Resilient relationships in the North West: what can the public sector contribute?

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Foreword

The social circumstances of our lives have a huge impact on our health. Our regional priority to reduce health inequalities and improve health will only be achieved if we take action to tackle the social determinants of health. A key determinant is having positive and supportive relationships with others. This work has therefore been commissioned to inform what action is needed. It raises the challenges we face and recommends how we can address this social determinant more effectively, through regional and local leadership and action and through fostering co-production between agencies, communities and individuals.

Action taken on the recommendations of this report will:

Assist communities to reduce inequalities by developing healthy, economically active and socially supportive environments or 'places' which 'release' communities own assets and resilience.

Liberate the caring and advocacy capacity of each member of the public to drive change for improvement in public services.

Increase the capacity of communities to actively participate in democratic renewal through playing a full part in:

securing their own and others human rights and

actively meeting their social responsibilities to the community.

Enable communities to work with the public sector to develop services that seek to co-produce outcomes with 'consumers as equal partners'.

Facilitate community capacity to take more effective control and responsibility of personalisation of services and self management of chronic disease and long term conditions.

Multiply the 'social value' of public sector investment, extending its impact in communities through (social) asset based investment in resources for improvement.

Support the transition from a passive 'detect and manage' model of public sector needs assessment and service commissioning / delivery to a more pro-active 'predict and prevent' approach with increasingly empowered, resilient and capable communities assisted to enter 'full engagement' in the transformation of services.

Prevent the need for avoidable social welfare system dependency and realise the shared improvement benefits for all.

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Acknowledgements

Summary

'Tend to the social and the individual will flourish'

(Rutherford 2008)

This briefing was commissioned by CSIP NW in partnership with the Department of Health NW in recognition of the impact of social relationships on health, wellbeing and a range of other social outcomes and a need to explore the role of the public sector in influencing resilient relationships and social networks.

A wide range of research demonstrates the health significance of social relationships and both formal and informal social systems or networks. This briefing provides:

- an overview of the current state of knowledge on social relationships as a determinant and/or mediator of health and social outcomes

- an overview of what works to build social relationships and the interventions that can impact upon them

- recommendations on the role of public agencies in relation to social networks

The findings draw out the key themes in the literature as a basis for making initial recommendations and stimulating further discussion and debate in the North West. They include feedback from telephone interviews with health and other professionals, as well as responses to a half day seminar with key sector representatives.

These questions about social relationships and public agencies are part of a growing **policy** interest in psychological and relationship needs as well as broader debates, intensified by the current financial crisis, about:

- the perceived decline in family, community and social cohesion

- the persistence of health and other inequalities

- the factors that distinguish *'resilient communities and localities'* i.e. those that do better than expected in the face of adversity

- the capacity of the public sector to respond to social problems and to engage with communities

- the balance between service provision and self care/self management

- the shift towards promotion, prevention and 'well-being'

While communities, social relationships and social networks are high on the policy agenda, what this means for resource allocation, commissioning and practice is less clear. In particular, there may be tensions between market oriented thinking and the discourse of consumers, personalisation and individual choice as distinct from the language of citizenship, collectivity and the common good.

There is a wealth of evidence on the **social determinants** of health. Socio-economic position appears to pattern social networks and social support, as well as characteristics associated with

'social functioning' for example 'positive affect'. Reducing inequalities is therefore central to any strategy for building, maintaining or repairing relationships.

At the same time, social relationships are a core feature of **resilience**: the combination of assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential.

Levels of social support and the quality of social relationships influence a wide range of outcomes for individuals and communities, including morbidity, mortality, physical health, mental health, health behaviour, recovery and quality of life, as well as education and employment. A further dimension is the importance of policy and practice responses that do not undermine those characteristics that individuals and communities need to survive adversity: respect, dignity, self-esteem, positive identity and connectedness.

Social relationships, social networks or what has been described as the *'core economy'* of home, family, community and civic life are high on the policy agenda and are also an issue of considerable public interest and concern. At the heart of this concern is the belief that the quality of social relationships matters: 'no one survives without community' and that economic and fiscal strategies have undermined family and community relationships: economic growth at the cost of social recession, described by Zygmunt Bauman as:

> "*A crisis of citizenship, commercialisation of human bonds and interaction, the advance of consumerist culture, the dissipation of human solidarity. It has many names, but a closer scrutiny reveals that they all relate to a shared referent: a deepening feeling of existential insecurity* "

<div align="right">(Bauman 2007)</div>

The need to protect or recreate opportunities for communities to remain or become connected is widely stated; the crucial question is what practices and interventions build social support and social networks and what policy and practice build positive relationships between public agencies and local communities?

The current picture: There are already strong traditions and a wide range of initiatives in the North West, notably within the voluntary and community sector, which build, draw on or maintain social networks at all levels. The North West has above average scores for a number of social indicators, including having a religious affiliation, social support and neighbourliness. There appears little information or explicit policy that reflects a role for public sector agencies in supporting or even addressing social relations/networks as a legitimate area for work.

Funding or other support from the NHS or councils appears to be chiefly around supporting or adding to core services. Much of this is concerned with benefits to individuals, with a recognition that those who are isolated or excluded may gain in some instances from access to 'a social environment'. A parallel development is the growing interest in self-care and self-management and the role of social functioning and social relationships in supporting this.

This individual or service level focus is distinct from broader debates about the strength of community connections and networks and the role of public agencies in supporting or enabling 'collective efficacy', as distinct from self efficacy.

Recommendations include:

1. Regional leadership and strategic support, including a long term vision for 'building community capacity and social relationships', aligned to wider regional goals and strategy

2. Greater consideration and assessment of how local and regional planning, availability to community amenities and public space impacts on attachment to place, inequalities and community connections

3. Alignment of action to existing targets and indicators that address community cohesion, improving wellbeing, promoting equality and diversity and engaging and empowering communities.

4. Develop an 'index of multiple assets' for the North West. Social relationships are an asset for health development and are therefore consistent with an interest across the North West in a greater focus on an 'assets, resilience, capabilities' approach.

5. Supporting effective **interventions**, which include:

   • those that strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need e.g. support for parents, support for older people, for those who are homeless, those who have mental health problems, those who have learning difficulties, people in transition e.g. from prison to the community, leaving care, facing redundancy

   • those that build and enable social support, social networks and social capital *within and between communities* e.g. reducing material inequalities, tackling discrimination, improving the physical environment, especially for children and young people, access to green, open spaces, reducing motor vehicle traffic in residential areas

   • those that strengthen and/or repair relationships *between* communities and health and social care agencies e.g. enhancing community control through co production, timebanks, asset sharing or transfer

   • those that improve the quality of the social relationships of care *between individuals and professionals* e.g. practice that avoids social disparagement

Examples of good practice include:

   • interventions that support family and early years e.g. surestart

   • strengthening the home learning environment and adolescent transition

   • building social capital for children and older people e.g. liveable streets, stop and chat spaces

   • reducing environmental barriers to social contact: reducing motor vehicle traffic, access to green, open spaces, affordable, accessible transport

   • asset sharing e.g. through co-production, social return on investment measures, credit unions, social enterprise

- protecting/reclaiming public space e.g. challenging restricted use of public areas like shopping malls in Business Improvement Districts; landshare schemes to open up land for community cultivation or bringing together those with gardens and those without

- collective opportunities for healthy lifestyles e.g. social prescribing/community referrals; green gyms, food production/distribution, life long learning

Resilient relationships: what can the public sector contribute?

1.0   Introduction

"Social networks make change possible. Social networks are the very immune system of society. Yet for the past 30 years they have been unravelling, leaving atomised, alienated neighbourhoods where ordinary people feel that they are powerless to cope with childbirth, education or parenting without professional help. Risk averse professional practices and targets imposed by government have exacerbated the trend."

(Stephens et al 2008)

"Opportunities for individuals and communities to retain or achieve social recognition and to stay or become connected, contribute significantly to resilience, but social recognition and collective activity are frequent casualties of current economic and cultural trends.

(Friedli 2009)

This briefing was commissioned by CSIP North West, to give an overview of the research literature on social relationships as a determinant and/or mediator of health and other outcomes. It also provides examples of interventions designed to strengthen social relationships at different levels, in different settings and across sectors. It is part of a wider concern in Public Health in the North West to *distinguish individual risk from social context of risk* (Armstrong et al 2008).

Social relationships, social networks, community connections or what has been described as the *'core economy'* of home, family, community and civic life (Stephens et al 2008; Cahn 2004), are high on the policy agenda and are also an issue of considerable public interest and concern. At the heart of this concern is the belief that:

- the quality of social relationships at all levels has far reaching consequences for society

- social relationships have been neglected and/or are damaged by contemporary cultural and economic trends in the UK

- the relationship between communities and the public sector is marked by lack of trust and lack of engagement

- the current configuration of public sector services cannot meet expectation/demand

These concerns have been given new impetus by the current financial crisis and broader disquiet about levels of inequality and their impact on social cohesion: a substantial majority of people in

Britain believe that the gap between rich and poor is too wide (Orton and Rowlingson 2007; Christopoulos et al 2008). A range of 'think tank' reports have called for a greater focus on *'psychological and relationship needs'* (Vale et al 2009), while others have argued that such needs cannot be abstracted from the material circumstances of people's lives (Wilkinson and Pickett 2009). Some commentators have described the current climate as one of endemic uncertainty: at a time of a marked decline in opportunities for social solidarity and collective action, responsibility rests with the individual to an unprecedented degree (Bauman 2007). The other side of this coin is the stigma attached to dependence. As Bauman notes, *"although the risks and contradictions of life go on being as socially produced as ever, the duty and necessity of coping with them has been delegated to our individual selves"* (Bauman 2007 p14).

Efforts to improve levels of public engagement and to encourage participation are central to the NHS and local government modernization agenda and the reorientation of services outlined in *Putting People First* (Department of Health, 2007a) and *World Class Commissioning* (Department of Health, 2007b). The literature on social capital has included analyses of the relationship between the statutory sector and communities and recent years have seen the emergence of new models for such relationships, for example co-production (Cahn 2004; Stephens et al 2008). These trends have important implications for thinking about social relationships and the role of health and social care agencies in supporting them.

