Chapter 2

Community Capacity Building and Social Policy: Health, Housing and Community Regeneration

by
Gary Craig, Professor of Social Justice, University of Hull, United Kingdom

This chapter examines the way in which the practice of community capacity building can be understood in the context of social development generally, and within the welfare sectors of housing, health and community regeneration particularly. Whilst the context of community capacity building varies from one sector to another, from the entrenched power of health professionals vis-à-vis *the "community" of health users to a longer history of debate within housing work, a range of common issues emerges from examining practice in these sectors. Drawing broadly on examples from OECD member countries in the three areas of social policy identified, this chapter explores these issues including the confusing use of language, the disparate power held by statutory partners as compared to the community when negotiating over building capacity, and a range of internal and external factors which promote, or impede, community capacity building.*

Introduction

This chapter focuses on the role that CCB plays in relation to social development, that is the development of social policies, and the contribution it could, and in some cases, does make. Three distinct but representative arenas of social policy, namely housing, health and community regeneration will be examined and the challenges and opportunities for CCB in these areas.

Before considering these three areas in depth, it is possible to summarise some of the core lessons which emerge from the following review of CCB within social policy programmes. First, the practice of CCB is clearly being applied in the three social policy contexts considered in this chapter. In some cases these policy contexts overlap. CCB is also being applied in other policy contexts, often in a holistic fashion. The evidence reviewed here suggests strongly that thinking, and organisational practice, is substantially more advanced in the social housing sector – where work on tenant participation has a long pedigree – and, to a lesser degree, in community regeneration work than it is in the health sector. In the latter, deeply engrained attitudes amongst health professionals, the individualisation of much healthcare and the impact of medical technology make CCB techniques to promote user involvement far less easy to adopt. Nevertheless, many of the dilemmas and tensions which can be identified are common to these three policy areas and to the practice of CCB more generally.

Secondly, the language of CCB, empowerment, participation, etc., is used loosely to cover a range of activities, many of which are not, in fact, being used to pursue "bottom-up" goals but reflect "top-down" government interventions. This means that the agenda of government departments, for example neighbourhood management and control, are driven through with little regard for the expressed interests or needs of local communities. At the same time, there is significant linguistic confusion which acts to obscure goals and methods. In some cases, government's use of the language of CCB results in the manipulation of communities and the co-option of local interests to government agendas, rather than their empowerment. Where communities do become organised effectively, government then often moves to regain control of processes.

Thirdly, the issue of power is crucial. Disparities of power between government and other statutory partners on the one hand, and local communities on the other, mean that communities are often structurally

disadvantaged when it comes to partnership working, to contesting control over resources, or deciding the ways in which those resources are to be used in CCB programmes. These disparities in power are particularly marked where communities are characterised by poverty, or disproportionately associated with marginalised or less powerful groups, such as black and minority ethnic groups, young people, or older people. In communities which have a very diverse demography, CCB faces increased difficulties and it is quite easy for government, or more powerful partners, to retain control of policy agendas. In the health context, the power of health professionals makes it even more difficult for user groups to determine agendas for change; indeed often they are not regarded as legitimate voices in policy and service debates at all. Many powerful partners seem unable to understand that CCB is not a zero sum game or that informed, knowledgeable, skilled and critical communities can make the development of policy and service delivery much more sensitive and, in the long run, more effective and indeed cost-efficient.

Fourthly, the evidence suggests that it is possible to identify clear external and internal factors which can promote or block the development of CCB. Positive internal factors include issues such as levels of leadership, knowledge, skills and real community control over resources. External blockages include the reluctance of powerful partners to cede control over resources, to take risks, to allow long developmental approaches to function properly, or even to take local community agendas seriously.

Finally, work is beginning to be undertaken to measure the effectiveness of CCB. This work is at an early stage, mirroring debates about the evaluation of community development work or empowerment more generally, but some projects and research studies have identified indicators of success which go beyond crude outputs to thinking about longer-term outcomes and impacts. In CCB also, the issue of process is critical as much community learning goes on through the process of CCB, or community development, and this learning is critical for ensuring that the gains of CCB are sustained over time.

Why is community capacity building relevant to social policy?

The relevance of community capacity building to social policy derives from interwoven strands of thought (Casswell, 2001). These include a growing distrust of the role of experts in central planning, an increased emphasis on the question of process rather than goals, an interest in the role of social capital and its relationship with social policy, and neo-liberal suspicion of central government intervention in people's lives all of which have contributed to the generation of community-based responses to social problems. Although community as a site of political action is problematic, because it often cannot address structural causes of communities' difficulties (CDPIIU, 1977b), "there

is widespread acknowledgment that, unless there is a capacity to identify and address social and health issues at the community level, central government's social policy initiatives will be ineffective" (DCLG, 2008).

Given the linguistic confusion surrounding the use of the term CCB it is important to identify those projects and examples which most closely accord to the definition of community development adopted by the Budapest Declaration (as outlined in the previous chapter). Furthermore, it is necessary to focus on the extent to which the work being examined can be said to support the development of skills, knowledge and other capacities in members of deprived communities to enable them to take greater control of their lives, particularly given that CCB is generally assumed to operate in relation to the most disadvantaged communities, including socially excluded communities, Black, minority ethnic and indigenous/First Nations groups (Chouhan and Lusane, 2004; CLES, 2002, Taylor, 2003; Rafelito and Wallerstein, 2004). Where "top-down" initiatives are involved, it will, conversely, be important to understand what the agendas of the relevant agencies are and how they accord with those of the communities whose capacity is said to be being built.

Whilst this review draws primarily on evidence from OECD countries, it is worth noting that the term CCB is now in use worldwide, despite the difficulties involved in translation from anglophone cultures to cultures based in other linguistic and political traditions. For example, it is used to describe reconstruction work in Cambodia, following the removal of the Khmer Rouge (White, 2006), and the encouragement of citizen participation in post-apartheid South Africa (Williams, 2006). In Mexico, a programme of rehabilitation for women in jail and their children is characterised as CCB: it "aims to enhance the comprehensive development of convicted women through training in economic activities, improves the living conditions of their children who live with them, and encourages family integration, with scholarships, psychological and health support for those who live outside."[1] Another Mexican CCB project is represented in the reformed planning system (COPLADEMUN) introduced in the municipality of Yecapixtla, close to Mexico City, where "community representatives have a major role in the decision-making process regarding local development". This process has replaced a moribund "top-down" planning system, encouraging local community participation in a range of planning procedures, including – through a participatory budgeting process – determining guidelines for the distribution of funds transferred from federal level to fund social infrastructure.

The role of government in community capacity building

For CCB, the policy context is extremely important; this will become clear when differing national and social policy contexts are examined. Frequently,

the language used can obscure what is actually happening on the ground. Many communities, which have been the object of "top-down" (*i.e.* government-driven) capacity building initiatives, experienced them as delivery of government agendas. This is far removed from the expressed views or needs of the communities themselves. Such criticism recurs frequently in this review of social policies. Programmes have also been delivered under "labels" other than CCB, and this variety of terminology has continued to expand. Thus, examples of CCB have been alternatively presented as:

- community engagement (Clear Plan UK, 2008);
- community empowerment (Clarke, 2005);
- community participation (Williams, 2006);
- community or popular involvement (Beaumont, 2003);
- civil renewal (Home Office, 2004);
- public participation (Burton, 2004);
- user participation (Simmons and Birchall, 2005);
- community building (Hughes, 2004);
- inclusive citizenship (Lister, 2007);
- developing community strengths (Skinner and Wilson, 2002);
- promoting community voice (Oakman and Smart Consultancy [Scotland] Ltd., 2007);
- community planning (Isaacs, 2006); and,
- community protest (Mooney and Fyfe, 2006).

Yet further descriptors have been used in the context of specific social policy areas. Whatever label is applied, it is important to focus on what, if any, sort of participation, is actually taking place. Arnstein's well-cited "ladder of participation" located differing forms of engagement between those holding power (governments, housing departments, health bodies and so on) and those who were the subject of policy interventions. The steps on the ladder of participation range from the least engaged, where communities might have no contact whatsoever with the processes of decision making that affect them, through forms of tokenistic participation, to joint forms of decision making and on up to situations where the community might have complete control over particular decisions (Arnstein, 1969). This remains a useful framework against which to judge forms of CCB-led participation.

Arguably, the term CCB has become distorted, particularly in its use by governments, as a result of programme goals which had little commitment to community empowerment, or even meaningful participation. This issue is particularly pertinent critical in relation to the most marginalised communities, such as indigenous peoples, Roma and gypsies. In these cases, many

governmental CCB approaches appeared to assume that such communities had no capacity of their own. From a general view of "indigenous community capacity building", Taylor (2003) argues that its meaning has indeed become corrupted and needs to be understood in the context of self-governance. Indeed, for Taylor CCB should be directed towards:

1. "more properly considered and more effective public policy;
2. [the] development of culturally appropriate and effective models of self-governance for indigenous … institutions;
3. greater potential for more indigenous peoples to have the capacity to influence positive change in their lives; and,
4. greater potential for [them] to expect and enjoy a better, healthier and more prosperous future."

There is, therefore, a need for those employing the term to commit to the legitimacy and primacy of community ownership, decision making and action, i.*e.* indigenous self-determination.

A concern is that much governmental language about community CCB, empowerment and so on now focuses on a version of empowerment which is about individual empowerment and the creation of "active citizenship" (DCLG, 2008) rather than about collective empowerment and developing the strengths of communities. This critique has been advanced strongly from a number of perspectives, including from the co-operative movement, for example, which argues from long historical experience that "as well as being 'members of a local community' people are in other roles – workers, tenants, users of financial services, which they can also be empowered to own and use through co-operation" (Co-operatives UK, 2008).

Despite criticism of governments hijacking the language and value base of CCB, there are those who argue that government can have a strong role in delivering CCB. Cavaye, reviewing the early CCB literature, recognises that government "top-down" approaches can limit community networks and self-reliance, overwhelm local organisations and leadership, lead working class groups into incorporation and impotence, and ravage existing social networks. He argues, nonetheless, that government needs to move beyond technical assistance programmes and traditional strategies of service and delivery, being well-placed to facilitate community capacity: indeed, "the processes of community engagement, partnership and facilitation could be considered as part of the 'service' provided by government" (Cavaye, 1998).

The next section examines CCB in a health context, where it is important to remember that health "communities" are not necessarily characterised by geographic proximity (although some small geographical communities may

relate to a single health provider) but in terms of the common relationship which health users have to health service providers.

The healthcare context: Major trends

Some general comments are appropriate regarding the political context in which healthcare is being delivered within OECD countries as a whole. The analysis below draws heavily on the UK policy context but the general trends and tensions reported, notably between public and private healthcare provision, apply within the healthcare systems of most OECD countries. First, across the "western" world, all welfare states have been under growing pressure to reduce public expenditure, particularly on what is often perceived to be non-productive welfare spending – housing, health, education and so on. This pressure has come from increasingly global economic market forces, the power of major corporations and the growing role of international agencies, such as the World Bank, which can influence national spending regimes, and will increase as a result of the current global fiscal crisis. The way in which governments respond to these pressures depends on a number of factors, including its ideological predisposition towards welfare provision as a whole, but "there is no consistent convergence towards a single model of state welfare support and no subsequent 'race to the bottom' to reduce commitments in the face of recent pressures of global economic change" (Alcock and Craig, 2009). Nevertheless, whilst the levelling down, predicted by many, is not happening, there remains severe downward pressure to contain public expenditure in most OECD countries. This often results in demands to outsource provision either to private agencies which claim to deliver public services at a cheaper price (claims often questionable in practice) or to the Third Sector, which purports both to deliver more cheaply and in a way which is more sensitive to health consumers' needs. Whilst some governments have resisted these pressures, at least in respect of health and education spending, there are indications that recent relative increases in spending in these areas may now be slowing substantially.

Secondly, whilst increased spending, where it has happened, has produced increased capacity in many health systems (notwithstanding widespread complaints that increased capacity has consisted rather more of health administrators and less of health professionals), it is often accompanied by a process of what governments have referred to as "modernisation", associated most strongly with "Third Way" social democratic governments (Secretary of State for Health, 1997). This modernisation process has been criticised as enhancing the tendency towards the scientific-bureaucratic model of medicine, with increased forms of clinical governance and "arm's-length" regulatory bodies, in such a way that ordinary health service users have had little direct opportunity to exercise "community" control over service delivery (Harrison,

2002). The UK government dismantled the strongest community health participation mechanism – the community health council – replacing it with weaker patient advisory, liaison and involvement structures, which have been considered to be little more than a token form of public involvement (Callaghan and Wistow, 2002; Callaghan and Wistow, 2006).

Thirdly, and contradictorily, there has been increased demand for "user involvement" in healthcare delivery, such as through the organisation of groups of service users. These organisations participate in the planning or even the management of health services. In part this pressure has arisen in response to increased awareness, including within governments, concerned at falling levels of voting and of reported levels of trust in government, of what is called the democratic deficit and the need for mechanisms and structures which could enhance active citizenship and democratic life. Within the context of health services, this has been characterised by a process of formal consultation which appears to place government in a more "listening" mode (Department of Health, 2001). Within the New Zealand context, this is described as re-territorialising health governance, where there is also recognition of the need for greater user ("community") input and for development work to support its expression (Craig, 2005). From governments' point of view, the need for "user involvement" has been accepted in many quarters as leading to improved trust and communication, thus reducing levels of conflict and discord, "smoothing" the process of implementation (Simmons and Birchall, 2005). This stance is viewed cynically by many commentators as "a technology of legitimation" (Harrison and Mort, 1998; Harrison, Dowswell and Milewa, 2002). It is a highly managed means for co-opting service users (through careful structuring of panels, public consultative processes, advisory groups with constrained roles and limited access to information) into a policy process which is still driven "top-down" by government, or by its health service bureaucrats, to legitimate management decisions, rather than responding openly to the demands of service users. However, the results reported by the evaluations of many initiatives in this field, for example of the UK government's recent Health Action Zones programmes (Albert *et al.,* 2000), do little to challenge the feeling of mistrust which, ironically, results from these recent government experiments in participation and involvement.

