminar speakers who have all contributed to this substantial body of learning over the last ten or more years. This report takes a cut through this evidence base to reflect on what we know about social contexts and health and the related actions that can be taken to help to improve health in Scotland. Thanks are also due to many GCPH and GoWell team members who provided very helpful comments on drafts of this report and who helped to finalise the publication, in particular: Joe Crossland, Ade Kearns, Lorna Kelly, Jennifer McLean, Pete Seaman, Carol Tannahill, David Walsh, and Gregor Yates.

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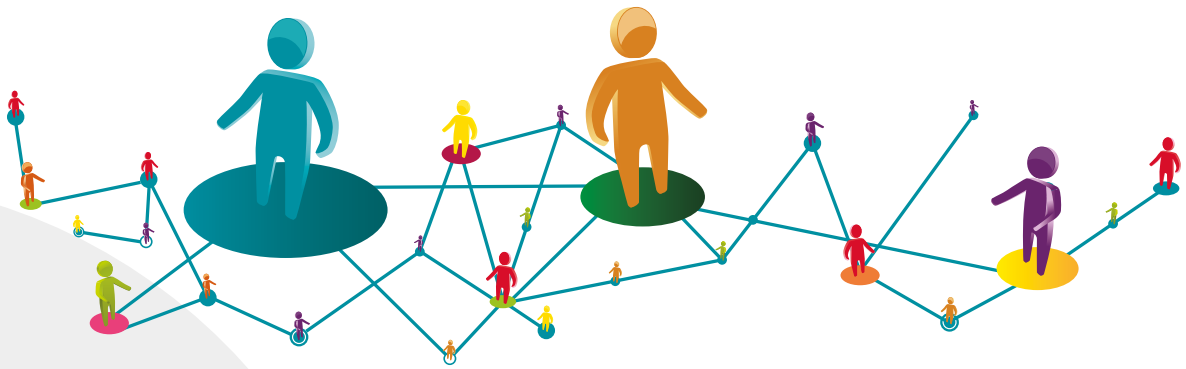

The Glasgow Centre for Population Health (GCPH) was established in 2004 to investigate issues relating to poor health, generate evidence about new approaches, and work with others to facilitate change. It is a partnership between NHS Greater Glasgow and Clyde, Glasgow City Council and the University of Glasgow, funded by the Scottish Government.

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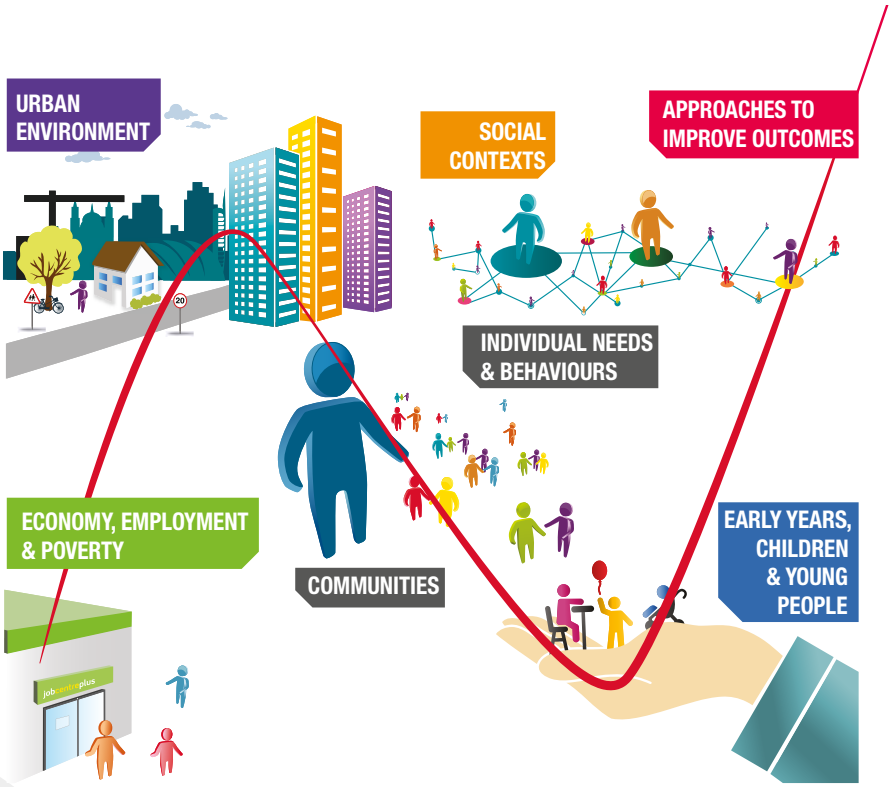
INTRODUCTION

Social contexts can be understood as the relationships and networks of support that people experience, the interconnections within communities, and the involvement of people and communities in decisions that affect their lives. Research has shown that these relationships and connections all have important influences on health in a range of ways. This report outlines Glasgow Centre for Population Health (GCPH) learning to date about how working with an understanding of social contexts can help improve health and tackle health inequalities.

This review of social contexts evidence follows on from the synthesis of ten years of GCPH evidence[1] published in October 2014 which emphasised, in line with international evidence, the importance of economic, environmental and social factors on health. In particular, the GCPH evidence emphasised the role of: the economy, employment and poverty; early life experience; neighbourhood environments; and social contexts (see Figure 1). Interacting with all of these, and having their own effect, are the services, interventions and approaches undertaken to improve outcomes for individuals and communities (represented by the red line in Figure 1).

Figure 1: Influences on health.



Following the synthesis of ten years of GCPH evidence[1] the GCPH engaged with partner organisations and others about the learning from this evidence base and the implications for future actions. During these discussions it emerged that there is an interest in increasing understanding about the links between people's health and their social contexts, and the related actions that can be taken to improve health and reduce health inequalities.

Therefore, this report looks in-depth at the GCPH evidence about the influence of relationships and social environments and draws out implications for working with an understanding of these to improve health.

This report outlines evidence about health and four key aspects of social contexts:

- **Social networks** (Chapter 2) – the role of family and friends.
- **Community cohesion** (Chapter 3) – the way people relate to each other within geographical communities.
- **Social participation** (Chapter 4) – volunteering and other types of participation in activities, clubs and groups.
- **Community empowerment** (Chapter 5) – the extent to which people in communities have control, and can influence decisions and actions to improve local issues.

Inevitably all of these social features are inter-connected, but for the purposes of this synthesis each is taken in turn to examine the evidence in detail. However, the linkages are highlighted throughout the report and the key implications of the evidence are summarised in Chapter 6. These different social features contain elements related to 'social capital'. Both the terms 'social contexts' and 'social capital' are used in this report as the evidence reviewed includes research with a particular social capital focus, as well as wider literature relevant to a consideration of relationships and social interconnections. Chapter 1, drawing on existing GCPH outputs, outlines some of the social capital theory and details how the chapters in this report relate to different aspects of social capital. The focus in this report, however, is not on the theoretical origins and uses of the terms 'social contexts' and 'social capital', rather on the implications of the evidence for future actions.

It is clear from the GCPH ten year review[1], as well as wider evidence, that actions relating to social contexts need to be in conjunction with, not in place of, actions across the range of other influences on health (including the economy, employment and poverty, early years and childhood experience, and neighbourhood environments). In particular, evidence emphasises the importance of addressing poverty. Poverty is the most ubiquitous and persistent risk factor for ill health; so a commitment to improving population health and to reducing health inequalities inherently means a commitment to reducing or eradicating poverty[2]. This report discusses the ways in which social contexts are intertwined with the impacts of poverty, as well as the interconnections with neighbourhood environments and children and young people's experiences (and other life-stages).

[a] GoWell is a collaborative partnership between the GCPH, and Urban Studies and the MRC/CSO Social and Public Health Sciences Unit at the University of Glasgow. GoWell is sponsored by Glasgow Housing Association, the Scottish Government, NHS Health Scotland and NHS Greater Glasgow and Clyde: www.gowellonline.com.

The evidence outlined in this report is drawn from the analysis, research and evidence reviews undertaken by or commissioned by the GCPH since it was established in 2004 and from the GoWell research and learning programme[a] established in 2005 to study health and wellbeing in disadvantaged communities. This report refers to only GCPH and GoWell outputs, rather than any original references reviewed in these outputs. This report also incorporates insights from events hosted by GoWell and the GCPH, including the GCPH Seminar Series lectures. The GCPH research studies have typically been undertaken in Glasgow or West Central Scotland, but some of the research, data analysis and evidence reviews also have a wider Scotland, UK or international focus. GoWell is investigating the impact of investment in housing, regeneration and neighbourhood renewal across 15 communities in Glasgow. Further information about the work programmes and evidence sources are available from the GCPH and GoWell websites and the individual publications referenced. Some key Glasgow data relevant to social contexts are included in this report, but more comprehensive and detailed information can be accessed on the Understanding Glasgow website[b].

[b] The Understanding Glasgow website (www.understandingglasgow.com) was developed by the GCPH, with support from a range of partners, to create an accessible resource providing information about the wellbeing of Glasgow's population across 12 domains (including social capital), each with a basket of indicators allowing progress to be monitored.

1. SOCIAL CAPITAL

Increasingly studies of factors influencing health have pointed to the importance of the social contexts in which people are living; often this is focused on the concept of social capital. A range of studies and reviews undertaken or commissioned by the GCPH have included a focus on social capital. Drawing on these outputs this chapter summarises the origins and definitions of social capital (Section 1.1), and the dimensions and types of social capital (Section 1.2). It also briefly outlines how social capital relates to health (Section 1.3), the interconnections with the economy and income (Section 1.4) and how social capital relates to subsequent chapters of this report (Section 1.5).

1.1 Origins and definitions of social capital

Social capital is not a new phenomenon but its importance to population health has been much discussed in recent years, particularly in the last two decades[3]. Social capital has its roots in the work of sociologists such as Durkheim but its acceptance as an explanatory concept in relation to health stemmed from the work of Bourdieu, Coleman and Putnam[4]. Reflecting their disciplinary backgrounds, each of these theorists is noted to have conceptualised social capital differently[3,4]:

- Bourdieu – networks and connections between individuals that provide potential support and access to resources.
- Coleman – resource of the social relations that exist between families and the communities that they are linked to.
- Putnam – a characteristic of communities, which includes features of social organisation (such as networks, norms and social trust) that facilitate co-ordination and co-operation for mutual benefit.

While debate continues about how social capital should be conceptualised, academics such as Kawachi have sought a more pluralistic approach, attempting to unify the different key elements[4]. This has resulted in relative consensus that social capital includes those elements of social networks that can bring about positive social, economic and health development at the micro (individual, family/household) and macro (local, national and international) level[4]. Despite the different definitions and commentaries about social capital, most definitions appear to be based on four key notions[3]:

1. Social trust/reciprocity.
2. Collective efficacy.
3. Participation in voluntary organisations.
4. Social integration for mutual benefit.

1.2 Dimensions and types of social capital

Social capital literature refers to different dimensions (structural versus cognitive) and different types (horizontal and vertical). Drawing on a range of research undertaken by the GCPH an explanation of these terms is offered below[3,4,5,6,7]:

Dimensions to social capital:

- **Cognitive** – norms, values, attitudes and beliefs (e.g. sense of trust, feeling of belonging to the local community, feeling valued).
- **Structural** – externally observable aspects of social organisation and networks (e.g. participation or club membership).

Types of social capital:

- **Horizontal** – connections made between people or groups perceived as equal, broken down into two different types:

1. **Bonding** – 'tight' relationships between homogenous groups (people with similar outlooks and values) and a source of social support for individuals.
2. **Bridging** – 'looser' connections between people from diverse groups (people with different outlooks, views and experiences).

- **Vertical** (often also referred to as linking social capital) – unequal or hierarchical connections, particularly to circuits of power and decision-making (e.g. between a community and formal local government organisation or structure) gained through participation in local decision-making or having access to power elites.

1.3 Social capital and health

In addition to debates about whether social capital is an individual or collective/community attribute, there have been debates about how social capital is measured and also whether social capital has potential negative effects (e.g. gang activity, peer effects of risky health behaviours, exclusion of 'outsiders' from social networks)[3]. Nevertheless, despite these debates there is evidence of significant associations between higher social capital and lower mortality[3]. A 2012 review of social capital and health studies is noted to have concluded that *"both individual social capital and area/workplace social capital had positive effects on health outcomes, regardless of study design, setting, follow-up period, or type of health outcome"*[3]. Overall, there is general agreement that social capital plays an important role as an 'asset' that has the potential to link and explain factors that influence health and wellbeing[4]. There is considerable variation, however, in how social capital operates, since it is influenced by geography, neighbourhood and life-stage[4].