The literature on the contribution of social relationships to health and other outcomes, for example education, employment and quality of life, is part of a broader attempt to explain outcomes, for individuals and for communities, *that cannot be wholly accounted for by material and other risk factors.*[1] The limitations of classical risk factors e.g. health behaviour, lifestyle and low income have prompted a growing interest in what protects health in the face of adversity and in the determinants of health, as distinct from the determinants of illness (Harrison et al 2004; Bartley et al forthcoming). An emerging literature on salutogenesis[2], health assets, capabilities[3] and resilience is centrally concerned with positive adaptation, protective factors and 'assets' that moderate risk factors and therefore reduce the impact of risk on outcomes (Bartley et al in press).

Such assets might be social or cultural and contribute to resilience at an individual or community level. Two central and related themes are evident:

- the protective nature of individual skills and attributes, broadly described as 'positive mental health and well-being'

- the protective nature of social relationships, social networks or *'social capacity'*

In the literature on resilience, defined as *'doing better than expected in the face of adversity'*, the importance of the emotional and social dimensions of people's lives and histories emerges clearly. A major programme of research exploring common factors that make resilience possible and increase human capability suggests that these *'mostly have to do with the quality of human relationships, and with the quality of public service responses to people with problems'* (Bartley 2006; see also Jones et al 2006; Cummins et al 2007).

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[1] Infant mortality in the North West is a good example, where rates vary between equally deprived localities (Armstrong et al 2008)

[2] Salutogenesis asks, "What are the causes and distribution of health and well-being in this group, community or country population". Epidemiology asks "what are the causes and distribution of disease and early death in this group, community or population". (Harrison et al 2004 p9)

[3] Amartya Sen defines capabilities as people's real freedoms to enjoy beings and doings that they value and have reason to value (Sen 1985; see also Zavaleta 2007)

The literature on health assets challenges the notion that individuals and communities are 'passive victims' of circumstance and could be seen as restoring agency, while also recognising the power of forces beyond individual control (Popay et al 2007). Recent thinking on agency also recognises the importance of 'other regarding agency' and the fact that people's own freedoms may be enhanced by abilities to act on others' behalf – an analysis that supports a greater focus on collectivity and common good (Alkire 2007 p17). In the North West, this 'focus on assets' has been framed in terms of a more 'optimistic' approach:

> *"…a realised capacity for positive physical and mental wellbeing; achieved through the social accumulation of capital, support, protection, information, expertise and confidence – an accumulation shared by individuals, enabling each to participate fully in their social contexts of choice."*

<div align="right">(Hennell 2008)</div>

Social relationships appear to be a fundamental element of resilience, but there are also strong *ecological and contextual* effects: social isolation is less damaging in cohesive communities (Berkman and Kawachi 2000) and both the built and natural environment influence social relationships. Levels of material affluence or deprivation and the distribution of resources pattern social characteristics: networks, norms, and community trust, cohesion, influence and co operation for mutual benefit (March and Susser 2006). The intersection of these different domains is also central to the recent report on global inequalities in health from the *Commission on the Social Determinants of Health* (CSDH) which identifies three key areas for action/empowerment:

- material requisites
- psycho-social (control over lives)
- political voice (participation in decision making)

As described in Section six, for individuals, communities and localities, there is a social gradient in the distribution of key features of psycho-social resilience and while psycho-social assets provide some protection, they are generally trumped by material advantage.

The wealth of research and competing theoretical perspectives on social relationships makes this a particularly challenging field. It is difficult to untangle the different determinants and to decide on the relative importance of the multiple factors that influence social relations, which might include:

> *attachment, emotional, cognitive and social attributes, cultural identity, spiritual/religious beliefs, family dynamics, customs of food preparation, work/life balance, transport, financial security, informal labour markets, levels of inequality, housing, the design of public space, opportunities for collective organisation and many, many other factors*

Indicators of the extent of a disconnected or 'broken society' are equally wide ranging[4], including fear of crime, the rising prison population, levels and patterns of alcohol consumption among young people, growing personal debt, declining civic engagement (e.g. volunteering, voting), concerns about anti-social behaviour and, in some areas, marked tensions between existing and newly arrived communities and other indicators of divided communities e.g. gated estates,

surveillance equipment and the use of ultra sonic sound devices to control young people's use of public space[5].

There is a significant tradition of research and intervention on different aspects of social capital in the North West and *"capitalising on neighbourhood and community infrastructures to engage individuals, families and communities"* is already identified as a strategic priority for tackling health inequalities in the North West[6]. Interestingly, a recent Association of Public Health Observatories (APHO) report on public health in the English regions found that on a number of key social support indicators, the North West is above average:

- having a religious affiliation

- social support

- neighbourliness

<div align="right">(Wilkinson et al 2007)</div>

More broadly, the North West is concerned with addressing the social context of risk and resilience:

> *"Becoming healthy is an accumulated social skill, which takes time and experience to acquire, which different populations acquire at different rates, and which some individuals never acquire at all. If progresses in health technology are to result in corresponding progress in health and wellbeing, there is an implied need for counterpart progress in the social capacity for wellbeing within user populations. In so far as some populations initially lag in developing the required social capacity, inequalities tend to arise and persist.*

<div align="right">(Hennell 2008)</div>

This briefing is intended as a basis for stimulating further discussion and debate on these issues within the region and for considering what additional action, if any, the North West public sector can take to support social relationships. Although few people would subscribe wholly to either the 'individual pathology' or the 'social pathology' models, the policy and practice options vary considerably according to whether a greater emphasis is placed on 'fixing the individual' or 'fixing society.' These are considered in the final recommendations.

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[4] See for example the Joseph Rowntree Foundation consultation on 'modern social evils' www.jrf.org.uk/work/workarea/social-evils

[5] "Remove unwanted youngsters from around your premises with Mosquito from compound security systems. Young person deterrent system for shops and homes" www.compoundsecurity.co.uk/clients

[6] Our Life in the North West: tackling health inequalities locally – a self assessment framework p.7

The briefing is structured as follows:

- Section two sets out the aims

- Section three describes the policy context

- Section four summarises key themes raised in interviews

- Section five outlines the impact of social relationships on outcomes

- Section six looks at inequalities

- Section seven covers the connections between social relationships and place

- Section eight summarises a range of interventions designed to strengthen social support at all levels

- Section nine sets out a series of recommendations

- Appendix One lists those who were interviewed and participants in the regional seminar

2.0   Aims

The primary aim is to tease out different ways of thinking about the impact of the public sector on *'relationships'* and *'association'* or *'community connections'* and their implications for the North West. This includes how local government and NHS organisations influence social relationships and social networks within communities, between communities and/or the quality of the relationship between public agencies and different communities. It also includes the contribution of public agencies to the quality of relationships or opportunities for association within a community. The presence or absence of transport, the opening or closures of a post office, pharmacy, hospital, day centre, local park or swimming pool are obvious examples. More subtle examples might be the local reputation or perceived attitude of a particular service or profession with particular communities.

The primary research questions were:

- what is the contribution of social support and social networks i.e. the quality of our relationships with each other at all levels – to health and other outcomes?

- what impact, if any, can the public sector, and in particular North West regional health and social care policy, commissioning and practice have on social relations?

If social networks act as mechanisms for a collective identity, mutuality and resilience that promotes individual, group or community wellbeing, what role does the public sector in the North West, specifically local government and NHS organisations, play in recognising, fostering and sustaining these networks? Given the diverse nature of networks and how they operate, whether formal or informal, are there examples of policy, planning, commissioning and practice within the North West that:

- demonstrate an understanding of the dynamics, strengths and weaknesses of networks?

- recognise and measure their contribution to population wellbeing in the region?

- take account of the impact of the public sector on social relationships?

The briefing:

- brings together some of the current thinking on social relationships, social networks or what has been described as the *core economy* of family, neighbourhood, community and civil society

- describes different pathways through which social relationships might influence health and other outcomes

- provides examples of interventions designed to support social relationships at different levels and in different settings

The briefing also includes feedback from a series of telephone interviews with health and other professionals, as well as responses to a half day regional seminar on social networks held in Manchester on 9th December 2008.

3.0   Policy environment

This section describes current policy trends and some of the key influences on debates about social relationships. Recent developments in thinking about *'community'* open up a wide range of possibilities, both for 'interventions' and for new ways of commissioning and delivering services that foster social networks. These are covered in more detail in section eight.

The significance of social relationships at all levels is high on the policy agenda, with calls for a greater emphasis on meeting 'psychological and relationship' needs (Vale et al 2009; Marks and Shah 2004) and is also an issue of considerable public interest and concern. Key themes include beliefs and perceptions regarding:

- the decline of family, community and social cohesion;

- individualism, consumerism and materialist values;

- the persistence of health and other inequalities;

- the factors that distinguish *'resilient communities and localities'* i.e. those that do better than expected in the face of adversity;

- the capacity of the public sector to respond to social problems and to engage with communities;

- the balance between service provision and self care/self management;

- the shift towards promotion, prevention and 'well-being'.

3.1   Contemporary social evils

In their major ongoing public consultation on current 'social evils', the Joseph Rowntree Foundation (JRF) found the following concerns:

- A *decline of community*: communities are weak and people are increasingly isolated from their neighbours, at considerable cost to well-being and happiness.

- *Individualism*: people tend to see themselves as individuals and not as part of wider society, leading to selfishness and insularity.

- *Consumerism and greed*: an excessive desire for money and consumer goods has eclipsed values and aspirations rooted in relationships and communities.

- *A decline of values*: there is no longer a set of shared values to guide behaviour. Participants emphasised a lack of tolerance, compassion and respect shown to others.

(Watts 2008)

A parallel consultation found that fears about the decline of family and decline of community were also voiced by the poorest and most marginalised (Mowlam and Creegan 2008).