Addressing the needs of the underserved

Arguably, the traditional model of public policy making has done little for the underserved and most disadvantaged communities. In relation to health issues, communities need to exercise more control over the policy-making process and policy makers need to learn how to work with communities more effectively. Without this, social policies ultimately will fail. In relation to health inequalities in particular, the Aspen Institute argues that CCB is essential for

tackling the root causes of health disparities. Citing troubling socio-economic indicators, including racial discrimination in housing, poor schools and educational achievement, within and between neighbourhoods in the USA, it notes that many public health practitioners have failed to generate "progress in core health measures for our most socially, politically and economically marginalised populations … [because] … public health has still ignored issues of power and its skewed distribution through society" (Iton, 2006). CCB, with an emphasis on empowerment of deprived communities, can bring these public health practitioners face-to-face with these power disparities. Indeed, the question of disparities in power between government and communities is a recurring theme in the social policy literature. In this sense, public health is a social justice enterprise.

It is worth noting that in many countries where market solutions to social and economic difficulties have been prioritised, this has led to widening health inequalities both in terms of health outcomes and access to health services. As the Irish Combat Poverty Agency notes, "inequalities in health are often compounded by inequalities in access to healthcare" (Crowley, 2005). Capacity building in relation to health issues can be seen as an important contributor to a wider attack on inequality. In these cases, community participation in health programmes is one means by which the health and well being of people in disadvantaged communities can be improved. In the UK, a series of briefing papers produced by the Race Equality Foundation has shown how minority ethnic groups suffer poor health outcomes and how these communities can be supported through community development approaches to improve these outcomes (Chau, 2008).

CCB has been a popular mode of intervention to underpin work on health promotion. One review argues that CCB "is part of a long-standing health promotion tradition involving community action in health promotion" (Raeburn *et al*., 2006). This analyses a range of health initiatives, arguing that the term community development should be retained where the development of competencies and a stress on social relationships are given equal weighting in health promotion work. It contrasts the notions of empowerment and "bottom-up" development to the common (clinical) medical approaches situated within paradigms of disease and deficiency and reviews attempts to "break down CCB into operational components". The variety of contexts studied include work to combat river blindness in Nigeria, participatory budgeting in Brazil, community health development in rural Honduras, community well-being Community Houses in New Zealand, and the development of sustainable agriculture in Thailand. A second review supports this position, suggesting that CCB occupies the same "social space" as community development, community empowerment, social capital and social cohesion, which all describe "elements of people's day-to-day relationships, conditioned and constrained by economic

and political practices, that are important determinants of the quality of their lives, and of communities' health functioning" (Labonte and Laverack, 2001a). CCB is said to be important in the context of health promotion as both means (processes) and ends (outcomes).

Given that health is one of the most basic human rights, it is not surprising to find that many development projects in the south (so-called "developing" countries) are focused around health issues. Typically, these are badged as capacity building for health promotion and usually focus on building the capacity of communities where health indicators are poor although, capacity building sometimes is used to apply to the goal of building the capacity of organisations to deliver health services. The most radical CCB approach – like the structural analysis underlying community development – challenges the pathological model of poverty and deprivation, arguing that inequalities are overwhelmingly the result of structural and systemic factors, rather than of individual malfunctioning. Similarly, in the health context, most authors argue that CCB addresses structurally-generated inequalities in health outcomes (BC Healthy Communities, 2006): this challenges those (usually clinicians) who work from a position shaped by the notions of disease, and individual and community deficiency. Again caution is necessary in relation to language. Many health programmes are badged as having a community development orientation but are predominantly "top-down" health interventions.

As noted, the CCB approach also lends itself to viewing communities holistically, with different sectoral issues intertwined; this tends to mean that the strongest examples of CCB in health are to be found in the primary healthcare sector where interventions can be made at the community level, typically to respond to poor health conditions in deprived communities. A UK project, whilst focused primarily on housing conditions, also undertakes CCB in both regeneration work and in health promotion, working with local residents to develop healthy lifestyles.[2] Another cross-sectoral project involves a public health advocacy campaign emerging from transportation concerns. Here, the local community was concerned about increased volumes of heavy industrial traffic through a small western Australian city. Immediate issues related to traffic accidents, road congestion, noise and atmospheric pollution. A community alliance campaigned through public meetings, petitions, fact sheets and other techniques for goods to be carried by rail instead of road. As a result, some companies shifted their traffic to rail and a feasibility study was initiated for an inland port (Gomm *et al.*, 2006).

Enabling user involvement

The issue of choice and user involvement in decision making has become the subject of fierce political debate about the delivery of healthcare (and other services). However, this consistently overlooks the fact that real choices

are limited for most healthcare users. "The more services become personalised, the more public resources will have to be skewed towards the less well-off, in order to equalise opportunities" (Craig, 2003a). Alongside this critique, a wider analysis of "top-down" CCB in the context of cuts in public expenditure has been reasserted in relation to health and other public services, that "community capacity building and empowerment has been particularly valued, from a market-orientated perspective, for its potential contribution to enhanced cost-effectiveness, promoting economic development and filling the potential gaps that might otherwise emerge in the provision of services as the local state has been rolled back" (Mayo and Anastacio, 1999). In short, privatisation is in conflict with the goals of CCB. Other commentators echo the critique of the hijacking of the CCB agenda by governments, suggesting that, in both health and other policy areas, whilst local activists have made some gains in shaping national policy and in the creation of local services more responsive to the health needs of particularly marginalised communities, they are open to co-option and manipulation by government (Bridgen, 2004).

Policy context is particularly significant in understanding the role of capacity building in healthcare. This covers not only care within the acute sector (*i.e.* in hospitals), but also in community settings (delivered by government or privately funded primary healthcare professionals such as community physicians, midwives and nurses), in so-called community or social care programmes, in public health programmes, or in residential and nursing care settings. Clearly, this encompasses differing population groups, such as older people, young people, children, women, people with disabilities, people with mental health difficulties, those from minorities, and indigenous groups. The language deployed may again be confusing: those using health services are variously referred to as users or service users, patients, health consumers or simply consumers. Here, the term "service user" covers all these formulations. However, it is important to note that the term "users" may also cover a range of different perspectives and levels of involvement in decision making. For example, Beresford and Croft distinguish between "consumerism" and "democracy", between the question of an individual health user's needs and those of health users as a "community":

- Users as consumers – focus on matters such as information about services, market research, needs assessment, evaluation of services, complaints procedures and so forth.
- Users as citizens – focus on participation and representation in formal and informal decision making (Beresford and Croft, 1993).

In part, user involvement/participation in health services has come about as a result of political struggle by service users, such as mental health users, those with disabilities, and older people, whose needs have historically been

marginalised within healthcare systems. These have now formed effective "bottom-up" organisations demanding equal rights, including access to healthcare and representation in shaping policy and practice, with the wider constituency of service users. Such groups, often building highly effective alliances and partnerships (Baggott, Allsop and Jones, 2004) with other groups of service users and with sympathetic health professionals, have also rejected the notion of individual choice as simply favouring the better-off, arguing that the needs of their whole constituency have to be addressed. These groups have "placed questions of inequality and power at the centre of [their] analysis of the distribution of resources in the health field, and sought to enhance local social and political relationships to improve the access of the least advantaged to these resources" (Young, 2000). In their view, the struggle to make health services sensitive to the needs of its most marginalised users, and the process of capacity building which facilitates that struggle – critically a "bottom-up" process – is every bit as important as the wider struggle to make health services more accountable to its users as a whole (Beresford, 2001).

In the territory of health, however, this becomes particularly problematic because of the power vested in medical professionals, particularly clinicians, and of their resistance to perspectives on health which are more socially, rather than medically-oriented. Achieving change is also particularly difficult within more institutionalised forms of healthcare – such as hospitals and residential care settings – where professionals' power is most marked. Hardly surprisingly, most of the accounts of effective CCB are therefore reported from "community" settings outside formal institutional settings.

The professional ideology, particularly pertinent, though not exclusive, to the practice of clinical medicine, has been the focus of increasing challenges over the past twenty years. Such challenges have been associated with the growth of the disability movement which has sought to establish an emancipatory account of disability (Oliver, 1990; Campbell and Oliver, 1996; Barker and Peck, 1996; Priestley, 2002; Beresford, Harrison and Wilson, 2002; Drake, 2002; Barnes and Mercer, 2003) rather than one which colludes in wider attempts by the state to regulate individual behaviour (Foucault, 1977). Examples of the struggles of such groups are now common in the literature and demonstrate that, even in the most difficult of circumstances, self-help groups have managed to build the capacity to challenge their marginalisation in health systems. Arguing not only for more sensitive and more responsive forms of service delivery but also taking on the most difficult and demanding roles in relation to health service delivery and in a wide range of health settings (Wistow, 2002; Kendall and Harker, 2002). A number of examples are shown in Boxes 2.1 and 2.2.

Box 2.1. **Health users taking control: Mental health work through different approaches**

- A mental health forum in the UK, challenged both forms of service treatment and broader understandings of the origins and nature of mental distress (Hodge, 2005). Professionals in the forum refused to accept that these were legitimate areas for discussion within a forum involving mental health service users, their opposition serving "ultimately to reinforce existing institutionally-defined power relations" (Hodge, 2005).
- A Canadian mental health promotion forum which, responding to youth suicide, developed a community helpers programme. This programme also argued that community capacity relates to the assets that already exist within a community and that "communities are never built from the top down or outside in" (Kretzman and McKnight, 1993). The programme emerged from the suicides of four young people, in rapid succession, and sought, by means of community development techniques, to create a network of community helpers, including peers of the young people themselves, to be available as trained mentors for other young people. Funding was secured from the municipality, and from provincial and other sources (Health Canada, 2003).
- One project in the UK sought to involve mental health service users in quality assurance. Service users at a day centre were involved in two types of quality inspection, one involving a traditional inspection-type event, the other an inclusive collaborative process two years later. Users were involved in the process from the outset and, for example, in the construction of a questionnaire in the second mode. The comparison between the two demonstrated how alienated users felt from the first event which was seen as simply satisfying regulatory processes with a report to the Management Board, whereas the second led to a much lengthier process and a wider range of outcomes including enhanced confidence and self-esteem amongst the users (Weinstein, 2006).
- The UK government recently developed a programme for the employment of community development workers specifically to work on issues of mental health with Black and minority ethnic communities. The programme will employ up to about 600 community development workers in a variety of settings (including by local authorities and Third Sector agencies) and with differing minority groups, dependent on the local context.* These build on the experience of a limited range of projects which have attempted to "hear the voices" of service users from Black and minority ethnic backgrounds and to build their capacity to argue their own case (Nazroo, 2006; Johnson, 1998).

* For further information see *www.newwaysofworking.org.uk*

Box 2.2. **Health users taking control: Community health issues tackled in different ways**

- Older people have been involved in the UK in health and social care projects aimed at shaping policy and practice. Brought in from the start of many projects, one participant commented that "you've invited us in before you've set the goalposts". They also acted as researchers, interviewers and members of advisory groups, challenging the two opposing models of older people either as passive recipients of services or as heroic people competing with younger ones. Here, major barriers to older people participating effectively, apart from their own physical and, at times, psychosocial limitations, were widespread external perceptions of them as vulnerable, burdensome and a problem to be solved rather than the source of experience, creativity and knowledge, and the consequent lack of resources committed to enabling them to participate more fully in developing policy and services for themselves (JRF, 2004; Hardy, Young and Wistow, 2001).
- In a project which spans issues to do with both housing and health, Keyring (UK) builds mini-communities or networks of people with learning disabilities and supports them with structures and processes that help people make the best of their own abilities, share these skills and build links with the local community. The model is seen as a modern "take" on the good neighbour concept. But, it is a high risk strategy for people who are still suffering the effects of long-term institutionalisation. It is regarded by many as a model of good practice for the integration of some of the most excluded people back into community life: it obviously raises questions about the meaning attached to "community" in this context but project staff define their work as capacity building amongst their community of users (*www.keyring.org*).
- A project in a deprived multi-ethnic inner city area in Mexico sought to build capacity amongst older people. This used the techniques of health promotion, including spectacular events, visuals and narrative as ways to provide information, thus increasing health awareness and ownership, with projects (such as a Diabetes Fair) focused on specific ailments or population groups, and events targeted at specific minorities. The project has placed substantial emphasis on continuous outreach work and encourages relationships between professionals and "patients" to foster patient expertise. A variant on this is the work of some London Libraries which, through a "Skilled for Health" training programme, developed courses for people with poor language, literacy or numeracy skills who were likely to be at risk of poor health, from within the relatively "safety" of local libraries (MLA, 2008).

Box 2.2. **Health users taking control: Community health issues tackled in different ways** *(cont.)*

- Research into young people's participation in decision making around road safety issues in an inner city area in the UK with a high rate of deaths and injuries from road traffic accidents found that early involvement of young people in engineering plans for their local community, led to a substantial reduction in accidents. Young people, however, supported by community development workers operating within the framework of the UN Convention on the Rights of the Child (1989) experienced severe barriers to their participation including most of all the attitudes and working practices of adults and their rigid adherence to processes and practices which were alienating for young people (Kimberlee, 2008).
- In Scotland, which has very poor health indicators, a series of projects has been established to tackle health inequalities from community bases. Typical of these are projects in Dundee and North Lanarkshire, created from an identification of needs by local community groups (*www.chex.org.uk*). One community health programme links housing conditions and health outcomes in 14 different Glasgow communities. This is a research and learning programme, investigating the impact of investment in housing, regeneration and neighbourhood renewal on the health and well being of individuals, families and communities over a ten year period. This was originally a "top-down" initiative, driven by a partnership body at a high level of governance, but there is increasing local consultation in the communities studied which are both shaping health policy agendas and providing important lessons for external partners on how to make best use of community engagement (*www.gowellonline.com*).

