Social Connectedness and Health: A Literature Review

Goetz Ottmann
John Dickson, PhD Candidate, LaTrobe University
Paula Wright, PhD Candidate, LaTrobe University

Social Connectedness and Health:

A Literature Review

Goetz Ottmann
John Dickson (PhD Candidate, LaTrobe University)
Paula Wright (PhD Candidate, LaTrobe University)

PO Box 8078
Burwood Heights VIC 3151
Goetz.ottmann@gmail.com

Melbourne, 21 July 2006

Introduction:

The assertion that social isolation as well as other detrimental environmental factors have potentially negative ramifications for the health of individuals has become one of the pillars of a new approach in public health. Influences such as the report commissioned in 1974 by the then Canadian Health Minister Marc Lalonde [1], the apparent failure of the Alma Ata Health for All Declaration, as well as the seminal work of epidemiologists such as Syme [2], Cassel [3], Antonovski [4], Hinkle [5] and Berkman [6] during the 1970s generated widespread, international interest in research focusing on the social and relational factors of health. This more holistic approach to public health became an important theme in subsequent WHO (World Health Organization)-sponsored congresses, such as the Ottawa Charter for Health Promotion in 1986 that still provides the basis for most contemporary health promotion strategies such as 'the new public health' [7] approach which emphasises social justice, self-determination, participation, community capacity-building, as well as structural determinants.[1] During the 1980s, social scientists such as Coleman [8], Bourdieu [9], and Putnam [10] focusing on the role of networks, collectives, and trust in political and social outcomes added to the impetus of public health debates by popularising the concept of 'social capital'. The impact of these debates has been profound, influencing health policies in globally-focused foundations such as the Ford Foundation, WHO, UN (United Nations), World Bank [11, 12] as well as government agencies across the world [13-15]. In Australia, the nexus of these trajectories gave rise towards the end of the 1990s to new government policy initiatives, such as VicHealth's conceptual framework for action and its Primary Care Partnership (PCP) approach to health promotion. The Inner East PCP led by Uniting Care Community Options is a regional initiative linked to this approach of health promotion that seeks to address the problem of social isolation through the promotion of social

[1] The basic action strategies that emerged during the Ottawa Charter were 'building health public policy, to create supportive environments, to strengthen community action, to develop personal skills, and to reorient health services'.

networks. Its Social Connectedness Project aims to connect socially isolated people with community groups and associations within the region.

This literature review forms part of the first stage of the Social Connectedness Project. Its aim is:

- To undertake a review of the literature focusing on the link between social isolation and well-being in potential target groups such as the elderly, young people, people with disabilities, and the seriously ill;
- To give an overview of strength-based community development strategies and, in particular, Asset-Based Community Development (ABCD);
- To provide an overview over community development projects that employed such a strategy; and to
- To elaborate possible themes that could encapsulate the spirit of the project.

The debates covered by the current literature review are indeed very voluminous. Given the broad terms of reference defined by Uniting Care at the start of the project, it has not been possible to cover all of the constituent debates in detail. Instead, a general overview is provided and, where appropriate, references to existing literature reviews addressing sub-topics are made.

The review is presented in four sections. Section 1 focuses on the key concepts employed in the literature and gives an overview of definitions and conceptual controversies. Section 2 provides an overview over epidemiological debates focusing on the health risks associated with social isolation. Section 3 outlines the ABCD community development approach as well as an overview of Action Research methodology and provides an overview of selected community development initiatives. Section 4 discusses and summarises the findings of the literature review. As requested in the project brief, PhD students were involved in the preparation of this literature review. Their contributions led to the drafting of section 3.

Section 1: Antecedents and Definitions of Key Concepts

Most key concepts and terms used in this literature review mean different things to different people. Whereas older debates such as those outlined by the literature focusing on social support and social networks have, over time, led to an 'unpacking' of these terms in order to increase the empirical validity of the concepts employed, this has only tentatively been the case in the relatively recent debates such as the one focusing on social capital. This section gives a brief conceptual and theoretical overview of social isolation, well-being, and social capital, terms that form the core of this literature review.

Definitions of social isolation generally fall into two categories. Studies that seek to employ 'objective' measures tend to focus on the number of relationships, social interactions, or the extent of networks, whereas subjective studies focus on the quality of interactions. Most recent studies employ both objective and subjective measures quantifying social interaction, while taking into account subjective feelings of emotional isolation and loneliness [16-19]. Indeed, not everyone with low levels of social interaction is necessarily lonely or socially isolated [20]. Hence, subjective measures are seen by some to be crucial in determining social isolation. More controversially, terms such as 'social exclusion' but also 'social fragmentation' or the Durkheimian term of 'anomia' are used to paraphrase social isolation.

Whereas defining social isolation is relatively unproblematic, terms that seek to express the opposite such 'well-being' are much more multifaceted and difficult to pin down. Although the concept of well-being has become a key term in health promotion, there has been little consensus as to the measurement, sources, and meaning of well-being [14]. For instance, whereas psychologists tend to approach the concept in terms of subjective reports of individual happiness and well-being, sociologists and public health professionals have focused on collective and objective measures such as longevity and infant mortality. Moreover, some epidemiologists have focused on the link between social isolation and well-being. In some of the literature, well-being expresses a positive state of individual, relational, or collective being based on a rather narrow conception of

health and mental health, whereas in other contributions, the term is defined in a much more holistic manner. For instance, in keeping with the spirit of the Ottawa Charter as well as the new public health approach, many authors define well-being as a "satisfactory state of affairs for individuals and communities that encompasses more than the absence of disease" [14]. Authors influenced by this theoretical trajectory tend to agree that spiritual, psychosocial, economic and political aspects, as well as the physical environment have bearings for the well-being of people and communities.

At the heart of this WHO-inspired public health approach is the insight that well-being harbours personal, relational, and collective domains and that each one of these domains must be addressed separately when elaborating measurements, determinants, and strategies. The personal domain includes psychosocial needs related to the various coping responses to stressors affecting the well-being of an individual. Determinants in this domain include personal characteristics, cognitive reappraisal processes, and goal-directed coping capabilities [21]. The relational domain includes variables that in the contemporary social science and public health literature are often circumscribed as 'social capital'. Most of the literature dealing with social capital draws on Robert Putnam's influential work and defines social capital as "the norms and networks of civil society that lubricate cooperative action among both citizens and their institutions" [10].[2] However, there has been significant controversy around how to measure of social capital [22, 23] and authors such as Woolcock [15, 24] have focused subcategories such as bonding, bridging, and linking in order to highlight particular forms of community formation expressed by the term. In the public health literature, relational attributes include support networks as well as psychological resources. The collective domain of well-being includes the wider social determinants of health containing variables such as employment, the affordability of housing, nutrition, transport, healthcare, and education as well as the quality of air [25, 26]. By distinguishing between these various domains and their associated methodological and strategic implications, proponents of this

[2] Bourdieu, by contrast, defines social capital as "an attribute of an individual in a social context. One can acquire social capital through purposeful actions and can transform social capital into conventional economic gains. The ability to do so, however, depends on the nature of the social obligations, connections, and network available to you." [9. Bourdieu, P., *Forms of Capital*, in *Handbook of Theory and Research for the Sociology of Education*, J.G. Richardson, Editor. 1986, Greenwood Press: Westport, CT. p. 241-60.

approach argue, it becomes possible to elaborate more appropriate intervention strategies [26-28].

Perhaps the most important development in public health over the course of the last two decades has been the departure from behaviouralist models focusing exclusively on the health of the individual. In fact, numerous studies have demonstrated that approaches that singularly focused on the personal sphere tend to be limited because of their failure to take into account the social surroundings that support individuals [29, 30]. Within public health, this insight has led a wide range of authors to focus on the relational, social, as well as environmental aspects of health [2, 31, 32]. Similarly, it has been recognised that strategies that focus exclusively on the promotion of well-being through community development are potentially limited because of a tendency to romanticise communal life [14, 20, 33]. Some authors go as far as to point out that certain groups can have a potentially detrimental impact on individuals [34-36]. Moreover, studies focusing on the impact of strategies that address the social determinants of health, although clearly demonstrating that social inequality is positively correlated with poor health [13, 25, 37-45], have suggested that such an approach often inadvertently disempowers the poor because of its failure to turn the poor into key protagonists [46]. Hence, what seems to emerge is an acknowledgement that health promotion interventions have to address each of the three domains bearing in mind the inter-connectedness of personal, relational, and collective aspects of wellbeing [38].

To be sure, by necessity such a multi-facetted approach draws on an interdisciplinary body of literature. Summarising this literature focusing on the **personal domain**, Susan Folkman and Steven Greer differentiate between dispositional and situational variables as well as coping processes that influence a person's well-being [21]. In her view, among the more promising variables are a person's ability to appraise a situation in a way that allows for a sense of control in the way to produce desired outcomes, personal resilience [47, 48], dispositional optimism [49], mastery [50], and internal locus of control [51]. Situational variables include efficacy beliefs and hope. Efficacy beliefs default into two categories: outcome efficacy (the belief that there is an appropriate strategy that can bring

about the desired outcome) and self-efficacy (the belief that one can successfully follow this strategy) [52]. However, research has conclusively demonstrated that efficacy beliefs are strongly related to intention and action. Hope is an alternative variable denoting an individual's belief that a favourable outcome is possible and the individual's ability to visualise how that outcome will come about [53]. Furthermore, various forms of coping, such as growth-related coping [54], transformational coping [55], benefit-finding and benefit-reminding [56], positive illusions [57], positive reappraisal [58], and goal revision and substitution [59], have been identified. Most coping processes involve facets of cognitive reframing, a practice that involves the re-evaluation of a situation consequently allowing a person to view aspects of the situation in a positive light. A more radical form of cognitive reframing entails the redefining of priorities so that they correspond more closely to a given situation. This mechanism generates a sense of meaning and personal control and facilitates goal-directed coping [21]. Translating these findings into a practical environment, Folkman and Greer emphasise the importance of creating the conditions for challenge (finding out what matters to the patient, establish goals, emphasise opportunities for personal control), encouraging behaviour to achieve goals, and maintaining a positive background mood [21].