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Although, as has been widely have observed, similar anxieties have been expressed for several millennia, their influence has been strengthened both by the current economic crisis and by environmental concerns. At the heart of these debates is the view that the relentless pursuit of economic growth is environmentally unsustainable and that economic and fiscal strategies for growth have also undermined family and community relationships: *economic growth at the cost of social recession* (Pickett et al 2006; Marks et al 2006; Eckersley 2005; 2006).[7] A recent report by the JRF, for example, argues that a growing number of families are both income and time poor:

> *"the government's welfare reform and child-poverty agendas risk freeing lone parents from income poverty only at the price of deepening their existing time poverty. This is unlikely to improve children's well-being."*

> (Burchardt 2008)

A number of commentators have argued that in the developed world, we have reached the limits of the benefits of affluence, that consumerism promotes individual anxiety and undermines social solidarity and that the goal now should be sustainability and greater equity through social justice (Bauman 2007; Rutherford 2008). A recent report by the Young Foundation on 'unmet need' states that public policy should be placing greater emphasis on psychological and relationship needs (Vale et al 2009). These concerns are finding a new resonance in the context of the economic recession, and are influencing debates across Europe, notably with the publication of a report, commissioned by President Sarkozy of France, calling for measures that capture social as well as economic progress (Stiglitz et al 2009).

3.2   Reclaiming the core economy

Economic growth at the cost of social recession has been described as a tension between two economies: the core economy of home, family and community relations and the money economy. Neva Goodwin, who coined the term 'core economy' argues that many social problems can be traced to the fact that the core economy has been damaged by the money economy (Stephens et al 2008).   In *co-production, a manifesto for growing the core economy*, Stephens et al argue that recognizing and rebuilding the core economy is critical for the future of public services.   The concept of co-production was developed from the underlying principles of time banking (the recognition of the exchange value of time), and is described as reclaiming territory for the core economy – territory lost to the commodification of life (Stephens et al 2008):

> *"The challenge was: how to value the labour and contribution of those whom the market excluded or devalued and whose genuine work was not acknowledged or rewarded."*

> (Edgar Cahn in Stephens et al 2008)

Co-production has important policy implications for public services and service delivery: although it recognises that relationships are at the heart of public services, it draws on a very specific understanding of the relationship between communities and the statutory sector. The point is not

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[7] See also www.neweconomics.org/gen/z_sys_publicationdetail.aspx?pid=193 and www.foresight.gov.uk. For a competing view suggesting a positive link between Grosse Domestic Product (GDP) and well-being see Stevenson and Wolfers 2008; see also HM Treasury 2008.

to consult more, or involve people more in decisions: it is to encourage them to use the human skills and experience they have to help deliver public or voluntary services.

The principles of co-production are:

- social networks make change possible and are the life blood of communities

- the equally important role played by those on the receiving end of services

- relationships need to be reciprocal for change to happen

Woodcraft (2009) calls for new forms of volunteering, as the number of local volunteers rises with the increase in unemployment. She argues that local authorities should consider new forms of time banking that allow people to get involved in their community by volunteering in return for council tax or rent reductions. Similar themes are picked up in David Brindle's recent paper arguing that social care has become isolated from mainstream society, that its recipients are cut off from their neighbourhoods and from each other and that care and support need to be reintegrated with, and owned by, the wider community

"Difficult questions about family and community responsibilities are being ducked and the issues risk being overshadowed by a focus on personalisation of services"

(Brindle 2008)

3.3   Investment for Social Return

These themes are also evident in a range of policy initiatives that focus on social rather than, or in addition to, financial returns (Lawlor et al 2008). They include efforts to support the economic development of communities e.g. credit unions and Community Development Finance Initiatives e.g. *Bradford Enterprise Fund*, and Community Interest Companies e.g. *Era Gallery on Merseyside* that are seeking to generate long-term social benefits, rather than financial profits (Thiel and Nissan 2008).[8] Investment for social return addresses the relationship between social and financial exclusion, for example through micro-lending, or strategies to advance local businesses and create employment opportunities. While co production operates *'beyond the market'*, social return on investment (SROI) translates social and environmental outcomes into monetary values: social outcomes matter to communities and also have a monetary value. Woodcraft describes new community assets as a response to the current crisis

"taking a new look at how councils define community assets so pubs, post offices or local shops can combine to become neighbourhood hubs; or using empty shops to create 'pop-up' community services – temporary neighbourhood drop-in centres, youth facilities or lunch clubs for older people"

(Woodcraft 2009)

Promoting social enterprise 'within the NHS' is highlighted in the Darzi report and will be a feature of Department of Health guidelines to be published shortly. Frontline NHS staff are to be

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[8] www.eragallery.co.uk; community interest companies www.cicregulator.gov.uk

encouraged to set up their own businesses in the community, run by practitioners working together and/or led by voluntary sector and service users.[9] Examples include a health centre in Bow that houses 100 different projects and social enterprises and the Sandwell Community Caring Trust, based in the Midlands, that cares for more than 350 disabled and disadvantaged children and adults and has contracts exceeding £8.5m.

3.4   Regenerating local democracy

The White Paper *Communities in Control* reflects government concerns about *'a feeling that voices are not being heard on a local level'* and:

- declining levels of democratic engagement in England

- declining perceptions of influence over local decision-making

- declining levels of satisfaction with local government in England

The White Paper aims to pass power into the hands of local communities:

> *"We want to generate vibrant local democracy in every part of the country, and to give real control over local decisions and services to a wider pool of active citizens."*

It addresses seven key areas for action: *being active in your community; access to information; having an influence; challenge; redress; standing for office; and ownership and control.* It is largely concerned with individuals and is illustrative of a recurring challenge: the modernisation agenda, with its focus on empowered consumers making informed choices, self determination and personalised budgets has coincided with an apparently declining sense of community engagement with public services and in some cases, very significant indicators of relationship breakdown e.g. attacks on A&E staff, no go areas for ambulance services. The prominence of the language of the market is perhaps at odds with a growing public awareness that there may be no individual, market driven solutions to health and social problems (Rutherford 2008 p17).

Communities in Control (Department for Communities and Local Government 2008) is consistent with *Putting People First*, the single community based support system for adult social care which should be *'designed around the needs of citizens'*:

> *"Binding together local Government, primary care, community based health   provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training. This will not require structural changes, but organisations coming together to re-design local systems around the needs of citizens."*

<div align="right">(Department of Health, 2007a)</div>

Both *Putting People First* and *World Class Commissioning* involve a shift from intervention at the point of crisis and/or diagnosis and treatment to prevention and well-being. Such a shift has significant implications for relationships between services and communities, as well as for the kind of interventions delivered. It also signals a renewed emphasis on the psycho-social

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[9] For a range of case studies see www.socialenterprise.org.uk/data/files/publications/final_pdf.pdf

determinants of health.

It has been argued that these local government White Papers in fact involved very limited devolution of real powers to either neighbourhoods or local authorities (Woodcraft 2009). However, the current escalation of public disaffection with political leadership, together with the ongoing recession could result in major changes in how both local government and the NHS respond to local communities:

Local government will *"need to prepare for a long and deep recession which will require radically different policies, from direct job creation to support for exchange networks that enable people to share time, skills and assets"*[10].

3.5   Happiness and well-being

There is cross Government interest in well-being generally (sometimes referred to as the 'happiness debate'),[11]   and in how a 'well-being focus' might influence the future direction of policy on the economy, health (the *'health and wellbeing narrative'*), education, employment, culture and sustainable development (Marks et al 2006). The Government's Office of Science and Innovation has completed a wide ranging review of *Mental Capital and Mental Well-being as part of its Foresight programme*.[12] The Department for Farming, the Environment and Rural Affairs (DEFRA) has commissioned a number of major reports on different aspects of well-being, including a review of influences on personal well-being and the relationship between sustainable development and well-being.[13]

The Treasury has also published an overview of developments in the economics of wellbeing from a central government perspective, looking at implications for policy and the need to:

> *"achieve an appropriate balance between policies that promote well-being and policies that maintain economic incentives to support innovation and growth"*

(HM Treasury 2008 p.5)

3.6   Policy conclusions

What all these developments have in common is an interest in the links between social relationships and a broad range of outcomes, whether the focus is on parenting, family breakdown, education, employment, productivity, criminal justice, sustainable development, volunteering, ageing well or community cohesion.

They also signal wider shifts in the relationship between public sector services and the community

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[10] Mulgen et al 2009 cited in Woodcraft 2009

[11] Layard 2005; New Economics Foundation 2007

[12] www.foresight.gov.uk

[13] www.sustainable-development.gov.uk/what/latestnews.htm#ln210906.

and open up new ways of thinking (potentially) about how services are delivered. Questions about social networks and the nature and extent of connections within communities are relevant to wider regional goals and a long term vision for a single accountability framework for health, social care and local government. Understanding the role of health and social care in enabling and supporting relationships can make a significant contribution to key NHS priorities, notably to World Class Commissioning and implementing the Darzi report recommendations. The NHS can potentially make a valuable contribution to the strength of communities through the way they plan, commission and deliver health services and through their position in Local Strategic Partnerships. Local authorities too, have been centrally concerned with 'community engagement' at a neighbourhood level, notably in deprived areas, and in developing a range of networks, forums and panels to support neighbourhood working.

While communities, social relationships and social networks are high on the policy agenda, what this means for resource allocation, commissioning and practice is less clear. In particular, there may be tensions between market oriented thinking and the discourse of consumers, personalisation and individual choice as distinct from the language of citizenship, collectivity and the common good.

4.0   Key themes from the interviews

A series of ten semi-structured telephone interviews[14] with colleagues working in the North West were carried out to explore:

- different understandings and perspectives on the connection between social relationships and health and the role, if any, of public agencies in influencing social relationships

- local or regional examples of what is happening around this agenda in the North West

- ideas or recommendations for what should be happening

Interviewees were mainly health or public health professionals, but also included one person from each of the following: local government, research, and the third sector.

There was a good level of knowledge of the evidence for the influence of social relationships on health and considerable support for more strategic regional action in recognition of *'relationships at all levels as a determinant or mediator of health'.*

Key themes included:

- social networks as an asset for public health or as a means of meeting certain goals e.g. behaviour change;

- the importance of social values and the potentially damaging impact of materialism;

- the problematic nature of the relationship between public agencies and (some) communities;

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[14] A list of those interviewed, together with participants in the Manchester seminar, is provided in Appendix One.

- social relationships and community engagement as 'policy priorities';

- the impact of factors like gender, age, ethnicity and levels of deprivation on social relationships, community connection and networks at all levels;

- the absence of indicators or measures of social outcomes.