A social capital question set developed by the Office of National Statistics (ONS), was used in a three-city survey undertaken by the GCPH to investigate the role of social capital as an explanatory factor for Glasgow's 'excess' mortality[c,3]. The survey was undertaken to compare results for Glasgow with two other UK post-industrial cities with similar deprivation profiles, Liverpool and Manchester. The ONS question set focused on five topics:

1. Views about the local area (perceived neighbourhood problems).
2. Civic participation (taking action and perceived levels of influence).
3. Social networks and support (frequency of contact and sources of help).
4. Social participation (volunteering).
5. Reciprocity and trust (within neighbourhoods).

In addition to the ONS question set, the notion of 'religious' social capital was also included in the survey using a modified version of the question on religious affiliation from the 2011 Scottish Census as a proxy for religious attendance. Overall, analysis of the three-city survey data on social capital showed that Glasgow's profile on views of the neighbourhood, civic participation, and social networks and support, was either favourable in comparison with, or similar to, the two other cities[3]. However, Glasgow, was found to have differences in some aspects of social capital, with[3]:

- significantly lower levels of trust (in terms of 'general' trust of people and more specifically trust of people in the neighbourhood) compared with both of the other cities
- significantly lower levels social participation (in terms of volunteering and the proxy for religious attendance) compared with both of the other cities
- lower levels of reciprocity, compared with Liverpool alone
- lower levels of neighbourhood 'problems' (e.g. vandalism, graffiti, rubbish lying about) compared with both of the other cities[8].

Based on the survey results it was concluded that it was plausible that there were differences in some aspects of social capital (trust and reciprocity, and social participation) between Glasgow and the two English cities which could potentially impact on levels of health and wellbeing in the population. A separate report (forthcoming) provides a synthesis of the evidence about the wide range of explanations for Glasgow's excess mortality[9].

[c] 'Excess' mortality refers to the higher mortality seen in Scotland, and in particular Glasgow, even after accounting for differences in deprivation and poverty (the main drivers of poor health in any society).

1.4 Social capital, the economy and income

It is not possible to discuss social capital in isolation from political and economic contexts and there is a danger that the promotion of social capital is used as a substitute for economic investment in poor communities and political change at a macro-level[10]. A report from the University of West of Scotland-Oxfam partnership, has argued that the concept of social capital is problematic since it implies that communities are disadvantaged as a result of a perceived 'deficit' of networks and relationships, as opposed to the root causes of poverty and disadvantage, such as deindustrialisation and housing clearances[11]. A fundamental problem, the authors argue, is that an emphasis on social capital can place responsibility on disadvantaged communities themselves for whether they thrive or 'fail'. Recognising these concerns this report, reviewing GCPH and GoWell evidence, emphasises the inter-relationship between social contexts and poverty and income inequalities; and explores how an understanding of social contexts can complement and contribute to actions focused on addressing poverty, deprivation and inequality.

1.5 Links between social capital and report content

The concept of social capital comprises so many different aspects of relationships and social interactions that referring to 'social capital' as a single entity is problematic. This report seeks to help move beyond generic messages about the need to increase social capital by being explicit about the social features being discussed and attempting to draw out the implications for policy and practice. As noted in the Introduction, this report uses both the terms 'social contexts' and 'social capital'. An outline of how the social features discussed in the subsequent chapters relate to the dimensions and types of social capital is detailed below:

- Chapter 2: **social networks** (*bonding capital*, an individual's contact with family, friends and neighbours) and **links to other social networks** (*bridging capital*, linkages beyond immediate individual networks and relationships).
- Chapter 3: **community cohesion** (*cognitive capital*, the extent to which people feel part of a community and *horizontal capital* the level of connections between people (*bonding*) and across groups (*bridging*)).
- Chapter 4: **social participation** (*structural capital and horizontal capital*, participation in activities, clubs, faith groups etc, and volunteering).
- Chapter 5: **community empowerment** (*vertical or linking capital*, opportunities and ability to influence local decisions).

2. SOCIAL NETWORKS

This chapter discusses social networks and people's health and wellbeing, drawing on evidence produced and commissioned by the GCPH and GoWell. It considers the following questions:

- What do we know about the health and wellbeing of people who have an absence of social networks, who are experiencing social isolation and potentially loneliness? (Section 2.1)
- What role do networks of family and friends play in supporting people's health? (Section 2.2)
- How do issues of income and work interact with social networks? (Section 2.3)
- Why and how should children and young people be supported to develop family relationships and social networks? (Section 2.4)
- What influence can social networks have on health behaviours (Section 2.5), and where might it be beneficial to support people to change or broaden their networks? (Section 2.6)

2.1 Social isolation and loneliness

Social isolation is generally understood as the absence of contact with other people, whereas loneliness is distinguished as a subjective perception and experience of isolation or lack of communication with others[12]. Evidence from across developed countries highlights growing concerns about both social isolation and loneliness; that the quality and/or quantity of social relationships are decreasing[13] and that there are high and increasing levels of loneliness[12]. These challenges are likely to increase given the expected increase in single adult households. In Glasgow single adult households are predicted to rise to form the majority (57%) of households by 2037[d].

Social isolation has been found to adversely affect people's health, regardless of social background[14]. A spectrum of health problems have also been found to be associated with loneliness, including mental health problems, sleep deprivation, negative effects on the immune and cardiovascular systems, and increases in health-damaging behaviours (e.g. overeating, unsafe alcohol consumption)[12]. A meta-review concluded that *"individuals with adequate social relationships have a 50% greater likelihood of survival compared to those with poor or insufficient social relationships"*[12]. The effects were reported to be comparable with smoking and greater than other risk factors on mortality, such as obesity and physical activity[12]. Analysis of GoWell data revealed that feelings of loneliness were most strongly associated with poor mental health, but were also associated with long-term problems of stress, anxiety and depression, and to a lesser degree with low mental wellbeing[12].

Research on community life in three UK cities observed that competition for housing and job opportunities outside of local areas was resulting in family networks being dispersed over wide areas[15]. This was perceived to be leading to services needing to respond to isolation and loneliness of older generations[15]. Older people

[d] As detailed on the Understanding Glasgow website within the 'Population' domain in the 'Households': http://www.understandingglasgow.com/indicators/population/households.

have reported that changes that occur in later life can often be accompanied by a constriction of social opportunities, these included reduced networks, bereavement, mobility issues, lack of transport, and becoming a full-time carer[16]. Although research on social isolation and loneliness has often focused on older people, it is also known, however, that the issues are not just restricted to this life-stage. The Castlemilk Timebank, for example, reported that a lack of close ties or support within the community has a negative effect on the confidence and self-esteem of individuals, in particular on young people from vulnerable groups[17]. In GoWell communities it was middle-aged people who were found to be experiencing more loneliness[12].

Social isolation and loneliness are issues affecting all developed societies and impact on individuals regardless of age and income; but many of the associated health problems have been found to be of greatest concern in deprived areas[12]. GoWell analysis revealed a high prevalence of loneliness in the deprived study areas; with two-in-five adults (39% men and 40% women) surveyed reporting they had experienced loneliness in the previous fortnight[12]. The analysis identified that 'neighbourly behaviours' of different kinds are important for protecting against loneliness, since those who had regular contact with family and neighbours, talked to people in the neighbourhood and had sources of support (practical and emotional) were less likely to be lonely[12]. People who used more local amenities were also less likely to report loneliness. However, those who reported more antisocial behaviour problems in the area, who thought it unlikely that neighbours would take action in an instance of antisocial behaviour, and those who felt unsafe walking alone at night-time were all more likely to report loneliness (antisocial behaviour is discussed in Section 3.5). Following the loneliness analysis GoWell recommended[12]:

- using neighbourhood design and planning of amenities to facilitate social contact and break down social barriers
- that public, third sector and local regeneration organisations should provide practical and emotional support for people with weak family and friendship networks
- that the issue of loneliness, and the broader related issues of social engagement and trust, should be given greater prominence within local plans and priorities.

2.2 Social networks of family and friends

Where people have positive social relationships and networks of family and friends (sometimes referred to as *bonding capital*), this is known to be beneficial for health. A body of evidence supports the positive influence of social relationships and social networks on mortality, morbidity, mental health and ageing[13]. Social relationships are associated with protective health effects through cognitive, emotional, behavioural and biological influences[13]. Being part of a social network has also been reported to give individuals meaningful roles that provide self-esteem and a purpose in life[13]. Richard Layard, in his 2005 GCPH seminar on 'happiness', promoted the importance of caring for others; stating that psychology studies have shown that people who care more about other people are happier than people who care less about other people[18]. This is an important point as it underlines the role social networks play in underpinning individuals' wellbeing, both as a giver of support, as well as a recipient.

It also highlights the fact that social support can be provided on an ongoing basis (where the right conditions allow), rather than it being perceived as a scarce or latent resource, as is sometimes the case when referring to 'social capital'.

Inevitably, the health and wellbeing benefits derived from networks of family and friends, are dependent on those relationships being supportive and positive. Conversely, where people experience problematic relationships we know this can have a damaging effects on health and wellbeing. GoWell reported that many of the study participants with health and wellbeing problems commonly ascribed these to problematic relationships, including abuse, bereavement, family circumstances, and problems with neighbours[19]. Although these participants welcomed improvements in their physical living conditions, they believed that addressing relationship problems would have the most impact on their health[19].

Social networks of supportive relationships with family and friends (sometimes referred to as *bonding capital*) have been identified as being important for being able to function again following a change or difficulty in their lives (described as *status quo resilience*)[6]. In such cases, social networks were reported to bolster a *sense of coherence*[e], and to be an important resource of support for individuals[6]. For example, social networks of family and friends have been found to play an important role in supporting people's positive self-identity, self-esteem and overall wellbeing, when these were not being provided by paid work[20]. Furthermore, these networks were also found to provide practical help with finances and childcare, underpinning the ability of unemployed people to access future paid work; although the networks were found to be of limited value in terms of access to employment opportunities[20]. This example underlines the need to also have wider networks (sometimes referred to as bridging capital) which are often important for further supporting resilience; enabling people to not only cope, but to have a change in circumstances which will help them to thrive (described as *transformational resilience*)[6]. Expanding social networks is discussed further in Section 2.6.

2.3 Social networks, income and work

Although social networks are important for people across all socioeconomic groups and operate in all types of communities, the need for support and the ability to provide it can depend on people's individual circumstances and resources. For example, having multiple relationships within a network of support has been found to be central to working lone mothers' ability to reconcile work and care responsibilities, especially in emergencies[21]. However, people within lone parents' social networks do not always have the resources or capacity to take on a support role and some lone parents do not have social ties to depend on[21]. Research with lone parents in Glasgow found that there was considerable variation in social networks; with some reporting strong networks and others reporting being relatively isolated[22]. Another study exploring community life, found that single parent households in a deprived community in Glasgow experienced isolation and reported that mutual support was not readily available[15].

[e] Sense of coherence: the ability to construct a view of the world as meaningful, manageable and predictable[6].

The challenges associated with material deprivation can impact on people's social connections and relationships. For example, GoWell research highlighted that tenants living in poor housing conditions (cold, dampness, water penetration, inadequate space) have reported feeling embarrassed and reluctant to have visitors; with some stating they withdrew from, or had disrupted, social relations as a result[23]. Other GoWell research found that people experiencing increased financial difficulties reported withdrawing from peer networks and social occasions, for example: due to costs of leisure activities, fear of the perceived stigma of their financial problems, and concern that hearing about other people's financial problems would worsen one's depression and anxiety[24]. The study suggested engaging those who self-exclude themselves from support networks and health services, to provide income maximisation advice and other forms of support to prevent mental health problems[24].

The interaction of people's material circumstances with their social networks further underlines the importance of income to people's lives and their health for those in work, and those out of work. Supporting people to gain and sustain good quality jobs is not only important in terms of income (providing pay is sufficient to lift people out of poverty), but also enables people to access the social benefits of work. The Marmot Review emphasised the role of good quality work in meeting basic psychological needs (e.g. self-esteem, sense of belonging and meaningfulness) and preventing social isolation[f,25]. For example, research with lone parents in Glasgow found that reported advantages of work included the opportunity to spend time with other adults, to provide respite from the demands of caring for children alone and to enable social contact while children were at school[21]. The Marmot Review, however, also emphasised the need for work to reconcile work/life demands (e.g. childcare)[25]. This relates to the following section on families, children and young people.

2.4 Children and young people

2.4.1 Relationships within families

Children's family environments have an important role in the development of close, supportive relationships (*bonding capital*)[4]. Children and adolescents are known to be able to achieve better health and wellbeing where families[4]:

- have strong, cohesive bonds between all members (i.e. children and adolescents have positive relationships with their parent(s) and other family members)
- engage in more frequent joint activities.