Development of indicators

The most prominent transnational programme building community capacity in a health context has been the Healthy Cities Initiative (HCI), established in 1986 by the World Health Organisation. It has since become an international movement with several thousand communities, health users within defined geographical contexts, participating worldwide. The most challenging methodological issues have concerned how indicators of improvement can be assessed and how local communities themselves can be engaged in determining these indicators. One review of HCI argues that the best forms of evaluation have emerged where the knowledge and skills of local communities and those of external evaluators have been combined, through negotiation, to define the process of evaluation. Throughout the development of the movement, evaluation has thus moved away from using a proscribed

"top-down" set of (often quantitative) indicators, which at one point numbered several hundred, and has moved towards more qualitative measures, including an understanding of process, and of the nature of empowerment. In turn, this led to the development of toolkits and guidebooks enabling local communities to self-evaluate their own HCIs (O'Neill and Simard, 2006).

This links to more general debates about the evaluation of community development which privilege a focus on qualitative measures, process and outcomes, rather than quantitative measures alone, usually expressed as inputs, targets and outputs. It situates the measurement of empowerment, or the evaluation of community development as much a political task, about control of agendas defining needs and resources, as it is a technological one (Littlejohns and Thompson, 2001; Carr, 2007; Health Promotion Clearing House, n.d.). The search for appropriate indicators of health outcomes, and appropriate methods for defining them in a CCB context remains key. It is essentially a political struggle for control of ideas and processes between those delivering services and those receiving them, *i.e.* a struggle about who defines needs and how they are met.

Several studies have reported results from investigations into the development of appropriate measures of community capacity (Maclellan-Wright *et al.*, 2007) such as the development of community indicators in a Healthy Communities Initiative in Canada (Smith *et al.*, 2008). If, as has been asserted, community capacity is essentially a measure of the assets which a community has (but is perhaps not exploiting), then these measures can be helpful in establishing what kind of developmental intervention might be helpful to build a "healthy" community (Hounslow, 2002). In one study, formal Healthy Communities Initiative indicators were rejected by communities as of no relevance to their situations, preferring instead to develop measures of success which were informal or experiential in nature. This underlines the need for CCB initiatives to engage with communities from the outset, including around the development of measures of success, according with the development of evaluative tools for community development work more generally (Craig, 2003b).

Country case studies

The United Kingdom

A number of national and transnational programmes have been established which have involved work targeted at deprived communities within cities or indeed at cities themselves, and which have had CCB or community development as explicit methods built into their programmatic frameworks. An example of the former is the Health Action Zone (HAZ) programme initiated by the UK government in 1997, to both modernise healthcare and reduce health inequalities in the most disadvantaged areas of England (usually discrete sub-

areas within specific urban settings). Most of the 26 individual HAZ programmes employed community health or community development workers. An evaluation of this work suggested that "community engagement was a key feature of the new ways of working that were developed and which started to contribute to improved health among those engage in health initiatives [and that] the experiential knowledge of community members was an important contribution to designing projects and developing strategies in many instances" (Bauld *et al.*, 2005). Ironically the programme was overtaken by a wider commitment from the UK government to address social exclusion in a more holistic way and the HAZ programme was terminated early. Although some activity survived the closure of the HAZ programme, much of the CCB work was flawed by a lack of community ownership, and it is widely seen as a lost opportunity for large-scale community-based action around healthcare delivery. Indeed, it has long been noted that government sponsorship of community development programmes has been associated with tensions about goals and ownership which has led on occasions to their closure or curtailment (Craig, 1989).

Although recent major planning and political documents regarding the UK NHS have stressed the need for a more patient-centred approach, "the government's policies in this area often appear contradictory and confusing" (Calman, Hunter and May, 2004). There is considerable doubt as to whether service user participation in many of the consultative fora into which they have been drawn have actually affected the quality and sensitivity of services as seen from their perspective (Carr, 2004). A review of service user participation observes, typically, that:

> The lack of organisational responsiveness and political commitment [from government and its health and social care agencies] is a critical issue. Difficulties with power relations were found to underlie the majority of identified problems with effective user-led change. Exclusionary structures, institutional practices and professional attitudes can affect the extent to which service users can influence change … power sharing can be difficult within established mainstream structures, formal consultation mechanisms and traditional ideologies (Carr, 2007).

This criticism is repeated in relation to the promotion of community involvement in other social programmes. Other research has shown how some health professionals have attempted to "reconceptualise the user in ways that draw on developments in professional conceptions of best practice, that respond to some of the challenges of user movements, and that acknowledge the need for legitimacy in the eyes of [individual] patients and [user] community" (Newman and Vidler, 2006).

Canada

Canadian experience also provides an interesting microcosm of the way in which contestations over the nature of CCB are emerging in the health literature. Health Canada commissioned-research analysed CCB "trends, identified issues and gaps and provided practice guidelines … to inform policy decisions related to community capacity building" (Crilly, 2003). This examined work with older people, and the development of early childhood health, concluding not only that there are no currently universally accepted definitions, processes or evaluation indicators for CCB, but that terminology was used inconsistently and often incorrectly (with practice often running counter to it). At the same time, reflecting how the term *is* used widely in Canadian health contexts, a Canadian community development organisation has produced guidance on aspects of CCB for health workers (Health Promotion Clearing House, n.d.). This includes a range of indicators to help with capacity building in health promotion and for measuring community capacity.

There is predictably a substantial literature describing CCB work with disadvantaged communities, including First Nations groups. Examples of this include the development of an interactive epidemiological manual specific to HIV/AIDs in conjunction with Canadian Aboriginal groups, to assist Aboriginal leaders in using HIV/AIDs epidemiology and surveillance data. Here, Aboriginal groups (First Nations, Inuit and Metis) helped to develop the manual which was then disseminated to workers and Aboriginal groups across Canada for use in HIV/AIDs prevention and health advocacy work (Albert *et al.*, 2000).

Australasia

In Australia, workers have developed programmes to tackle environmental health issues including rodent infestation, rubbish tipping, water quality monitoring and personal hygiene issues amongst indigenous Australians. Environmental health workers have adopted a new (for them) approach involving working in "bottom-up" partnerships with indigenous communities, seeking continuous input from them, maintaining good communication and networking and providing technical support and advice where necessary. The team also attempts to work laterally with other agencies, regarding work with these communities as everyone's responsibility (Australian Government, 2004). Similar work in New Zealand/Aotearoa with Maori groups acknowledges that the strong holistic relationship which Maori groups have with their environment may be undermined when the health promotion system is driven by "western" approaches and workforces oriented towards a fragmented approach to health protection. A scholarship and development programme has been initiated to ensure that more Maori public health workers can be employed in environmental health promotion work (Poole, 1997).

Rural populations have had great difficulty in accessing services of any kind, a difficulty exacerbated by recent tendencies in many countries to centralise the provision of many healthcare services. This problem is being addressed in Victoria, Australia, by a CCB programme which specifically aims to strengthen the ability of rural communities to access health funding. This programme works through targeting specific rural communities, developing an information kit, running workshops on funding bids, facilitating community consultations and providing ongoing support for local communities. The outcomes have been successful in generating funding for a range of new primary care posts and projects, including health promotion on diabetes and cardiovascular disease, injury prevention programmes, counselling and physiotherapy. As well as increasing the critical mass of primary healthcare staff and improving connections between them and local communities, the communities themselves, despite continuing difficulties, feel more in control of their own health agendas (McDonald, Brown and Murphy, 2002).

Women's Health Victoria (Australia) pursues CCB strategies for health promotion, working by both building its own organisational capacity (managing the statewide clearing house of women's health information) and the capacity of other groups, ensuring a strong gender dimension, through public forums, health advocacy, skills development and information resource development (*www.whv.org.au/capacity_building.htm*). The promotion of health services in south-eastern Sydney, New South Wales, has involved interventions such as the provision of small seeding grants; outreach staff working with parents to improve dental health in children; and tobacco cessation projects amongst indigenous communities. This project noted that because much of this work was invisible (as is often the way with community development interventions) it had not been officially recognised as significant. Appropriate outcome indicators would help in this process of gaining recognition (*www.health.nsw.gov.au*).

This has been echoed in other research, including from Finland. Community organisations noted that their work, even where it was not focused on health, "had a positive impact on the health and well-being of people living in the municipalities" (Simonsen-Rehn *et al.*, 2006). One way, this study argued, to conceptualise the ability to act is by examining the nature of community capacity. In line with other studies, they analysed a range of perspectives, concluding that the key dimensions of community capacity were to do with values, competencies, opportunities and municipality – the latter referring to the local (socio-political) context and thus to barriers which might obstruct participation. A wider range of dimensions of community capacity – participation, leadership, skills, values, resources, history, networks and sense of community – has also been identified (Goodman *et al.*, 1998).

Housing policy: A long history of community involvement

Definition and history of social housing

A common definition of social housing would be difficult to identify across the OECD, or even within just Europe as a whole. From the perspective of providers, social housing refers to the intervention of public authorities in providing and owning stock, and the existence of allocation procedures. From the perspective of those who occupy the housing, the key characteristic is generally their inability to be otherwise housed appropriately at a decent standard within the private market. Of central importance is therefore the nature of the relationship between often large bureaucratic housing providers and individual tenants, who have, historically, typically formed tenants' organisations to press for improvements of one kind or another. Whilst social housing has increasingly become stigmatised because owner-occupation has ideologically been defined as the "normal" housing tenure, it has a significant economic function, a point recently emphasised by the European Commission.[3] Social housing is associated not just with campaigns for improving the physical state of housing, but also with levels of social support for more vulnerable populations which private market provision regards as unprofitable. It also has a significant social function in the sense that it is often seen, at least rhetorically, as promoting the cohesion and integration of the most socially excluded. The literature reflects that state-sponsored social housing has had a much more prominent role within the UK historically than elsewhere.

Autonomous organisation and activity amongst tenants has a very long and often colourful pedigree; for example, during the First World War, tenants of private sector housing in Scotland and elsewhere campaigned against profiteering landlords at a time when many families were financially hard-pressed with the male breadwinner fighting away from home (Melling, 1983). These strikes led for the first time to rent control in the UK private sector. However, the focus for most tenant activity and capacity building has been within the public sector (including new and overspill towns built after the Second World War in many European countries to replace damaged, destroyed or dilapidated inner city housing of older urban areas). The government or local government-built and owned sector (and the social housing sector more widely, into which much public sector housing was later transferred) emerged as a significant housing provider throughout the twentieth century. The peak period for social housing was from the end of the First World War to the 1970s.

As community development emerged as a distinct practice in the post-Second World War period, it also largely focused on housing issues, helping to build tenants organisations which went on to agitate for improved building standards, repairs, maintenance and facilities, often creating federal bodies at local, regional and even national levels. The UK provides a good example of

these sorts of developments with squatting campaigns which occupied empty houses at a time of housing shortages in the late 1940s, the creation of the Association of London Housing Estates in 1957 (Craig, 1989), a huge range of tenant activity during the 1960s and 1970s as governments sought the marketisation of rent levels in the public sector, and the creation of a National Tenants Organisation (now known as TAROE) from the late 1970s onwards. In the late 1970s, the UK government published a handbook, *Getting Tenants Involved*, which argued for greater levels of tenant participation: this gave a boost to the number of tenant participation schemes, although the extent to which tenants were enabled fully to participate in key policy decisions remained questionable.

Recent trends in social housing

The proportion of so-called "council housing" relative to owner-occupied housing has been variable between differing countries. The UK had one of the highest levels of public sector housing[4] until the period from the 1980s when right-wing governments substantially reduced the level of public sector housing, by individual sell-offs, large-scale stock transfer to quasi-private companies, a moratorium on the building of social housing, and shifting government from a role as housing provider to housing enabler. Many tenants' campaigns around this period were in opposition to these trends (Mooney and Poole, 2005) and to the fact that the most vulnerable tenants may suffer disproportionately from the marketisation and commodification of housing. In many countries, the effects of these attacks on social housing have been to increase rents at a rate beyond the general rate of inflation. This led many tenants to experience difficulties, including affordability. In some western Europe countries, the recent crisis of affordability and availability of housing, has led to suggestions that social housing may now again have an enhanced role (Hills, 2007). This trend may be further accelerated by the impact of the worldwide credit crunch.

At the same time, there has been a growth in the number and variety of housing associations catering for specific population groups, including older people, people with disabilities and people from minority groups. Increasingly, housing associations are also addressing the housing needs of low-paid workers, such as key-workers (nurses, teachers, etc.), who have difficulty in accessing housing because of the pressure on house prices. Many of these are relatively small organisations, often with some degree of self-management. Within the general housing association movement, the growth of housing co-operatives has been important. Co-operatives, as legal associations formed for the purpose of providing housing to its members, who own and control them, require considerable levels of capacity amongst the "communities" which run them. The co-operative movement as a whole emerged in the early 19th century as a direct response to the detrimental impact of industrialisation both on workplaces and living conditions. It can be argued that housing co-operatives –

at their best – embody the principles of community engagement and even empowerment (Co-operatives UK, 2008) promoted by many governments. Some housing co-operatives argue that they offer opportunities for capacity building which may be key to the regeneration of cities (CHIBAH, 2006).