The interviews also explored:

- Current work and opportunities. Whilst only a very limited number of specific case studies were mentioned, most interviewees identified policy or practice relevant to the agenda and could see a range of opportunities for the future, including strengthening the leadership role of the public sector, taking an assets based approach to communities and creating 'collective', rather than individual opportunities for health.

- What could be improved? There was broad agreement that public agencies, and particularly the NHS, had some way to go in the whole area of community development and strengthening opportunities for community connections and social networks at all levels.

In conclusion, those interviewed expressed considerable support for more strategic regional action in recognition of *'relationships at all levels as a determinant or mediator of health'* and this view was also supported at the regional seminar. For some, NHS efforts to strengthen social networks or 'build social capital' were primarily instrumental, a means to delivering public sector goals around health or crime. For others, the whole question of the impact of public agencies on social relationships raised complex issues about the relationship between the public sector and local communities and the influence of poverty and inequalities, as well as factors like age, ethnicity and gender.

5.0   Impact of social relationships on outcomes

'Generally, associating with other people is good for you, and associating with people outside your own household is even better'

(Hennell 2008)

Notwithstanding the complexity of the terrain, the overall message from a significant body of research is that good quality social relationships across the life course protect health, are associated with a wide range of other beneficial outcomes and that these effects are both *individual* **and** *ecological*. Conversely, social isolation and/or exclusion are risk factors for a range of adverse outcomes. For example, emerging evidence in the North West suggests that maternal social isolation is a risk factor for infant mortality (Armstrong et al 2008).

While many benefits come from the perceived quality of relationships, quantity may also be a factor: those who are 'network rich' enjoy additional benefits over those who are network poor. The recent Office for National Statistics (ONS) study found that 'social capital' indicators (friends, support networks, valued social roles and positive views on neighbourhood) also predicted onset and persistence of emotional and behavioural disorders in children (Clements et al 2008). For older

people, high social support pre and during adversity increased likelihood of resilience by 40-60% compared with those with low social support (Netuveli et al 2008). Voting abstention, possibly an indicator of low social capital, has negative lifetime health effects, over and above low socio-economic position (Arah 2008).

Although direction of causation is not always easy to establish, these findings are increasingly confirmed in longitudinal studies. Mechanisms include:

- stress buffering

- access to information

- health behaviour/help seeking

- psychological benefits

- functional: practical and material help

- access to valued resources e.g. employment opportunities

- quality of life

(Stansfeld 2006; Dolan et al 2006; Melzer et al 2004; Brugha et al 2005; Clements et al 2008; Ferrie 2007 ; Vale et al 2009)

6.0   Social support and inequalities

Although levels of social support may buffer the effects of deprivation, socio-economic status also influences the quality and availability of support (Berkman and Glass 2000; Siegrist and Marmot 2006; Stansfeld 2006). A recent analysis demonstrated a strong correlation between socio-economic disadvantage and poor social networks and social support (Box 1), using the following measures:

- availability of a confidant

- partnership

- close ties

- social participation

- summary index of social integration

Box 1: Social support and deprivation

"Socially disadvantaged persons are more often exposed to poor social networks and social support. In bivariate analyses it becomes obvious that there is a higher percentage of having no confidant and no partner, of no participation, of being socially isolated and of lacking social support. In multivariate analyses, odds ratios are elevated in low socio-economic position (SEP) groups".

"Based on education, odds ratios range[15] from 1.0 (highest education) to 4.9 (lowest education). Findings based on income show similar effects, ranging from 1.0 to 2.5. In some cases (no confidant, poor social support), the association of SEP with poor social networks and support gets stronger with decreasing SEP, but by far the strongest effects are observed in most disadvantaged groups."

(Weyer et al 2008)

For some people, even high levels of support may not be sufficient in the face of profound, complex or persistent social problems. Strong social networks may also demand high levels of reciprocal support. Some studies suggest that this may explain why women have the highest levels of social support but also the highest prevalence of psychological distress.

A key question is the extent to which social capital mediates the effects of material deprivation. Many studies have found that social support and social participation do not mediate these effects (Mohan et al 2004; Morgan and Swann 2004). A recent ecological study of 23 high and low income countries found no significant association between trust and adult mortality, life expectancy and infant mortality. Rather the results supported the importance of both absolute and relative income distribution (Lindstrom and Lindstrom 2006).

This does not mean that neighbourhood effects are insignificant: we know that indicators of social fragmentation and conflict in communities, as well as high levels of neighbourhood problems influence outcomes independently of socio-economic status (Agyemang et al 2007; Steptoe and Feldman 2001). This is explored further in section seven.

Richard Wilkinson's work analyses deprivation as a catalyst for a range of *feelings* which influence health through physiological responses to chronic stress, through the damaging impact of low status on social relationships and through a range of behaviours seen as a direct or indirect response to the social injuries associated with inequalities (Wilkinson 1996; 2005). More recent analysis suggests a significant relationship between inequality and levels of violence, trust and social capital (Wilkinson and Pickett 2007b). Taking the UNICEF data on children's well-being as a starting point, Wilkinson and Pickett found that adolescent pregnancy, violence, poor educational performance, mental illness and imprisonment rates were all higher in more unequal countries and states (Pickett and Wilkinson 2007).[16]

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[15] Odds Ratio: ratio of two odds to compare two groups, used in logistic regression. If the odds are the same in the two groups, then the odds ratio is one and the groups do not differ in the risk of a particular outcome. The 'odds' in itself is another ratio: the number of times an event occurs to the number of times it does not, e.g. the probability of a newborn baby being a girl is approximately 50%, but the odds are 50/50, which is one.

[16] Unicef looked at 40 indicators (for the period 2000-2003) covering material well-being, family and peer relationships, health and safety, behaviour risks, education and sense of well-being. Those at the top of the list: the Netherlands, Sweden, Denmark and Finland were also those with the lowest levels of relative income poverty (Unicef 2007).

Wilkinson and Pickett argue that the UNICEF data suggests that children's responses to inequality are similar to those found in the adult population and are similarly related to the effects of social status differentiation: greater inequality heightens status competition and status insecurity (and does so across all income groups) (Pickett and Wilkinson 2007; Wilkinson and Pickett 2007a).

Other research suggests that contact with public welfare that transmits or reproduces stigma and humiliation has a significant influence on health and wellbeing and helps to explain why poverty is more damaging in some circumstances than in others (Jones et al 2006). Such findings have strengthened concerns to address both the material and psychological dimensions of deprivation.

> *"In Britain it is very evident that some of the poorest people feel abused and disrespected by public welfare provision and are hurt by the manner in which they are characterized by the tabloid press. Not only do they get less welfare than their Swedish counterparts, but they receive it in a context that is often dehumanizing and unpleasant."*

7.0   Social relationships and place

'patterns of social segregation in cities largely reflect the outcome of competition for access to local public goods such as better schools or amenities…. Concentrations of poverty are mainly the result of inequality of income'

(Cheshire 2007 pviii)

Liverpool is also one of the most segregated and security-conscious places in the country, with one of the largest CCTV networks in Britain, with even the black cabs in this city notifying passengers that CCTV is operating inside the taxi. In the city centre the newly privatised shopping area employs uniformed private guards known as 'quartermasters' and   'sheriffs' to police the streets, and enforces restrictive policies on who may or may not enter the area and what they can and cannot do there.

Begging, selling the Big Issue, rollerblading, skateboarding and political demonstrations are banned, and even taking a photograph or eating a sandwich is not allowed except in designated areas. That's in the city centre, which has been reconstructed as a tightly controlled high end shopping centre. In contrast, in outlying parts of Liverpool, drones, which are the unmanned spy planes used in Iraq, are used to patrol deprived parts of the city.

(Minton 2006 p4)

Contextual factors have a significant impact on social relationships and opportunities for association and 'community connections'. The quality, nature, scope and history of social relationships also influence neighbourhood outcomes. The increase in spatial polarization of wealthy and poor people from 1970 – 2005 and the urban clustering of poverty have generated renewed interest in the relative importance of area level and individual effects (Taylor 2008).

7.1   Attachment to place

Attachment to place (the emotional bonds an individual feels to an area or place) is highest in areas with strong social networks and strong attachment is a defence against some aspects of deprivation (Livingston et al 2008). Factors that promote attachment are the same in high and low deprivation areas but attachment is lower in deprived areas, where security is more likely to be a concern:

> *'People expressed attachment to the communities in which they lived and to their networks of families and friends, rather than to the physical places. ….Social and family networks and feelings of safety were what helped to retain people in deprived areas'*

(Livingston et al p3)

Place attachment is an important feature of resilience because it can limit population turnover and may encourage positive formal and informal engagement in an area. While attachment can limit people's horizons, influencing attitudes to potential work locations and how/if people access jobs, including among young people, strong attachment relating to strong social networks can also help people get into work, providing information, practical and emotional support (Taylor 2008; Green and White 2007; Gore 2007).