At the **relational level**, health promotion interventions need to draw on a range of debates focusing on variables such as social isolation, support, and social networks. Over the course of the last decade a growing number of authors have emphasised the importance of community participation for successful health promotion outcomes. Participation represents also a core component in 'social capital' a further category that is increasingly related to health outcomes [24, 60-64]. Also, participation means different things to different people. Baum and Bush et al. [22], for instance, have argued that much of the health literature links the concept of participation to organisational imperatives and associated aims of increased community participation. Yet, Baum has lent emphasis to the claim that if participation is encouraged by external agencies pursuing particular policy ends, it has a very limited impact indeed [7]. Baum and Bush et al. foreground that genuine participation can produce much more developmental outcomes [22]. Under such conditions, however, participation has "dynamic, unquantifiable and essentially

unpredictable" characteristics that permanently and intrinsically shape organisational and communal life producing the kind of trust and networks that form the basis of social capital [65]. However, this form of "engaged and ongoing participation" does not easily occur [22]. The study of Baum and Bush et al. concludes that the "crucial messages for policy makers are that social capital and its constituent community processes such as social and civic participation are extremely complex, reflect existing patterns of social disadvantage and are not well suited to "quick and dirty" measurements [22].

Moreover, several of the above studies suggest that the variables that influence the personal and relational level are in many ways shaped by **social determinants**. Indeed, the social determinants of health have been well studied and although some claims within the field are still hotly debated, many authors would agree that poverty, inequality, social exclusion, unemployment, stressful work, low levels of communal and civic participation and health promotion, substandard or inaccessible public education, health, day-care, and leisure facilities, and poor access to nutrition, affordable housing, and public transport, impact negatively on health and mental health outcomes [13, 25, 38-41, 43, 45, 66-70]. Hence, health promotion interventions have to factor in and respond to political decisions affecting the collective domain. To be sure, the social determinants of health have been exhaustively studied and excellent overviews can be easily found [25]. Hence this review does not deal with this body of literature in detail.

Section 2: Social Isolation and Health

Overview over different approaches;

Various definitional constructs, such as networks size, network characteristics, social integration, social engagement, perceived support, and received support, have been applied in studies linking social connectedness/isolation to health. The results have been varied. And although inroads have been made into linking specific relational elements such as social support to health outcomes, the available evidence suggests that these links are often complex and that these variables are often, at best, moderately correlated [71]. This section provides a brief overview over the measures that have been employed and the relative success to correlate these measures with health outcomes. The section draws an extensive review conducted by Bassuk [71].

Network Size has been employed in a range of studies focusing on health outcomes. However, its explanatory power regarding health outcomes as well as network integration is relatively weak. **Network density** is a more promising indicator when focusing on network integration. High-density networks appear to play an important part in the maintenance of a sense of identity and provide access to collective support resources. Low-density networks play an important role during life transition events such as divorce, unemployment, and geographic relocation. However, few attempts have been undertaken to develop more sophisticated measures of how networks affect health [71].

A wide range of **social network participation** measures has been developed over the last two decades. Among the more important ones is Cohen's Social Network Index (SNI) assessing participation in 12 types of social relationships. The SNI was employed in Cohen's well-known study relating the diversity of social networks to the susceptibility to the common cold [72]. In general, the SNI has been employed in studies that show some correlation between the measure and health.

Perceived integration measures have been used to establish scales of subjective integration measures. For instance, Heidrich and Ryff's study associates subscales of perceived integration with decreased psychological distress and increased life satisfaction. Other perceived integration measures include the Malmo Influence, Contact and Anchorage Measure (MICAM), the MICAM, the Rand Social Health Battery measure (RSHB), and Berkman's Social Network Index (BSNI). The BSNI measures four indexed and weighted categories of social networks (marital status, contact with friends and family, church membership, group membership) foregrounding the importance of intimate contacts. The BSNI was used in Berkman and Syme's well-known Alameda County study [6]. In the Alameda County study, low BSNI scores were associated with greater total mortality. Subsequent studies using a slightly modified BSNI demonstrated that this link is much more tenuous and needs qualification [71].

Social Support Measures have been widely used in epidemiology and community psychology. In fact, social support measures have been regarded by some as the most appropriate measures for studying processes through which social resources contribute to coping with stress (Wills & Shinar 2000). A wide range of social support measures has been developed. Among the more widely used measures are the Interview Schedule for Social Interaction (ISSI), the OARS social support scale, the Arizona Social Support Interview Schedule, the Perceived Social Support from Family and Friends (PSS), the Social Support Questionnaire (SSQ), the Interpersonal Support Evaluation List (ISEL), the Work Relationship and Family Relationship Index, Multidimensional Scale of Perceived Social Support (MSPSS), the UCLA Social Support Interview, Seeman & Berkman's (1988) EPESE perceived support measures, the Duke Social Support Index, the Medical Outcomes Study Social Support Survey, the Close Persons Questionnaire developed for the well-known Whitehall II study, and the more recent and more sophisticated ENRICHD social support instrument. The more recent measures allow a differentiation between specific support functions (emotional, instrumental, companionship, etc.).

The literature on social support suggests that the availability of social resources such as physical and emotional support are positively associated with the survival and recovery from stressful life events such as serious illness, traumatic loss, or transition than predicting the onset of health related problems. Moreover, participation in social networks is correlated with positive physical health outcomes irrespective of stress levels [73]. It appears, thus, that social resources play an important role in the protection against the pathological impact of stressors and may enhance the factors that contribute towards greater resilience. Moreover, studies suggest that ethnic and cultural factors may have important bearings on health outcomes related to social connectedness and social capital.

Measures of social capital, social cohesion, and psychological sense of community have been generally derived from larger social surveys conducted by opinion research centres. In Australia, the notion of social capital has spawned a wide range of attempts to operationalise the concept [60, 74, 75]. This, however, has been far from easy and in many studies social capital became a catch all category incorporating most of the above-mentioned terms [see, for instance, 60]. To some extent, this reflects the fact that empirical studies focusing on the link between social capital and health have developed only relatively recently. However, it is also true that attempts to link social capital variables to health outcomes have been stifled by conceptual weaknesses [22, 23, 76]. More recently, the Saguaro institute associated with Robert Putnam has developed a range of tools and measures, such as the Social Capital Index that represent a useful point of departure for future studies as well as community development interventions (http://www.ksg.harvard.edu/saguaro). Whereas the evidence linking social capital to health has been limited to date, the concept and its underpinning idea that communities are the bedrock of society play an important role in community development initiatives outlined in Section III.

Recent studies that have focused both on personal, relational, as well as social determinants of health have foregrounded that these variables are heavily inter-related. This again reinforces the point that a three-tiered approach focusing on all three domains is needed to address health inequalities [39, 42, 44, 45, 67, 69, 70, 77-79].

Social Isolation and Youth

The relationship between **psychological and social resources and resilience** has been explored by numerous studies focusing on youth. More recently, studies incorporate personal, relational, and collective aspects of resilience and risk. Within that literature, resilience generally refers to factors and processes that help to overcome the negative effects of risk exposure and assist in coping with traumatic and stressful experiences [80]. Thus, studies focusing on resilience concentrate on strengths rather than individual or social pathologies. *It is important to bear in mind that resilience in this debate does not refer to innate personal traits***.** Three models of resilience (compensatory, protective, and challenge) have emerged in the literature emphasising different mechanisms of resilience-enhancing variables. Variables that have been associated with greater resilience in the face of substance use and stressful life events are self-esteem, internal locus of control, positive affect, social competence, academic achievement, and religiosity. Family connectedness, support, and parental involvement at school was found to be a protective factor against emotional distress that could lead to greater susceptibility to risk influenced behaviour [80]. Other factors such as parental authority, family income, and parental education also seem to have a protective influence. Focusing on violence, maternal support, parental monitoring, parental presence, school connectedness and perceived social status are important variables [80]. Sexual behaviour is associated with variables such as self esteem, participation in extra-curricular activities, school connectedness, educational measures, and religiosity as well as socio-economic status, parental monitoring, and open communication [80]. Peer groups are, by and large, perceived as risk factors.

Similarly, in debates that approach questions of social isolation and youth in a different manner close family ties seem to function as a stress buffer [81, 82]. And some claim that' social capital has a strong protective influence on alcohol abuse and harm in college including among high risk students [83].

Social Isolation and Mental Health

The link between social support and especially intimate emotional support and health has been particularly emphasised in earlier studies that focus on psychological outcomes [71]. For instance, this link between supportive intimate relationships and health outcomes has been emphasised in studies focusing on depression and psychological distress [84, 85]. Other studies have documented that the disruption of such ties results in substantial levels of psychological distress [86]. The relationship between social support and depressive symptoms has been also emphasized by studies focusing on depression as a result of serious, deformation-causing illness such as cancer of the neck [34].

Research focusing on the role of intimate partnerships and cohabitation corroborates these findings but highlights important gender differences. The dissolution of partnerships was associated with poorer mental health, partially reversed by the reformation of partnerships. Yet, women appeared to be more negatively affected by multiple partnership transitions and take longer to recover from partnership break-ups. However, single women had good mental health relative to other women but the same was not true for single men relative to other male partnership groups [87].

More recently, authors have focused on the potentially beneficial effect of social networks on psychological and emotional health and well-being [88]. Drawing on the work of Cohen and Willis [73], Kawachi and Berkman emphasised two complementary mechanism in which social networks have a stress buffering effect and a general effect irrespective of stress to explain the impact of social networks on mental health [88]. Whereas the structural aspects of social networks are seen to influence levels of well-being irrespective of stress levels, functional aspects are seen to operate as stress buffers. Moreover, recent studies have foregrounded the importance of approaching mental health from a ‘life-course’ perspective taking into account the impact of key periods of development on long-term wellbeing [89]. It has been suggested that social networks have a psychosocial as well as a psychological effect on mental health outcomes. In particular, social networks are said to generate psychological effects when they provide

social support, social influence, opportunity for social engagement and meaningful roles, resources and material goods, and intimate contact [89]. The psychosocial impact of social networks is claimed to transform behaviours. Others, however, have cautioned that critical or overly demanding social networks may have detrimental impacts on individuals [90].

A number of studies have asserted an inverse relationship between social capital and common mental disorders [91], binge drinking [92-94], happiness and well-being [95], depressive symptoms [96], feelings of vulnerability regarding crime [97], distress [98], emotional health [99], child psychological adjustment, suicide, and anti-social behaviour [60]. For instance, there is moderate evidence for an inverse relation between cognitive social capital and child mental illness [100]. However, a range of authors revising these and similar studies have argued that the current evidence is inadequate to inform the development of specific social capital-based interventions to combat mental illness [96, 97, 101, 102].

Social isolation is a grave problem for homeless people suffering from mental illness [103].