As social housing has increasingly tended to become the preserve of poorer and, not infrequently, less skilled or organised tenants, this has undercut their ability to maintain community organisations, with the sector as a whole becoming more stigmatised as a residual sector (Priemus and Dieleman, 2002). One common response to this has been to argue for the dispersal, rather than concentration of social housing tenants, to provide housing schemes with a social mix in terms of class, income and occupation. A range of case studies have been assembled in support of this argument, from across Europe, including Hungary, Scotland and Norway (Holt-Jensen, 2002). In Finland, a scheme to build non-profit rental housing has also focused on the need to ensure that there is a sustainable mix of tenants. Whilst it takes as tenants people with various difficulties, such as the homeless, it seeks also to ensure that there is always a balance within the scheme as a whole to avoid the unfavourable tendency to segregation (*www.syfo.fi*). The scheme is also structured to provide ongoing support for vulnerable tenants. The difficulty with this approach in relation to CCB is that the tenure mix also leads to the possibility of a fragmented community, with differing levels of apparent commitment to improvement programmes, making it much more difficult to adopt conventional community organising techniques.

Another aspect of the trend towards social "mixing" is reflected in the tendency towards the creation of "difficult-to-let" estates (as better housing has been sold off), increasingly filled by housing professionals with vulnerable people (those with criminal records, the homeless, drug takers, people with learning disabilities, etc.) who have little bargaining power in the housing marketplace (Allen and Sprigings, 2001). This poses particular difficulties for CCB but there is evidence of the ability to organise some of these most vulnerable people to participate in housing (and other) service delivery issues. In Denmark, a national interest organisation of homeless people has been formed after several years work at local and then national levels using a variety of techniques including radio projects, reach out work and fieldwork at night shelters. This organisation defines itself not as a protest organisation but as one which is concerned with self-help and voluntary work. It nevertheless has had considerable impact on social policy. A review of its work (Anker, 2008) argues that the general facilitative institutional framework in Denmark responds fairly openly to interest groups. Built on this growing interest in participatory practices more generally, and the support of progressive professionals, this has enhanced the prospect of the organisation surviving and having some effect. This might not have happened, it is argued, in a political context which

was more confrontational. These examples all demonstrate the need for CCB work in social housing schemes to adopt an increasingly more nuanced approach, recognising the disparate needs of a variety of population groups.

Examples of tenant participation

It is not possible to summarise this vast historical experience of participation in housing here (Melling, 1983; Merritt, 1979; Cooper and Hawtin, 1997; Goodlad, 2001; Shapley, 2008). Therefore more recent experiences will be briefly reviewed but it is important to see this in the context of more than one hundred years of tenant struggles for control over their housing conditions, a struggle which has now become institutionalised to a degree far greater than in the corresponding area of health. In many countries, the right of tenants to create organisations and to participate in policy debates about housing conditions is now in fact recognised as a basic right and government itself funds many tenants' organisations or research into their conditions.[5] For example, Scottish research (Communities Scotland, 2008) sought to assess the extent to which landlords have increased the opportunity for tenants to influence the decisions they take, under the terms of permissive legislation. Landlords appear to have taken a more formal approach to tenant participation but much more needs to be done to demonstrate clear policy influence (National Assembly for Wales, 2001). The formal interest of government brings with it the familiar fear that the agenda of tenants groups may be co-opted by government; and many commentators have challenged the commitment of governments to support meaningful participation (Somerville, 2004).

Tenant participation is "becoming an almost ubiquitous feature of the planning and provision of social housing [where] a range of opportunities has been (and is being) created by and for tenants to participate in the planning, provision and evaluation of housing services" (Simmons and Birchall, 2007). There remains, however, a perennial problem in getting more than a small core of tenants to participate, an issue which is also reviewed in the context of regeneration. Simmons and Birchall (2007) analyse the different forms which tenant participation has taken in the past years, focussing in particular on tenants associations, historically the most common form of organisation. They see the role of such organisations as "a bulwark against either the perceived paternalism or perceived commercialism of their social landlord". Less common, but of increasing importance have been tenant management organisations, which have taken on devolved powers from their landlords for certain budgetary and management functions. Other research cites key factors promoting tenant participation; these are when providers:

- "accept tenants as both equals and a valuable resource right from the start;
- develop with tenants a structure of decision making;

- ensure that tenants have the time they need for consultation and discussion within the community;
- give tenants accurate and honest information, and ensure that everything is made clear …; and,
- fund the tenants" (Kelly and Clarke, 1997).

Both in terms of ideological stance and the preparedness to make resources available to tenants, few social landlords match this overall standard. Thinking about why tenants themselves want to participate, it is important to distinguish between broader agitational issues and more everyday activities such as improving services and facilities; and writers suggest participation can be motivated by three variables – shared goals, values and a sense of community. Resources, including time, can be critical; "working at different links" in what Kelly and Clarke call the "Participation Chain" – a detailed framework for understanding what makes individual tenants participate – can highlight factors affecting whether or not tenants participate.

The United Kingdom

Reflecting the long history of social housing in the UK, an infrastructure has developed to support tenant participation. There are now national experienced arm's-length bodies which provide support and advice to tenants' organisations such as the Tenant Information Service (*www.tis.org.uk*) and the Tenant Participation Advisory Service (*www.tpasscotland.org.uk*). As a further example of how tenant participation has become incorporated into formal housing policy structures, the UK Chartered Institute of Housing, which regulates qualifications for housing officers, includes a module on tenant participation in professional training. The UK government has also invested in an "innovative and practical capacity building programme of residential training linked to follow-up small grants, for social housing tenants" (Beck and Richardson, 2004). This concluded that there would be a continuing need for funding to support tenant participation and CCB and that housing was often the starting point for much organised activity in low income areas. The programme took place at a venue, Trafford Hall, which had been created specifically to provide training for social housing tenants, which is partly funded by the government and offers support to those working in low-income communities. In the UK, the recent establishment of National Tenant Voice, a government-funded body which aims to represent tenants interests at a national level, is moving in the same direction but has yet to establish a firm reputation for independence. Alongside a potential government commitment to building enhanced levels of social housing, this may enhance both the power of tenants in decision making at a national level, and challenge the marginalised status of social housing.

Another analysis of approaches to tenant participation (Hickman, 2006) identified three major local authority responses which have evolved in the English context: traditional, consumer and citizenship, the latter involving the empowerment of tenants. It was suggested that most local authorities were committed to the traditional approach to tenant participation. Local councils essentially remained in control of power in their relationships with tenants, even to the point of determining which questions were to be asked at public meetings. An increasing number (perhaps a majority by the late 1990s) were pursuing the consumerist approach, wherein the local authority's relationship with (individual) tenants focused on the delivery of services. Only a very small minority were concerned to pursue the citizenship or empowering approach and, even here, landlords appeared to want to retain control over the participation process. A very fluid and dynamic policy context has meant that the issue of participation has become much more complex. Nevertheless there remains little evidence of the willingness of social landlords to encourage full-scale participation of the kind outlined above. Despite years of legislation, and of campaigning by tenants, the level of *strategic* tenant participation has changed little. Most tenant consultation and participation throughout the 20th century is characterised by a "top-down" approach with "little meaningful reference to the tenant" (McDonald, Brown and Murphy, 2002).

The dismantling of the social housing sector has led to both enhanced campaigns from tenants for its protection but also an undermining of the sense of solidarity amongst tenants. Capacity building amongst remaining tenants has thus faced increasing difficulties. Housing Action Trusts (HATs) were essentially a UK form of regeneration, but targeted on deprived social housing areas at a time when central and local government were in conflict. The Trusts were seen by many as a means by which right-wing governments attempted to undermine the ideology of social housing by transferring, with the support of private sector finance, ownership of large housing estates to individual tenants. In many areas, tenants actively campaigned against transfer to the private sector, forcing government to create mechanisms for tenant involvement in the process of regenerating the estates and for ongoing involvement in advisory or management boards. In some HATs, a fully-fledged community development team was appointed to work with tenants. Nevertheless, familiar problems were apparent, such as lack of consultation or an over-rapid pace of change, and external organisational barriers included changes in funding and policy regimes. A shift in the role of HATs from service delivery to quality assurance created confusion and further difficulties for tenants attempting to steer policy on the ground (Hull, 2008).

Western Europe

As noted earlier, across western Europe, the proportion of housing within the social sector has declined albeit from differing baselines, with most governments committed ideologically to owner-occupation. The 1980s UK "Right to Buy" legislation saw the transfer of millions of the best council-owned housing to sitting tenants, and the Netherlands government indicated recently that it wished to transfer more than half a million units over a ten-year period to prospective home-owners. In eastern Europe, of course, state housing provision was the norm although most east and central European countries are now pursuing more market-led housing strategies, again emphasising owner-occupation.[6] At the same time, the opening up of the social sector has meant that new community development organisations – often initially supported by external philanthropic funding following the removal of the Berlin Wall – are becoming a feature of the local landscape, able to press for housing improvements for tenants in general (see, for example, for Hungary *www.kka.hu*).

Elsewhere in Scandinavia, public sector housing is not seen as a residual form only for those with no market or social power to buy into home ownership. Sweden and Denmark are regarded by some as "the only two countries in Europe where tenants can truly access public housing" (Brandon, 2008). In Sweden, the national tenants union – essentially an organisation for the community of tenants – negotiates rents on behalf of all tenants (with municipal rents being used as a baseline for setting private rents). Sweden and Germany are regarded as models of tenant involvement across Europe in this respect.

A different approach to tenant empowerment, or capacity building, has been pursued within the Netherlands. Despite the government's drive to sell off much social housing, there is also a recognition that many low income people are likely to remain within the sector. Faced with this tension, one association has developed a client's choice programme, experimenting with different forms of tenure, including traditional rent contracts, fixed-term fixed rent contracts, fixed rent increase contracts, socially-bound ownership and ownership with a buy-back option, thus offering a much greater degree of flexibility between renting and owning (Gruis *et al.*, 2005). This demonstrated that, where tenants were able to bring financial assets to bear, financial arguments were far more important than empowerment issues for individual tenants.

Australia

Housing trends in Australasia have tended to mirror those in western Europe, and the UK in particular. Thus, there has been a substantial public housing sector but local government (in the Australian case at the State level) has also attempted to divest itself of much of its housing stock over the past

years. State housing has also been subject to national legislation promoting tenant participation, for example the 1983 Australian Housing Act which sought "the participation of tenants and other community groups in the management of public housing and non-trading co-operatives engaged in the provision of rental housing to their members" and to promote consultation. There has been a move since the late 1970s towards what are called community housing organisations (roughly equivalent to UK housing associations), bodies which, it was claimed, would address the problems of state-run housing, *e.g.* that it was "bureaucratic, resistant to change and offered limited consumer choice" (Gilmour and Bourke, 2008). Community housing was said to be more flexible, both in response to community needs and to groups with particular special needs. With the vagaries of state and federal housing policy, the outcome has been a "complex set of organisations [which is] eclectic and diverse" and with the sector dominated by a small number of very large housing organisations (Gilmour and Bourke, 2008). There has been relatively less debate about tenant participation or CCB within this sector in Australia. Some states (*e.g.* New South Wales) offer small grants schemes to promote tenant participation, including in environmental sustainability (Housing NSW, 2007). The key problem at present appears to be to do with organisational capacity building and the management of risk.

In most Australian States, there has however been more general investment in tenant participation and substantial "top-down" work. Victoria, for example, has been involved in the creation of a statewide peak organisation, the Victorian Public Tenants Association, one form of CCB. The Victorian Office of Housing has provided training, convened regional tenant forums, offered information on housing policy, provided development work to help build tenants groups, and provided support to groups on an ongoing basis: the effectiveness of this work has yet to be assessed. In states where there is a significant Aboriginal and Torres Strait Island population (Western Australia, Northern Territory and Queensland), special housing schemes are developed for indigenous people. These not only provide support for tenant participation but also to support indigenous tenants to enable them to "participate in activities with other tenants and the community that enhances their resilience" (*www.housing.qld.gov.au*).

In Sydney, again demonstrating the cross-over between health and housing conditions, resident groups have been supported by health bodies to enhance the community's competence to solve health problems. Key factors for individual participants were seen "in efforts to reduce costs, increase benefits and increase the satisfaction of group members with group processes. Training, for example, to help members acquire the skills necessary to participate in decision making may be perceived by members as a benefit associated with participation and also increase satisfaction with group processes" (Butler, Rissel and Khavarpour, 1999). This study also argues that community participation is an important

principle of community health although this tends to focus on individual rather than community outcomes.

Researchers in Tasmania provide a strategic view of CCB within the housing sector. They argue that CCB is distinguishable from community development in that CCB strategies are often "devised by organisations outside those communities, even if the ethos is still ultimately to try and build skills and coping abilities within communities. CCB also differs, in their view, from the community development model in that *all* communities are perceived as having inherent strengths, skills and abilities (or assets) within them" (Atkinson and Willis, 2005). The first stage in CCB here is to identify assets in a community such as talents and skills, existing organisations and networks, physical assets such as buildings and equipment, and local knowledge, including community stories. Good practice means involving local people from the start, developing local resources, providing adequate development time and ensuring that decision-making processes are appropriate to local community experience. Examples of CCB projects are given, including small grants schemes, community gardens and neighbourhood renewal programmes. A framework for evaluating the effectiveness of CCB work is also developed. Capacity indicators might include, for example, organising ability, technical skills, a supportive community (measures which show inclusiveness of all cultures and groups), positive perceptions by residents about their community, and a sense of control and ownership. These can all be tested and measured using participatory action research techniques.