Constraints on parents to develop good family relationships, however, were highlighted by Oliver James in his 2008 GCPH seminar on 'Selfish capitalism'[26]. James outlined the financial pressures on parents to work, often for low wages, even though many parents report wanting to spend more time with their children. He also noted that despite increasing female participation in the labour market, women in the UK still carry most of the weight of domestic work; in contrast to Denmark

[f] In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review to propose the most effective evidence-based strategies for reducing health inequalities in England from 2010. The final report, 'Fair Society Healthy Lives', was published in February 2010.

where male workers (even at senior levels) work shorter hours to share domestic and child-rearing duties[26]. Social support networks have been found to be crucial to the wellbeing of lone parent households and to lone parents' ability to sustain employment[21]. In particular, the important role of grandparents for children in lone parent households has been highlighted. Growing up in Scotland (GUS) data showed that children in lone parent families (compared with other families) have more contact with a grandparent and a greater proportion have a resident grandparent[21]. Across all family types, grandparental involvement was found to be associated with fewer emotional problems and more prosocial behaviour (actions intended to help others), and this effect was stronger in lone parent families[21].

2.4.2 Wider family networks

In addition to the importance of relationships and activities for young people *within* the family, social networks beyond the family are also important for young people. Positive friendships can facilitate opportunities for young people to develop their social skills, experience different kinds of social support, and to face new situations[4]. GoWell research has also observed that peer friendships can help young people to feel safe in neighbourhoods that were partly hostile and violent[27]. Potential 'downsides' to young people's social network, however, have also been identified. For example, young people with wider peer networks may have more opportunities and encouragement from their peers to experiment with risk behaviours, such as substance use[4].

Young people have access to their own social support networks but they also appear to benefit from the networks that their parent(s), and their family, are embedded in[4]. Where parents and families provide access to a high quantity and quality of wider social support networks, young people have been found to be more likely to have better mental health outcomes, fewer behavioural problems and to participate in health-promoting behaviours[4]. GoWell has found that where young people established connection to adults in their neighbourhood this helped overcome the problem of adults stereotyping the young people as troublemakers[27].

A review of evidence about young people and social capital recommended that opportunities are created for[4]:

- parents to develop their social networks (particularly important in the context of pre-school and school-aged children)
- children and young people to expand their own social networks and to develop the skills and competencies to effectively operate across a range of different networks.

The review[4] highlighted two case studies[17] of community projects as examples where such opportunities were being put into action:

- Templehall Dads' Group engages young fathers in gardening activities, provides them with practical support and works to build self-esteem and confidence. This helps the young dads to expand their social networks, and supports their relationships with their children[17].
- The Fair Isle Primary School's *Opportunities for All* project provides opportunities for families to spend time together to nurture family relationships, as well as enabling families to develop supportive social networks with others[17].

Templehall Dads' Group. Image taken from Assets in Action[17].

Fair Isle Primary School's Opportunities for All project. Image taken from Assets in Action[17].

This latter example highlights the way in which children not only require support in building their networks, but can also give parents a reason to get to know each other and form connections[28]. The example also demonstrates the important community function that schools can play in enabling residents to participate in activities and develop networks. For pupils, schools play a critical role in the development of their social networks and their experiences of social relationships (with peers and school staff)[4]. Pupils who attend schools where they feel safe and where they feel a sense of community have better health and wellbeing outcomes[4]. Hence, it was recommended that policies and initiatives promote higher quality school environments and involve young people in decision-making about how to support health and wellbeing in schools[4]. It is also critical, however, that education and school policies and practices take account of income differences, since poverty has been found to be a barrier to participation in social opportunities and to the development of friendships in school[29].

The impacts of material issues were also emphasised in a study of children's resilience in disadvantaged communities in the West of Scotland[30]. While it was found that most of the children felt supported and safeguarded by close social networks, there was limited linkage to educational and job opportunities which children in more affluent communities are more likely to gain. Therefore, children who aspired to professional careers, for example, lacked individuals in their networks who could act as role models, provide information about the requirements for such jobs or facilitate access to suitable preparatory work[30].

2.5 Social networks and health behaviours

As discussed, positive social networks are important for adults and young people in terms of social contact, support and overall health and wellbeing. In addition social networks play a role in influencing people's health behaviours. Friends and family are known to have a powerful influence on behaviour change and helping people to believe that it is possible to take positive actions to improve health and wellbeing[13]. It is also true, however, that social networks can have a negative influence on health behaviours. Two examples of the influence of social networks on health behaviours are discussed below, firstly positive influences in terms of adopting running; and secondly negative influences in terms of excessive drinking of alcohol.

2.5.1 Running in disadvantaged communities

Research exploring running participation in disadvantaged communities in Glasgow found that running was often not perceived as the norm or even a socially acceptable activity within the communities[31]. For residents who had become runners, their immediate network of family and friends had often played an important role. It was found that it was family and friends who had often motivated them to start and sustain running and provided them with moral support and encouragement. Some respondents reported that they started running to support a family member or friend who was training for a race which resulted in them running together or increasing their own interest in running individually. Those contemplating taking up running stated that they were unlikely to initiate registering for an event, but could be persuaded to start running if somebody they knew suggested entering an event

with them. The research also found that other residents who had become runners had done so because they worked outside of their own community where they were exposed to different social norms or lived in a recently regenerated area where there had been population changes and different social norms operating. The research suggested a number of approaches to changing social norms in neighbourhoods where running is uncommon, including a mix of physical changes (e.g. establishing safe and appealing routes for running) and social interventions (e.g. encouraging use of local greenspaces by promoting running clubs/groups and organising local fun run events for people of all ages and abilities)[31]. The interaction of physical and social aspects of communities is discussed further in Section 3.4.

2.5.2 Young people and alcohol

Research exploring young people's relationship with alcohol reported how excessive alcohol consumption was socially and culturally constructed as a normal and characteristic form of socialising for young adults[32]. Excessive drinking was reported as a temporary behaviour associated with the freedom of young adulthood, so it was not perceived by young people to pose a long-term health risk. This perception was reinforced by young people's increasingly delayed development of full adult identities (e.g. delayed entry to the labour market) and by the marketing of alcohol to young people. The research found that some young people stated that they wanted alternatives to excessive drinking. It also found that as young people mature and start to 'settle down' (e.g. find employment, gain partners, have children) they move to habitual drinking of smaller amounts, rather than drunkenness (although they may still be consuming high amounts of alcohol). The association between social activity and alcohol was reported to remain difficult to decouple, even as people mature, since it was observed that alcohol and social participation are closely intertwined in Scottish culture and there is often a lack of alternative socialising spaces[33]. The research highlighted how participating in social networks can be simultaneously health promoting and risky. The challenge is how to best support people to manage this tension between potential threats and benefits. In some cases problem drinkers whose social networks are detrimental to their health need new networks offering different forms of support[34].

The research pointed to a number of recommendations, that[32,33]:

- planning agencies and licensing boards should consider the number of alcohol retail outlets and the variety of leisure opportunities on offer in an area
- health promotion messages should avoid further normalising excessive drinking as inevitable 'youth' behaviours
- different information should be targeted at younger age ranges, compared with those aged 25-30 who typically move into a different phase of adulthood and different ways of relating to alcohol.

2.6 Expanding social networks

As noted in Section 2.2, in addition to the importance of immediate networks of support from family and friends, wider networks can also play an important role for health and wellbeing. In particular, for people experiencing difficulties in life it can be beneficial to expand their networks to engage with people with different experiences and values (*bridging capital*) and to interact with formal organisations (*linking capital*)[6]. These broader contacts and networks can enable people to find new responses to their difficulties and different ways forward[6]. Examples are discussed below where expanding social networks were shown to be beneficial for health in a range of different circumstances: people at risk of criminal offending (Section 2.6.1), people experiencing unemployment (Section 2.6.2), and people in younger and older generations seeking to broaden their social connections (Section 2.6.3).

2.6.1 Networks to reduce criminal offending and reoffending

Young people involved in gangs reported, as part of research on the Includem gang pilot[g], that their gang-related networks were important for social and emotional support, particularly in the face of challenges they experienced, such as poverty or parental substance misuse[7]. However, they also outlined the negative influences that their networks had in terms of offending and gang fighting. The research highlighted the importance of a trusting relationship, provided by *Includem* project workers, in compensation for damaging peer relationships[7]. Given the loss of emotional support that results from moving away from these peer relationships, the project workers encouraged a focus on future aspirations by identifying and linking the young people to more positive social networks, as well as community and educational resources[7]. Although project workers helped young people with the transition to alternative social networks and the move away from gang activity; the structural deficits within communities or wider society (e.g. prejudice, lack of job opportunities) could prevent young people from establishing successful lives, regardless of changes at the individual level[7]. The young people still had to navigate issues of poverty, parents with difficult life circumstances and issues related to remaining in neighbourhoods where they may need to handle risky situations. The *Includem* gang pilot, however, was part of the wider Community Initiative to Reduce Violence (CIRV), which linked agencies and services working with young people. Through consistency of approach *Includem* and CIRV were able to help the young people to navigate the risks posed by their immediate environments[7]. This is a good example of how facilitating joint working across agencies and services can help address the multiple dimensions of a problem.

A similar multi-agency approach to supporting women in the criminal justice system was outlined at Linda de Caestecker's 2015 GCPH seminar on re-imagining justice for women[35]. It was highlighted that, as a result of a custodial sentence, women often

[g] The Includem project, in Glasgow, works with young people at risk of custodial sentences from involvement in gangs and other forms of antisocial behaviour: http://includem.org/.

[h] Tomorrow's Women work across services focusing on the needs of the individual women, with a particular focus on understanding the traumatic experiences many of the women have experienced during their lives. Tomorrow's Women links the women to support they need across a range of services and takes account of the importance of social networks, for example, helping women secure tenancies in a place where they have family or friends who can provide support[34].

lose their tenancy and lose contact with their family and community. This combination of homelessness and alienation means that women who are not offered support at the end of their sentence often reoffend as a way of returning to prison. Reflecting on the conclusions of the 2012 Commission on Women Offenders, it was reported that prison and vocational training are not sufficiently effective and that successful approaches involve supporting the women to: maintain family and other relationships; remove practical barriers to everyday living; and change their belief in themselves[35]. A key outcome of the Commission highlighted was the establishment of community justice centres across Scotland, including one in Glasgow called Tomorrow's Women[h]. This Centre links women to the support they need across a range of services and also takes account of the importance of social networks, for example, helping women secure tenancies in a place where they have family or friends who can provide support[35].

2.6.2 Employment and networks

Research on an employment initiative identified that the influence of social networks was important for employability, in addition to the established influences of the labour market and individual factors (e.g. qualifications and skills). The research on the Full Employment Areas (FEA) initiative[i] found that although clients typically had high *bonding capital* with networks of family and friends important for support (discussed in Section 2.2), they tended to have limited *bridging capital* of links to different networks of employment information and opportunity[20]. In areas with high levels of worklessness, access to *bridging capital* can be scarce, tending to limit the availability of options to low-paid, low-status positions with little career development potential[19]. The FEA outreach workers were found to play a crucial role in overcoming these network-based barriers to employment, by sharing information, linking clients to sources of support, and providing 'softer' advice, such as how to fill in applications, prepare for interviews and how to dress for interviews[20]. Individuals' existing social networks, however, were also found to be crucial for maintaining self-worth and feeling valued, in the absence of secure and/or meaningful employment opportunities[19]. Therefore, it is important that approaches acknowledge and work with the strengths of people's existing social networks, as well as looking at how supporting people to connect with other networks and formal organisations can bring further benefits.

2.6.3 Cross-generation networks

Case studies of community projects found that one of the key purposes of many of the projects was connecting people[17]. For example, the Playbusters Connecting Generations Project focused on increasing links between younger and older people within the East End of Glasgow. Young people in the area had expressed a lack of close contact with extended family and the lack of opportunity to learn from and build positive relationships with older citizens, as well as share their technology skills with older people. Many older people also reported not having contact with young people, despite having spare time available and skills to offer. Intergenerational activities

[i] The Full Employment Areas (FEA) initiative was set up to demonstrate news ways of reaching and engaging workless people in three small areas of concentrated worklessness in Glasgow. Support workers, who have experienced unemployment themselves, mentored clients and worked in a client-led way to overcome barriers to work. The report notes that worklessness is likely to be experienced either as long-term, life-long unemployment or a 'cycling' between periods of employment, (re) training and benefits[13].

were hosted by the project to provide joint learning and shared experiences (e.g. gardening, heritage workshops, art programmes, traditional crafts, games and sports, and technology workshops)[17]. GoWell research has further highlighted the need for increasing cross-generational networks. Adults in disadvantaged areas, who had very little contact with young people, tended to only recall negative interactions with young people and to sometimes stereotype young people as troublesome[36].