Social Isolation and Serious Illness

There is substantial evidence that social isolation is a significant risk factor for people facing serious illness. In particular, the lack of social support appears to increase stress pathologies, such as post-traumatic stress disorder or depression, associated with cancer diagnosis, treatment, and physical effect [34, 104]. Moreover, social isolation, among other factors, appears to significantly reduce the quality of life of cancer survivors [105, 106].

Social Isolation and People with Disabilities

Although the detrimental impact of social isolation on people with disabilities has been highlighted by seminal research four decades ago [107], studies focusing on the impact of social isolation on health outcomes for people with disabilities are scarce. Perhaps the most coherent longitudinal research addressing this issue has been conducted in the United States. For instance, a longitudinal study commissioned by the National Organization on Disability highlights the most important, persistent problems that affect people with disabilities: unemployment, poverty, discrimination in the labour market, lack of adequate school support, lack of transport [108], unsuitable architecture and infrastructure, social stigma, as well as social isolation [19, 109-112].

In particular, social isolation has been identified by the U.S.-based Baylor College of Medicine as a common secondary condition associated with any primary disability in women. Moreover, it has been recognised that social isolation can have detrimental effects regarding both mental and physical health in both men and women. This is aggravated by an increased sense of vulnerability in the face of sexual or physical violence. Interestingly, the Baylor summary report argues that age, education, and disability are weak predictor of social isolation. Positive school environments, less over-protection, more affection at home, and the sharing of experiences with other women tends to lessen the degree of experienced social isolation and potentially contributes to positive health outcomes [113].

A recent study focusing on the social connectedness of young people with physical disability revealed that the most important predictors of participation were energy and pain, disability, and self-efficacy [114]. The efficacy of different coping strategies has been explored by other studies [115].

That disability has detrimental effects on the leisure activities of carer families has been born out by a recent study commissioned by the U.K.-based NGO Contact A Family [116].

Social Isolation and the Elderly

A growing body of literature provides strong evidence that social isolation is common problem for the elderly with potentially devastating consequences. A recent Queensland Government report regards social isolation as an outcome of a range of contributing factors such as loss of health and in particular mobility, vision, hearing and associated loss of independence; loss of partners, relationships, and networks; mental illness, providing long-term care, lack of functional and technical literacy, lack of language skills, remote place of residence, the transition into an aged care facility, a sense of fear and vulnerability, lack of suitable transport options, and community attitudes [117].

Moreover, longitudinal studies indicates that a depressed general outlook in conjunction with functional disability [118], the loss of a spouse and the lack of a confidant [118], lack of emotional support [118], and few social ties [119], poor integration into [119], the lack of children visiting [118], and social disengagement [119-121] are risk factors for cognitive decline and poor mental health outcomes. Moreover, attempts to qualify the networks that are of importance to the elderly have shown that having diverse networks of friends able to offer support are associated with low depressive symptomatology [122]. Interestingly, the presence of a network of friends in the absence of family was rated less grave than the presence of a network of family in the absence of friends [122]. Nevertheless, the absence of a life partner is associated with serious health concerns as it appears to increases the risk of, for instance, Alzheimer's disease [123].

Social Isolation, Gender, Ethnicity, and Culture:

In the above-mentioned studies, a wide range of authors have alerted to the fact that gender, ethnicity, and culture are important variables and need to be taken into account

[42, 67, 77, 78, 87, 94, 119, 124-126]. Such accounts support the view that health and well-being is importantly shaped by socially constructed roles and behaviours that are also influenced by economic variables [127, 128].

Section 3: Applied Community Development

This section describes some themes and approaches to applied community development aimed at increasing social connectedness. It discusses asset based community development (ABCD), action research as frameworks for planning and evaluating projects, and describes Australian and some international project case studies which display useful ideas.

Asset-Based Community Development (ABCD)

Asset-Based Community Development (ABCD) is an approach to community development which seeks to identify and develop existing strengths (assets) in the community [129, 130]. These form the building blocks for community-based projects to address local needs. ABCD posits that in every community there are latent capabilities, skills, and opportunities for individuals and groups to build upon. This approach contrasts with traditional forms of community development "from above", which identifies needs and deficiencies and establishes programs to address them. It is argued that the traditional process of identifying and addressing problems can develop and perpetuate negative identities for clients, whose needs and deficiencies come to determine the provision of services. Clients may increasingly focus on their negative characteristics rather than on capabilities that could be developed. Further, when it is need and not capability that determines community investment, clients have an incentive to exaggerate and perpetuate their deficiencies and little reason to identify and develop their strengths.

ABCD argues that no strong and vital community is built out of weaknesses. If meaningful progress is to be made in renewing community bonds and the benefits that come from them, strengths and capabilities need to be identified and developed across the spectrum of community actors [131, 132]. For ABCD to be truly effective it needs to be

driven by community members and have broad-based support within the community. Few successful community development projects are imposed “from above” or implemented by a select few.

The first step in implementing Asset-Based Community Development is the identification of strengths in the community [133, 134]. This is often carried out with the use of questionnaires, sent to all individuals and associations within the community, which identify abilities and survey the willingness of community members to participate in local developments. It also surveys ideas from community members on how local life could be improved and how they or others might contribute to it [134]. The process of asset identification provides a useful base from which potential community developments can be evaluated by community leaders. It can also serve to highlight synergies between different individuals and groups by requesting proposals for developments from those surveyed and identifying actors who might be prepared to work on them. An asset “map” of the community forms the basis from which community developments can be evaluated. Often, merely the process of cataloguing community actors can reveal potentially beneficial relationships. Potential actors in community development projects number not only the traditional participants such as citizens and neighbourhood and voluntary associations, but also schools, hospitals, police stations, and even those not often associated with community life such as banks and other private businesses. Significant community development lies not only in developing the human and social capital of the community, physical spaces also play an important role and can be symbolic of community renewal. Part of the mapping process is also to identify urban spaces, such as disused lots, parks, and school grounds, which could be the site for development projects or merely provide meeting sites for groups that form out of the asset identification process. In many cases the transformation of dilapidated urban spaces, through processes such as ABCD, can prove to be symbolic for their communities. Changes to the urban aesthetic can also help the region economically as businesses and real-estate investors recognise the improved environmental conditions.

By drawing together community actors in a democratic development process and focusing on strengths and rather than deficiencies, ABCD can help to enforce positive identities for socially excluded and stigmatised individuals [130]. Labels such as “unemployed”, “disabled”, and “mentally ill” that have been reinforced by years of needs-based service provision, can give way to more positive identities as the focus moves to the contributions that individuals can make instead of the problems they have. Building relationships between people with negative “labels” and the community can thus help mend the process of social exclusion, as a diverse array of community actors work together collaboratively and build relationships they otherwise would not have had. The processes of social exclusion, that have been aggravated in recent years by neoliberal policies, including industrial decline, large-scale redundancies, and a reduction in social services, have renewed the impetus for stronger and more vital communities of the type the ABCD approach seeks to build.

Another of the ABCD’s strengths is its ability to draw together disparate community actors that are committed to community development. As ABCD is based on grassroots input from willing individual and associational participants, the process can reconnect members of the community to work collaboratively on development projects. Perceived weaknesses, such as high unemployment, can become opportunities as new local developments require time inputs, either paid or voluntary, which can in turn develop new skills, improving the employability of participants. Of course, a potential weakness of this approach is that it requires willing and committed community actors that are prepared to invest in local developments. It also requires that participants are able to agree on which projects to develop given available resources. As in all democratic settings, there can be conflict as priorities naturally differ between participants and groups. Here, local leadership can play an important role in managing disagreement. To that end, the assets identification process will often give direction to the development effort by highlighting potential strengths and synergies in the community.

So, while ABCD has the potential to make a significant contribution to community building efforts, there are several weaknesses to the approach. First, it requires a

committed leadership group which can coordinate, inspire community participation, and manage conflict effectively. Second, and perhaps most importantly, it requires committed community actors. Without a self-motivated and broad-base of participants and associations, the ABCD approach cannot sustain itself. Many people that have little or no history in community development may be unwilling or unable, due to time constraints or other commitments, to participate in the development process and their voice may not be heard. Indeed, these may precisely be the "socially excluded" whose integration into the community ABCD attempts to accomplish. Third, ABCD is not a proscriptive process leaving the possibility for some community developments to become directionless. Following the "mapping" process outlined above there is only a minimal guide for ABCD projects. It could be well argued, however, that an overly proscriptive system could not address the diversity of community development projects, and that it would, in any case, stifle the approach's democratic process. Fourth, in a context of diminishing social services, ABCD risks placing responsibility on community members for social services that can realistically only be delivered by the government. While, in many cases, degrading social services may simply be a fact of life, ABCD might be able to build into its approach the possibility of lobbying local government, or other state institutions, by community organisations to support their efforts.

Notwithstanding these qualifications, many community leaders are recognising that substantial help from outside the community is not to be relied upon. Concurrently, many studies of community development projects have found that the most successful are those that are driven by community members and that are built on the strengths of the community. To that end, the ABCD approach is an important consideration, even if not strictly adhered to, for community leaders seeking to improve social relations between community members and draw on their strengths for local developments.

As a guide, Kretzmann describes asset-maximised communities as those in which assets are:

1. discovered, inventoried and made visible;

2. convened for the purposes of planning and strategizing about their own future and about the future of their neighbourhood;
3. connected with each other in a newly strengthened web of mutually beneficial relationships; and
4. engaged, as a final step, in attracting and controlling additional outside resources [135].

Action Research:

Action research has emerged as a form of inquiry often used on social change projects. Three elements are important: the participatory character of action research; its democratic impulse; and its simultaneous contribution to social science and social change [136]

It is particularly suited to evaluation research as it is practiced on projects as they are in progress, and is carried out as part of the project itself, usually by the project staff [137]. It is conceived of as a reflective and evaluative part of a social change project, rather than a research project conducted separately [138]. The evidence collected through action research is usually qualitative, though interviews and discussions, rather than quantitative survey data. It appears to be particularly compatible with health, educational and other community projects because of the compatibility of values (with health and social work ethics and ideals), and the skills of project workers in that area. Crane and Richardson [138], writing on action research use for the Department of Families, Community Services and Indigenous Affairs, report that action research became a well-regarded part of project planning and implementation for the human services workers they worked with.