7.2   Resilience and place

Research on resilient localities attempts to explain why poverty is more damaging to health in some contexts than in others and to identify protective or adaptive factors:

'resilience reflects the extent to which communities are able to exercise informal social controls or come together to tackle common problems. It is people's social networks, more than any physical characteristics of place that appear to be most crucial in creating a sense of attachment to place'
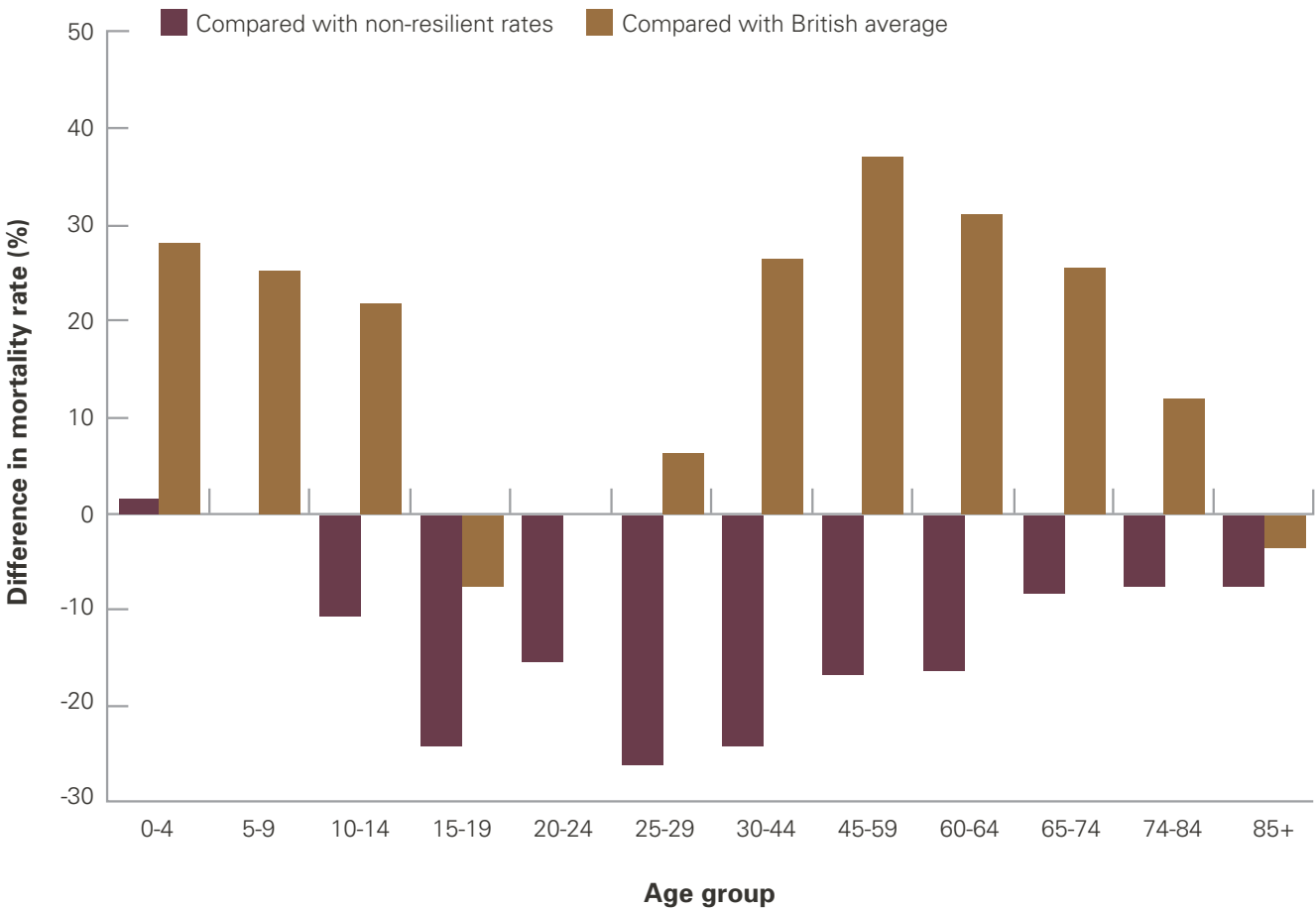
(Taylor 2008 p7; Livingston et al 2008)

Some deprived localities consistently 'over perform' or appear to be resilient: for example a study of mortality rates in Britain found significant differences between deprived areas that are resilient and non resilient: for 30-44 year olds this was in the order of 25% (Tunstall et al 2007). However, although the resilient constituencies have low mortality relative to their economic peers, their rates remain high (25%) relative to the British average (Figure 1). The effects of economic disadvantage on health in resilient localities are lessened, but not entirely removed – a characteristic finding from studies on resilience at all levels (Bartley 2006; Friedli 2009).

The extent of differences in mortality between equally disadvantaged localities makes these important findings but it remains unclear what factors are responsible. They might include selective migration, protective characteristics of the community e.g. collective efficacy or

progressive local policies and or, at a European level, different responses to post industrial decline (Tunstall et al 2007; Mitchell and Backett Milburn 2006; Walsh et al 2008; see also Doran et al 2006).

In the North West, some areas with a high percentage of routine and manual occupation households have low infant mortality (e.g. Workington, Kirkby), while some areas with lower than average routine and manual   rates have high infant mortality (e.g. Chester, Lancaster). This suggests that predominant social class is not the most significant, or robust, identifier of high risk populations, although it does have a residual effect. While local presence of particular ethnic groups is associated with high risk, maternal isolation is a risk factor and social cohesion and stability appear to be protective (Armstrong et al 2008).

Figure 1: Comparison between mortality in resilient and non-resilient constituencies, and between resilient constituencies and the British average (1996–2001).

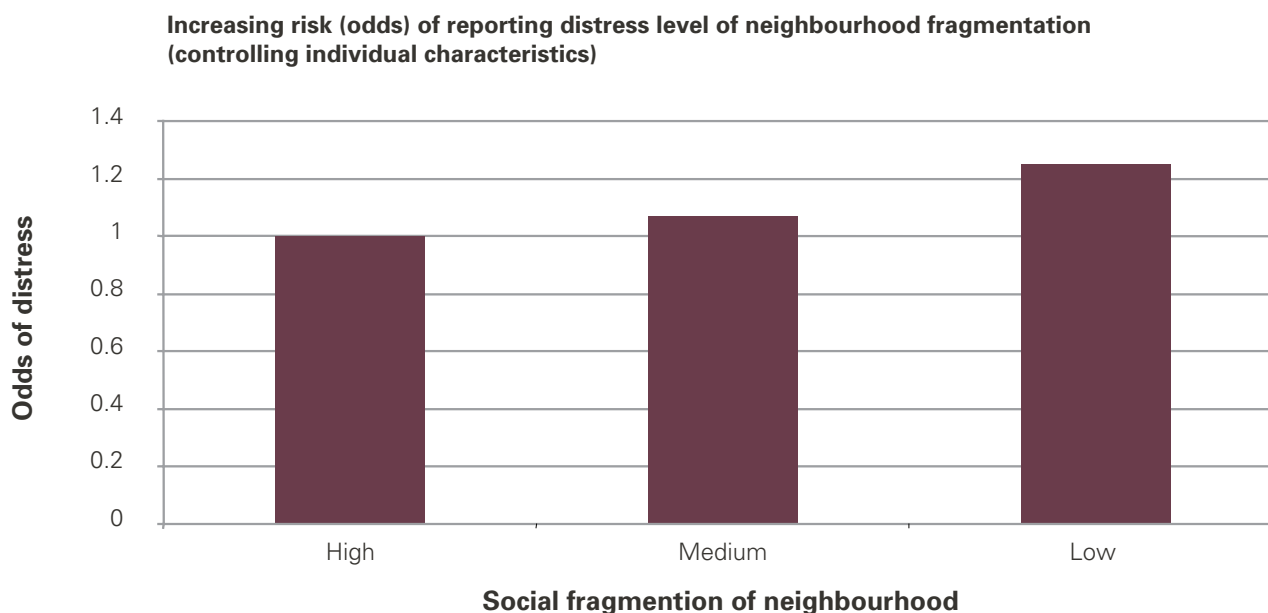

Reproduced from Tunstall et al 2007

7.3   Neighbourhood fragmentation

A number of studies show a relationship between levels of neighbourhood fragmentation and health and other outcomes. Mistrust and powerlessness amplify the effect of neighbourhood disorder; risk of violence is constructed by locality: by economic deprivation and by levels of inequality (as well as by gender and by ethnicity) (Krantz 2002; Krueger et al 2004).[17]

Poor, socially disorganised neighbourhoods have higher rates of violence and strong norms of violence. The social variables which predict suicide, (which is more strongly associated with social fragmentation than with deprivation), also predict violence to others. Socially disorganised areas provide a dangerous mix; large numbers of potential offenders who have few opportunities other than crime, many potential victims, and few organisations or individuals who are capable of protecting others from violence (Krueger et al 2004). Area level effects may be particularly significant for some causes of mortality: in Scotland, for example, increases in inequalities in mortality are driven by increases in death rates at a young age in areas of high deprivation, for example for liver disease, suicide and assault and mental and behavioural disorders due to drugs (Leyland 2007).

Curtis and colleagues found that although neighbourhood characteristics were significant (Figure 2), there were also differences among individuals in these areas. Young people with strong social support were much less likely to report distress (the odds of distress is around 30% lower, compared with those with weak social support within the family and immediate social network). This was true in all geographical settings.

Figure 2: Mental distress and neighbourhood fragmentation

Increasing risk (odds) of reporting distress level of neighbourhood fragmentation (controlling individual characteristics)

Reproduced from Curtis et al 2007

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[17] The finding that both violence and teenage births are associated with relative, rather than absolute poverty may reflect gender differentiated responses to low social status (Pickett et al 2005) and is consistent with wider evidence on gender differences in how mental distress is expressed.

A significant feature of the current policy response to the geography of social problems are changes in landownership, with the rise of individual landlords owning and managing entire city centres, and initiatives like the Business Improvement Districts (BIDs), which delegate control of town and city centres to local businesses.

> *"the key issue is that while local government has previously controlled, managed and maintained all streets and public squares, the creation of these new 'private public' places means that, as in the early Victorian period, they will be owned and managed by individual private landlords who have the power to restrict access and control activities"*

(Minton 2006 p11)

> *"BIDs change the concept of public space. This is the area of greatest concern in the research literature. The effects of privatising town centre spaces will change town centre use and the town centre experience. This may impact on social cohesion and inclusion and the meaning of public space"*

(Findlay and Sparks 2007).

Key themes include:

- Fear and mistrust related to visible physical inequality and segregation

- Policy approaches that focus on security

- Way that inequality is reflected in the physical environment underpins culture of fear

- Privatising of public space

Business Improvement District areas in the North West

The North West Development Agency has provided support to the development of eight pilot BID areas in the region. Five of these areas have so far secured positive ballots to develop BIDs. These are Blackpool Town Centre, Keswick Town Centre, Liverpool City Centre, Oldham Town Centre and Altham Industrial Estate. Ongoing development work is underway in Southport and Chester, and a second BID area is being considered in Blackpool on the promenade.

Further details on each of the eight pilot BID areas are available at the link below.