The benefits of linking older people to schools were also highlighted by Bruce McEwen at his 2007 and 2015 GCPH seminars on neurology research[37,38]. He outlined evidence from the Experience Corp programme developed in Baltimore, USA, which trains older people to become teaching assistants in elementary schools. Children were found relate to an older 'grandmotherly' or 'grandfatherly' personality and benefit from the additional classroom help. Older volunteers benefited from the increase in physical activity and social interaction. Many of the older volunteers also reported increased meaning and purpose in life[37,38]. McEwen discussed this programme as an example of an intervention that encompasses two important factors, social support and physical activity, that help both children and older adults 'open windows of plasticity' in the brain[j] to enable recovery from past negative experiences and to support improved cognitive function[38].

Playbusters Connecting Generations project. Image taken from Assets in Action[17].

[j] Bruce McEwen discussed research showing that there is brain plasticity for people of all ages, meaning that the architecture of the brain can be remodeled due to experiences and changes in the environment. 'Opening windows of plasticity' refers to the importance of creating environments and experiences that help the brain develop and adapt positively, essentially to 'push the brain in the right direction'. Regular physical activity, mindfulness stress reduction, and social support were all discussed as important in this context[38].

3. COMMUNITY COHESION

There has been much debate about how to define a 'community'. The focus here is on a geographic community and the quality of life for people living together in a particular locality. The term 'community cohesion' is also understood and used in a range of ways, but it is useful to draw on the GoWell definition: the extent to which people in an area relate to each other and have a degree of common purpose and values[39]. As discussed in Chapter 2, social networks are clearly important, and are inevitably related to community cohesion. However, an additional focus on the functioning of communities is needed, as the mere existence of individual relations or networks of support does not necessarily lead to wider cohesion. For example, GoWell has observed that although there were overall high proportions of respondents reporting that they have regular contact with friends and neighbours and that they have someone they can rely on for support, there were much less positive findings on indicators of wider community cohesion over time (e.g. feelings of safety, perceptions of honesty, informal control exercised by co-residents and feelings of being part of the community)[39].

There is a need to increase understanding of how policy and practice and community cohesion interact, be it intentionally or unintentionally, and to focus efforts on supporting the social aspects of communities in a way that enhances the health and wellbeing of populations. This chapter considers the following key questions:

- Why is community cohesion important to health? (Section 3.1)
- How have communities changed following deindustrialisation and how are they continuing to change? (Section 3.2)
- What is known about the integration of migrants into communities? (Section 3.3)
- How do physical and social environments interact to influence cohesion? (Section 3.4)
- What is known about the impacts of antisocial behaviour in communities and how to reduce it? (Section 3.5)

3.1 Community cohesion and health

Community cohesion is essentially about the social functioning of a community. There are important features of the social functioning of communities that need nurturing as they are fundamental to the health and wellbeing of residents. The key features of community cohesion described by GoWell are[39]:

- Less antisocial behaviour.
- Less isolation and distrust.
- More integration and social support.
- A greater sense of belonging and valuing of other members of the community.

There is a risk when discussing community cohesion of appearing to romanticise the notion of community and to overlook the way in which communities can be fragmented, and that there can be tensions between individual and community needs[40]. However, a focus on the social functioning of a community is important as levels of cohesion influence quality of life and the feelings that residents have while they are living in a community and interacting with other residents; sometimes referred to as the 'psychosocial' aspects of a community environment. GoWell has stated that a good psychosocial environment is one which promotes a positive experience or view of oneself in relation to others, for example in terms of trust, control, self-esteem and status[41]. These psychosocial aspects of a community are known to affect health, along with the physical characteristics of housing and neighbourhoods[42]. GoWell has observed that levels of mental wellbeing[43] and feelings of loneliness[44] are associated with indicators of community cohesion (such as feelings of safety, perceptions of honesty, informal control exercised by co-residents, and feelings of being part of a community). Similarly, other research has found that feelings of belonging and trust in others was the strongest predictor of mental wellbeing, after controlling for physical health problems[5]. In particular, this effect was found to be stronger among those aged 65 years and older, suggesting that feelings of purpose and belonging within the neighbourhood may become even more important for older adults. Community cohesion is also reported to be important to young people, who have been found to thrive in communities where they report cohesion, feeling bonded with their neighbours, and engaging in civic decision-making[4]. Living in a high-quality neighbourhood (e.g. with fewer hazards and higher levels of informal social control) and attending schools with higher quality environments (e.g. feeling school is a safe place to be) have both been found to be associated with better mental health and fewer problem behaviours[4].

Overall, evidence has shown that social fragmentation and the loss of social cohesion can be detrimental to mental and physical health[40]. Health has been found to decline (with premature mortality and increased morbidity, particularly in stress related conditions) in communities where levels of interaction are low and where people feel insecure[13]. Community cohesion is clearly important to any consideration of how to improve health and reduce health inequalities, but the continued need for action on the structural determinants of health (i.e. distribution of money, power and resources) has been emphasised[13]. Evidence suggests that more socially cohesive communities can, through effective local action, safeguard services and amenities (e.g. that might be threatened from budget cuts)[3]. It has also been observed that in more cohesive communities it is easier for public services to develop a dialogue with local people and meet local needs[13]. Cohesive communities are reported to be more stable and sustainable, and in turn are less dependent on external services and interventions[39]. Research also suggests that more cohesive communities can respond more effectively to shocks, for example the collective action observed following the 1995 Kobe earthquake in Japan[6]. The importance of community cohesion and neighbourhood support systems have also been highlighted in terms of future needs to respond and adapt to ongoing, long-term challenges of climate change[6,42].

3.2 Deindustrialisation, changing communities and cohesion

A key point when discussing community cohesion is to understand the dynamic nature of communities – that they have changed and continue to evolve in response to social and economic forces. This section discusses the impacts of deindustrialisation and subsequent changes on communities.

Deindustrialisation has had a negative impact on the social fabric of all countries, regions and communities that have experienced it[45]. However, the problems of deindustrialisation were found to have been compounded in West Central Scotland (compared with the other European regions) by the policy priority placed (at local and UK level) on economic growth, emphasising employment and physical regeneration, with less focus on social outcomes, such as community cohesion[45]. Research investigating reasons for Glasgow's 'excess' mortality, based on comparisons with two similar post-industrial UK cities (Liverpool and Manchester), has suggested that a number of historical factors combined to make Glasgow more vulnerable to the detrimental effects of poverty, deindustrialisation and the UK economic policies that were implemented from the 1980s onwards; which in turn impacted on social and community networks[9].

A case study of Clydebank (a post-industrial town in West Central Scotland) documented that, prior to deindustrialisation, ample work opportunities in the town meant family and friends stayed nearby and the working environments enabled the development of friendships and networks. These conditions provided the basis for unions, tenants committees, clubs, societies and church-based organisations[46]. The density and multiplicity of these social relationships proved initially important for helping residents' experiencing unemployment (e.g. support from the Unemployed Action Group) as the processes of deindustrialisation began to have impact. As time went on, however, the capacity for residents to provide mutual emotional and practical support was significantly reduced by further unemployment, the increase in non-unionised service sector jobs, people moving away for work, and the redevelopment of the town's public spaces[46,k].

From 1980 the 'right to buy' housing legislation and the deterioration in public housing in Clydebank resulted in the most vulnerable residents being housed in the poorest quality properties, creating concentrations of tenants with the least capacity to provide mutual support[46]. Furthermore, the lack of neighbourhood-based social relations was often coupled with unemployment and lack of access to work-based social networks. Less vulnerable tenants who had stayed in the town's remaining social housing also experienced changes to neighbourhood social networks, as some of those, often with more resources, had moved away from the area. A coping strategy for some of the towns' long-standing residents was to dissociate from the area and the problems related to poverty; this diminished their capacity to take action and to stimulate improvements and was part of a much broader process of disempowerment and political disengagement from the 1980s onwards. The subsequent New Labour policy emphasis on communities addressing their own

[k] Physical redevelopment of Clydebank was undertaken from the late 1970s onwards involving building new road transport links and a new shopping centre, which involved demolition of defunct industrial premises, tenement housing in the centre of the town, and removal of the high street. This was reported to lead to a change of identity of the town and to reinforce a sense of loss felt by many of the town's inhabitants[40].

problems is reported not to have helped overcome the political disempowerment and diminished social networks in Clydebank. The private investment-focused regeneration of this period is also reported to have largely failed to address Clydebank's long-standing issues of poor quality and scarce employment, and poor housing. In addition, the 'New Deal' welfare reforms, which began in 1998, are noted to have deepened poverty and inequality[46].

Changes to housing tenures and movements of populations can be seen to have influenced levels of cohesion following deindustrialisation, as in the example of Clydebank above, and continue to exert influence. Research in communities, across the three post-industrial cities of Glasgow, Liverpool and Manchester, similarly found that residents did not express the attachments to place and shared outlooks which had been observed prior to deindustralisation, underpinned by the industrial economy[15]. The communities were observed to be continuing a trajectory of change with community life adapting to the current economic context in different ways. Residents in one of the communities in Liverpool reported that the sense of community was being threatened by the increasing transience of residents, due to a rise in private social landlords and people moving out to seek work opportunities elsewhere[15]. Cohesion was stated to be strengthened when people lived alongside each for a long time: *"if you've got a transient population people don't have ownership of the area in quite the same way"*[15]. Similarly, Gorbals residents participating in GoWell research discussed the high number of private renters in the area, who they perceived to be more transitory and less likely to contribute to the community[47].

The large concentration of private housing in Govanhill, Glasgow, combined with transient and vulnerable populations, is observed to have led to the proliferation of 'rogue' landlords and an increase in overcrowding and below tolerable standard living conditions[48]. This is reported to have undermined community cohesion in the area (e.g. noise pollution and nuisance for neighbours, overflowing bins)[48]. An evaluation of a partnership approach established in Govanhill to improve the health of residents, recognised the importance of social and community networks for residents[49]. It found there was strong networks within the area; both for social purposes and for distinct purposes (e.g. tenants' associations)[49]. However, it was identified that there were significant challenges in engaging and promoting community cohesion with many individuals or sub-sections of the Govanhill community[49]. This serves to reinforce the different ways residents can experience the same neighbourhood and have varying levels of connections with people in the area. GoWell has observed that cohesion is more difficult to achieve where populations are highly transient and diverse, and where the environment (in terms of public spaces, safety, services and amenities) is not conducive to communal activity and interaction[39]. Population change, in terms of the integration of migrants, is discussed further in Section 3.3 below and environmental influences are discussed in Section 3.4.

3.3 Integration of migrants

The ethnic diversity of communities in Scotland has been changing in recent years. Identifying how well communities are adapting to growing diversity, is an important issue for the health and wellbeing of migrants and for Scotland's successful development in the future[50]. In Glasgow, the ethnic minority population has doubled over the past 15 years, and there are a dozen neighbourhoods across the city that now have 12% or more ethnic minority residents, including nine neighbourhoods where ethnic minority residents make up a quarter to a half of the population[50].

A GoWell survey[l] of residents across 15 areas of Glasgow found that most migrants did not feel part of the community, knew very few of their neighbours, and felt unsafe in the local area after dark[51]. Recent GoWell analysis has found that reported levels of social integration were lower for migrants compared with British-born citizens[52]. For example, among migrants, there were found to be lower levels of: trust in informal social control in the neighbourhood; speaking with and exchanging things with neighbours; available social support; and feelings of neighbourhood belonging. Overall, lower social integration among migrants was found on 20 out of 21 indicators, the only exception being that, compared with British-born citizens, migrants reported slightly higher rates of using social amenities (e.g. parks and play areas, libraries, community centres)[52].

Asylum seekers and refugees (ASRs) expressed appreciation for different aspects of their lives (e.g. homes, schools, churches, and support from other ASRs and Scottish friends) in GoWell research undertaken in regeneration areas, but they also reported experiences of hostility and aggression in the early years of new migrant settlement in the city from 2000 onwards[53]. The ASR participants stated that they needed to have more opportunities to mix with Scottish people and to know how to do so. Both ASRs and local Scottish residents talked about the children getting on well together, and visiting one another's homes, also thereby helping parents to know one another[53]. However, in general White Scottish residents who participated in the research tended to be quite negative about ASRs[53]. They expressed resentment about perceived unequal treatment, and social unease about the amount of foreign people on the streets; with suggestions that this had negative effects on the image and stability of the neighbourhood. There were different views about the desirability of greater mixing, with some respondents stating they wanted to keep their own culture and others suggesting that there should be more opportunities to mix and learn from each other[53].