In ‘participatory action research’, the ideal is for all parties to have a stake in the research process. However, Reed, [139] reports that the democratic nature of participatory action research may pose some problems in health practice. The study she reports on was conducted in a residential facility with nurses as researchers. The research stalled when the response rate fell dramatically, and this was attributed to a reduction in interest from

the nurses. The study had not originated with the nurses and although they were and felt a part of the process the study investigated, they had little ownership in the study. So, while participation by all parties involved is an ideal, consideration must be given to varying interest levels from parties. For example, the nurses in the study above may have been more interested in participating by actively including external researchers rather than collecting information directly.

Moyer and others carried out a study which used action research to identify older people in need [140]. In the absence of agreement on exactly what aspects of social ties determine health, the researchers collected a broad range of data including accepted scales of self-functioning, ethnographic data and social network maps. They found differences in social networks of older people in need, according to the size, density and shape of the social network, and whether a key person (typically a spouse) was present. In discussing their research they emphasise the difficulties resolving the need for well trained professionals spending time with individuals to provide the depth needed for adequate evaluation, and the need for efficient processes so more individuals can be assessed (breadth).

Case Studies

Below a range of case studies are described. They display different methods of implementation and planning, and the specific approach of one funding body, the Victorian Department of Communities, is discussed. There is great variety in the substantive content of the programs, and project with different target groups, both general and specific, are discussed as they display characteristics of interest.

St Luke's Shared Action project: Long Gully, Bendigo, Victoria.

The Long Gully project began with a year of Shared Action promotion and conversation through schools and the Long Gully Community House. Weekly meetings commenced after some people indicated a desire to join Shared Action. They organised a series of

barbecues and parties and a ‘visioning’ process, aimed at picturing a stronger community, began after these social events [141]. Meetings were held at the Community House and involved parents and teachers of two schools with a high proportion of Long Gully as well as the working group and their recruits from the social gatherings. A comprehensive picture of how teachers, parents and children would like their community look emerged from these meetings. Four months later, a planning meeting was held to discuss project priorities that could be derived from the shared vision. Two projects were selected, which adequately addressed their criterion of increased social interaction, child safety and the preference for activities unrelated to welfare dependency: the construction of a family park and the establishment of a Sport and Recreation Club [141].

Under the umbrella of the Sport and Recreation Club, another committee decided to organise a concert to fundraise for the Club. The concert was a great success as various other groups participated in the organisation: the local council, from local business and even local well-known radio announcers. Another initiative of the Club was the emergence of an Under 12 Football team which was a successful social capital building exercise because it required many volunteers and had broad family appeal. While the working group for the family park successfully built connections with local government, Rotary, the Office of Housing and gained support from local business, the construction of the park was laboured due to bureaucratic regulations and some members of the group were disappointed after having expectations that the project would be realised sooner than it was and with more active participation. This disappointment underlines the importance of establishing realistic expectations from the community building process. Especially dangerous is the sense of disillusionment with welfare agencies that may ensue after high expectations are not met.

It is the opinion of the St Luke’s project workers that prior to involvement in Shared Action, people in the community did not trust each other sufficiently to warrant any joint action [141]. Therefore, the most positive outcome was the discovery of the possibility of building trust by working together for a shared goal. Another successful sustainability strategy was to deliberately not include money for community projects within St Luke’s

budget. This meant that with the assistance of the project worker, the community learnt how to access resources themselves and communicate with bureaucracies (from local fundraising efforts to council, government and business funding). Despite these positives, the Shared Action team realised that due to the high support needs of many of the community, regular commitment was difficult to sustain. To counter this trend, consultations were made with other welfare agencies to ensure that once project funding ceased , the community would receive sufficient encouragement and support to allow for continued participation in the activities [141].

Department of Victorian Communities Program case studies

A number of projects across Victoria were funded by the Department of Victorian Communities (DVC), with the aim of building stronger communities. The Department sought partnerships with local governments in the area and the DVC program design included local governance or advisory committees which would devise project content and manage the operation with a project manager. The program structure was based on a philosophy that local governments must be involved in local projects. DVC also included and funded a program planning stage, in which a community worker led a local committee in discussion and decisions on what the community needed. The inclusion of a funded community consultation stage is compatible with the ABCD processes' emphasis on community leadership and the need for communities to audit their strengths and needs.

Bass Coast Shire Creatively Connecting Communities project.

Place: In and around Wonthaggi, Phillip Island and Inverloch, Victoria.

Target: Scarce social networks generally

Content: 'Oral Histories'

Structure: Department of Victorian Communities (DVC) funded, auspiced by Bass Coast Shire Council.

Process: Project facilitator formed a project working party from local people to collect oral histories from people in the shire. Working party chose subjects, recorded histories, and developed another part of the project- to

create a live ‘performance’. Another group formed to create music and stage the performance in the local pub.

Central Goldfields Connecting Confident Communities.

Place: Maryborough and surrounding townships, Victoria.

Target: General

Content: Small grants program

Structure: Department of Victorian Communities (DVC) funded, auspiced by Central Goldfields Shire council.

Process: $13,000 (part of DVC grant) allocated to small grants program. Volunteer committee established to create grant program, allocate and manage grants. Grant program aimed at small community groups, including informal ones, for activities which encouraged people who would not normally meet to get together. Funding recipients required to provide short written report.

Difficulties: Program funds were exhausted quickly and group then spent a great deal of time attempting to solicit funding from businesses. Grant payment, and reports, took longer to process than group anticipated.

Darebin Community Building Project

Place: Melbourne suburbs of East Preston, East Reservoir, Victoria

Target: Long term and new residents without social networks in the area, or with limited networks which excluded other residents.

Content: Community festival

Structure: Department of Victorian Communities (DVC) funded, auspiced by the City of Darebin.

Process: ‘Growing together group’ established to encourage community participation. Decided to have a community festival. After planning, festival attracted 400 people and, more importantly, broad interest in participating in next festival planning.

Difficulties: Group began slowly but community workers encouraged participation and numbers increased.

StreetsAhead

Place: Geelong suburbs of Norlane, Corio, Rosewall and Whittington

Target: Broad, increase community participation through organisational partnerships

Content: StreetsAhead committee formed of a number of agencies.

Structure: Department of Victorian Communities (DVC) funded, auspiced by the City of Geelong

Process: Consultative committee formed and priorities set; a range of funding types made to work more efficiently.

Difficulties: Some organisations unable to participate because of the very specific requirements of their funding contract.

'Doggies to Highpoint'

Place: Melbourne suburb of Footscray

Target: Isolated older residents of public housing

Content: Cooking classes, newsletter, art and photography exhibition

Structure: Department of Victorian Communities (DVC) funded, managed by Mission Australia and Maribyrnong city council.

Process: Project worker employed, who began with cooking classes and developed other ideas with input from participants

Difficulties: Participation numbers initially low but grew, many participants wanted to attend but not take on organising work.

'Doggies to Highpoint' (2)

Place: Melbourne suburb of Footscray

Target: Recently diversified area, few cross-cultural local networks

Content: Maps provided and map skills classes provided

Structure: Department of Victorian Communities (DVC) funded, managed by Mission Australia and Maribyrnong city council.

Process: Local leadership group established. Map reading project proposed, and map reading workshops developed.

Difficulties: Committee skills needed to be learnt before the leadership group could make progress. Initial low response to advertising of workshops.

Rural Isolated Transport Enterprise (RITE Of Way),

Place: Maryborough, Victoria

Target: General, those without cars

Content: Better public transport

Structure: Lobby group for better public transport.

Process: A committee took up the issue of poor public transport. They took up a federal report on the state of transport and initially lobbied local transport operators. This was unsuccessful, and so were approaches to local and state governments. The committee changed focus and produces a comprehensive leaflet of existing transport options, which was very popular. They then developed a plan for a pilot program which would supply a community bus which would be operated by volunteers.

Difficulties: Several knock backs by transport operators and governments.

Proud to Participate

Place: Melbourne suburb of Noble Park

Target: General; socially disadvantaged area

Content: Movies

Structure: Department of Victorian Communities (DVC) funded, managed by the City of Greater Dandenong

Process: A shopfront was staffed with project workers and locals invited to opening. A community committee was created, which decided a free movie night and stalls in a local park would be a good way of connecting local residents with existing groups.

Difficulties: The outdoor event was cancelled because of rain, although community interest was so high a second event was organised very quickly.

Proud to Participate (2)

Place: Melbourne suburb of Noble Park

Target: General; socially disadvantaged area

Content: Audit of skills, resources and capacities in local area

Structure: Department of Victorian Communities (DVC) funded, managed by the City of Greater Dandenong

Process: Subcommittee of volunteers investigated research methods and recommended interviews based on questionnaires. Volunteers received training and participated as community consultation leaders. Data was collected and a report produced.

Difficulties: Time delay in project while suitable training sourced, with some volunteers losing interest in the meantime. Volunteer schedules difficult to match with respondents and project availability.

Pyrenees Community Building Project

Place: Towns of Avoca, Beaufort, Landsborough, Lexton and Snake Valley in Victoria

Target: General

Content: Developing a community and business phone book

Structure: Department of Victorian Communities (DVC) funded, managed by Pyrenees Shire Council.

Process: Idea initially proposed by the local council prior to funding. Steering committee established, of council, community organisations and community members.

Difficulties: The committee sub-contracted some, and carried out the remaining data collection work, which was time consuming and included some errors.

Pyrenees Community Building Project (2)

Place: Towns of Avoca, Beaufort, Landsborough, Lexton and Snake Valley in Victoria

Target: General

Content: Upgrade community hall

Structure: Department of Victorian Communities (DVC) funded, managed by Pyrenees Shire Council.

Process: A committee was formed with participants from local government and business, which developed a plan for building upgrade. Funding was sought from state and federal bodies and some fundraising was undertaken.

Difficulties: Disagreement over building colour scheme.

Warrnambool Action Vision for Everyone (WAVE)

Place: East Warrnambool, Victoria

Target: General, local community

Content: Whitehead Meeting Place

Structure: Department of Victorian Communities (DVC) funded, managed by Warrnambool city council

Process: East Warrnambool Residents Association formed. The Office of Housing was approached and agreed to provide space which would provide local community organisations offices to work from and local residents with a community space. A house was identified and provided. Agencies are now able to work together and, closer to their target communities.

Difficulties: It may take some time before residents feel familiar and comfortable using the space

Warrnambool Action Vision for Everyone (WAVE) (2)

Place: East Warrnambool, Victoria

Target: General, local community

Content: Better parks and gardens, local festival

Structure: Department of Victorian Communities (DVC) funded, managed by Warrnambool city council

Process: East Warrnambool Residents Association formed. Group lobbied local government to increase maintenance in local parks and gardens. The association then devised activities to increase the use of facilities, including bicycle safely programs and a local festival.