Stockport BID

Blackpool BID

Chester BID

Keswick BID

Hyndburn BID

Liverpool BID

Oldham BID

Southport BID

www.nwda.co.uk/areas-of-work/people--jobs/business-improvement-districts.aspx

7.5   Community Cohesion

The "Our Shared Futures" report of the Commission on Integration and Cohesion recommended that there should be a single national Public Service Agreement (PSA) target and the Government has now adopted a new cross-government PSA (PSA21) "to build cohesive, empowered and active communities". This will be measured against four national indicators:

- the percentage of people who believe people from different backgrounds get on well together in their local area;

- the percentage of people who believe they belong to their area;

- the percentage of people who have meaningful interactions with people from different backgrounds;

- the percentage of people who feel they can influence decisions in their locality.

Where Local Strategic Partnerships decide that improving community cohesion is a priority within their Local Area Agreements, these indicators will be used to assess performance and provide an incentive for action.

8.0   Supporting social relationships: what works?

'it is easy to forget that life is lived in relationships, and the quality of those relationships has much to do with how life turns out'

(Lewis, 1998)

"It is harder to help others than it used to be, and doing so in any structured way has become fraught with bureaucracy and barriers, so that where altruism still exists, it is harder to express"

(Julia Neuberger, 2008)

'the problem is poverty, not where people live'

(Cheshire 2007)

The concerns outlined in Section three - a perceived decline of community and the erosion of social bonds, together with the need to repair or rethink relationships between the public sector and communities - have generated considerable debate about possible solutions. This section

looks firstly at the general principles that underpin some of the key recommendations for action, for example from voluntary agencies, think tanks and Government policy, and secondly at specific interventions, drawn from the research literature.

8.1   Key themes

There appears to be a growing consensus about the problems that need to be tackled. These include:

> • **Placing a greater value on social outcomes e.g. time banking, investment for social return; citizens' income**

Co production enables people to use the human skills and experience they have to help deliver public or voluntary services. Time banking is one vehicle for co production and might include the 'person to agency' and 'the agency to agency' model:

- person-to-person: reweaving social networks, strengthening communities.

- person-to-agency: enlisting people to contribute to agencies' missions.

- agency-to-agency: ensuring agencies share existing skills and resources.

Local authorities can use time banking to enable people to get involved in delivering services in return for council tax or rent reductions. In Wales, person to agency models are used to promote active citizenship, with Time bank credits used for social events, leisure activities, internet access, bingo and community cafes (Ryan-Collins et al 2008; Aked et al 2009).

> • **Repairing social divisions e.g. reducing inequalities; policy and practice that avoid social disparagement; combating discrimination and exclusion**

Local and regional public sector attitudes to reducing economic inequalities can be fatalistic, but there are feasible, effective and/or plausibly effective opportunities to take action locally and regionally, including income maximisation and increasing access to valued assets, asset transfer, debt advice, micro-credit, adult literacy, traffic reduction in high motor vehicle traffic (MVT) areas, land share and access to green open spaces. Policy and practice responses that treat people experiencing problems/adversity with respect are more likely where those living in poverty or adversity are fully able to participate in decision making that affects their lives.

> • **Addressing barriers to helping others e.g. fear of litigation, bureaucracy**

There is a widely perceived growth in barriers to mutual aid, reciprocity and 'doing things for others'. These include risk aversion, fear and mistrust, self obsession and bureaucracy (Neuberger 2008). Neuberger argues that the state can set *the circumstances in which more of us can and would wish to do things for each other as part of normal behaviour* and identifies:

- opening up institutions to ordinary people e.g. care homes, children's homes

- reducing the burden of regulation, notably in relation to insurance

Others believe that current levels of materialism and consumerism promote an extreme individualism – a vision of the good life as personal fulfilment (Christopher and Hickinbottom 2008) which is incompatible with and damages both family and community relationships. Action to discourage materialism includes:
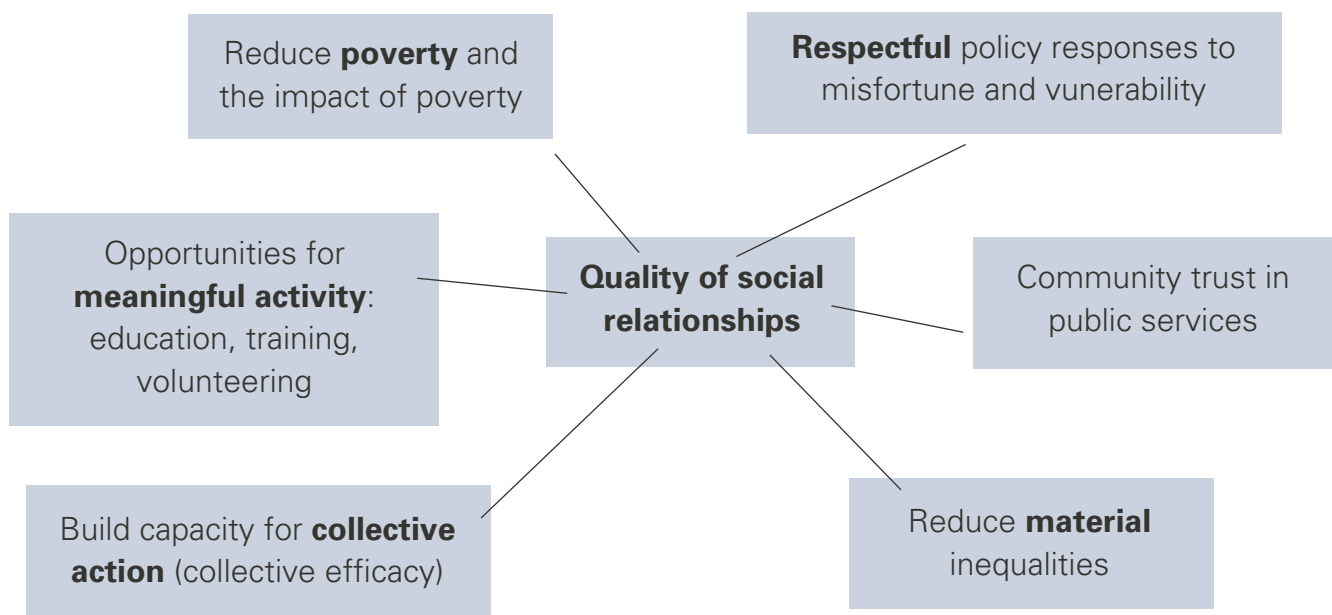
- restrictions on advertising

- broadening the school curriculum to include 'happiness' debates

- valuing social, sport and creative achievement, as well as academic performance

The New Economics Foundation puts social relationships at the heart of its *Well-being Manifesto*, which suggests: reclaiming time, active citizenship, discouraging materialism and advertising and supporting family life (Marks and Shah 2004).

- ***Protecting/reclaiming public space***

This might include considering the social impact of landownership or privatisation (of shopping malls, Business Improvement Districts), as well as increasing access to green open spaces. Recent evidence highlights the potential of environmental interventions to reduce health inequalities (Mitchell and Popham 2008; Newton 2007). Both action to reduce heavy motor vehicle traffic in residential areas and interventions to increase access to green open spaces can contribute to reducing health inequalities, as well as improving mental and physical health.

Figure 3: Framework for action to protect and promote resilient community relationships

Reduce **poverty** and the impact of poverty

Respectful policy responses to misfortune and vunerability

Opportunities for **meaningful activity**: education, training, volunteering

Quality of social relationships

Community trust in public services

Build capacity for **collective action** (collective efficacy)

Reduce **material** inequalities

8.2   Interventions

This section provides some examples of interventions designed to strengthen, support or enable social relationships, 'resilient relationships', social networks, community connections or association at different levels (Figure 3). It is not a comprehensive list but is designed to illustrate the range of opportunities, including examples from review level studies, as well as more recent, emerging findings.

8.2.1 Parents, families and home life

There is a comprehensive evidence base on the importance of supportive parent and family relationships, notably in the early years and in adolescence, but more limited evidence on what interventions actually work to support parents.   Such support may be formal or informal, providing both emotional and practical support and is known to play a significant role in parenting although the relationship is complex: absence of social support is not necessarily problematic. However for some groups, an impoverished social environment is a significant risk factor for various difficulties, including child abuse and neglect (Moran et al 2004).

Interventions to strengthen social support for parents include:

> befriending, home visits (by professionals or volunteers), assistance to increase take up of services, support groups, parenting training (individual and group) and support with social skills (see for example Sure Start, Box 2).[18]

Box 2: Supporting Parents: Sure Start

A very recent evaluation of Sure Start found the following beneficial effects in the Sure Start as compared with the non Sure Start areas:

- *Children: better social development*, with more positive social behaviour (mean difference 0·45, 95% CI 0·09 to 0·80, p=0·01) and greater independence (0·32, 0·18 to 0·47, p<0·0001).

- *Families: less negative parenting* (−0·90, −1·11 to −0·69, p<0·0001); a better home-learning environment (1·30, 0·75 to 1·86, p<0·0001); used more services for supporting child and family development (0·98, 0·86 to 1·09, p<0·0001).

- Effects of Sure Start Local Programmes (SSLPs) seemed to apply to all subpopulations and Sure Start areas.

Some evidence raises questions about whether the focus should be on improving the support provided by mainstream services or developing alternatives. An evaluation of Home Start showed that improvements measured among women visited by Home-Start were not significantly greater than those among mothers with similar problems who were not.

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[18] Although there is some evidence of effectiveness in enhancing social support in all these areas, a systematic review commissioned by the DFES concluded, as systematic reviews tend to, that there is insufficient robust evidence to draw firm conclusions (Moran et al 2004).

Box 3: Home Start Evaluation

Eleven months after they were first interviewed, the situation of most mothers in the Home-Start group had improved. They were experiencing less parenting stress and showed fewer symptoms of depression. They had higher self esteem, more social support and there was evidence that their children's emotional adjustment had improved. However, mothers in the comparison group, who only had access to the NHS and other statutory services, showed a similar level of improvement.

(McAuley et al 2004; see also Frost et al 1996)

Other evidence suggests that notwithstanding the benefits of support groups to reduce isolation, e.g. for parents of children with disabilities, without continuing professional facilitation the networks may not be sustainable (Ghate and Ramella 2002). Interventions that focus on strengthening personal resources and skills may have more enduring value (Moran et al 2004).

Parent support: what works? A review of the international evidence

Programmes that are 'promising' involve:

- Befriending schemes, but these require more rigorous evaluation.