GoWell, however, noted that some of the difficulties stem from the fact that the locations concerned are very deprived communities that are undergoing disruptive change through regeneration and a high turnover of occupants, as well as being very diverse communities (in terms of ethnicity and citizenship status)[52]. GoWell has articulated that the challenge for policy and practice is to find a way to stabilise the community composition in regeneration areas, and provide leadership and support to help establish cross-group relations so that migrants can feel they are a greater part of what is going on in their area[46]. For example, GoWell research reported

[l] A GoWell community health and wellbeing survey conducted in 2008, in which a total of 4,648 people took part from 15 areas across Glasgow. In total, 16% of respondents were migrants (from over 30 different countries)[48].

improvements in ethnic relations in one of the study areas where there had been joint efforts by the police, community organisations and residents themselves, to bridge divisions within the community[19].

GoWell subsequently found that the social integration of migrants improves over time and, as would be expected, that the amount of time spent in the neighbourhood had a stronger effect than the length of time spent in the UK as a whole[52]. It was suggested that integration projects are likely to have made a difference over the years and should be continued given the overall low levels of social integration of migrants currently observed[52]. The importance of employment and education, in particular access to English language classes were also highlighted, since it was found that[52]:

- migrants who were in employment were more likely to feel part of the community compared with other migrants
- migrants with educational qualifications experienced better social relations than other migrants
- migrants who could speak English without difficulty were more likely to have available practical social support compared with other migrants.

The importance of access to English language classes for migrants was emphasised in the 2015 GCPH seminar on migration by Alison Phipps[54]. This was within the context of valuing multilingualism and the assets that migrants bring. Many ways of enabling migrants to experience greater social integration and less stress were highlighted, including: increasing access for migrants to English language classes, enabling greater opportunities for migrants to interact with and use the new language with English speaking residents, and increasing understanding within public services of the needs of people who do not have English as a first language[54].

3.4 Interaction of physical and social environments

Well maintained, distinctive, attractive and safe-feeling public spaces and routes are reported to enable social activity and can encourage a sense of community[42]. Evidence has indicated that it is important to develop, manage and protect the surroundings in which people live to foster positive social interaction and to avoid or minimise the development of distrust and fear within communities[10]. Looking across research from the GCPH and GoWell, it is clear that improving the physical environment within communities is important, but how residents are involved in decision-making and the changes that take place is critical (see Chapter 5). Furthermore, physical changes need to also be alongside support to foster and nurture social interactions in communities. The evidence points to a range of ways in which the physical environment is important to social interactions, for example:

- **Car traffic** – The negative impact of 'car-dependent sprawl' on social interactions was highlighted by Howard Frumkin in the 2006 GCPH seminar on urban design55. The volume and speed of traffic along residential streets has been found to have a negative impact on the 'liveability' of the street, the strength of social networks and social interaction[10].
- **Street design** – Aspects of urban design, such as street patterns and having well-lit, pedestrian-friendly footpaths, can make a difference to levels of informal contact among residents[42].

- **Community facilities** – It is has been observed that there is often less provision of meeting places and spaces (community halls, greenspaces) in disadvantaged communities and/or they tend to be of poorer quality[5]. Research into neighbourhood improvements in Calton, Glasgow found that the opening of a new Heritage Centre was viewed very positively by most residents as a new resource for the community[56]. However, the research also highlighted accessibility issues, for example, there were concerns about high charges for community groups to use the centre and young people reported not feeling welcome at the centre[56].
- **Greenspaces and play areas** – There are a wide range of benefits associated with the availability of and quality of greenspaces (parks, gardens and areas of vegetation which offer space for recreational activity)[42]. Research has highlighted that greenspaces need to be flexible enough to cater for the varying needs of community members and different age groups[57,m]. However, use of greenspaces is known to be dependent on how attractive and safe they are[42,57]. Features such as litter, graffiti and broken bottles have been reported to indicate risk of danger[57]. Play areas that are vandalised or attract groups drinking alcohol have been reported to prevent children from playing outside[19,58]. Research on greenspaces and community facilities suggested that "get to know your local parks" events could encourage new users[57]. Such a process was undertaken by the Stobs WELLbeing Project in Dundee to address underutilisation of the regenerated local park, with the aim of improving mental health and wellbeing[17]. Picnics were held which were successful in encouraging social interaction, partnership working and better use of greenspace[17].
  The example highlights the importance of both physical improvements and active social support to increase the use of community resources, such as greenspaces.

Stobs WELLbeing project. Image taken from Assets in Action[17].

[m] The research found that parents of young children sought safe and pleasant spaces to play, those without dependent children prioritised spaces for socialising with others (e.g. private communal gardens) and young people sought places to 'hang out'[52].

3.5 Antisocial behaviour

Community safety is important to any consideration of how to improve the health of people and communities. Antisocial behaviour (ASB) in general, and young people hanging around in particular, were among the most commonly cited neighbourhood problems in GoWell surveys in 2006 and 2008[59]. The ASB term became widely used in the UK during the 1990s and has featured in UK legislation since 1998[56,n]. GoWell found that levels of mental wellbeing were linked to perceptions of ASB and to whether people considered their neighbourhoods to be 'quiet and peaceful'[60]. GoWell residents described ASB as reducing their quality of life, for example: feeling stress and anxiety when hearing disturbances taking place outside or within the high-rise block; and feeling fearful when their children were outside in environments that were not considered safe[59]. ASB, therefore, was found to be impacting on psychosocial wellbeing as well as levels of physical activity for adults and children.

Some commentators have been critical of the way the ASB term is often used in association with population subgroups that are already disempowered, such as disadvantaged young people[61]. It has been argued that apparent examples of young people's ASB often include harmless activities such as 'free play' (hanging out with friends in the street) and that young people are sometimes the object of intolerance from older people[61]. However, GoWell analysis found that it was not older people who were most concerned about ASB, rather it was younger adults (16-24) and people who were either vulnerable themselves or concerned for their own children[61]. Nevertheless, some young people reported experiencing negative reactions and stereotyping from adult residents who failed to distinguish between problems with gangs and groups of friends hanging around together[61]. Among the adult research participants there were varying views about whether 'hanging around' was really (or always) antisocial[59]. Both young and adult residents did report low levels of social connections between younger and older generations, but many of the adults were found to empathise with young people and to state that many young people do not pose problems for the rest of the community[59,61].

However, both young and adult residents did report experiences of violence, vandalism, harassment and problems related to substance abuse, which suggest that negative perceptions of ASB in the communities is based on more than just misunderstandings or intolerance[59,61]. It was also reported that these behaviours were perpetrated by people from a range of ages, not just young people[59,61]. For example, young people reported experiencing aggressive behaviour and problem drinking by adults in their homes and/or local streets[61]. Overall, the GoWell research emphasised the importance of addressing ASB for health improvement and pointed to the need for a multi-layered approach. Research by GoWell and the GCPH has suggested the following areas for action:

[n] The 1998 Crime and Disorder Act defined antisocial behaviour (ASB) as "acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not in the same household as (the defendant)". This definition stipulated that the ASB must be an action or speech; it must be directed at someone who is not related to the perpetrator and is likely to cause a negative response. The Antisocial Behaviour (Scotland) Act (2004) built on this definition and stipulated that the action must occur on at least two occasions and could adversely affect witnesses, as well as direct victims.

- **Increasing connections between younger and older generations** to help reduce the incidence of adults misreading harmless behaviours as threatening[59]. However, this is not the sole solution, since residents reported experiences of ASB which are difficult to tolerate regardless of how connected residents are[59,61]. Understandably residents stated that they do not want to 'connect' with the people who hang around public spaces while intoxicated by alcohol or other drugs[59,61].
- **Improving facilities for young people** to address the reported lack of community amenities and leisure activities[7,48,57] and to provide safe, welcoming places to socialise with likeminded friends[61]. However, it has also been suggested that this needs to be in conjunction with providing young people with personal support, given observations that some young people lack parental support and guidance, and suffer from low self-esteem and lack of confidence[62].
- **Physical neighbourhood improvements** can have positive individual and community impacts, particularly when they are supported by local people and are accessible to all, but they need to be implemented alongside other actions to address social issues and improve community safety[56].
- **Maintenance and management of neighbourhood environments** (e.g. parks, play areas, open spaces) has also been found to be important[57,58,62]. For example, research participants have suggested the need to have park rangers and clear lines of communication for reporting graffiti, vandalism and ASB[57].
- **Involvement of community members and grassroots organisations**, as well as statutory bodies, in the development of urban greenspace planning and implementation has been advocated[57].
- **Tackling drink and drug problems** is important since they act as a barrier to social cohesion and add to perceptions of poor neighbourhood safety[59].
- **Working with communities to more clearly define 'intolerable behaviours'**. GoWell suggested this would help discourage the ASB label being applied to activities that are not intended to or likely to be problematic[59].

4. SOCIAL PARTICIPATION

A range of social influences on people's health has been discussed so far in this report, including social contact and friendships and feelings of safety and belonging in communities. This chapter, drawing on GCPH and GoWell outputs, discusses the ways in which social participation can contribute to the development of social networks and community cohesion, and support people's health and wellbeing. This chapter does not cover the important role of family and friends in providing help and support, discussed in Chapter 2, and wider evidence sources. For example, Joseph Rowntree Foundation research in Glasgow has detailed how the help and support of family and friends plays out in day-to-day life (e.g. unpaid childcare, running errands, helping with chores, or giving people time and emotional support)[o]. The focus of this chapter is on the benefits of volunteering and different types of social participation including: 'restorative participation' to overcome health and social difficulties, environmental participation, arts or cultural participation, and religious participation. Further types of social participation also operate, but these are the key types of participation identified from the GCPH and GoWell evidence base.

Measures of social participation often focus on volunteering, although there are other types of social participation which are also beneficial to health and wellbeing. However, in some cases there can be a blurred distinction between being a 'volunteer' or another type of participant. For example, individuals involved in community projects did not describe themselves in formal terms as 'a volunteer'; rather they often referred to their contribution more informally as 'helping out' or 'supporting'[17].

This chapter considers the questions of:

- How does volunteering relate to health and wellbeing? (Section 4.1)
- What different types of social participation operate and how do these relate to health and wellbeing? (Sections 4.2 to 4.5).

4.1 Volunteering, health and wellbeing

Volunteering can take many forms, including formal and informal activity and different types of opportunities, including 'one-off large events' (e.g. Commonwealth Games) and ongoing small-scale projects[63]. Case studies of community projects observed that volunteering played an important role for the majority of the projects, although there was a wide range of ways in which time, skills and energy were given[17]. There can also be mutual volunteering arrangements within a community, often called time banking, which involves participants 'depositing' their time in the bank by giving practical help and support to others and 'withdrawing' when they need something done themselves[64].

[o] As captured in the Joseph Rowntree Foundation 'Liveable Lives' study (published May 2015), of everyday acts of help and support across three areas in Glasgow: https://www.jrf.org.uk/report/liveable-lives-study-understanding-everyday-help-and-support.

Studies have pointed to the potential health impacts of volunteering, with improved self-rated health, self-esteem and coping ability being found in volunteers over non-volunteers[65]. A systematic review of the association between volunteering and health suggested benefits in terms of outcomes related to depression, life satisfaction, and wellbeing, with some links to lower all-cause mortality[66]. Evidence has also suggested that youth volunteering reduces the likelihood of engaging in problem behaviours such as school truancy and drug abuse[13]. Looking across the GCPH research and evidence reviews there appear to be a number of ways in which volunteering has been shown to support people's health and wellbeing:

- Skills – Volunteering is recognised as an important means for people to gain and strengthen skills, which can be important for gaining employment and 'getting on in life'[63]. Volunteering may improve the employability of those out of work by helping them acquire skills and develop routines and behaviours suitable for regular employment[67]. For example, the Gorbals Recycles community project provides volunteering opportunities in the local community and was reported to help volunteers move into employment, training and further education[17]. A survey of Commonwealth Games volunteers found that most, in particular younger volunteers, reported developing new skills during the experience[68]. These were most commonly transferrable skills (e.g. communication, listening, teamwork and problem-solving)[68].
- Social networks – Case studies of a range of volunteering projects have highlighted the social benefits of developing and broadening networks to which individuals and groups can connect[10]. For example, volunteering opportunities at the Gorbals Recycles project were found to have helped volunteers to overcome isolation, with positive effects on participants' health and maintaining addiction free status[17]. Time banks have also been reported to develop mutual networks of support that underpin healthy communities[65].
- Meaning and purpose – Volunteering opportunities provide a route for people to contribute to society and other people's lives in meaningful and rewarding ways[63]. Indeed, community project participants and staff members reported that volunteering helped to give volunteers a sense of purpose and structure and was a common mechanism for participants to demonstrate their worth to themselves and their community[17]. Similarly, older people volunteering in classrooms as part of the Experience Corp programme (discussed in Section 2.6.3) also reported increased sense of purpose[37,38].