Difficulties: High turnover of residents continues, which makes establishing networks more difficult

Other Australian projects

The Benevolent Society "Old Friends" visiting program

Place: Sydney, NSW

Target: Older people, already receiving a Benevolent Society service, who are socially isolated

Content: Volunteers visit people at home or their residential care.

Structure: Managed by the Benevolent Society

Process: Volunteers are recruited and trained by the Benevolent Society. They are then matched with an older person and arrange a visit time at least once a fortnight.

Warnervale District Community Survey

An excellent example of the asset-articulation and needs assessment phase of ABCD is the Warnervale District Community Survey. It was established in 2000 and is planned to continue until 2010. The survey had a mixed methodology, incorporating focus groups, questionnaires, interviews and participant observation. The aims of the survey were broad and included information collection on the substance and method of community development. It investigated local area and facility use, public and private groups, and also investigate the specific experience of new arrivals to the community. Some findings included;

- Participation in local community groups, meetings or events was associated with positive changes in feelings about the area, and feelings of connection to others in the area.
- The time when new families arrive in the area is a key time for establishing feelings about living in the area, and patterns of participation in local networks.
- While all types of community participation are connected with positive changes for people, in some cases, the type of participation seemed to be specific to the type of changes. For example, people who participate in the Community Centre had an increased perception that they had the ability to change things they care about, while people who participate in the festival were more likely to be able to get help from friends when they need to, but show no significant difference in their feelings that they have the ability to change things they care about. Other activities were associated with broader positive changes.

Health and Community Participation in the Barwon and Otway Region (Victoria)

The Barwon Primary Care Partnership Alliance developed a project aimed at measuring subjective levels of health and community participation in the Geelong area. They used existing psychometric indicators to measure physical and mental health, and collected certain demographic information.

They found that increased age and low income levels were associated with lower physical activity levels and that low income, a younger age, and poor physical health was associated with less community engagement. They also included subjective measures of self-efficacy; the feeling of an individual that they are able to change their community or environment themselves. From this data, the project team prepared some recommendations for interventions and target groups, and aimed to survey the population again to measure any changes after implementation of interventions.

The Latrobe Valley Community Partnering Project

The Latrobe Valley is an area which has suffered job losses, population losses and associated withdrawals of services since the privatisation and decline of the main industry

in the area. The area had previously relied on attempts to attract large new industries to revitalise the townships, but this project developed community based enterprises though partnerships with local individuals.

Action research and an asset-based community development model were employed, and the researchers involved began the project with a somewhat radical idea of introducing social theoretical concepts to participants. In practice, this meant translating social theories into key principles which were meaningful to participants, for example, geographic economic work prompted the researchers to build a more diverse model of the economy with participants, one that included unpaid work, exchange and barter, and unutilized skills as resources, and characterising research as finding information. The information gathering beginning of the project used photo-essays from local residents to discover the dominant images of the area held by locals, and residents were employed as researchers. An additional qualitative stage followed, with informal interviews of residents, prompted by the photo-essays. While working informally to introduce the research to residents and draw out often repeated ideas and criticisms of the circumstances they were in, the researchers were also finding some strengths and resources already existing in the community. A more formal stage of collecting positive ideas of the community followed, through some written but still relatively informal data.
Once this picture of strengths was built, the researchers sought to use the skills and strengths broadly. This happened in a series of workshops with both the participants of existing programs, and by open invitation. They were activity themed workshops-making pizzas and fixing bikes, and aimed at generated ideas about further social assets and enterprises. It is reported that over 60 ideas were generated [142]. Ultimately, four projects were established; a community garden, a Christmas decoration workshop, a woodworking shed, and an electronic music and performance co-op. Federal, State and local government resources and funds were sought and mobilized for the projects. Two years after the Community Partnering Project ended, two of the projects had ended. The music co-op wound up after conflict between young people operating it. The community garden had had a broad and ambitious plan to operate a range of programs, but was unable to attract enough new members to perform the necessary work. The Christmas

decoration workshop, supported by the local Council, continued to operate, and the committee of the woodworking shed continued but suffered under the pressure to find grant money.

Rooming House Outreach Project: St Kilda, Victoria

A project with residents of a rooming house in Melbourne, this was a collaboration between local and state governments and community organisations. With an ABCD compatible framework, several workers led and resourced residents to change the culture and environment of the rooming house. They also coordinated other local services. There were positive changes made to the physical environment of the rooming house, and the introduction of information forums which also served as an opportunity for residents to work together to get information and plan additional activities.

Other projects

Dudley Street Neighbourhood Initiative: Massachusetts, U.S.A.

The aim of the project is organising; by 'DSNI organizes residents to identify and select partners and resources and to monitor program implementation" [143]. It works on a range of declared principles compatible with ABCD, which emphasise the responsibility and capabilities of residents to shape their community. It leads community research and planning, and seeks funding and partnership from a range of external organisations. Activities include urban renewal focussing on parks and community spaces, employment and mentoring programs. It is a very broad initiative which is firmly focussed on its local space and residents.

Mid-Bronx Senior Citizens Council: Bronx, New York

A very large project which addressed housing, health, safety and other needs for older citizens of New York. Again, it is firmly focussed on its geographical area. The project ran for seven years, beginning with a large data collecting stage. In practice, it recognised but was not able to address a large number of infrastructure needs, but established citizen committees which worked and lobbied on broad and smaller issues. Although the project

was aimed at older residents, some unusual approaches were taken. For example, it appears that safety issues were addressed by some community building ventures for young people. The resulting community projects ranged from community councils and community centres, to partnerships in delivering home based services to older people in their homes. It may be that some of the substantial success the council had in attracting additional funding to the project can be attributed to the community based but also a professional and well resourced council, which was obviously committed to excellent outcomes for additional projects.

Computer Learning Centre at the Neighborhood Technology Resource Center (NTRC): Illinois, New York

This project is based in a large low-income housing tower. It provides computer access and training to nearby residents. The project began with a skills and wants survey, and found that along with a low level of skill in computers and Internet, there was a high willingness to acquire skills. Residents felt that computer and Internet skills could be a gateway to professional and trade skills, and so, employment. Businesses and associations were then surveyed and a local computer network and website established.

Content & Resources

ABCD has, at its core, participants identifying their own strengths and needs and choosing activities which suit them. However, it may be useful to look at a few possible content resources which are available for implementation the following three examples are activity programs which are available and suit certain needs.

Keen-Agers

Table Tennis Victoria have taken up VicHealth funding to develop a social table tennis program for older Victorians. It is a low-cost program which includes inter-club matches at a range of venues, and is suitable for those with low mobility. The ‘Keen-Agers’ program is developed as a unit and picked up by existing table tennis clubs, or Keen-Agers organisational support can be used to set up a new club.

Growing Together...

'Growing Together' is a programme of research exploring the use and benefits of 'social and therapeutic horticulture' (organised gardening and horticulture activities) for vulnerable adults in the UK. The use of therapeutic horticulture is considered particularly beneficial for vulnerable adults, though, traditionally the technique, also known as horticultural therapy, has been used for adults with developmental or psychiatric disabilities living in group homes [144]. The UK project assessed at Loughborough University was used by a wide range of adults [145] but men were overrepresented. There was no evaluation data available but it was reported that the services were generally popular and well used. Education and training in horticulture were provided in some projects.

Rural Peninsula Disability Support Inc- Housebound & elderly Disabled Online / Elderly Citizens Online for the over 50's mobility disabled.

RPDS is a community organisation which provides low or no cost computers to older disabled people, along with training and low cost internet. It is based on the Mornington Peninsula and has received funding from a range of government and philanthropic organisations. The aim is to allow older less mobile people to keep in contact with friends and family by email and find information on the internet.

It is run by volunteers and there is little formal information available on the project, but they report high satisfaction from participants.

Evaluations

In addition to case studies above, we present three detailed evaluations (below), which provide assessments on program content and delivery. Dorothy Scott writes on a number of highly successful community programs, and Cattan and White published a ‘meta data’ review of published program evaluations, drawing out some common themes of successful programs. An Australian coalition of agencies also report on their collaboration issues in practice.

Evaluation reviews

Professor Dorothy Scott has reviewed a number of successful community and family strengthening programs. She identifies several characteristics of successful projects [146].

- They are all located within natural, non-stigmatising social settings
- Professionals delivering programs are focussed as much on "process" or on the generation of social cohesion and interaction between participants as they are on delivering the "content" or achieving a specific task.
- While having community building as a latent goal, these programs had their appeal by adopting manifest goals which were very specific, and which were not problem focussed

The programs Scott discusses are innovative but nevertheless built on existing service systems. Professional development programs were essential to develop the skills of staff working on the program and on another practical note, it also appears that some discretionary funds were available to staff which facilitated the responsive nature of the project.

She also provides some useful cautions; programs which go beyond the usual boundaries of health/welfare are "….vulnerable to 'buck passing' when it comes to government funding". Alternatively, a passion for innovation in programming may mean 'old' programs are discarded in favour of newer ones. There may be value in more traditional services, as well as community goodwill and organisational and professional experience which is easily lost when services are withdrawn.

A meta-data project examining evaluations of health interventions for older people was carried out the U.K., reviewing reported evaluations of programs from the U.S., U.K., and Europe. The programs were evaluated using control groups, with some quasi-

experimental and before and after designed evaluations. The review [147] noted the scarcity of ‘outcome studies’, with difficulties apparent in evaluation method. They were, however, able to provide some conclusions about the content and method of effective programs;

- They were based around a long term group activity
- There was a clearly specified target group
- The activity was appropriate to the target group
- More than one method was employed
- Some participant control was included
- Program process was evaluated with an intervention-specific evaluation

Cattan and White’s review did note that there was conflict between ‘hard evidence and practitioner experience’ of programs, and that the complex nature of psycho-social and behavioural change made measurement difficult. Evaluation in this context is, however, focussed on public health research in professional journals, and appropriate evaluation of programs may have different aims.

Agency issues in practice

The Illawarra Community Development Project was a community development project operated by a consortium of community agencies; Albion Park Neighbourhood Association, Barnardos Australia South Coast, and Shellharbour City Council, in the Illawarra area of New South Wales. It is an example of an agency led, community consultative project. The project team report a positive collaboration and provide some detail on aspects of the collaboration which led to the successful relationships between agencies [148]. It used action research to plan and to evaluate the program, which they call a “concurrent research component” [149].