Indicators and evaluation

Workers in Toronto, Canada, have been developing similar indicators of community capacity (Jackson *et al.*, 2003; Labonte and Laverack, 2001b). This project was situated in a health and social development context, but its conclusions could equally be applied to housing contexts. A collaborative research approach was devised to measure community capacity, based upon community experience in seven neighbourhoods defined as deprived or "problem" areas. CCB, these workers argued, was as much about what is done to the community as it is about what happens within it. Thus, increasing community capacity means "not only improving the skills of local residents but also creating the conditions inside and outside the community that maximise the potential for these to develop and find full expression." These indicators include a welcoming and supportive community; residents having positive perceptions of their community, able to organise and celebrate together, participating actively in the social, political and economic life of the community; and, again, community members having a sense of control and ownership. Internal and external barriers to this happening and factors which could facilitate them were identified. For example, an internal barrier might

be the existence of community factions which work to exclude some groups, perhaps because of racist attitudes; external barriers might be a negative image of the community or unhelpful government policies. A North American study also identified leadership as a critical "internal" factor: leadership training programmes were found to increase participants' capacity by strengthening their knowledge, skills and self-efficacy (human capital) and by increasing their access to networks and resources (political capital). Programme participants identified how they helped them understand, for example, how communities worked (Emery *et al.*, 2007). The Toronto work in particular builds on and extends previous work both on capacity building and on community resilience models (Kretzman and McKnight, 1993) and emphasises the use of research which is both participatory and qualitative in its orientation. The Toronto Community Housing Corporation now emphasises the importance of CCB for community safety work, arguably bridging both housing and health aspects of a community's life (*www.theconstellation.ca*).

As noted, the development and measurement of a community's capacity must be distinguished from the capacity of organisations delivering the service, whether housing or some other public service. In the USA, work has been undertaken to assess the capacity of community development corporations (CDCs) to carry out their functions more effectively and help to build capacity in communities. This work identifies five categories of capacity which are needed by CDCs: resource, political, organisational, networking, and programmatic (Glickman and Servon, 2003). Clearly, lack of some, or all, of these capacities would constitute, in the Toronto researchers' terms, external barriers to building community capacity.

Finally, the role of CCB in community regeneration is considered.

Community capacity building and community regeneration: A complex policy mix

Definition and history of community regeneration

Neighbourhood regeneration (the term most commonly used within the UK) refers to the economic, social and environmental renewal of what are variously described as "run-down", deprived, excluded or poor areas. The balance between economic, social or environmental elements may vary depending on the programme although UK local government, as the agent of what are usually government-funded programmes has, since the end of the 20th century, been legally required to promote all three elements for the residents living within its boundaries. Initially, drawing on US experience, neighbourhood regeneration in the UK focused more heavily on the development of economic activity, aiming to address joblessness amongst residents of areas subject to high levels of unemployment as the older industrial base had

withdrawn from these areas (Banks and Shenton, 2001). It is only recently that the dimension of social renewal has emerged in response to the recognition of what has been termed social exclusion, and, more recently still, that the need to address environmental conditions in poorer areas has been acknowledged and begun to be acted on (Adebowale, 2008).

The term neighbourhood renewal has been used in other territories: for example, in Germany, the neighbourhoods targeted for these programmes are generally described as "urban quarters with special renewal needs." These programmes, of *nachtbarschaftsmanagemen*t (neighbourhood management – involving CCB) fall within the general context, of what are known as socially integrative cities (*www.sozialetadt.de*; *www.soziale-stadt.nrw.de*), known in the Netherlands alternatively as "distressed urban areas" (Dekker, 2007). Over a longer timeframe, the term "redevelopment" has also been in common usage.

In the UK, neighbourhood regeneration has been a very significant part of official urban policy since the late 1960s. This has encompassed a long series of programmes such as the Urban Programme (largely consisting of grants for local authorities and organisations working in areas of high minority ethnic concentration), Community Development Projects, Single Regeneration Budget (Alcock *et al.,* 1998), (which brought together a range of regeneration funding streams), Enterprise Zones (with an emphasis on private sector economic development through public subsidy), New Life for Urban Scotland, City Challenge, Neighbourhood Renewal, Housing Action Trusts, Neighbourhood Management, and, most recently, the New Deal for Communities, targeting 88 of the most deprived English communities with large-scale government funding (Social Exclusion Unit, 2001). In some deprived areas, there has been a confusing succession of local projects deriving from national programmes. The focus on neighbourhood regeneration, *i.e.* on community as *place*, has meant that the possibilities for CCB are considerable. What the literature shows is that repeated messages about community involvement and CCB have often failed to become embedded in their practice.

The natural history of these schemes, and in parallel schemes elsewhere, such as Ireland (Maclaran, Clayton and Brudell, 2007) or Israel (Weinstein, 2008), reveals a steadily increasing rhetorical focus on the need to involve residents in regeneration processes, in particular, to include them in the early stages of programme design, (JRF, 1999; Carley, 1999; Taylor, 2000), and also a growing emphasis on holistic regeneration (Alcock, Craig and Lawless, 1998). Accompanying schemes supported by government departments responsible for urban policy are others devised by different government actors, such as those providing training support for "community champions" (*i.e.* people within deprived communities who were targeted as potential leaders) (Duncan and Thomas, 2001; Scarman Trust, 2008) and those aimed at building the capacity of Third Sector organisations to respond to the needs of the most vulnerable

groups (*www.capacitybuilders.org.uk*). Many in the Third Sector have argued that CCB in deprived neighbourhoods and amongst vulnerable communities has been core to their work for many years and that they are more effective at it than government because they can get "closer" to these communities and are more trusted by them. In the field of regeneration, typical examples of the sectoral work of Third Sector organisations include the Black Training and Enterprise Group (which works to help build the capacity of Third Sector organisations and small businesses working with Black and Asian people, upskilling them and helping them into appropriate employment) (*www.bteg.co.uk*); and, in a neighbourhood context, the work of the London-based Coin Street Community Project, which developed as a major community-based organisation to oppose large-scale commercial redevelopment of a city centre area in favour of protecting existing residents' interests (*www.coinstreet.org*).

Major trends

The focus on economic, social and environmental regeneration means that the character of programmes becomes quite complex, particularly given the increasingly uneven levels of economic growth at regional levels within specific countries, and, because seeing renewal through a neighbourhood lens is even more inappropriate than it might be in, say, housing work. Commentators argue, citing UK and Danish experience, that a more strategic regional level of governance is required to address urban renewal, an approach which is far more apparent in Denmark than it is in the UK (Cole and Etherington, 2005). This makes the question of building (neighbourhood) community capacity more complex still. The notion of neighbourhood renewal in any case raises the contentious issue of the meaning of community and the assumptions that residents within a specific geographical area not only share that space but also interests, lifestyles, goals and patterns of consumption. This assumption has increasingly been challenged with neighbourhoods being seen as sites of contest and conflict over resources and perspectives (Shirlow and Murtagh, 2004). This is problematic for the sorts of communitarian analysis promoted by "Third Way" governments which have seen the state as needing simply to "generate social interaction between individuals based in communities in order to strengthen civic society and, thereby, enhance community safety, cohesion and social well being" (Cooper, 2008), a perspective which informs a simplistic view of CCB goals.

Neighbourhood renewal programmes have thus increasingly had to work with the recognition of complexity at a local level and, in some cases, have collapsed because of a failure to manage the consequent tensions. More generally, and critically, neighbourhood renewal programmes – which have inevitably (because of the scale of resources involved) tended to emerge as "top-down" targeted, government-driven initiatives – have been characterised as being "less about democratic self-determination and more about managing

social tensions and assisting state bureaucracies to accomplish their objectives" (Crow and Allan, 1994). That is, it is about neighbourhood management rather than neighbourhood/community control. This critique also has a long pedigree and, in the context of the UK, goes back at least to the ill-starred Community Development Projects of the 1970s (CDPIIU, 1977a) whilst continuing to be applied to the government's more recent interest in the concept of community cohesion. The UK government-sponsored Commission on Cohesion and Integration published case studies showing how local participation might improve local cohesion and community integration, regarding participation and integration as not only an indicator but also as a lever of cohesion. These demonstrated how effective participation led to increased trust in institutions and agencies, and improved inter-community relations (Commission on Integration and Cohesion, 2007).

The latter is seen by some as a thinly veiled attempt to operationalise the government's "war on terror" – *i.e.* to increase levels of neighbourhood surveillance within communities perceived to be at high risk of civil disturbance (Worley, 2005).

The increasing complexity of neighbourhood renewal, recognising that the dimensions of renewal go beyond merely physical reconstruction, has driven programmes to incorporate other important sectoral elements such as health. One innovative regeneration capacity building programme involves the notion of "health trainers" where such trainers are recruited from deprived communities, trained and developed towards an accredited certificate. These then provide "one-to-one healthy lifestyle guidance and behaviour change interventions to people from these communities who wish to change a behaviour related to their health, linked more widely within health provision into the public health workforce development strategy".[7] The following chapter deals in detail with local economic development but again local regeneration programmes also increasingly incorporate dimensions which focus on local economic development and on unemployment in particular. Thus, in Canada, the Community Employment Innovation Project is testing "an alternative form of income transfer that has dual goals of supporting the unemployed whilst building community capacity" (Gyarmati *et al.*, 2008). Early work indicated "substantially higher rates of full-time employment, increased earning … reduced receipt of benefits … improved well-being, with reductions in the extent and severity of poverty and hardship, and increased life satisfaction." Although many of the measures were individualised, the capacity of the community was also increased in terms of skills and knowledge, for example.

CCB in the context of neighbourhood renewal or regeneration may involve the acquisition of enhanced capacities both for individuals living within an area but also for the sustainability of the area itself, as residents move into and out of it. It is important also to recall that regeneration may take place in rural as

well as urban areas and there is an increasing literature describing community involvement in rural regeneration work. For example, one northern Irish study reviews the way that local rural regeneration partnerships have helped to develop a "collaborative culture that will enable people with diverse and sometimes hostile interests to mediate and negotiate shared perspectives" (Williamson, Beattie and Osborne, 2004). In remote Scottish Highland areas, typical of many of the projects funded under the EU Leader programmes (Craig *et al.,* 2004), similar conclusions emerged as well as the recognition that, for effective rural regeneration work there still needed to be strong local democratic practices, representative structures (problematic in areas with dispersed populations) *and* a strong and sympathetic institutional framework[8], reinforcing earlier messages about the impact of external barriers to effective CCB.

Drawing on the huge volume of regeneration programmes in most national settings, there has been an equally large volume of research exploring the issue of community involvement and CCB. A representative selection of studies is summarised in Boxes 2.3 and 2.4 below.

Box 2.3. **Lessons for CCB in regeneration programmes: Partnership working**

- A study of community participants' involvement in early area regeneration projects in the UK suggested that communities were diverse and that conflict needed to be acknowledged. There was a gap between the rhetoric of involvement and actual practice with little time for effective consultation and involvement (Anastacio *et al*., 2000).
- Work on the notion of community leadership suggested that successful regeneration required effective community involvement and that this in turn required a strong contribution from community leaders. Again, the rhetoric and reality of community involvement were not matched: leaders needed more time and resources than were often available, and a recognition that the nature of leadership might change over time (Purdue *et al.,* 2000). Echoing other research on partnership working, local regeneration partnerships often marginalised the voice of the community. Local community representatives find they have inadequate time or resources to operate as effective partners at the table with well-resourced policy actors such as local government and health bodies, and to represent community interests (Rowe and Devanney, 2003; Craig and Taylor, 2002).
- A review of a range of regeneration case studies in the UK noted the failings of partnership working for promoting effective public participation. In communities which had strong social networks but were often deeply divided on sectarian grounds, the community voice was often fragmented or contested and powerful partners dominated the development of policy. Government was unable or unwilling to explore alternative means of consultation which would have overcome these difficulties (Muir, 2004).

Box 2.4. **Lessons for CCB in regeneration programmes: Funding as a lever**

- An evaluation of a government community participation programme in the UK, which included funds for promoting local action and empowerment, specifically aimed at enhancing the level of community participation in wider neighbourhood renewal work, identified a range of strengths, weaknesses, opportunities and threats. Local communities were superficially given enhanced opportunities for participation, for decision making and accessing resources on the one hand; but the process, driven by political imperatives, was rushed, sometimes superficial, under-resourced, fragmented and contested, reflecting divisions within the communities. Again, powerful external partners refused to engage effectively with communities, either driving through their own decisions or co-opting local groups into their processes and undermining the distinctiveness of the community voice. This compromised some major gains, particularly the flexibility of the funding regime and the sense that communities had of controlling important decisions (NRU, 2005).
- A programme of "light touch" support to 20 UK communities offered a local facilitator/advocate, small grants, networking opportunities, help with action planning and a broker to negotiate with more powerful bodies. This made a real difference to these communities in enabling them to stay abreast of policy change and to advocate for its own needs, although it was recognised that long-term intensive community development support would also be needed where there was a long history of disadvantage. This approach depended, however, on sustainable local organisations with strong community participation, effective leadership and continued funding (internal factors) and committed partners, opportunities for dialogue between residents and authorities, time and resources (external factors) (Taylor *et al.*, 2007).
- A funding scheme for community regeneration activity in Scotland's most deprived communities was linked to a series of Regeneration Outcome Agreements (ROAs). These Agreements, stressing the significance of outcomes (such as building strong, safe and attractive communities, getting people back to work, and improving health), were found, because of their clarity, to have enhanced community involvement in decisions about service provision. However, the speed at which ROAs were pushed through, again a product of political imperatives rather than sensitivity to local conditions, created difficulties. A similar programme was developed in Wales. Here there was a balance between national and local priorities (although in practice, national priorities took precedence). The communities were targeted on the basis of deprivation indices and the evaluation of the programme argued both for a longer timeframe to be able to assess outcomes properly, and also to be able to target not just geographical communities but specific population groups such as ethnic minorities which might not be concentrated geographically but which experienced severe disadvantage (ODS Consulting, 2007).