- Services that offer specific information and advice on accessing support fromagencies etc in the local areas

- Services that help isolated parents 'rehearse' how to seek help (e.g. through role play)

- Some time-limited parent group programmes. Although the elements that make them successful or not are unclear, the group situation may lessen feelings of isolation and promote a sense of 'kinship' with others in similar situations.

(Moran et al 2004)

The current policy emphasis on moving lone parents into employment has raised questions about tensions between economic imperatives and the emotional and social needs of children:

"Around half (between 42 and 56 per cent, depending on the poverty definition used) of lone parents are not in a position to generate sufficient income to be above an income poverty line while still meeting basic obligations (for example, to ensure their children are looked after, by themselves or someone else), however long or hard they work."

(Burchardt 2008)

31

8.2.2 Home Learning Environment

There is a strong relationship between the quality of the 'Home Learning Environment' (HLE) and positive cognitive and social skills which influence readiness for school or learning and continue to influence outcomes throughout primary school (Sylva et al 2007. Two key aspects of the HLE are specifically relevant to social relationships

- Interaction with parents: being read to; conversation, learning songs/nursery rhymes, visiting the library;

- Interaction with others: both playing with other children and being looked after by other adults/relatives.

The Effective Pre-School and Primary Education (EPPE) study also found that for disadvantaged children, attending a high quality school or having a good home learning environment were not enough on their own: they required both to overcome disadvantage (Sylva et al 2007). There is a crucial role for pre-school and primary school in supporting parents to provide a good HLE.

8.2.3 Adult literacy and lifelong learning

"To be literate is to become liberated from the constraints of dependency. To be literate is to gain a voice and to participate meaningfully and assertively in decisions that affect one's life. To be literate is to gain self-confidence. To be literate is to become self-assertive. To be literate is to become politically conscious and critically aware, and to demystify social reality."

(Kassam 1994 cited in Dugdale and Clark 2008)

Recent research drawn from an analysis of BHPS data highlights the importance of literacy in the profile of disadvantaged adult lives. Drawing on this, Rochdale Borough Council has argued that literacy is critical to *"social mobility, regeneration, social cohesion and democracy. No service can ignore literacy – it's a fundamental issue which affects all aspects of community life and of service delivery"* (Dugdale and Clark 2008). Dugdale and Clark found significant links with levels of civic engagement: Non-readers are:

- less likely to vote or have an interest in politics;

- less likely to participate in their local community;

- less likely to belong to a membership organisation;

- individuals with poor basic skills are much more likely to report being 'not at all' interested in politics (in the BCS, 42 per cent for men with poor basic skills and 17 per cent for men with good basic skills and 50 per cent and 21 per cent respectively for women);

- men and women with the poorest literacy or numeracy skills were the least likely to have voted in the 1987 and 1997 general election;
- community participation is higher among men and women with higher literacy skills.

These and other findings have prompted Rochdale to develop a comprehensive strategy for increasing literacy across the borough.[19]

8.2.4 Social support and transition

Resilience in adolescence is also strongly influenced by the strength of social relationships and has powerful effects, including an increased likelihood of escape from social and economic disadvantage, a lower risk for psychological problems in adulthood and protection in the context of continuing disadvantage. (Sacker et al 2002; Sacker and Schoon 2007). The RELACHS (Research with East London Adolescents: Comunity Health Survey) study also found that largest part of the variability in adolescent 'strengths and difficulties' (SDQ as a measure of mental health) was associated with individual and family level (e.g. harmonious relationships) characteristics.[20] Most of the adolescents in this study were living in areas of high social disadvantage but the greatest distress scores were for White adolescents, compared with both Asian and Black groups. Individual or family level protective factors or psychological resilience had a significant influence in the face of urban deprivation (Fagg et al 2006; Stansfeld et al 2004).

A Joseph Rowntree Foundation (JRF) study on place attachment found that for young people – policy needs to recognise that local, place based social networks affect aspirations and behaviour (Green and White 2007). Key interventions include:

- transport; visits, trips, social and sporting activities to:
- provide new experiences/widen spatial horizons;
- raise awareness of routes into employment

8.2.5 Children's mental health

Social capital measures had a significant impact on risk of onset and persistence of emotional and behavioural disorders in children aged 11-16 (ONS 2008). Aspects of social capital include child friendships, parent's approval of friends, the child's social support networks, their views on neighbourhood, the help they provide to others and their participation in clubs and groups.

The Communities that Care programme[21] school survey of risk and protective factors identified clusters of risk factors with strong social themes, with deprivation intersecting with family conflict, school disorganisation, community disorganisation and neglect, high turnover and lack of place

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[19] A recent survey run by the National Institute for Adult and Continuing Education (NIACE) among nearly 5,000 people has found that the proportion of adult learners is at its lowest level since Labour came to power. The study also found that those in the highest socio-economic groups were twice as likely as those in the poorest to participate.

[20] Research with East London Adolescents: Community Health Survey (RELACHS). The survey collected data on mental health measured by the Strengths and Difficulties Questionnaire (SDQ), and on various aspects of individual and family circumstances.

[21] www.raineronline.org/gen/Rainer_CtC_process.aspx

attachment, alienation and lack of social commitment. Protective factors were very similar to those identified by Clements et al (2008), including:

- strong bonds with family, friends and teachers;

- opportunities for involvement in families, schools and communities;

- good social and learning skills;

- recognition and praise for positive behaviour.

8.2.6 Older People

Befriending schemes have had positive results for people experiencing depression and could also improve the physical health of older people (Jorm 2005). Other effective approaches include addressing 'daily hassles' e.g. through approved trader schemes, community transport, and 'food trains'.

8.2.7 Participation

Attempts to increase social capital through increasing participation have had mixed results. One study concluded:

"*The vast majority of proposals that they put forward are concerned with down-to-earth-problems relating to traffic, crime, and a lack of public greens. Increasing levels of social capital seems to be a much too indirect way to tackle these problems, with little support from citizens, and therefore very uncertain outcomes. Neighbourhoods will be much better off when they deal with the most pressing issues directly."*

(Lelieveldt 2003)

Falk and Kilpatrick (1999) argue that participatory methods under-represent the most vulnerable. They suggest that a precondition to building social capital is the existence of a sufficient quantity and quality of learning interactions – these include an historical context, external interactions, reciprocity, trust, shared norms and values. It's less clear how to deliver such learning interactions, although the planning and implementation of community projects may be one route.

8.2.8 Time banking

Described as a new form of recession proof exchange, Time banking has developed considerably in the past decade and is used to deliver a very wide range of services including mental and physical health, services for families, young people and older people, regeneration, housing and criminal justice. A recent report describes time banking, as a tool to stimulate co-production and argues that public services and commissioners should embed networks of exchange, such as time banking, within public organisations, including GP practices, hospitals, schools and housing

estates: *"These institutions should become community hubs, rather than simply service delivery vehicles".*

<div align="right">(Ryan-Collins et al 2008)</div>

"people and societies flourish more readily where relationships are built on reciprocity and equity: enabling people to give freely, yet also facilitating the give-and-take of time, knowledge, skills, compassion and other assets. These are not commodified through allocating them a 'price'. They are abundant, not scarce, in our communities. This is not to say such activities don't have value."

Time banking models include:

- person-to-person: reweaving social networks, strengthening communities;
- person-to-agency: enlisting people to contribute to agencies missions;
- agency-to-agency: ensuring agencies share existing skills and resources.

Local authorities can use time banking to enable people to get involved in delivering services in return for council tax or rent reductions. In Wales, person-to-agency models are used to promote active citizenship, with Timebank credits used for social events, leisure activities, internet access, bingo, and community cafes (Ryan-Collins et al 2008).

8.2.9 Motor Vehicle Traffic

A recent study in Bristol replicates earlier research and found a dramatic deterioration in the social life of streets with heavy motor vehicle traffic (MVT) (Hart 2008). The average resident on a busy street had less than one quarter of local friends compared with those living on a similar street with little traffic. Hart found that levels of motor traffic on residential streets are associated both with poor health and weakened social cohesion. In light traffic streets, the 'home territory' i.e. the area over which people feel a sense of responsibility is far broader than in heavy traffic areas and included three times the number of 'gathering spots'. The study controlled for personality differences, showing that the primary influence was the external effect of traffic, with a particular toll on children and the elderly.

A study by Kevin Leyden (2003) carried out in and around Galway, Ireland found that "persons living in walkable, mixed use neighbourhoods were more likely to know their neighbours, participate politically, trust others and be socially engaged, compared with those living in car-oriented suburbs."

For many areas, the growth in motorised traffic now represents a major threat to quality of life. As heavy MVT is more prevalent in deprived residential areas, action on traffic control can make a contribution to reducing health inequalities, in addition to strengthening opportunities for social contact.

8.2.10   Transfer of assets

There are a number of examples of transfer of ownership and management of public assets to community groups and through the establishment of Development Trusts. Recommendations for making this more effective are included in the Quirk Review.[22] In the North East, One North East looked at building social capital in tandem with economic development (Miles et al 2005). Although such programmes involve a major commitment of resources and there is limited evidence on their long term effectiveness, they have the merit of addressing the established relationship between financial and social exclusion in deprived localities.

The current concern with increasing access to good quality, affordable food and broader issues of 'food security' has generated a range of initiatives to bring communities together to grow and produce food (see case study Vacant Lot). 'Landshare' is a national campaign, launched by Channel 4, bringing together landowners, growers, land spotters and facilitators, who volunteer to help or support those who want to grow food.

"With allotment waiting lists massively over-subscribed and people right across the country keener than ever to grow their own fruit and veg, the aim for Landshare is to become a UK wide initiative to make British land more productive and fresh local produce more accessible to all." http://landshare.channel4.com/

8.2.11   Community Philosophy

This study explores the trial of a Community Philosophy approach to reduce 'nuisance' behaviour and increase tolerance (Seeley and Porter 2008). It involves convening discussion groups or 'Communities of Enquiry', through which participants learn new ways to speak and listen to each other. Community Philosophy seems to offer a mechanism for addressing these conflicts in a non-adversarial way. The philosophical conversations covered a range of issues, from addictions to prejudices, bullying, anti-social behaviour, leisure facilities for young people and human rights.