The key factor in the success of the relationships between agencies in the collaboration was a ‘natural’ affiliation between agencies, stemming from affinities in practice bases, core business, perceptions of their target groups and experience in multidisciplinary work. The collaboration used some principles drawn from Richard Catalano’s (2003)

"Communities That Care" model3. Important first steps included a community readiness assessment and identification of key stakeholders.

- The project combined involvement of all agencies in key areas of planning and research, and autonomy of agencies in application.
- Collaboration established in the early stages of the project. All organisations participated in the program planning and development.
- Long standing affiliation between the agency and the population or area the program was applied to.

Data collection, through focus groups, quantitative data collection and program research, was the first step carried out by the collaboration and formed the base for program development. This research was carried out by the managers and service staff of the agencies themselves.
The sub-project on each site was then carried out by the agency on the ground, using the program collaboration as a framework and resource.

Following the action research model, data collection was incorporated into the project planning. A comprehensive data collection framework was develop, and at the project delivery stage, community development workers had a time allowance of up to 10 hours per week dedicated to documentation of their practice, which fed into research.

Themes, commonalities; some recommendations

Content and structure

There is variety in both the content and structure of the projects described above. The content ranges from service delivery to community arts and lobby group activity. The projects were operated with a range of end-user input into the project management, from individuals as service receivers from the Benevolent Society, to active researchers and

[3] The "Communities That Care" model is a proprietary system for community mobilization which is aimed at preventing adolescent anti-social behaviour.

project planners in the Latrobe Valley Community Partnering Project. There was also a variety of input and guidance from funding bodies, and particularly noteworthy is the structure of the program from the Department of Victorian Communities. The substance of the projects varied, and in some cases (for instance, Whitehead meeting place) the result of the project was a recognised public good, but in others (oral histories), the process itself created benefit.

DVC includes community consultation and research in its funding structure, recognising the value and additional cost of these activities in community programs. The provision of funded project workers tasked with carrying out the initial steps allowed communities an involvement which might otherwise be difficult. The program also took a broad view of program content; for example, the Rural Isolated Transport Enterprise project consisted of a community council which was essentially a lobby group for improved transport. Those involved were disappointed in the failure to succeed but energised by working together and remained committed to the project.
Reports on the projects also display an appreciation for the community-building action of the organising itself, aside from the end result of projects.

However both, Scott, and Cattan and White, in their reviews of successful community projects emphasise that having a substantive aim for the project is necessary as a focus for the important relationships which build around it. The content of the program is that which attracts and initially bonds the participants.

These two concepts of content and process of community projects are central. Hunt [150] makes an important distinction when discussing community capacity building, between capacity building as a means, and capacity building as an end itself; ‘Thus as a means, capacity building may be designed to enable an organization to deliver a service or program defined by another agency; as a process, capacity building may be about developing the capacity to deal with constant change in the external environment; finally as an end – capacity building may be to strengthen an organisation to participate in sustainable development [Bebington, 1996, in 150].

One idea which illustrates a closer relationship between content and process is the Warnervale District Community Survey. This project mobilized local resident support behind community research and project planning as an activity in the initial stages. The data collection phase of the project, with community meetings, focus groups, surveys and interviews, served to promote the project to residents and led naturally into the discussion and planning stage.

Program design- funding bodies

Although the philosophy of asset-based community development includes a firm commitment to individuals in communities making decisions and taking action on their own behalf, both process and content have been influenced by project funding guidelines. DVC includes consultation and community needs assessment in the project set-up, Illawarra Community Development Project incorporated a generous time allowance for project staff to collect and reflect on data during the project.

The aims of ABCD for community self-determination may seem incongruous with some more proscriptive, infrastructure oriented funding programs traditionally operated by Government. This is not to say that ABCD is incompatible; in fact, the first, auditing and researching phase should produce excellent research of need and capacity, which will be useful for certain funding program applications. Well-resourced and supported community coalitions may be attractive to external funding bodies if they can show good evidence of need and commitment to carrying out programs.

Section 4: Summary of Findings

This literature review brought together theoretical trajectories ranging from public health and health promotion to applied community development. In particular, it attempted to construct a link between the WHO-inspired 'new public health' approach and asset-based community development (ABCD). To this end, a three-tiered approach to health promotion including a personal, relational, and collective sphere was chosen. Such an approach manages to incorporate an ABCD-inspired methodology, while highlighting other important factors that have to be taken into account when developing health intervention strategies. In fact, much can be gained by integrating the ABCD approach into an overall framework which directly addresses some of the implicit assumptions that underpin the ABCD approach.

To be sure, ABCD-inspired community development has certainly much to offer when the aim is to generate a collective momentum for political, cultural, or economic change. However, health promotion interventions differ in important ways from such social change-focused community development models. Whereas community development is an end in itself for social-change-focused collective action, this is not necessarily the case for health promotion strategies. Indeed, health promotion initiatives should benefit individuals in the first place. Community development is a means to that end. The overview over the public health literature provided in this review clearly demonstrates that it would be overly simplistic to assume that community development automatically results in better health outcomes. Thus, health promotion initiatives following the ABCD approach would do well to remain aware of the multifaceted needs of potential beneficiaries.

Although the current literature suggests that health and social networks are, by and large, only moderately associated, this does not necessarily mean that social networks are irrelevant for health and wellbeing. Rather, the reviewed literature suggests that the linkages between health and social networks are extremely complex and poorly understood. Yet common sense suggests that social networks do play a role in the

wellbeing of most people. It appears that the association between social networks and health and wellbeing is mediated by a range of variables that often escape empirical analyses. Indeed, social determinants of health such as poverty and unemployment are often better predictors of poor health than indicators of social connectedness. Attempts to transform community development initiatives into a health promotion strategy should bear this in mind. Yet, the reviewed literature also suggests that certain population groups, such as the elderly or people with disabilities, might benefit more from community-based intervention than others. For instance, elderly people and people with disabilities are often trying to maintain a certain degree of independence - especially from an over-protective family environment - and thus would benefit from community support. An ABCD approach especially when enriched with an Action Research methodology could do much to support these population groups in their quest for greater autonomy. While this holds true, it is equally important to bear in mind that personal as well as collective determinants also shape the lives of these population groups. For instance, factors such as poverty, lack of adequate transport, and the build environment are grave problems for both the elderly as well as people with disabilities and need to be addressed by ABCD-inspired programs. What is more, elderly people suffering from a degenerative mental illness may require a degree of care, reassurance, and affection that might transcend the capacity of community groups. Thus, whereas an ABCD approach can contribute to the wellbeing of population groups such as the elderly and people with disabilities, it is important to, on the one hand, translate the needs of these population groups into political demands as well as political action. On the other, it is equally important not to fall into the trap to regard the construction of strong communities as the default answer to all health problems. This literature review argues in favour of a three-tier approach that not only integrates the personal, relational, as well as collective sphere but also is capable of drawing on the benefits of a strength-based methodology.

Reference Material:

Websites:

http://www.ksg.harvard.edu/saguaro

http://www.keenagers.org.au

http://www.lboro.ac.uk/departments/ss/growingtogether/

Books & Articles:

1. Lalonde, M., *A new perspective on the health of canadians*. 1974, Ottawa: National Ministry of Health and Welfare.
2. Schwab, M. and S.L. Syme, *On paradigms, community participation, and the future of public health.* American Journal of Public Health, 1997. **87**: p. 2049-51.
3. Cassel, J., *The contribution of the social environment to host resistance.* Am J Epidemiol, 1976. **104**: p. 107-23.
4. Antonovski, A., *Breakdown: a needed forth step in the conceptual armamentarium of modern medicine.* Social Science & Medicine, 1972. **6**: p. 537-44.
5. Hinkle, L.E., *The concepts of "stress" in the biological and social sciences.* Sci Med Man, 1973. **1**(31-48).
6. Berkman, L., *Social Networks, Host Resistance, and Mortality: A Nin-Year Follow-up Study of Alameda County Residents.* American Journal of Epidemiology, 1979. **109**(2): p. 186-204.
7. Baum, F.E., *The new public health*. 2nd edition ed. 1999, Melbourne: Oxford University Press.
8. Coleman, J.S., *Social captial in the creation of human capital.* American Journal of Sociology, 1988. **94**: p. 95-120.
9. Bourdieu, P., *Forms of Capital*, in *Handbook of Theory and Research for the Sociology of Education*, J.G. Richardson, Editor. 1986, Greenwood Press: Westport, CT. p. 241-60.
10. Putnam, R., *Foreword.* Housing Policy Debate, 1998. **9**(1): p. v-viii.
11. Foundation), F., *Building Assets to reduce poverty and injustice*. 2002, Asset Building and Community Development Program.
12. Tibaijuka, A.K. *ABCD and the enabling approach: complimentary strategies for developing countries*. in *Agents rather than patients - realizing the potential for asset-based community development*. 2003. Windsor Castle: A Building and Housing Foundation consultation.
13. Shields, M.A. and S. Wheatley Price, *Exploring the economic and social determinants of psychological well-being and perceived social support in England.* Journal of the Royal Statistical Society Series A, 2005. **168**: p. 513.