Given the reported benefits of volunteering, it is interesting to note that Glasgow has been observed to have lower rates of volunteering than other places. Looking within Scotland, data from the Scottish Household Survey (detailed on the Understanding Glasgow website) shows volunteering rates in Glasgow to be lower than other Scottish cities. A survey of UK residents who applied to volunteer for the Glasgow 2014 Commonwealth Games revealed that the proportion of people engaged in formal volunteering over the past 12 months was significantly lower for people from Glasgow than those from elsewhere[63]. A survey of residents in Glasgow, Liverpool and Manchester (the 2011 three-city survey discussed in Chapter 1) also identified lower rates of volunteering in Glasgow[3]. Only 7% of Glasgow respondents stated they had given any unpaid help to groups, clubs or organisations in the previous

12 months, less than half the equivalent figures for those in Liverpool (17%) and Manchester (15%)[3]. Volunteering in the UK is known to be highly socially patterned; with greater levels of participation among those of higher social class[9]. GoWell research in the East End of Glasgow found that relatively low proportions of those furthest from the labour market were engaged with volunteering. The rate at which those in work or education volunteered was two-to-three times the rate at which people out of work volunteered[69].

4.2 Restorative participation

For some individuals, participating in projects or social activities can be a route to overcoming health difficulties and building social support, what is described here as 'restorative participation'. The benefits of 'restorative participation' as a means of helping people with health problems or social, emotional or practical needs has been increasingly recognised. Providing opportunities for restorative participation, is strongly rooted in asset-based approaches, which focus on developing people's capacities and capabilities, enabling them to have more control in their lives and better connect with others for mutual support[17]. Case studies of community projects identified a range of ways in which they provided opportunities to participate in activities as a route to helping people with difficulties in their lives[17]. For example, both the GalGael Trust and the Coach House Trust projects in Glasgow support adults with experience of deprivation, exclusion and complex difficulties including addictions, homelessness, lack of qualifications, mental health issues, and offending[17]. The GalGael community teaches participants traditional crafts, providing them with a place to work and connect with others, supporting participants' sense of belonging, positive forms of identity and positive values. The Coach House Trust provides a range of occupational and learning opportunities (e.g. environmental conservation, landscaping, ceramics, traditional crafts and horticulture) to support the participants to move into employment, training or education[17].

Galgael Trust. Image taken from Assets in Action[17].

Coach House Trust. Image taken from Assets in Action[17].

A further example of 'restorative participation', the Recovery through Nature (RtN) programme, provides practical conservation work in a natural, outdoor environment for people in treatment for drug or alcohol addiction[70]. The model is underpinned by academic evidence about the role of natural therapeutic environments in facilitating restoration and recovery (closely related to environmental participation discussed in Section 4.3 below). The RtN approach is reported to work by increasing self-esteem, confidence and people's belief in their ability to change[70].

4.3 Environmental participation

Relating to the previous discussion of restorative participation, the Glasgow-based community project, Urban Roots, also involves work with people (up to half of its project participants) recognised as 'vulnerable', with common issues including mental ill health, alcoholism and learning difficulties. They are supported to build confidence, new skills and new friendships[17]. Urban Roots empowers residents to use and take ownership of the local environment by involving them in transforming derelict or unused greenspaces into community gardens, with the aim of inspiring a connection with nature and promoting practical, local actions to tackle climate change[17]. There are benefits for both the community (e.g. improving the attractiveness of the area, creating more used, social and safe places, and growing food) and individual participants (e.g. opportunities to socialise and develop relationships, learn skills such as gardening and cooking, and increase knowledge of environmental and health issues)[17].

Urban Roots. Image taken from Assets in Action[17].

Community gardening has been found to enhance social opportunities, improve access to nutritional food, increase levels of physical activity and improve people's mental health[65]. The Stalled Spaces initiative in Glasgow provided funding for community groups to improve the quality of underused spaces through short-term lease agreements[65]. Most commonly groups undertook general maintenance (clearing and planting) of the spaces and grew food, and sometimes the spaces were used for educational purpose or art projects[65]. Research with recipients of Stalled Spaces funding, although not the only form of funding for most groups, revealed that it had a positive effect on their wellbeing, providing important opportunities for socialising, learning new skills and personal development[65]. The research also observed, however, low participation rates across many of the sites, suggesting that additional support may be required in some areas to encourage involvement65. Overall, it was concluded that approaches such as Stalled Spaces should be promoted as they have the potential to support social activity, place improvement, skills development and more sustainable behaviours (e.g. recycling and local food production)[65].

4.4 Arts and cultural participation

The evidence base on the outcomes from arts and cultural participation is still developing, but reviews have identified positive impacts in terms of social relations, social cohesion and reduced levels of isolation[71]. Individual benefits include the development of new skills and the realisation of creative potential and undiscovered talent, potentially enhancing self-esteem and employability[71]. Arts or cultural programmes which involve group or teamwork can help to foster trust and reciprocity, and promote tolerance and awareness of other races, religions and cultures within

multicultural communities[71]. Community cultural projects, such as blogs, storytelling websites and community radio stations, have been noted as important, not only for supporting individual wellbeing, but also for providing opportunities for sharing a diversity of perspectives and facilitating new shared meanings to be expressed in local communities[6]. However, it is known that community cultural participation and production alone cannot ameliorate complex social problems, particularly those experienced by disadvantaged groups[6].

An initial evaluation of the Big Noise programmep, operating community-based orchestras for children in disadvantaged communities, identified a range of benefits from the programme[48]. Participants were found to be increasing in confidence and self-esteem, acquiring skills for life (e.g. self-discipline, time management, organisation), and to have higher school attendance. In addition, relationships were found to have developed between participants from different schools and even different countries (for children who participated in a visit to Venezuela, the birthplace of the music social programme). Hence, Big Noise appears to be a good example of creating opportunities for young people to expand their social networks (outlined as important in Chapter 2). Social networks formed through participation in community clubs and societies are known to promote good health and wellbeing outcomes[4]. Opportunities for participants' families to broaden and strengthen social networks were also identified, for example by families attending orchestra performances[48]. The programme was also reported to support community cohesion, for example, by enabling interaction of new and long-standing residents or residents from different ethnic and religious groups[48].

The Big Noise programme. Image taken from Evaluating Sistema Scotland[48].

[p] Big Noise (www.makeabignoise.org.uk) is an orchestra programme that aims to use music making to foster confidence, teamwork, pride and aspiration in the children taking part and across their wider community. It is based on the methods of Venezuela's "El Sistema" movement and is run by the charity Sistema Scotland, which has established three orchestras in: Raploch, Stirling (2008), Govanhill, Glasgow (2013), and Torry, Aberdeen (2015).

4.5 Religious participation

Focusing on children and young people specifically, more frequent attendance at religious services has been found to be related to better mental health and fewer behavioural problems[4]. However, it appears to be the social, rather than the faith element of religious participation that is important in this context[4]. It was hypothesised that religious participation is a proxy-indictor of social support networks and that participation in these groups may facilitate the development of such networks[4]. Considering the adult population, there is a considerable amount of evidence (mainly from the USA) of the beneficial impact of religious participation on health outcomes[3]. A 'meta-analytic' review found that higher levels of religious attendance were associated with almost 30% lower all-cause mortality compared with those with lower levels of participation[3]. Potential pathways have been proposed to explain the apparent link between religious attendance and better health outcomes, including[3]:

- greater social networks, support and integration
- less association with damaging lifestyle factors (e.g. alcohol, drugs, violence, risky sexual behaviour) through 'social regulation'
- increased psychological resources and coping mechanisms
- encouragement of volunteering, (which, as discussed in Section 4.1, is linked to better health outcomes).

Given the evidence of the beneficial impact of religious participation on health outcomes, as noted in Chapter 1, the three-city survey of adult respondents included the notion of 'religious social capital' in the assessment of levels of social capital[3]. Although the benefits of 'religious social capital' are known to relate to active participation, the survey included a question about religious affiliation as a proxy for participation, with the caveat that not everyone affiliating with a particular religion will be an active participant[3]. Nonetheless, it is still of potential interest that a higher proportion of the Glasgow sample (46.5%) had no religious affiliation, compared with Manchester (33%) and Liverpool (28%)[3].

It should be noted that Scotland (and Glasgow and the West of Scotland in particular) is recognised as having problems with sectarianism revolving around a divide between Catholic and Protestant groups[72]. The issue of sectarianism is separate however, from the evidence discussed in this section about the benefits of religious participation. However, some have suggested a number of potential health impacts of sectarianism on the health of Glasgow's population, including: impeding the social mobility of sections of the population; and detrimentally affecting the health and wellbeing of those discriminated against through psychosocial processes, the effects of violence from sectarian attacks, and through the uneasy social relations between population subgroups[73]. Although disputed by some, there appears to be some evidence to support the thesis that there is a culture of sectarianism with potential health impacts[73]. However, it is unlikely that religious sectarianism contributes to Glasgow's excess mortality compared with other cities (Belfast, Liverpool and Manchester)[9].

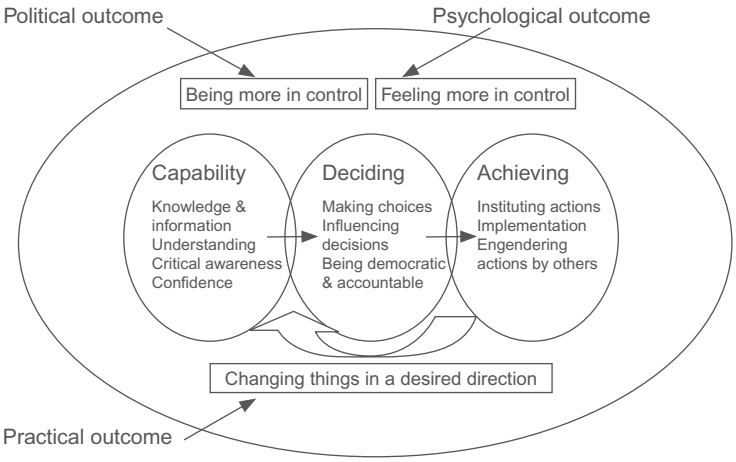
5. COMMUNITY EMPOWERMENT

The term 'community empowerment', like 'community cohesion' and 'social capital', is used widely but is not always well defined and is subject to different interpretations. GoWell has stated that it is a multi-faceted concept, including the ability for people in communities to[74]:

- control what happens in a community on a **day-to-day** basis
- influence **key decisions** affecting the area
- influence **public services**, making them more responsive to local contexts
- be proactive in finding **improvements or solutions** to local issues.

GoWell defined community empowerment as a community's "*capacity to make effective choices, and then to transform those choices into desired actions and outcomes*"[75]. The GoWell model of community empowerment (see Figure 2 below) has three key inter-linked domains: capability; deciding; and achieving[76].

Figure 2: GoWell model of community empowerment[76].



There are degrees of empowerment in all three of the domains of the GoWell community empowerment model; however, it is argued that ultimately the overall outcomes should be about people in communities being or feeling more in control and/or gaining the ability to make changes or influence decisions[40].

This chapter outlines evidence from the GCPH and GoWell to consider the following questions:

- How do socioeconomic differences and inequalities relate to differences in empowerment? (Section 5.1)
- How is community empowerment relevant to health? (Section 5.2)
- What have we learned from research about: community participation in neighbourhood improvements (Section 5.3), community development (Section 5.4), and community and user involvement (Section 5.5) in service design and delivery?

5.1 Inequalities and community empowerment

It has been found that people living in more socioeconomically deprived parts of Scotland feel less able to influence decision-making than those from more affluent areas[77]. For example, GoWell research in deprived communities in Glasgow, established that although over time there were improvements in residents' perceptions of their ability to influence neighbourhood change processes, the majority felt they could not influence decisions affecting their area (only about two-in-five felt they could)[78]. Research undertaken across three UK post-industrial cities observed that citizens' roles and levels of community action were strongly influenced by communities' different income profiles[15]. In more affluent areas it was observed that there was not the need to pursue a shared vision of collective improvement, and the role of organisations in these communities was more often about creating a sense of belonging[15]. In the disadvantaged communities, however, collective action was reported to focus on key issues affecting the areas (e.g. employment, housing, services investment)[15]. GoWell research in disadvantaged areas of Glasgow has observed that where communities have a sufficient level of good quality housing and public services this frees up the time and energy of community groups to address other more developmental issues for the future, as they were not having to 'firefight' over the basics[50].

The research in communities across three post-industrial cities highlighted that there is a need for greater awareness of how advantage tends to agglomerate within affluent networks, meaning that such networks can be a further process through which inequality is maintained rather than reduced[15]. If more affluent communities do want to take action to address any perceived problems, however, they can typically draw on greater reserves of what is termed in the social capital literature as 'linking capital'. This has been described as a community's connections and ability to influence people and organisations that allocate resources, plan and make decisions[6]. This has implications for how different communities take advantage of policies such as the Community Empowerment Act[q] (designed to promote community engagement and ownership) and the Place Standardr (developed to improve places and reduce inequalities). GoWell has recently cautioned that the Place Standard has scope to widen rather than narrow inequalities, if more advantaged communities are able to make better use of the tool than others[50].