Examples from the UK

As political devolution developed within the UK, separate major regeneration schemes emerged within the devolved administrations. For example in Wales, the Welsh Assembly sponsored a major regeneration scheme called Communities First, defined by the Assembly as a capacity building programme – although the findings of a recent review has labelled its objectives more as regeneration. This is because whilst the capacity building objectives of the programme were said to have been achieved to a large extent, the schemes had failed to "bend" mainstream services towards the most deprived areas which remained high on most indicators of deprivation. This represents a major tension within such schemes as process goals compete with outcome goals; in this programme, the statutory sector effectively "failed to respond to the community sector". In terms of capacity building, the programme's effectiveness lay in providing multiple approaches to participation, often within a partnership and aiming to accommodate the interests of local residents (Adamson and Bromiley, 2008). This also rehearses, in a regeneration context, the familiar tension between "top-down" and "bottom-up" approaches.

A Scottish study also explored the meaning of effective community engagement in regeneration, defined as leading to change which could be measured, whether improvement in local services, an increase in the skills and capacity of community or individuals, or a more general measure such as an enhanced quality of life or sense of pride in the community. One key finding was that representative (*i.e.* councillors and MPs) and participative (community groups) forms of democracy should be able to work alongside each other, that inclusion of all groups should be valued and that emphasis should be given to process as much as outcome. The baseline evaluation noted that community engagement needs to be assessed within each local context with no single measure being appropriate for all work in this area (ODS Consulting, 2006).

The work of autonomous organisations such as the Tenants Information Service (TIS) in promoting tenant participation in housing was alluded to earlier. TIS has also developed frameworks for involving tenants in regeneration work, recognising that "improving housing alone is no longer enough. Jobs, resources and services are essential if regeneration is to succeed" (TIS, 2000). A handbook for tenants involved in regeneration provides a checklist of knowledge, skills and other resources, together with the core elements of a participation strategy required by tenants actively seeking to influence the development of regeneration schemes. Hardly surprisingly, housing has often been at the heart of regeneration work. However, although housing associations and other groups were steered away by policy and funding constraints from involvement in the UK regeneration programmes during the 1980s, by the

late 1990s housing associations were again encouraged to be involved in community regeneration. This shift was particularly important where these housing associations focused on the needs of more vulnerable people who might need an enhanced level of support and care (Driffill and Hill, 2001). Housing associations in the UK are now beginning to explore a wider role in CCB, for example in building capacity in other smaller Third Sector organisations in the areas in which they have housing stock, defining themselves as "community anchors" (Wadhams, 2006).

A review of the UK government's National Strategy for Neighbourhood Renewal observed that a range of agencies resourced CCB but that provision was neither comprehensive nor well-coordinated. This "patchwork quilt" of agency intervention took little account of difference in local conditions and those areas outside the nominated target areas received no help at all, a criticism which has been made of most area-based social policies. Many areas had experienced little previous commitment to community development and where there had been such a commitment, it had waned over time (Thomas and Duncan, 2000). A review of Scottish research evidence on CCB argued that it took time and involved both financial and non-financial resources: it was risky but there was little appreciation of the risks involved. Continual social and urban policy change – characteristic of many developed countries in recent years – can undermine CCB. There are specific ways in which individuals and communities can promote sustainable regeneration including training, supporting leaders, building individual capacity, networking, identifying information needs and creating a financial framework to support CCB (Chapman and Kirk, 2001).

A strong critique is emerging in relation to CCB within the New Deal for Communities (NDC), the UK New Labour government's biggest single social policy investment, and involving major "capacity building" initiatives in 39 very deprived neighbourhoods throughout England. Not all the evaluations of the work of NDCs were critical, most observing some gains for local residents (*www.avencentral.org.uk*). In some areas, however, tensions within the communities (often over control of financial and other resources) led to the collapse of the scheme. In other areas conflicts developed between the perspectives of the local community and that of government officials responsible for overseeing the scheme and in some of these the schemes also faltered.[9] Difficulties were occasionally related to ethnic divisions within these communities. An analysis of the experience of all NDC projects suggested that whilst the long timeframe (of up to ten years) provided, potentially, a stable base, the availability of substantial financial resources created problems with respondents, implying that this placed a burden on communities. Thus communities had not been given the support they might need to manage this aspect of major regeneration programmes (Carpenter, 2008); most of the

literature evaluating the performance of the NDC (such as Dinham, 2005) argues that effective community leadership is critical in boosting the regeneration effort in certain areas.

Others suggest that whilst community involvement is not easy, the building of community capacity in the NDC has been limited, representation of residents difficult to achieve and there have been tensions between local residents and their "democratic" representatives (local councillors). Both structures and processes need to be right (Robinson, Shaw and Davidson, 2005). Similarly, a detailed reflection on one NDC project suggested that there was a substantial gap between the communitarian rhetoric of New Labour and the need for sustained community development to support local communities. Community development needed to start where the skills, capacities and abilities of local people were but the structures created to manage and advise the development of this and other NDCs were often beyond the abilities of local people to participate. For example, opportunities for participation were seen as too formal and places on Boards too often occupied by professionals external to the communities (Dinham, 2005). The need to start "where people are" was particularly emphasised in another ethnographic study which suggested that many people in disadvantaged neighbourhoods actively avoided participation as part of "'survival strategies' developed to cope with long-term multiple disadvantage". This study examined participation through the lens of "rational actor theory" (*i.e.* that people choose actions which are best for them). Peoples' experience of the state, which had frequently criticised or tried to change residents' behaviour, was seen as so critical and threatening, that residents absented themselves from a programme which was seen as state-directed (Mathers, Parry and Jones, 2008).

Social Inclusion Partnerships (SIPs) were developed at an early stage of the devolved Scottish Parliament. An evaluation of one SIP observed that the rhetoric of New Labour had been matched so poorly with its actual practice on the ground that the level of community involvement in local regeneration was little different from what it had been under previous Conservative administrations, where community involvement had barely been privileged at all. Residents had not been involved at the critical early stages of programme design, and deadlines for subsequent phases were so tight that effective consultation and involvement was precluded. Overall, these processes were at best "tokenistic and at worst, local people were being 'exploited' to legitimise the policy process" (McWilliams, 2004; Craig, 1990). A similar critique, drawing on NDC experience in two northern UK cities (Diamond, 2004), observed that the NDC, whilst being wrapped in a new vocabulary (of which CCB was a significant part), was "steeped in old practices". Changing structures (with a plethora of new partnership bodies) does not, of itself, alter power differences inherent in local neighbourhoods where community groups are cast as

"dependent" by regeneration managers seeking to meet performance targets. This is a critical point since it again confronts the tensions between the needs and desires of community groups and those of managers in statutory agencies, charged with delivering programmes, generating outputs and meeting targets. Such tensions were usually played out in the arena of newly-created partnership bodies where the power was stacked heavily in favour of statutory bodies (Diamond, 2004). Diamond points out that "we have been here before … the renewed emphasis on 'capacity building' [is] seen as part of a perceived need to strengthen institutions of civil society as well as address 'social exclusion'". It differed from previous programmes, however, as government now emphasised the needs of individuals above those of the wider community.

Elsewhere

In line with a growing realisation of the need for ownership of such programmes by the residents/tenants most affected by renewal/re-development, regeneration programmes have generally come with at least a rhetorical policy commitment to community involvement and capacity building. In Australia, a review of both Australian and international research on community regeneration within public housing redevelopment indicated not only that the separate elements of economic, social and environmental renewal need to be worked on in parallel, but that "building community empowerment, cohesiveness and problem-solving capacity require both initial effort and ongoing investment because of the impacts of disadvantage and resident mobility" (Atkinson and Willis, 2005). The latter issue is particularly critical for renewal work because, given that these neighbourhoods are often what used to be termed "zones of transition", i.*e*. areas with a substantial turnover of residents (as those who manage to escape the poor neighbourhoods do so, to be replaced by other poor in-migrants), there is enhanced demographic change thus making it more difficult for community organisers to build sustainable community organisations or for government agencies to connect with a relatively stable group of local people.

Research into the renewal of "distressed areas in the Netherlands" has explored the factors which promote participation within particular neighbourhoods, finding that the combined effects of neighbourhood attachment and social capital can be crucial in promoting participation and thus underpinning CCB work. Neighbourhood attachment involves having strong local social networks and rejecting deviant behaviour (*e.g.* noise, drunkenness, petty crime); what residents have and what their attitudes are, in combination, may promote participation in regeneration programmes. This might imply that people participate more readily in more ethnically homogenous areas, for example, or conversely, that capacity building in neighbourhood regeneration programmes needs to pay attention to bridging work between differing ethnic groups to ensure widespread participation in more mixed areas. This is all the

more significant in areas where there is substantial population "churn". One proposal put forward by the Dutch study (Dekker, 2007) is for increasing housing tenure mix in such areas, in particular increasing the level of home ownership alongside rented properties, although this may bring tensions of their own and potentially increase the level of both population "churn" and segregation.

Concluding comments

The notion of CCB in healthcare is a relatively recent phenomenon and challenges the power base of clinicians in a service area which, additionally, is complicated by the language of health technology. Gains have therefore been modest, uneven and, in general, fairly recent. In housing, the level of tenant participation has been considerable for many years and in many countries there are now established structures to support it, based on the notion of participation in determining housing conditions as a right, although there are still serious questions about the extent of real participation in important decisions. In community regeneration, however, despite extensive experience in most developed countries, the literature suggests that "we have not yet succeeded in developing more effective ways of achieving these crucial and long-standing aspirations of urban planning and regeneration. Why is it that almost one hundred years of regeneration practice has not yet led to more success in achieving the goals of public participation in planning within poor neighbourhoods?" (Burton, 2002). The review dismisses the notion that "we", the professionals, are slow to learn from experience, or that the familiar barriers to the participation of community members – ignorance, self-interest, prejudice or lacking rationality – are the key to understanding this failure in policy and practice. The critique made time and time again – that government, at whatever level, is simply less interested in promoting involvement than it is in achieving "criteria of financial viability and administrative structure" – is a powerful one, suggesting that governments continually fail to set targets or outcomes which are realistic and reasonable in the context of (hoped-for) large-scale participation. But alongside this is a continuing failure to accept the importance of participatory democracy alongside the traditional (and withering) forms of representative democracy which those in power cling to. As a result, where levels of involvement are modest, they are immediately criticised as being unrepresentative; community representatives are often chosen rather than elected (and thus actually *are* unrepresentative); and the range of modes of participation are often too few to allow for a varied form of participation, truly representative of difference and diversity within communities. Until this basic lesson in democratic politics is absorbed into programmatic design and execution, the same continuing critique will be made of the failure of CCB within regeneration programmes.

Notes

1. Correspondence from Ady Carrera, Researcher at the Centre of Research and Teaching of Economics (CIDE) in Mexico City (ady.carrera@cide.edu).
2. Private communication: Sarah Clay, Castle Vale Community Regeneration Services, 26 August 2008.
3. See EC decision N 89/2004 *http://ec.europa.eu/community_law/state_aids/comp-2004/n089-04.pdf*.
4. In western Europe, only the Netherlands (at 41%) and Denmark (27%) had higher proportions of social housing in the late 1990s than the UK (at 25%). In countries such as Spain and Greece, social housing barely exists as a separate category.
5. Most local authorities in the UK now have a formal Tenant Participation Strategy which negotiates with registered Tenants Organisations: see for example *www.moray.gov.uk/moray_standard/page-1920.html*. In England, the relationships between local authorities and council tenants has been formalised through what is commonly known as the "Tenant Participation Compact", supported by the Government's National Framework for Tenant Participation Compacts (published in 1999 and available from *www.communities.gov.uk/publications/housing/nationalframework*): see for example for Rochdale, *www.rb housing.org.uk/information/tenantcompact.htm*. The commitment to tenant participation, supported by community capacity building by housing officers, is also apparent in other national contexts: for the case of Ireland, see for example *www.wexford.ie/wex/Departments/Housing/AreaHousingOfficers*. In the USA, the general provisions laid down by the Housing and Urban Development department include "the promotion of tenant participation and the active involvement of tenants in all aspects of any housing agency/association" as laid down by a series of federal Housing Acts.
6. See, for Lithuania, the section on the existing policy context in response to a questionnaire on sustainable building in Europe, available from *rimvydas.pranaitas@aplinkuma* which makes it clear that social housing is solely for inhabitants with low incomes.
7. Private communication: Joanna Chapman-Andrews, South Central Strategic Health Authority, UKNHS, Winchester, 7 August 2008.
8. Reports on rural advocacy work from Ionad Naisenta Na H-Imrich (National Centre for Migration Studies), Skye, available from *www.ini.smo.uhi.ac.uk/projects/completed-projects.htm*.
9. A full evaluation of the scheme is due shortly from the Centre for Regional Economic and Social Research at Sheffield Hallam University, *www.shu.ac.uk*. Their interim evaluation suggested that there was little change in terms of health indicators and that "evidence does not point to there being a great deal of change in economic activity".

Bibliography

Adamson, D. and R. Bromiley (2008), *Community Empowerment in Practice: Lessons from Communities First,* Joseph Rowntree Foundation, York.

Adebowale, M. (2008), "Understanding Environmental Justice: Making the Connection Between Sustainable Development and Social Justice", in G. Craig, *et al.* (eds.), *Social Justice and Public Policy*, Policy Press, Bristol, pp. 251-276.

Albert, D., *et al.* (2000), *Aboriginal Community Capacity Building: Implementing AIDS/HIV Epidemiology and Surveillance in Health Policy and Planning*, paper to international AIDS conference, Durban, South Africa, 9-14 July.