14. Prilleltensky, I., *Promoting well-being: Time for a paradigm shift in health and human services.* Scandinavian Journal of public health, 2005. **33**(Suppl. 66): p. 53-60.
15. Szreter, S. and M. Woolcock, *Health by association? Social captial, social theory and the political economy of public health.* International Journal of Epidemiology, 2004. **33**(4): p. 650.
16. Day, A. *Opening address*. in *Social Isolation in Australia Conference*. 1992. Canberra.
17. Gardner, I., et al., *Improving social networks: A research report*. 1998, Lincoln Gerontology Centre, La Trobe University: Adelaide.
18. Cattan, M. and M. White. *Health promotion interventions targeting social isolation and loneliness*. in *A research into ageing workshop*. 1999. London: London School of Hygiene and Tropical Medicine.
19. Hall, E., *Social geographies of learning disability: narratives of exclusion and inclusion.* Area, 2004. **36**(3): p. 298.
20. Gibson, H.B., *Loneliness in the life cycle*. 2000, New York: St. Martins Press.
21. Folkman, S. and S. Greer, *Promoting Psychological Well-being in the face of serious illness: When theory, research and practice inform each other.* Psycho-Oncology, 2000. **9**: p. 11-19.
22. Baum, F.E., et al., *Epidemiology of participation: an Australian community study.* J Epidemiol Community Health, 2000. **54**(6): p. 414-423.
23. Muntaner, C., J. Lynch, and G. Davey Smith, *Social Capital and the thrid way in public health.* Critical Public Heatlh, 2000. **10**(2): p. 107-124.
24. Kim, D., S.V. Subramanian, and I. Kawachi, *Bonding versus bridging social capital and their associations with self rated health: a multilevel analysis of 40 US communities.* J Epidemiol Community Health, 2006. **60**(2): p. 116-122.
25. Wilkinson, R. and M. Marmot, *The solid facts: Social determinants of health.* 1998, World Health Organisation.
26. WHO, *Promoting Mental Health: Concepts, Emerging Evidence, Practice*. 2004, World Health Organization: Geneva.
27. Seedhouse, D., *Health: a universal concern.* Nursing Times, 1986. **82**: p. 36-8.
28. Tones, K. and S. Tilford, *Health Promotion: effectiveness, efficiency and equity.* 2001, Cheltenham: Nelson Thornes Ltd.
29. Berkman, L., *The role of social relations in health promotion.* Psychosom Med, 1995. **57**(3): p. 245-254.
30. Syme, S.L., *Psychosocial intervention to improve successful aging.* Annals of Internal Medicine, 2003. **139**: p. 400-2.
31. Labonte, R., et al., *Community capacity building: A parallel track for health promotion programs.* Canadian Journal of Public Health, 2002. **93**: p. 181-2.
32. Labonte, R. and J. Spiegel, *Setting global health research priorities.* BMJ, 2003: p. 722-3.
33. McKee-Ryan, F., et al., *Psychological and physical well-being during unemployment: a meta-analytic study.* Journal of Applied Psychology, 2005. **90**(1): p. 53-76.

34. Leeuw de, J.R.J., et al., *Negative and positive influences of social support on depression in patients with head and neck cancer: A prospective study.* Psycho-Oncology, 2000. **9**: p. 20-28.
35. Ziersch, A.M. and F.E. Baum, *Involvement in civil society groups: Is it good for your health?* J Epidemiol Community Health, 2004. **58**(6): p. 493-500.
36. Greenwald, H.P. and W.L. Beery, *Reducing Isolation among Inner-City Elders: An Outcome Evaluation.* Health Promot Pract, 2001. **2**(3): p. 233-241.
37. Eckersley, R. *Measuring well-being: Material progress and quality of life*. in *Made to Measure Conference*. 1999. Sydney: Council of Social Services of NSW.
38. Turell, G., et al., *Socioeconomic Determinants of Health: towards a national research program and a policy and intervention agenda*. 1999, Queensland University of Technology, School of Public Health: Canberra.
39. Ronzio, C.R., E. Pamuk, and G.D. Squires, *The politics of preventable deaths: local spending, income inequality, and premature mortality in US cities.* J Epidemiol Community Health, 2004. **58**(3): p. 175-179.
40. De Vogli, R., et al., *Has the relation between income inequality and life expectancy disappeared? Evidence from Italy and top industrialised countries.* J Epidemiol Community Health, 2005. **59**(2): p. 158-162.
41. Dunn, J.R., *Are widening income inequalities making Canada less healthy?* 2002, The Health Determinants Partnership: Toronto.
42. Hurt, L.S., C. Ronsmans, and S. Saha, *Effects of education and other socioeconomic factors on middle age mortality in rural Bangladesh.* J Epidemiol Community Health, 2004. **58**(4): p. 315-320.
43. Labonet, R., *Dying for Trade: Why globalization can be bad for our health*. 2006, The CSJ Foundation for Research and Education: Toronto.
44. Osler, M., et al., *Relation between early life socioeconomic position and all cause mortality in two generations. A longitudinal study of Danish men born in 1953 and their parents.* J Epidemiol Community Health, 2005. **59**(1): p. 38-41.
45. Raphael, D., *Poverty, Income Inequality, and Health in Canada*. 2002, The CSJ Foundation for Research and Education: Toronto.
46. Thomson, H., et al., *Do urban regeneration programmes improve public health and reduce health inequalities? A synthesis of the evidence from UK policy and practice (1980-2004).* J Epidemiol Community Health, 2006. **60**(2): p. 108-115.
47. Oulette, S.C., *Religious and nonreligious copin with the death of a friend.* Cognit. Ther. Res., 1993. **17**: p. 561-77.
48. Rutter, M., *Resilience in the face of adversity.* British Journal of Psychiatry, 1985. **147**: p. 598-601.
49. Scheier, M.F. and C.S. Carver, *Optimism, coping, and health: assessment and implications of generalised outome expectancies.* Health Psychology, 1985. **4**: p. 219-47.
50. Pearlin, L.I., et al., *The stress process.* J. Health Soc. Behav., 1981. **22**: p. 337-352.
51. Rotter, J.B., *Generalised expectancies for internal versus external control of reinforcement.* Psychol. Monogr. Gen. Appl., 1966. **80**: p. 1-28.
52. Bandura, A., *Self efficacy mechanism in human agency.* Am. Psychol., 1982. **37**: p. 122-47.

53. Snyder, C.R., et al., *The will and the ways: development and validation of an individual-differences measure of hope.* J. Personality Soc. Psychol., 1991. **60**: p. 570-585.
54. Park, C.L. and L.H. Cohen, *Religious and nonreligious coping with the death of a friend.* Cognit. Ther. Res., 1993. **17**: p. 561-77.
55. Aldwin, C., *Stress, Coping, and Development*. 1994, New York: Guilford.
56. Affleck, G. and H. Tenne, *Construing benefits from adversity: adaptational significance and dispositional underpinnings.* J. Personality Soc. Psychol., 1996. **64**(889-922).
57. Taylor, S.E. and J.D. Brown, *Illusion and well-being: a social psychological perspective on mental health.* Psychol. Bull., 1988. **103**(193-210).
58. Lazarus, R.S. and S. Folkman, *Stress, Appraisal, and Coping*. 1984, New York: Springer.
59. Folkman, S. and N. Stein, *The analysis of belief and goal processes druing reports of stressful events by caregivers of men with AIDS*, in *Memory for Everyday and Emotional Events*, N. Stein, et al., Editors. 1996, Lawrence Erlbaum: Hillsdale, NJ. p. 113-137.
60. Cullen, M. and H. Whiteford, *The Interrelations of Social Capital with Health and Mental Health: Discussion Paper*. 2001.
61. Furstenberg, F.F. and M.E. Hughes, *Social Capital and successful development among at-risk youth.* Journal of Marriage and the Family, 1995. **57**(3): p. 580.
62. Giorgas, D. *Community Formation and Social Capital in Australi*. in *7th Australian Institute of Family Studies Conference*. 2000. Sydney: Australian Institute of Family Studies.
63. Leeder, S. *Social Capital and its Relevance to Heatlh and Family Policy*. 1998.
64. KAWACHI, I., *Social Capital and Community Effects on Population and Individual Health.* Ann NY Acad Sci, 1999. **896**(1): p. 120-130.
65. Oakley, P., *Community involvement in health development: an examination of the critical issues*. 1989, Geneva: World Health Organisation.
66. Woodward, A. and I. Kawachi, *Why reduce health inequalities?* J Epidemiol Community Health, 2000. **54**(12): p. 923-929.
67. Zimmerman, F.J. and J.F. Bell, *Income inequality and physical and mental health: testing associations consistent with proposed causal pathways.* J Epidemiol Community Health, 2006. **60**(6): p. 513-521.
68. Marmot, A.F., et al., *Building health: an epidemiological study of "sick building syndrome" in the Whitehall II study.* Occup Environ Med, 2006. **63**(4): p. 283-289.
69. Sacker, A., et al., *Social dynamics of health inequalities: a growth curve analysis of aging and self assessed health in the British household panel survey 1991-2001.* J Epidemiol Community Health, 2005. **59**(6): p. 495-501.
70. WILKINSON, R.G., *Health, Hierarchy, and Social Anxiety.* Annals of the New York Academy of Sciences, 1999. **896**(1): p. 48-63.
71. Bassuk, S., *Cognitive and Emotional Health Project: A Literature Review*, National Institue of Health.
72. Cohen, S., et al., *Social ties and suceptibility to the common cold.* JAMA, 1997. **277**(24).

73. Cohen, S. and T.A. Willis, *Stress, social support, and the buffering hypothesis.* Psychol. Bull., 1985. **98**: p. 310-57.
74. Winter, I.e., *Social capital and public policy in Australia*. 2000, Melbourne :: Australian Institute of Family Studies.
75. Stone, W. and J. Hughes, *Social capital: Empirical meaning and measurement validity*. 2002, Australian Institute of Family Studies: Melbourne.
76. Morrow, V., *Conceptualising social capital in relation to the well-being of children and young people: a critical review.* The Sociological Review, 1999. **47**(4): p. 744.
77. Martikainen, P., et al., *Effects of income and wealth on GHQ depression and poor self rated health in white collar women and men in the Whitehall II study.* J Epidemiol Community Health, 2003. **57**(9): p. 718-723.
78. Rahkonen, O., et al., *Job control, job demands, or social class? The impact of working conditions on the relation between social class and health.* J Epidemiol Community Health, 2006. **60**(1): p. 50-54.
79. Siegrist, J., *Psychosocial work environment and health: new evidence.* J Epidemiol Community Health, 2004. **58**(11): p. 888-.
80. Stevenson, F. and M.A. Zimmerman, *Adolescent resilience: A framework for understanding health development in the face of risk.* Annu. Rev. Public Health, 2005. **26**: p. 399-419.
81. Kaslow, F.W., K. Hansson, and A.M. Lundblad, *Long marriages in Sweden: And some comparison with similar couples in the US.* Contemporary Family Therapy 1994. **16**(6): p. 521-537.
82. Russek, L.G. and G.E. Schwartz, *Feeling of Parental Caring Predict Health Status in Midlife: A 35-year follow up of the Harvard Mastery of Stress Study.* Journal of Behavioral Medicine, 1997. **20**(1): p. 1-13.
83. Weitzman, E.R. and Y.-Y. Chen, *Risk modifying effect of social capital on measures of heavy alcohol consumption, alcohol abuse, harms, and secondhand effects: national survey findings.* J Epidemiol Community Health, 2005. **59**(4): p. 303-309.
84. Broadhead, W.E., et al., *The epidemiological evidence for a relationship between social support and health.* Am. J. Epidemiol., 1983. **117**(5): p. 521-37.
85. Barnett, P.A. and I.H. Gotlieb, *Dysfunctional Attitudes and Psychological Stress: The differential prediction of future psychological symptomatology.* Motivation and Emotion, 1988. **12**(3): p. 251.
86. Aseltine, R.H. and R.C. Kessler, *Marital Disruption and Depression in a Community Sample.* Journal of Health and Society, 1993. **34**(3): p. 237-51.
87. Willitts, M., M. Benzeval, and S. Stansfeld, *Partnership history and mental health over time.* J Epidemiol Community Health, 2004. **58**(1): p. 53-58.
88. Kawachi, I. and L. Berkman, *Social Ties and mental health.* Journal of Urban Health, 2001. **78**(3): p. 458-467.
89. Berkman, L. and T. Glass, *Social integration, social networks, social support and health*, in *Social Epidemiology*, L. Berkman and I. Kawachi, Editors. 2000, Oxford University Press: New York.
90. Berkman, L., et al., *From social integration to health: Durkheim in the new millennium.* Social Science & Medicine, 2000. **51**: p. 843-857.