It has been argued that area-based interventions and community development would yield further benefits when allied to city-wide efforts to create a shared ownership of the challenges being faced[15], not just *within* communities, but *across* different neighbourhoods of a city[15]. Although the focus in this chapter is on local improvements within communities, this point about working across communities also relates to wider debates about what is valued in society overall and the role of its citizens. In the very first GCPH Seminar Series lecture in 2004[79], Anthony Grayling,

[q] The 2015 Community Empowerment (Scotland) Act gives community bodies new rights (e.g. ownership of land and buildings, strengthening voices in decisions) and public sector authorities new duties to boost community empowerment and engagement: http://www.gov.scot/Topics/People/engage/CommEmpowerBill.

[r] The Place Standard was developed in partnership by Scottish Government Architecture & Place, NHS Health Scotland and Architecture & Design Scotland and launched in December 2015. It is a tool to support the delivery of high quality places and to maximise the potential of the physical and social environment in supporting health, wellbeing and a high quality of life: www.placestandard.scot.

suggested the need for a collective consideration about what sort of people we are, how we live our lives and what choices we make. A consistent theme throughout the GCPH Seminar Series has been about what we value in our society and how we perceive our relationship to others.

Reflecting on Scotland's history, Tom Devine, in a 2005 GCPH seminar, outlined that in recent times a much more competitive, individualised notion of self has emerged, following the decline of the early industrial influences of the empire, church, work and family on Scots' sense of self and society[80]. Both Richard Layard in his 2005 seminar on happiness[12] and Anver Offer in his 2008 seminar on 'The Challenge of Affluence'[81], argued for the need to shift away from competitive, indvidualised notions of increasing income and materialism. They pointed to the importance of social connection for happiness. Layard advocated for the need to counter individualism by developing a better concept of the common good, based on compassion towards others and one's self[18]. Maria Pereira, in her 2013 GCPH seminar on 'Money, Love and Virtue', reflected that throughout the 18th and 19th centuries economists emphasised the role of the common good, as well as wealth creation[82]. Pereira called for a reconsideration in our current era about how the financial system can be made to work for the common good. Contemplating ten years of the GCPH Seminar Series in 2014, Phil Hanlon, concluded that our sense of what a human being is, what our purpose is, and what a 'good society' is, all have a powerful influence on how we behave, how we organise our society and what our health status is like[83].

5.2 Community empowerment and health

To address health inequalities, it is most important that the individuals, families and communities who are at greatest risk of poor outcomes are enabled to contribute to decision-making in order to reach relevant solutions and build capacity for self-determination and wellbeing[84]. This is not advocated as an alternative to tackling the structural causes of disadvantage and health inequalities, but can be seen as part of the process, so that communities are supported to develop greater confidence and a stronger voice to engage with systems in addressing the structural causes of injustice and inequalities[13]. Community empowerment has the potential to deliver physical, psychological and psychosocial health gains for participating individuals[75]. However, it matters both what actions are taken and how things are done[1].

GoWell research highlights that the process and outcome of empowerment matter for mental wellbeing – mental health has been found to be better when people are involved in decisions that affect them, and when they feel their views are taken into account[78]. In two sets of analysis, on different GoWell data sets, positive associations between feeling of neighbourhood empowerment and mental health and mental wellbeing have been found[43,85]. GoWell, however, did not find evidence of links between empowerment and improvements in physical health[85]. GoWell note that other research has found that physical health is only affected by empowerment once the community felt empowered and then chose to change the delivery of local services, such as local leisure facilities[85]. GoWell has suggested that there may be a pathway whereby mental health gains are necessary precursors to physical ones, as residents' self-efficacy, confidence and coping behaviours lead to an ability to influence factors in their environment that in turn benefit physical

health[85]. Jennie Popay in a 2006 GCPH seminar on lay knowledge, cited evidence that negative experiences of community engagement not only deter residents and subsequent generations from engaging again, but can also have a damaging effect on people's mental health[86]. GoWell research has also highlighted that experiences of empowerment can differ for different groups; since it found that those with a long-term illness or disability feel less empowered[85]. GoWell stated this may suggest that current practices employed by stakeholders have failed to engage with residents with a long-term illness or disability, and particular attention is required to ensure that these individuals can interact with decision-making[85].

It is crucial to understand how to 'get it right', if community empowerment is to deliver societal benefits rather than exacerbate disadvantages for people and communities[75]. A key aspect of getting it right is to understand local contexts[1], which can vary across communities with similar income profiles, for example, in relation to population turnover, housing quality and proximity to more affluent areas[75.] The following sections outline research findings about community involvement in neighbourhood improvements (Section 5.3), community development (Section 5.4), and involvement of communities and service users in the design and delivery of services (Section 5.5).

5.3 Neighbourhood planning and improvements

James Scott emphasised, in his 2008 GCPH seminar on local knowledge, that before intervening in a community it is essential to recognise that the experts are the people who live there, and to work with an understanding of residents' experiences and feelings[87]. Residents' involvement in decision-making can be associated with increased feelings of neighbourhood pride and a greater willingness to participate in subsequent forms of engagement; conversely feeling disempowered can be associated with increased feelings of dissatisfaction towards a neighbourhood[42]. Drawing on GoWell and GCPH evidence, some key learning points about involving communities in neighbourhood planning and improvements are outlined below:

- **Information** matters for communities' ability to influence[88]. For example, communities experiencing regeneration sometimes have little information about what is being undertaken by whom and the consequences for residents (e.g. where they would be re-housed, who they would be living next to, where their children would be going to school)[88]. Information needs to be practical, relevant to residents and provided on an ongoing basis (even where there is uncertainty and lack of clarity), rather than in an ad hoc way or when organisations deem necessary[75]. GoWell has observed, in relation to large regeneration projects, that sometimes communities need support (e.g. from independent consultants) to understand regeneration processes and the possibilities for the community to achieve its goals[75]. Residents with experiences of this have reported that it enabled them to understand the complexities of regeneration and consequently make decisions that they felt were realistic and feasible[75].
- **Community engagement** requires a focus on the social as well as physical aspects of neighbourhood change[75]. More attention needs to be given to the nature and purpose of community engagement, and the mechanisms for implementing any agreed course of action[75]. To be empowering, community

engagement needs to be ongoing, use appropriate approaches with different groups/people over time, and be integrated with other initiatives and local strategies (e.g. development plans, community planning for services)[75]. Engaging local people over a prolonged period is also dependent on there being clear signs of progress[56].

- **Representativeness** is a critical issue for community engagement and empowerment, since there can be debates about who is most accountable to, and representative of, communities[75]. For example, problems have been identified with consultations and surveys undertaken without proper consideration of the size, scope and representativeness of the exercise, yet which are reported as valid and authoritative[75]. Concerns have also been raised about more vocal residents dominating decision-making[56] and the legitimacy and effectiveness of community organisations to act as the 'voice of the community'[75]. Community organisations need to establish regular means of communicating with residents, both reporting to them and collecting views from them[75]. In particular, young people are noted to have been excluded from discussions about neighbourhood improvements[56] and regeneration plans[78]. Neighbourhood improvement approaches should work to ensure that people with different experiences and characteristics (including young people) are involved[56] and regeneration agencies should strive to better engage with young people (e.g. involving local schools)[78].
- **Community-led approaches**, which support communities to identify the issues which are important to them and develop their ability to inform and influence decisions, can be used to enable residents to take a more proactive role in neighbourhood improvements. Attempts to stimulate community-led action and to improve the quality of environmental conditions have been initiated through such approaches as street audits and more comprehensive neighbourhood audits[77]. If delivered effectively, these can support increased social contact between members of the community, help to create a better quality neighbourhood environment and foster a shared sense of ownership[77]. The street audit approach used in Calton increased understanding of local concerns about the physical environment and led to a number of key improvements in the neighbourhood[56]. However, it was not able to address other ongoing concerns, such as the amount of vacant and derelict land and buildings[56]. Hence, it was concluded that audits are an effective tool for identifying neighbourhood priorities, but also need to be part of a process feeding into a broader strategic vision for an area[56].

5.4 Community development

Simply creating greater opportunities for involvement and participation is not sufficient to empower communities, as some communities have fewer resources and less capacity, and can be excluded by processes that are taken for granted by other partners[75]. Policy approaches to community engagement and empowerment have been criticised on account of power imbalances between communities and others. This is particularly in relation to 'top-down' strategies that start with the agenda of a public organisation, rather than local priorities, and where there is seen to be a lack of 'bottom-up' community development activity[75]. Community development approaches

start with residents' concerns and then work to enable residents to improve their own conditions through their own activities and by influencing public agencies[75]. It is argued that community development work is able to support and shape social networks, to help create flexible, effective and empowering forms of collective capacity and action[10].

Initiatives designed to engage with, develop the capacity of and empower communities in a wide range of ways have operated in diverse contexts around the world, under a range of names, for many years[13,75]. Approaches that value the positive capacity, skills, knowledge and connections in a community have also been operating effectively across Scotland[11]. They are now increasingly being described in the language of 'assets'. As noted in Section 4.2, asset-based approaches focus on developing people's capacities and capabilities, enabling them to have more control in their lives, and to better connect with others for mutual support[17]. Such approaches are reported to make visible and value the skills, knowledge, connections and potential in a community, in contrast to 'deficit' approaches which instead focus on problems, needs and deficiencies, and make observations and interventions[13]. A number of different methods are used to assess and/or mobilise community assets to engage and empower individuals, build capacity within communities, and support professionals and community members to work together differently[64]. However, this does not mean that struggling communities are expected to achieve change on their own, since long-term investment is needed to strengthen and support local networks and associations, to build-up local confidence and a sense of empowerment[13].

Asset-based approaches, a case study from Milton. Image taken from Animating Assets[89].

Case studies of community projects working in asset-based ways observed that the projects had typically grown from a particular individual or community need or issue (e.g. lack of safe play areas for children, wanting to improve an area or have more say in services)[17]. Typically these projects worked in a way which generated a feeling of ownership for participants and were premised on 'working with' rather than 'doing to' the participants[17]. Importantly, the projects had an explicit focus on *both* individual life circumstances and overall community life, by supporting the development of

individual skills and networks and seeking to promote greater cohesion across the community. For example, the Connecting Generations project (discussed in Section 2.6), expanded older individuals' social networks, which reduced isolation and improved life circumstances, but also created stronger connections across generations within the community and promoted greater community cohesion[17]. The case study research did highlight, however, challenges for these community-based projects of ongoing financial uncertainty and of measuring success and demonstrating the benefits of the projects to funders[17].

An action researchs and learning programme, *Animating Assets*, supported the initiation and development of asset-based approaches in community settings and agency-led partnerships, and reflected on learning from the process of engagement[89]. It was found, across all the research sites, that relationships and personal attributes were crucial in building and sustaining effective working relations and establishing networks of allies and contacts[89]. There was discussion and shared responsibility for trying to address complex social issues, by recognising the skills and knowledge of the range of organisations and individuals involved. However, it was clear that limited time constrained the ability to work in ways required to develop and nurture relationships[89]. It was noted that although there has been increasing policy emphasis on asset-based approaches, the barriers and challenges within systems can limit practitioner capacity to work flexibly, responsively to communities, and across systems and services. It was emphasised that asset-based approaches require planned and co-ordinated action, investment and commitment[89].

A further approach to empowering communities and mobilising 'assets' is participatory budgeting, which allows local people to identify, discuss, and prioritise public spending projects, and gives them the power to make decisions about how money is spent[64]. A participatory budgeting pilot in Govanhill was undertaken in 2010. It was found that the group of residents used the allocated funds to focus on a small number of local issues with the aim of enabling disadvantaged Govanhill residents to lead richer lives[90]. The process was reported to have enabled purposeful and reciprocal dialogue between community members and the public and third sectors, and to have facilitated community connectedness[90]. However, it was noted that the pilot could have included a greater diversity of local residents[90]. Overall, the pilot demonstrated that participatory budgeting is an effective method of engaging and involving local residents in defining local priorities, as well as shaping delivery of localised services and projects[90]. The learning and insight from this Govanhill participatory budgeting pilot also features in a recently published joint GCPH/What Works Scotland report which aims to support the strategic and operational delivery of participatory budgeting in Scotland[91]. The model of participatory budgeting appears to be in line with the call, made by Manfred Hellrigl in the 2012 GCPH seminar on self-organisation and civil engagement[92], for more creative and democratic processes involving citizens. Hellrigl reflected on his experience in Austria of using approaches that engage citizens. He argued that there needs to be a shift away from treating people as 'passive consumers' towards developing a shared sense of responsibility among citizens[92].