Community Philosophy appears to be a useful technique to build relationships, increase understanding, develop empathy and cultivate tolerance although the evaluation did not produce evidence of any reduction in nuisance behaviour.

8.2.12   Green open spaces

Parks, play areas and other open spaces provide an established route to increasing opportunities for social contact (Robertson et al 2007; Worpole and Knox 2007; see case study 'what if?'). In a recent population study, Mitchell and Popham (2008) found that populations exposed to the greenest environments (parks, woodlands, open spaces) *also have lowest levels of income-related inequality in health* (Mitchell and Popham 2008).

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[22] Making assets work: The Quirk Review of community management and ownership of public assets (2007)
    www.communities.gov.uk/documents/communities/pdf/321083.pdf; Department for Communities and Local Government Development Trusts
    www.dta.org.uk/aboutus/dtaintheregions/northwest/

Health inequalities related to income deprivation in all-cause mortality and mortality from circulatory diseases were lower in populations living in the greenest areas.[23] The health gap was roughly halved compared with those with fewest green spaces. Possible mechanisms include physical activity, stress buffering and the direct relationship between contact with nature and reduced blood pressure.

A Japanese study found longevity of older people in urban areas increased in accordance with the access to proximity of walk-able green spaces (Takano et al 2002). After controlling the effects of the residents' age, sex, marital status, and socioeconomic status, the factor of walk-able green streets and spaces near the residence showed significant predictive value for the survival of the urban senior citizens over the following five years (p<0.01).

Environmental predictors of poor mental well-being include:

- neighbour noise;
- feeling overcrowded;
- feeling unsafe/fear of crime.

Protective features include places to escape to (e.g. green open spaces), places to stop and chat, events to bring people together, community facilities and social and entertainment facilities.

Street level environmental incivilities, most common in deprived areas, also impact on opportunities for social contact e.g. litter, dog fouling, lack of safe places for children to play, few pleasant places to walk. Those with the highest level of street level incivilities are twice as likely to report anxiety and 1.8 times more likely to report depression (Curtice et al 2005). These findings, although from cross sectional studies, suggest the potential of addressing street level concerns that may be relatively low in cost.

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[23] The incidence rate ratio (IRR) for all-cause mortality for the most income deprived quartile compared with the least deprived was 1·93 (95% CI 1·86—2·01) in the least green areas, whereas it was 1·43 (1·34—1·53) in the most green. For circulatory diseases, the IRR was 2·19 (2·04—2·34) in the least green areas and 1·54 (1·38—1·73) in the most green (Mitchell and Popham 2008).

Case Study: Vacant lot: Grow your greens in a bag

This project was set up to meet the demand for 'grow-your-own' within dense urban areas where available land is scarce. What-if: projects together with local residents of an inner city housing estate in Shoreditch have transformed a formerly inaccessible and run-down plot of housing estate land into a beautiful oasis of green. Seventy 1/2 tonne bags of soil have been arranged to form an allotment space. Within their individual plots, local residents are carefully tending a spectacular array of vegetables, salads, fruit and flowers. A new sense of community has emerged.

The idea of Vacant Lot has also been used to forge partnerships between developers unable to develop land due to the recession, local authorities with long waiting lists for allotments and local communities lacking green space. Other disused spots in Hoxton Square, Store Street and Cheapside have also been colonised by What If's growing bags.

www.what-if.info/VACANT_LOT.html

Case Study: 'What if?'
Reducing barriers to social contact: creating social spaces

WHAT IF the large areas of derelict land that characterise Toxteth were used by the local community and became an asset rather than a void that divides?

If every household in the Noel Street neighbourhood were given ownership of a park bench and invited to place it on the square, how might Noel Street Green be transformed?

Would people begin to sit and linger in the space? Might young and old get the chance to hangout together? Would residents gather there with their neighbours? Could it become a place for parties or barbecues? Would the community start to adjust the Green and personalise and modify their own benches? Would this space begin to be cared for and maintained?

www.what-if.info/SIT_IN_part1.html#

9.0   Recommendations

The following recommendations set out what is needed to move this agenda forward within the region. They are also intended to stimulate further debate and reflection on some of the challenges this issue presents and to support localities in mapping, assessing and reviewing their own contribution.

The recommendations draw on the published literature, key themes emerging from the interviews and seminar and on the input of Jennie Popay, Professor of Sociology and Public Health at Lancaster University and Director of Health Research and Development for the North West, who contributed centrally by sharing findings from her research during her interview.

Regional leadership

- Regional leadership for the contribution of public agencies to building and maintaining *'resilient relationships'* should be explicitly linked to action to reduce economic inequalities and respectful public agency responses to people experiencing problems. Identify champions for the social determinants agenda within the Regional Leadership Team

- Strategic support for social relationships needs to be aligned to wider goals for the North West i.e. the Regional Improvement and Efficiency Partnership, Regional Strategy and Regional Health and Well-being Investment for Health.

- Develop a long term '10 year vision' for resilient relationships. Public sector involvement in 'building community capacity and social relationships' may have adverse effects, including undermining the third sector. This is a particular problem for short term approaches.

- Develop an 'index of multiple assets' for the North West. Social relationships are an asset for health development and are therefore consistent with an interest across the North West in a greater focus on an 'assets, resilience, capabilities' approach.

- Building resilient relationships involves addressing factors that influence social relations within and between communities **and also** addressing the quality of relationships between public agencies and local communities. *Co-production* (e.g. the time banking model) offers considerable potential for transforming the relationship between those who deliver and those who receive public services and could be explored further to test its feasibility as a model for the North West.

- There may be tensions and value conflicts between 'community empowerment' models and models which are essentially concerned with using social networks to deliver performance goals for professionals. Bringing clarity to these two agendas would be beneficial.

- Attachment to place, which is one characteristic of resilient communities, is closely related to strong social networks (which can also help people get into work, access services, and information, and recieve practical and emotional support). This highlights the need for a greater focus on how public sector decisions affect *'community connections'* for example, the opening or closure of a local shop, swimming pool, park, post office. The regional place agenda can strengthen 'attachment to place' and its significance in building strong social networks.

- Access to and use of public space may be influenced by the rise of individual landlords owning and managing city centres, and initiatives like the Business Improvement Districts, which delegate control of town and city centres to local businesses. The Single Regional Strategy is key to considering social, spatial and economic factors, as well as the potential of public space to reduce or to reinforce or exacerbate inequalities.

- Placing a greater value on social outcomes depends on thinking creatively about appropriate targets and indicators e.g. those that recognise investment for social return. Interventions to build resilient relationships can be aligned to key national, regional and local targets. The four national PSA indicators on community cohesion (from *Our Shared Future*[24]) are relevant, as are public sector requirements to improve wellbeing, promote equality and diversity, engage and empower communities .

- Build on and learn from local authority experience in the North West in working at a neighbourhood level and developing collaborative approaches to monitoring community cohesion.

- Assess and address barriers to helping others e.g. fear of litigation, bureaucracy and 'disconnection' as an unintended consequence of the way services are commissioned and delivered.

Effective interventions

Interventions should include:

- Those that strengthen social relationships and opportunities for community connection for individuals and families, especially those in greatest need e.g. support for parents, support for older people, for those who are homeless, those who have mental health problems, those who have learning difficulties, people in transition e.g. from prison to the community, leaving care, facing redundancy;

- Those that build and enable social support, social networks and social capital *within and between communities* e.g. reducing material inequalities, tackling discrimination, improving the physical environment, especially for children and young people, access to green, open spaces, reducing motor vehicle traffic in residential areas;

[24] 'Our Shared Future', the report of the Commission on Integration and Cohesion chaired by Darra Singh (June 2007).

- Those that strengthen and/or repair relationships *between* communities and health and social care agencies e.g. enhancing community control through co production, timebanks, asset sharing or transfer;

- Those that improve the quality of the social relationships of care *between individuals and professionals* e.g. practice that avoids social disparagement.

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Appendix One: Consultation

Social network scoping meeting Dec 9th 2008, Manchester

Attendance:

1. Dominic Harrison, Deputy Regional Director of Public Health

2. Ian MacArthur, Director Groundwork Trust (leading the regional BLF well-being portfolio)

3. Janet Matthewman, Communities Team, Government Office North West

4. Jackie Kilbane, Manchester After Care voluntary sector organisation

5. Tom Hennell, Regional Analyst

6. Danila Armstrong, Regional Public Health Specialist – Health Inequalities Lead

7. Gulab Singh, Central Lancs PCT, Cohesion lead

8. Mike Chambers, Head of partnerships, Government Office North West

9. Charlie Barker, Director of Social Services, Sefton LA

10. Mike Leaf, Director of Public Health, Blackburn with Darwen PCT (on secondment to North Lancs PCT as a consultant)

11. Eileen O'Meara, Asst Director Public Health, Halton & St Helens

12. Eustace De Sousa, Children & Families lead, NHS North West

13. Jude Stansfield, CSIP Public Mental Health Lead

14. Kate Adams, Age Concern

15. Jo Purcell, Heywood Middleton and Rochdale PCT

Apologies:

Paula Grey, Director of Public Health Liverpool

Jennie Popay, Lancaster University

Alison Giles, Director Our Life (regional public campaign)

Paul Greenwood, LiNKS lead, CSIP NWDC

Marie Duggan, consultant leading the regional investment for health regional strategy

Telephone Interviews

Dominic Harrison, Deputy Regional Director of Public Health

Ian MacArthur, Director Groundwork Trust (leading the regional BLF well-being portfolio)

Danila Armstrong, Regional Public Health Specialist – Health Inequalities Lead

Gulab Singh, Central Lancs PCT, Cohesion lead

Mike Chambers, Head of partnerships, Government Office North West

Charlie Barker, Director of Social Services, Sefton LA

Mike Leaf, Director of Public Health, Blackburn with Darwen PCT (on secondment to North Lancs PCT as a consultant)

Eustace De Sousa, Children & Families lead, NHS North West

Jennie Popay, Lancaster University

Paula Grey, Director of Public Health Liverpool

Alison Giles, Director Our Life (regional public campaign)

Thanks for additional material contributed by

Joe Monaghan, Liverpool Citizen Advocacy

Susan Ross-Turner, Ashworth Timebank

Ian Summerscales, Eden MIND