Alcock, P. and G. Craig (2009), "The International Context", in P. Alcock and G. Craig (eds.), *International Social Policy: Welfare Regimes in the Developed World*, Palgrave, Basingstoke, (2nd edition).

Alcock, P., *et al.* (1998), *Inclusive Regeneration*, Department for the Environment, Transport and the Regions (UK), London.

Allen, C. and N. Sprigings (2001), "Housing Policy, Housing Management and Tenant Power in the 'Risk Society': Some Critical Observations on the Welfare Politics of 'Radical Doubt'", *Critical Social Policy*, Vol. 21, No. 3, pp. 384-412.

Anastacio, J., *et al.* (2000), *Reflecting Realities: Participants' Perspectives on Integrated Communities and Sustainable Development*, Policy Press, Bristol.

Anker, J. (2008), "Organising Homeless People: Exploring the Emergence of a User Organisation in Denmark", *Critical Social Policy*, Vol. 28, No. 1, pp. 27-50.

Arnstein, A. (1969), "A Ladder of Citizen Participation", *American Institute of Planners Journal*, Vol. 35, No. 4, pp. 216-224.

Atkinson, R. and P. Willis (2005), *Community Capacity Building – A Practical Guide*, Paper No. 6, Housing and Community Research Unit, University of Tasmania, Hobart, *www.utas.edu.au/sociology/HACRU/6%20Community%20Capacity%20building.pdf*.

Baggott, R., J. Allsop and K. Jones (2004), "Representing the Repressed: Health Consumer Groups and the National Policy Process", *Policy and Politics*, Vol. 32, No. 3, pp. 317-331.

Banks, S. and F. Shenton (2001), "Regenerating Neighbourhoods: A Critical Look at the Role of Community Capacity Building", *Local Economy*, Vol. 16, No. 4, pp. 286-298.

Barker, I. and E. Peck (1996), "User Empowerment: A Decade of Experience", *Mental Health Review*, Vol. 1, No. 4, pp. 5-13.

Barnes, C. and G. Mercer (2003), *Disability*, Polity, Cambridge.

Bauld, L., *et al.* (2005), "Promoting Social Change: The Experience of Health Action Zones in England", *Journal of Social Policy,* Vol. 34, No. 3, pp. 427-445.

BC Healthy Communities (2006), *Building Capacity: Building Healthy Community*, BC Healthy Communities, Victoria.

Beaumont, J. (2003), "Governance and Popular Involvement in Local Anti-Poverty Strategies in the UK and Netherlands", *Journal of Comparative Policy Analysis: Research and Practice*, Vol. 5, Nos. 2-3, pp. 189-207.

Beck, H. and L. Richardson (2004), *Evaluation of the Trafford Hall Making Things Happen Capacity Building Programme 1999-2003,* LSSE/ODPM, CASE Report 26.

Beresford, P. (2001), "Service Users, Social Policy and the Future of Welfare", *Critical Social Policy*, Vol. 21, No. 4, pp. 494-512.

Beresford, P. and S. Croft (1993), *Citizen Involvement: A Practical Guide for Change*, Macmillan, Basingstoke.

Beresford, P., C. Harrison and A. Wilson (2002), "Mental Health Service Users and Disability: Implications for Future Strategies", *Policy and Politics*, Vol. 30, No. 3, pp. 384-396.

Brandon, S. (2008), "World Class", *Inside Housing,* 11 July.

Bridgen, P. (2004), "Social Capital, Community Empowerment and Public Health: Policy Developments in the UK since 1997", *Policy and Politics*, Vol. 34, No. 1, pp. 27-50.

Burton, P. (2002), *Community Involvement in Neighbourhood Regeneration: Stairway to Heaven or Road to Nowhere?*, paper to the annual conference of the Social Policy Association, Middlesbrough, 16-18 July.

Burton, P. (2004), "Power to the People?: How to Judge Public Participation", *Local Economy,* Vol. 19, No. 3, pp. 193-198.

Butler, C., C. Rissel and F. Khavarpour (1999), "Factors Associated with Resident Action Groups in Metropolitan Sydney: A Cross-Sectional Survey", *Australian and New Zealand Journal of Public Health*, Vol. 23, No. 6, pp. 634-638.

Callaghan, G. and G. Wistow (2002), "Public and Patient Participation in Primary Care Groups: New Beginning for Old Power Structures", *Nuffield Portfolio Programme Report No. 19*, Nuffield Institute for Health, Leeds.

Callaghan, G. and G. Wistow (2006), "Governance and Public Involvement in the British National Health Service: Understanding Difficulties and Developments", *Social Science and Medicine*, Vol. 63, No. 9, pp. 2289-2300.

Calman, K., D. Hunter and A. May (2004), "Lost in Translation: a Commentary on Labour's Health Policy Four Years into the NHS Plan", Wolfson Research Institute, University of Durham, mimeo: 4.

Campbell, J. and M. Oliver (1996), *Disability Politics: Understanding Our Past, Changing Our Future*, Macmillan, Basingstoke.

Carley, M., *et al*. (2000), *Urban Regeneration through Partnership: A Study in Nine Urban Regions in England, Scotland and Wales*, Policy Press, Bristol.

Carr, S. (2004), "Has Service User Participation Made a Difference to Social Care Services?", *SCIE Position Paper No. 3*, Social Care Institute for Excellence, London.

Carr, S. (2007), "Participation, Power, Conflict and Change: Theorizing Dynamics of Service User Participation in the Social Care System of England and Wales", *Critical Social Policy*, Vol. 27, No. 2, pp. 266-276.

Carpenter, J. (2008), "How the New Deal was Dealt", *Regeneration and Renewal,* 11 January.

Casswell, S. (2001), "Community Capacity Building and Social Policy: What Can be Achieved?", *Social Policy Journal of New Zealand,* Issue 17, December, pp. 22-35.

Cavaye, J. (1998), *The Role of Government in Community Capacity Building*, Department of Primary Industries, Queensland, Australia, mimeo: available from *cavayej@dpi.qld.gov.uk*.

CDPIIU (Community Development Project Information and Intelligence Unit) (1977a), *Gilding the Ghetto,* CDPIIU, London.

CDPIIU (1977b), *The Costs of Industrial Change*, CDPIIU, London.

Chapman, M. and K. Kirk (2001), *Lessons for Community Capacity Building: A Summary of Research Evidence,* Scottish Homes, Edinburgh.

Chau, R. (2008), *Health Experiences of Chinese People in the UK,* Race Equality Foundation, London.

CHIBAH (Co-operative Housing in Brighton and Hove) (2006), *The Case for Developing Housing Cooperatives in Brighton and Hove*, CHIBAH, Brighton.

Chouhan, K. and C. Lusane (2004), *Black Voluntary and Community Sector Funding: Its Impact on Civic Engagement and Capacity Building*, Joseph Rowntree Foundation, York.

Clarke, J. (2005), "New Labour's Citizens: Activated, Empowered, Responsibilised, Abandoned?", *Critical Social Policy*, Vol. 25, No. 4, pp. 447-463.

Clear Plan UK (2008), *Evaluation of the Impact of the National Standards for Community Engagement,* Report to the Scottish Government, Glasgow.

CLES (2002), *Good Practice in Supporting Access to Information, Communications and Technology (ICT) for Black and Minority Ethnic (BME) Groups in Deprived Areas*, Report for Department for Education and Skills (UK), Centre for Local Economic Strategies, Manchester.

Cole, I. and D. Etherington (2005), "Neighbourhood Renewal Policy and Spatial Differentiation in Housing Markets: Recent Trends in England and Denmark", *European Journal of Housing Policy*, Vol. 5, No. 1, pp. 75-88.

Commission on Integration and Cohesion (2007), *What Works in Community Cohesion?*, Department of Communities and Local Government, London.

Communities Scotland (2008), *Evaluating Scottish Social Landlords' Progress on Tenant Participation*, Research Report No. 98, Communities Scotland, Glasgow.

Cooper, C. (2008), *Community, Conflict and the State*, Palgrave, Basingstoke.

Cooper, C. and M. Hawtin (eds.) (1997), *Housing, Community and Conflict*, Arena, Aldershot.

Co-operatives UK (2008), *Commentary on Communities in Control*, Co-operatives UK, Manchester.

Craig, D. (2005), "Reterritorialising Health: Inclusive Partnerships, Joined-up Governance and Common Accountability Platforms in Third Way New Zealand", *Policy and Politics,* Vol. 31, No. 5, pp. 333-352.

Craig, G. (1989), "Community Work and the State", *Community Development Journal*, Vol. 24, No. 1, pp. 3-18.

Craig, G. (1990), *Poverty in Scotland,* Scottish Anti-Poverty Network, Glasgow.

Craig, G. (2003a), "Children's Participation through Community Development: Assessing the Lessons from International Experience", in C. Hallet and A. Prout (eds.), *Hearing the Voices of Children*, Routledge, London, pp. 38-56.

Craig, G. (2003b), "Measuring Empowerment: the Evaluation of Community Development", *Journal of Community Development Society,* Vol. 33, No. 1, pp. 124-146.

Craig, G. and M. Taylor (2002), "Dangerous Liaisons: Local Government and the Voluntary and Community Sectors" in C. Glendinning, M. Powell and K. Rummery (eds.), *Partnership, New Labour and the Governance of Welfare*, Policy Press, Bristol, pp. 131-147.

Craig, G., *et al.* (2004), *Rural Community Development in Europe*, Carnegie UK Trust, Dunfermline.

Crilly, R. (2003), *Synthesis Research on Community Capacity*, Lawson Health Research Institute, Ontario for Health Canada.

Crow, G. and G. Allan (1994), *Community Life: An Introduction to Local Social Relations*, Harvester Wheatsheaf, Hertford.

Crowley, P. (2005), *Community Participation and Primary Care*, Building Healthy Communities Programme, Dublin.

DCLG (Department of Communities and Local Government) (2008), *Empowerment White Paper,* Department of Communities and Local Government, London.

Dekker, K. (2007), "Social Capital, Neighbourhood Attachment and Participation in Distressed Urban Areas: A Case Study in The Hague and Utrecht, the Netherlands", *Housing Studies*, Vol. 22, No. 3, pp. 355-379.

Department of Health (2001), *Involving Patients and the Public in Healthcare: A Discussion Document*, Department of Health, London.

Diamond, J. (2004), "Local Regeneration Initiatives and Capacity Building: Whose 'Capacity' and 'Building' for What?", *Community Development Journal*, Vol. 39, No. 2, pp. 177-189.

Dinham, A. (2005), "Empowered or Over-Powered?: The Real Experiences of Local Participation in the UK's New Deal for Communities", *Community Development Journal*, Vol. 40, No. 3, pp. 301-312.

Drake, R. (2002), "Disabled People, Voluntary Organisations and Participation in Policy Making", *Policy and Politics*, Vol. 30, No. 3, pp. 372-383.

Driffill, J. and A. Hill (2001), *Values into Action: Lessons for Successful Community Development and Sustainable Regeneration,* paper presented to the conference Area-Based Initiatives in contemporary urban policy, Danish Building and Urban Research and European Urban Research Association, Copenhagen, 17-19 May.

Duncan, P. and S. Thomas (2001), *Evaluation of the Community Champions and the Community Development Learning Fund,* Research Report No. 280, Department for Education and Skills, London.

Emery, M., *et al.* (2007), "Leadership as Community Capacity Building: A Study on the Impact of Leadership Development on Community", *Community Development,* Vol. 38, No. 4, pp. 60-70.

Foucault, M. (1977), *Discipline and Punish: The Birth of the Prison*, translated by A. Sheridan, Pantheon Books, New York.

Gilmour, T. and E. Bourke (2008), "The Role of Organisation Structure, Relationships and Networks in Building Australia's Community Housing Sector", paper to 3rd Australasian Housing Researchers' Conference, Melbourne, June 18-20.

Glickman, N.J. and L. Servon (2003), "By the Numbers: Measuring Community Development Corporations Capacity", *Journal of Planning Education and Research*, Vol. 22, No. 3, pp. 240-256.

Gomm, M., *et al.* (2006), "Planning and Implementing a Community-Based Public Health Advocacy Campaign: A Transport Case Study from Australia", *Health Promotion International*, Vol. 21, No. 4, pp. 284-292.

Goodlad, R. (2001), "Developments in Tenant Participation – Accounting for Growth", in D. Cowan and A. Marsh (eds.), *Two Steps Forward: Housing Policy into the New Millennium,* Policy Press, Bristol, pp. 179-197.

Goodman, R., *et al.* (1998), "Identifying and Defining the Dimensions of Community Capacity to Provide a Basis for Measurement", *Health Education and Behaviour,* Vol. 25, No. 3, pp. 258-279.

Gruis, V., *et al.* (2005), "Tenant Empowerment through Innovative Tenures: An Analysis of Woonbron-Maasoevers' Client's Choice Programme", *Housing Studies*, Vol. 20, No. 1, pp. 127-147.

Gyarmati, D., *et al.* (2008), *Engaging Communities in Support of Local Development,* Social Research and Demonstration Corporation, Ottawa.

Hardy, B., R. Young and G. Wistow (2001), "Dimensions of Choice in the Assessment and Care Management Process: The Views of Older People, Carers and Care Managers", *Health and Social Care in the Community,* Vol. 7, Issue 6, pp. 483-491.

Harrison, S. (2002), "New Labour, Modernisation and the Medical Labour Process", *Journal of Social Policy*, Vol. 31, No. 3, pp. 465-485.

Harrison, S. and M. Mort (1998), "Which Champions, Which People?: Public and User Involvement in Health Care as a Technology of Legitimation", *Social Policy and Administration*, Vol. 31, No. 1, pp. 60-70.