[s] The *Animating Assets* report states that action research is an overarching term for a range of research practices that focus on knowledge creation involving researchers working alongside local people or practitioners to try out, develop and learn from different ways of doing things. It thus explicitly sets out to bring about change[89].

5.5 Service design and delivery

There has been growing recognition within the public sector in Scotland (and wider) of the value of strengthening the involvement of service users and communities in service design and delivery. This has been contrasted with a 'consumer model' of public services, with professional systems that deliver services to passive clients, and overlook the equally important role played by those on the receiving end[93]. The term 'co-production' describes an equal and reciprocal relationship between service provider and service user that draws on the knowledge, ability and resources of both, hence it has been described as complementary to asset-based approaches[64]. Co-production stems from the recognition that to deliver successful services, organisations must understand the needs of service users or local residents and engage them closely in the design and delivery of those services[64]. It is not about 'self-help', rather it is about investing in strategies that develop the capacities of individuals and local communities[64]. Co-production is well established within the third sector and there has been growing interest in co-production approaches for public service delivery[64].

It has been argued that co-production has the capacity to transform public services by rebuilding empathy and mutuality within services and evidence also suggests that public services can be more cost-effective when they are built around co-production, because they produce more effective outcomes[64]. GoWell has suggested that their findings regarding the role of housing services also provide a 'health rationale' for co-production[85]. GoWell has found that respondents who felt that they were kept well informed by their landlord, who felt that their views were taken into account by the landlord, and who felt they were provided with good quality housing services overall, were approximately twice as likely to have high mental wellbeing as those who did not feel empowered in these ways[50]. In other analysis, GoWell has also found that this 'housing empowerment' doubled or tripled the odds that someone would feel very safe at home and in the neighbourhood over time[50]. These are important wellbeing outcomes, that also help protect against loneliness[50].

Co-production is reported to work best when dealing with small constituencies, such as a neighbourhood or those affected by a particular service[64]. The case studies of community projects provide examples of facilitating engagement in service decision-making[17]. For example, the Healthy 'n' Happy Community Development Trust, in Cambuslang and Rutherglen, brings together community residents, services and agencies to create more responsive and successful services through local participation[17]. In terms of participation of older residents, the O4O project empowers older people to be involved in the design and development of service provision for older people living in four remote and rural communities in the Scottish Highlands[17]. The approach taken by O4O was said to support the changing role of public services from 'top-down delivery' to a model of co-production[17]. An example of young people having an influence, the Big ShoutER project in East Renfrewshire, was established by young residents to influence positive change in the design and delivery of their local youth services[17]. This project was highlighted as a good example of encouraging and supporting young people's active citizenship and involvement in local decision-making; which is known to be associated with positive health and wellbeing outcomes in children and adolescents[4].

BigShoutER. Image taken from Assets in Action[17].

A further example of engaging young people is provided by the Animating Assets case study of a Neighbourhood Partnership in Edinburgh, which included a Youth Talk initiative to engage with young people about their experiences of local services and support[89]. As a result the Neighbourhood Partnership took a range of actions on the issues identified, including[89]:

- involving young people in recruiting local youth workers
- commissioning a new service, Positive Realities, run by local young people
- hosting Youth Talk awards where young people honoured their peers
- initiating a participatory budgeting scheme for young people to award money to local agencies addressing their concerns
- developing a plan (forming part of the wider Neighbourhood Plan) addressing services for young people and methods for meaningfully engaging them in the planning process.

6. SUMMARY AND IMPLICATIONS

It is clear from this review of evidence from the GCPH and GoWell that social contexts (people's networks of support, interconnections within communities, and empowerment of people and communities) need dedicated attention and that the actions required are very much interrelated with the other areas of action required to improve health. These interactions can be understood in terms of Figure 1 (detailed in the Introduction and reproduced below), in that social contexts clearly interact with all the other key influences on health. These interactions need to be harnessed in a way that maximises the role of social contexts to improve health and reduce health inequalities. The key conclusions and actions from this evidence review are summarised below, firstly focusing specifically on social contexts, followed by an outline of the interactions with: the economy, employment and poverty; the experiences of children and young people; neighbourhood environments; and the delivery of services and interventions.

Figure 1: Influences on health.

6.1 Social contexts: key learning points

- Social networks of **positive relationships with family and friends** provide emotional and practical support, and they have health gains for people both when giving and receiving support. In the right conditions social support can be provided on an ongoing basis – it is not a latent or scarce resource.
- In certain circumstances some people (e.g. young people involved in gangs, people leaving prison, people experiencing unemployment, people experiencing social exclusion) need support with **changing or expanding their networks** of relationships and linking to organisations and agencies that can help them.
- Given the crucial role of social networks for everyday living and long-term health, it is essential that factors leading to **social isolation and loneliness** are minimised (e.g. poverty, illness and poor health, poor housing, antisocial behaviour, discrimination) and opportunities for social participation are provided to develop and expand networks.
- **Social participation** (volunteering at or participating in projects, clubs, activities etc) can improve individual health; as well as developing connections across a community and improving community life (e.g. in terms of improving local greenspaces). In some cases specific support is needed, such as financial assistance to enable people with fewer resources to be volunteers, and emotional support to help vulnerable people (e.g. experiencing problems with addictions) to participate in activities.
- **Community cohesion**, the social functioning of communities, is important for residents' health and helps communities as a whole (e.g. in safeguarding services or responding to shocks). The social functioning of a community depends on the level of connections between residents, the quality and safety of the environment, and the extent to which residents feel integrated or have a sense of belonging.
- **Community empowerment** should ultimately be about residents feeling more control and gaining the ability to make decisions/influence change. Both the process (how residents are engaged) and outcome (the changes that result) are important for health.
- **Community development** is important for strengthening social networks in a community and for empowering residents by supporting their capacity to influence decisions and take action. In particular, **asset-based approaches** that value the skills, knowledge and connections that exist within a community are needed, alongside long-term financial investment and commitment of time by systems and services.
- Further questions need to be considered, not just about how to empower disadvantaged communities, but also about how **greater cohesion is fostered across cities or regions**, and more broadly about how to **counter individualism in society** and increase a shared sense of responsibility among citizens.

6.2 Social contexts, the economy, employment and poverty

- **People's life circumstances and income levels** impact on individuals' ability to develop and maintain social networks of support (e.g. not participating in social activities due to living in poverty, not inviting people to the home due to poor housing quality, not being able to socialise due to a lack of access to English language classes). Furthermore, such individuals may also lack access to networks which can enable educational and employment opportunities.
- Supporting people to gain and sustain **good quality work** is important, not only in terms of income, but also for social advantages (e.g. providing a sense of belonging and meaning, preventing social isolation). However, to be beneficial for health, employees need sufficient pay to lift them out of poverty and to have time outside of work to meet other needs and demands (e.g. childcare).
- **Deindustrialisation** has had a negative impact on the social fabric of communities in Scotland, compounded by a policy focus on economic growth and regeneration without also attending to social outcomes and community functioning. The legacy of deindustrialisation is still apparent and community life continues to be subject to current economic changes (e.g. welfare reform, higher job turnover, an increase in private rented housing).
- Additional support and resources are required to enable disadvantaged communities to **participate in decision-making and address structural causes of inequalities**. Otherwise, engagement and empowerment processes may reinforce inequalities in income and access to power (e.g. disadvantaged communities experiencing further disadvantage because they have a lack of resources, limited access to decision-makers, and a need to respond to immediate challenges).

6.3 Social contexts and children and young people

- Children and young people have improved health and wellbeing outcomes where they: have positive relationships with their parent(s) and other family members, engage in frequent joint family activities, and have access to both their own social networks and those that their parent(s) and family are embedded in. This emphasises the need to support and enable parents to create **positive family conditions** (e.g. addressing difficult life circumstances, providing parenting support) and strengthening and expanding parents' **social networks** (e.g. through community-based groups).
- **Schools** play an important function both in enabling wider community activities for all ages that strengthen social networks, and in their particular role of educating and supporting young people. It is important that schools are safe, provide a sense of community, and take account of income differences (e.g. pupils' ability to pay for social activities).
- The lives of young people, particularly those experiencing economic disadvantage, can be improved by the provision of **community amenities and leisure activities**, alongside **personal support** for those experiencing difficulties and/or efforts to increase **social connections** (e.g. through social opportunities for young people and/or which increase connections with older generations).

6.4 Social contexts and neighbourhood environments

- **Neighbourhood design, maintenance and safety of public spaces** all have an impact on levels of social contact and people's sense of community.
- Ensuring **improvements to the physical environment** lead to health gains depends on involving local residents in decision-making about changes and facilitating residents' use of new or changed aspects of the physical environment (e.g. organising picnics in the park to increase use of regenerated greenspaces, setting up clubs establishing running routes in neighbourhoods).
- **Involving local residents** in neighbourhood planning and improvements requires information provision to residents, attention to representativeness (e.g. specific actions to engage people not involved in community groups and young people), and adopting community-led approaches and linking these to larger-scale plans and visions where appropriate.
- **Housing policy is important to social networks**. Historically, large-scale urban change impacted negatively on the social fabric of communities, and in some places residents perceive that the current increase in private renting is impacting on community cohesion.

6.5 Social contexts, services and interventions

The preceding learning and action points are all relevant to a consideration of how services, interventions and projects can build on the strengths of social contexts and seek to support and enhance these social features. Some related and additional key points are:

- Where **health promotion messages and interventions** are provided, these need to operate with an understanding of the strong influence of social networks (e.g. not normalising excessive alcohol consumption as a 'youth' behaviour and providing alternative socialising options to alcohol, encouraging existing runners to 'recruit' family or friends in their networks to adopt running).
- Issues related to **social connections and loneliness need to be given greater prominence** (e.g. in service delivery, local development plans, regeneration plans). For example, to look at ways of identifying people with weak family and friendship networks and providing practical and emotional support.
- The **design and delivery of services** is enhanced by drawing on the knowledge and experience of service users and community residents (often referred to as co-production), and relating to service users and residents as mutual partners and seeking to develop their capacities (i.e. doing things *with* rather than *to* people).
- **Multi-agency working** is important for enhancing the social functioning of communities (e.g. reducing antisocial behaviour to improve community safety, reducing racism to support the integration of migrants into communities) and linking people to social networks, relevant services and other sources of support (e.g. supporting people to move away from offending).

7. CONCLUSION

A wide range of evidence sources from the GCPH and GoWell have been reviewed here, but the learning all points in the same direction – that efforts to strengthen individuals' networks of support, to build connections within communities, and to empower people and communities, are all important for health and wellbeing. A focus on these issues will continue to underpin future work by the GCPH.

There is clearly a lot to be celebrated in terms of approaches that have been, and continue to be, undertaken with individuals and communities. However, there is also a critical need to continue to invest and support these efforts, and to ensure that work focusing on 'social' aspects of life are not undertaken as 'extra' interventions, rather that they are integrated into existing and future approaches. In particular that they are integrated into other areas of work we know impact on health: the economy, employment and poverty; early years, children and young people; neighbourhood design and maintenance; and the delivery of services and interventions. There is a need for the public sector, third sector, private sector (e.g. as employers, land developers), and community groups to ensure that they adopt approaches that build, rather than undermine or damage, social connections and empowerment of individuals and communities. This applies to all aspects of work that aim to improve people's lives, even those that may appear to be unrelated to 'social' aspects of life, such as the development of physical infrastructure. This also applies to the delivery of services, which are often focused on individual outcomes, yet networks and communities play an important role. The evidence points to the benefits of understanding people's social circumstances and of multi-agency approaches.

There is sometimes a distinction made between 'material' and 'non-material' influences on health, but the evidence reviewed here suggests that this is a blurred distinction; since individuals' networks, social dynamics within communities and levels of empowerment are also clearly related to structural issues of income and inequalities within society. Evidence detailed in this report highlights the way that these social features are vulnerable to social and economic forces, for example, our learning about the impact that deindustrialisation had on the social fabric of communities. Actions related to social contexts clearly need to be integrated with actions to tackle broader inequalities, to address the historical impacts of deindustrialisation, and to mitigate the impact of current economic and poverty challenges (e.g. in-work poverty). It is important too that we to seek to build strong social connections and increase community empowerment for the future, in the face of continual changes (e.g. demographic changes of an ageing population and expected increases in single adult households, challenges of climate change, continued technological development). Whatever changes come there appears to be convincing evidence that face-to-face interaction, practical day-to-day support, and feelings of neighbourliness and safety within our communities all matter. Reflecting on the importance of social contexts for health prompts wider questions about what we value in our society and how we promote greater co-operation between citizens, as we know that this will have a bearing on responses to change and on Scotland's future health status.

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