Harrison, S., G. Dowswell and T. Milewa (2002), "Public and User 'Involvement' in the UK National Health Service", *Health and Social Care in the Community*, Vol. 10, No. 2, pp. 63-66.

Health Canada (2003), *Community Capacity Building and Mobilization in Youth Mental Health Promotion, the Story of the Community of West Carleton*, Health Canada, Ottawa.

Health Promotion Clearing House (n.d.), *Measuring Community Capacity*, Handbook available from Health Promotion Clearing House at *www.horizonscda.ca/reports/ccresources.pdf*.

Hickman, P. (2006), "Approaches to Tenant Participation in the English Local Authority Sector", *Housing Studies*, Vol. 21, No. 2, pp. 209-225.

Hills, J. (2007), *The Ends and Means: The Future Role of Social Housing in England*, London School of Economics, London.

Hodge, S. (2005), "Participation, Discourse and Power: A Case Study in Service User Involvement", *Critical Social Policy*, Vol. 25, No. 2, pp. 164-179.

Holt-Jensen, P.A. (2002), *Housing Policy and Local Initiatives in 8 European Countries: Aiming at Promoting Social Inclusion at Neighbourhood Level: the NEHOM Project*, EU FP5, Report on Key Action 4 "City of Tomorrow and Cultural Heritage".

Home Office (2004), *Building Civil Renewal: A Review of Government Support for Community Capacity Building and Proposals for Change,* Home Office, London.

Hounslow, B. (2002), "Community Capacity Building Explained", *Stronger Families Learning Exchange Bulletin*, Australian Institute of Family Studies, Melbourne, No. 1, Autumn, pp. 20-22.

Housing NSW (2007), *Eco-wise Community Grants Scheme,* Community and Tenant Participation Unit, Housing NSW, Sydney, *www.housing.nsw.gov.au/NR/rdonlyres/24780062-F2ED-424D-B676-4594E8B0757C/0/Ecowisegrantsfactsheet.pdf*.

Hughes, V. (2004), *Putting the "Community" in Community Building*, presentation to the Centre for Public Policy, University of Melbourne, Forum on Capacity Building and Social Capital, 16 September.

Hull, A. (2008), "Facilitating Structures for Neighbourhood Regeneration in the UK: The Contribution of the Housing Action Trusts", *Urban Studies*, Vol. 43, No. 12, pp. 2317-2350.

Isaacs, L. (2006), *Citizen Participation and Community Empowerment: The Development of Local Community Planning in Leith*, MSc thesis, University of Edinburgh, unpublished.

Iton, A. (2006), "Tackling the Root Causes of Health Disparities through Community Capacity Building", R. Hofrichter (ed.), *Tackling Health Inequities Through Public Health Practice: A Handbook for Action*, NACCHO, Washington DC, pp. 115-136.

Jackson, S.F., *et al*. (2003), "Working with Toronto Neighbourhoods Towards Developing Indicators of Community Capacity", *Health Promotion International*, Vol. 18, No. 4, pp. 339-350.

Johnson, M. (1998), "The Involvement of Black and Minority Ethnic Consumers in Health Research", Working Paper 3, Mary Seacole Research Centre, Leicester.

JRF (Joseph Rowntree Foundation) (1999), *Developing Effective Community Involvement Strategies: Guidance for Single Regeneration Budget Bids*, Joseph Rowntree Foundation, York.

JRF (2004), *Older People Shaping Policy and Practice*, Joseph Rowntree Foundation, York.

Kelly, M. and C. Clarke (1997), *Good Practice Manual on Tenant Participation*, Women's Design Service, London.

Kendall, L. and L. Harker (eds.) (2002), *From Welfare to Wellbeing*, Institute of Public Policy Research, London.

Kimberlee, R. (2008), "Streets Ahead on Safety", *Health and Social Care in the Community*, Vol. 16, No. 3, pp. 322-328.

Kretzman, J. and J. McKnight (1993), *Building Communities from the Inside Out: A Path towards Finding and Mobilizing a Community's Assets,* ACTA Publishing, Chicago.

Labonte, R. and G. Laverack (2001a), "Capacity Building in Health Promotion, Part 1: For Whom? and For What Purpose?", *Critical Public Health*, Vol. 11, No. 2, pp. 111-127.

Labonte, R. and G. Laverack (2001b), "Capacity Building in Health Promotion, Part 2", *Critical Public Health*, Vol. 11, No. 2, pp. 129-138.

Lister, R. (2007), "From Object to Subject: Including Marginalised Citizens in Policy Making", *Policy and Politics*, Vol. 35, No. 3, pp. 437-455.

Littlejohns, L.B. and D. Thompson (2001), "Cobwebs: Insights into Community Capacity and its Relation to Health Outcomes", *Community Development Journal*, Vol. 36, No. 1, pp. 30-42.

Maclaran, A., V. Clayton and P. Brudell (2007), *Empowering Communities in Disadvantaged Areas*, Combat Poverty Agency, Dublin.

Maclellan-Wright, M.F., *et al.* (2007), "The Development of Measures of Community Capacity for Community-Based Funding Programs in Canada", *Health Promotion International*, Vol. 22, No. 4, pp. 299-306.

Mathers, J., J. Parry and S. Jones (2008), "Exploring Resident (non)-Participation in the UK New Deal for Communities Regeneration Programme", *Urban Studies*, Vol. 45, No. 3, pp. 591-606.

Mayo, M. and J. Anastacio (1999), "Welfare Models and Approaches to Empowerment", *Policy Studies*, Vol. 20, No. 1, pp. 5-21.

McDonald, J., L. Brown and A. Murphy (2002), "Strengthening Primary Health Care: Building the Capacity of Rural Communities to Access Health Funding", *Australian Journal of Rural Health*, Vol. 10, No. 3, pp. 173-177.

McWilliams, C. (2004), "Including the Community in Local Regeneration: The Case of Greater Pollok Social Inclusion Partnership", *Local Economy*, Vol. 19, No. 3, pp. 364-375.

Melling, J. (1983), *Rent Strikes: People's Struggle for Housing in Western Scotland, 1860-1916,* Polygon Books, Edinburgh.

Merritt, S. (1979), *State Housing in Britain*, Routledge Kegan Paul, London.

MLA (Museums Library Archives) (2008), *Skilled for Health in Libraries*, Museums Libraries Archives, London.

Mooney, G. and L. Poole (2005), "Marginalised Voices: Resisting the Privatisation of Council Housing in Glasgow", *Local Economy,* Vol. 20, No. 1, pp. 27-39.

Mooney, G. and N. Fyfe (2006), "New Labour and Community Protests: The Case of the Govan Hill Swimming Pool Campaign, Glasgow", *Local Economy,* Vol. 21, No. 2, pp. 136-150.

Muir, J. (2004), "Public Participation in Area-Based Urban Regeneration Programmes", *Housing Studies,* Vol. 19, No. 6, pp. 947-966.

National Assembly for Wales (2001), *A Review of Tenant Participation in Wales,* National Assembly for Wales, Cardiff.

Nazroo, J.Y. (ed.) (2006), *Health and Social Research in Multiethnic Societies*, Routledge, London.

Newman, J. and E. Vidler (2006), "Discriminating Customers, Responsible Patients, Empowered Users: Consumerism and the Modernisation of Health Care", *Journal of Social Policy*, Vol. 35, No. 2, pp. 193-209.

NRU (Neighbourhood Renewal Unit) (2005), *Making Connections: An Evaluation of the Community Participation Programmes,* Office of the Deputy Prime Minister, London.

O'Neill, M. and P. Simard (2006), "Choosing Indicators to Evaluate Healthy Cities Projects: A Political Task?", *Health Promotion International*, Vol. 21, No. 2, pp. 145-152.

Oakman, B. and Smart Consultancy (Scotland) Ltd. (2007), *Interim Evaluation of the Community Voices Network,* Communities Scotland, Glasgow.

ODS Consulting (2006), *Evaluation of the Effective Engagement of Communities in Regeneration,* Communities Scotland, Edinburgh.

ODS Consulting (2007), *Evaluation of the Implementation of Regeneration Outcome Agreements*, Communities Scotland, Edinburgh.

Oliver, M. (1990), *The Politics of Disablement*, Macmillan, Basingstoke.

Poole, D.L. (1997), "Building Community Capacity to Promote Social and Public Health: Challenges for Universities", *Health and Social Work,* Vol. 22, No. 3, pp. 163-170.

Priemus, H. and F. Dieleman (2002), "Social Housing Policy in the European Union: Past, Present and Perspectives", *Urban Studies*, Vol. 39, No. 2, pp. 191-200.

Priestley, M. (2002), "Whose Voices: Representing the Claims of Older Disabled People under New Labour", *Policy and Politics,* Vol. 30, No. 3, pp. 361-372.

Purdue, D., *et al.* (2000), *Community Leadership in Area Regeneration,* Policy Press, Bristol.

Raeburn, J., *et al.* (2006), "Community Capacity Building and Health Promotion in a Globalised World", *Health Promotion International*, Vol. 21, No. S1, pp. 84-90.

Rafelito, A. and N. Wallerstein (2004), *Tribal Community Capacity Building: Mixed Methods*, paper to American Public Health Association Meeting, November, mimeo.

Robinson, F., K. Shaw and G. Davidson (2005), "'On the Side of the Angels': Community Involvement in the Governance of Neighbourhood Renewal", *Local Economy*, Vol. 20, No. 1, pp. 13-26.

Rowe, M. and C. Devanney (2003), "Partnership and the Governance of Regeneration", *Critical Social Policy*, Vol. 23, No. 3, pp. 375-397.

Scarman Trust (2008), *Community Champions Award,* Impact Report London Region, Scarman Trust, London.

Secretary of State for Health (1997), *The New NHS: Modern, Dependable*, Cm 3807, The Stationery Office, London.

Shapely, P. (2008), *Social Housing and Tenant Participation* at *www.historyandpolicy.org/papers/policy-paper-71.html*.

Shirlow, P. and B. Murtagh (2004), "Capacity Building, Representation and Intracommunity Conflict", *Urban Studies,* Vol. 41, No. 1, pp. 57-70.

Simmons, R. and J. Birchall (2005), "A Joined-Up Approach to User Participation in Public Services: Strengthening the 'Participation Chain'", *Social Policy and Administration*, Vol. 39, No. 3, pp. 260-283.

Simmons, R. and J. Birchall (2007), "Tenant Participation and Social Housing in the UK: Applying a Theoretical Model", *Housing Studies*, Vol. 22, No. 4, pp. 573-595.

Simonsen-Rehn, N., *et al.* (2006), "Determinants of Health Promotion Action: Comparative Analysis of Local Voluntary Associations in Four Municipalities in Finland", *Health Promotion International*, Vol. 21, No. 4, pp. 274-283.

Skinner, S. and M. Wilson (2002), *Assessing Community Strengths: A Practical Handbook for Planning Capacity Building*, Community Development Foundation, London.

Smith, N., *et al.* (2008), "Great Expectations and Hard Times: Developing Community Indicators in a Health Communities Initiative in Canada", *Health Promotion International*, Vol. 23, No. 2, pp. 119-126.

Social Exclusion Unit (2001), *A New Commitment to Neighbourhood Renewal*, National Strategy Action Plan, Social Exclusion Unit, London.

Somerville, P. (2004), *Transforming Council Housing*, paper presented at Spring Housing Studies Association Conference, Sheffield Hallam University, 15-16 April.

Taylor, M. (2000), *Top Down Meets Bottom Up: Neighbourhood Management,* Joseph Rowntree Foundation, York.

Taylor, M., *et al.* (2007), *Changing Neighbourhoods: Lessons from the Joseph Rowntree Foundation Neighbourhood Programme*, Policy Press, Bristol.

Taylor, R. (2003), "Indigenous Community Capacity Building and the Relationship to Sound Governance and Leadership", paper to Australian Indigenous Leadership Centre, Canberra, National Conference, June, mimeo.

Thomas, S. and P. Duncan (2000), *Resourcing Community Involvement in Neighbourhood Regeneration*, Joseph Rowntree Foundation, York.

TIS (Tenant Information Service) (2000), *Involving Tenants in Regeneration*, Tenants Information Service, Glasgow.

Wadhams, C. (2006), *An Opportunity Waiting to Happen, Housing Associations as Community Anchors*, HACT, London.

Weinstein, J. (2006), "Involving Mental Health Users in Quality Assurance", *Health Expectations*, Vol. 9, No. 2, pp. 98-109.

Weinstein, Z. (2008), "Citizen Participation – The Case of Israel Project Renewal", *Journal of Urbanism*, Vol. 1, No. 2, pp. 129-155.

White, A. (2006), "Decentralisation, Governance and Capacity Building in Cambodia", *Local Economy*, Vol. 21, No. 4, pp. 423-428.

Williams, J. (2006), "Community Participation: Lessons from Post-Apartheid South Africa", *Policy Studies*, Vol. 27, No. 3, pp. 197-217.

Williamson, A.P., R.S. Beattie and S.P. Osborne (2004), "Addressing Fragmentation and Social Exclusion through Community Involvement in Rural Regeneration Partnerships", *Policy and Politics*, Vol. 32, No. 3, pp. 248-263.

Wistow, G. (2002), "The Future Aims and Objectives of Social Care" in L. Kendall and L. Harker (eds.), *From Welfare to Wellbeing*, London: Institute of Public Policy Research, London, pp. 38-67.

Worley, C. (2005), "It's Not About 'Race', It's About the Community. New Labour and Community Cohesion", *Critical Social Policy*, Vol. 25, No. 4, pp. 483-496.

Young, S. (2000), "Participation Strategies and Local Environmental Politics: Local Agenda 21", in G. Stoker (ed.), *The New Politics of British Local Governance*, Macmillan, Basingstoke, pp. 181-197.