91. Pevalin, D. and D. Rose, *Social Capital for health; investigating the link between social capital and health using the British Household Panel Survey.* NHS, 2002.
92. Weitzman, E.R. and I. Kawachi, *Giving means receiving:the protective effect of social capital on binge drinking on college campuses.* 2000, 2000. **American Journal of Public Health**(90): p. 12.
93. Hyyppae, M.T. and J. Maeki, *Social participation and health in a community rich in stock of social captial.* Health Education Research, 2003. **18**(6): p. 770-779.
94. Skrabski, A., M. Kopp, and I. Kawachi, *Social capital and collective efficacy in Hungary: cross sectional associations with middle aged female and male mortality rates.* J Epidemiol Community Health, 2004. **58**(4): p. 340-345.
95. Saguro Seminar, *The social capital communiyt benchmark survey.* . Civic engagement in America. 2001: John F. Kennedy School of Government, Harvard University.
96. Ostir, G.V., et al., *Neighbourhood composition and depressive symptoms among older Mexican Americans.* Journal of Epidemiology and Community Health, 2003. **57**: p. 987-992.
97. Lindstrom, M., J. Merlo, and P. Ostergren, *Social capital and sense of insecurity in the neighbourhood: a population-based multilevel analysis in Malmo, Sweden.* Social Science and Medicine, 2003. **56**: p. 111-1120.
98. Berry, H.L. and D.J. Rinckwood, *Measuring social capital at the individual level: personal social capital, values and psychological distress.* International Journal of Mental Health Promotion, 2000. **2**(3): p. 35-44.
99. Rose, R., *How much does social coapital add to individual health? A survey study of Russians.* Social Science and Medicine, 2000. **51**: p. 1421-1435.
100. Shannon, D. and F. Rex., *The relation of social captial to child psychological adjustment difficulties: the role of positive parenting and neighbourhood dangerousness.* Journal of Psychopatholog & Behavioural Assessment, 2003. **25**(1): p. 11-23.
101. De Silva, M.J., et al., *Social capital and mental illness: a systematic review.* J Epidemiol Community Health, 2005. **59**(8): p. 619-627.
102. Rychetnik, L. and A. Todd, *VicHealth Mental Health Promotion Evidence Review: A Literature review focusing on the VicHealth 1999-2002 Mental Health Promotion Framework.* 2004,.
103. *Social Isolation Among People Who Are Homeless: Bibliography # 19*. 2005, Health Care for the Homeless Information Resource Center: New York.
104. Adrykowski, M.A., et al., *Stability and change in posttraumatic stress disorder symptoms following breast cancer treatment: A 1-year follow-up.* Psycho-Oncology, 2000. **9**: p. 69-78.
105. Long Foley, K., et al., *A qualitative exploration of the cancer experience among long-term survivors: comparison by cancer type, ethnicity, gender, and age.* Psycho-Oncology, 2006. **15**: p. 248-258.
106. Steginga, S.K., et al., *The supportive care needs of men with prostate cancer.* Psycho-Oncology, 2001. **10**: p. 66-75.
107. MacFarland, D.C., *Social Isolation of the blind: an underrated aspect of disability and dependency.* J Rehabil, 1966. **32**(1): p. 32.
108. *Access to Transport*. 2002, National Organization on Disability.

109. *Landmark Disability Survey Findings Pervasive Disadvantages*. 2004, National Organization on Disability.
110. Hanson, K., *2004 Gap Survey*. 2004, Harris Interactive Inc.: New York.
111. Hendershot, G., *Community Participation and Life Satisfaction*. 2004, National Organization on Disability.
112. Hendershot, G., *Building Design is leading barrier to community participation*. 2004, National Organization on Disability.
113. *Psychosocial Health - Social Connectedness*. 2006, Baylor College of Medicine.
114. Bent, N., et al., *Factors determining participation in young adults with a physical disability: a pilot study.* Clin Rehabil., 2001. **15**(5): p. 552-61.
115. Wahl, A., et al., *Coping and equality of life in patients with psoriasis.* Quality of Life Research, 1999. **8**(5): p. 427-433.
116. Contact A Family (UK), *Disabled children and their families suffer isolation*, in *Carersnetnz*. 2002, Contact A Family (UK).
117. Findlay, R. and C. Cartwright, *Social Isolation & Older People: A Literature Review*. 2002, Queensland Government: Seniors Interest Branch & Ministerial Advisory Council on Older People, The University of Queensland, Australasian Centre on Ageing.: Brisbane.
118. Oxman, T.E., et al., *Social Support and Depressive Symptoms in the Elderly.* Am. J. Epidemiol., 1992. **135**(4): p. 356-368.
119. Zunzunegui, M.-V., et al., *Social Networks, Social Integration, and Social Engagement Determine Cognitive Decline in Community-Dwelling Spanish Older Adults.* J Gerontol B Psychol Sci Soc Sci, 2003. **58**(2): p. S93-100.
120. Bassuk, S., *Social Disengagement and Incident Cognitive Decline in Community-Dwelling Elderly Persons.* Annals of Internal Medicine, 1999. **131**(3): p. 165.
121. Fratiglioni, L., et al., *Influence of social network on occurrence of dementia: A community-based longitudinal study.* Lancet, 2000. **355**: p. 1315-9.
122. Fiori, K.L., T.C. Antonucci, and K.S. Cortina, *Social Network Typologies and Mental Health Among Older Adults.* J Gerontol B Psychol Sci Soc Sci, 2006. **61**(1): p. P25-32.
123. Helmer, C., et al., *Marital status and risk of Alzheimer's disease: A French population-based cohort study.* Neurology, 1999. **53**(9): p. 1953-.
124. Stansfeld, S.A., et al., *Social inequalities in depressive symptoms and physical functioning in the Whitehall II study: exploring a common cause explanation.* J Epidemiol Community Health, 2003. **57**(5): p. 361-367.
125. Kendrick, T., *Review: black people are more likely than white people to be detained in psychiatric wards in the United Kingdom.* Evid Based Ment Health, 2003. **6**(3): p. 76-.
126. Regidor, E., et al., *Association of adult socioeconomic position with hypertension in older people.* J Epidemiol Community Health, 2006. **60**(1): p. 74-80.
127. Courtenay, W.H., *Construction of masculinity and their influence on men's well-being: a theory of gender and health.* Social Science and Medicine, 2000. **50**: p. 1385-1401.
128. van Holst Pellekaan, S.M. and L. Clague, *Toward health and wellbeing for indigenous Australians.* Postgrad Med J, 2005. **81**(960): p. 618-624.

129. McKnight, J.L., ed. *Regenerating Community: The Recovery of a Space for Citizens*. The IPR Distinguished Public Policy Lecture Series. 2003, Northwestern University: Evanston.
130. Rans, S.A., *Hidden Treasures: Building Community Connections by Engaging the Gifts of**. ABCD Institute, Evanston Il, 2005.
131. Mathie, A. and G. Cunningham, *From clients to citizens: Asset-based Community Development as a strategy for community-driven development.* Development in Practice, 2003. **13**(5): p. 474-486.
132. Elliott, C., *Locating the Energy for Change: An Introduction to Appreciative Inquiry*. International Institute for Sustainable Development, Winnipeg, 1999.
133. McKnight, J.L. and J.P. Kretzmann, *Mapping Community Capacity*. 1996 [1990], Chicago Community Trust: Chicago.
134. Kretzmann, J.P. and J.L. McKnight, *Discovering Community Power: A guide to mobilising local assets and your organisation's capacity*. 2005, Evanston: Northwestern University.
135. Kretzmann, J.P., *Community-based development and local schools: A promising partnership*. 1991, Evanston: Northwestern University.
136. Meyer, J., *Qualitative research in health care: Using qualitative methods in health related action research.* British Medical Journal, 2000(320): p. 178-181.
137. Lienert, T., *Why use action research?* 2002, Melbourne: Australian Institute of Family Studies.
138. Crane, L.P.R., *Reconnect Action Kit.* 2000.
139. Reed, J., *Using Action Research in Nursing Practice with Older People: Democratizing Knowledge.* Journal of Clinical Nursing, 2005. **14**(5): p. 594-600.
140. Moyer, A., et al., *Identifying Older People in Need Using Action Research.* Journal of Clinical Nursing, 1999. **8**(1): p. 103-111.
141. Beilharz, L., *Building community : the shared action experience / by Linda Beilharz*. 2002, Bendigo, Vic. : Solutions Press.
142. Cameron, J. and K. Gibson, *'Alternative Pathways to Community and Economic Development: The Latrobe Valley Community Partnering Project'*. Geographical Research, 2005. **43**((3)): p. 274-85.
143. Meyer, D.A., et al., *Dudley Street Neighborhood Initiative,* in *On the Ground with Comprehensive Community Initiatives*, D.A. Meyer, Editor. 2000, The Enterprise Foundation. p. 1 - 20.
144. Sempik, J. and J. Aldridge, *Social and Therapeutic Horticulture: Evidence and Messages from Research*. 2002, Leicestershire: Centre for Child and Family Research, Loughborough University.
145. Sempik, J., J. Aldridge, and L. Finnis, *Social and Therapeutic Horticulture: The state of practice in the UK*. 2004, Leicestershire: Centre for Child and Family Research, Loughborough University.
146. Scott, D., *Building Communities that Strengthen Families: Elements of Effective Approaches* 2000, Melbourne: Australian Institute of Family Studies Seminar Series.
147. Cattan, M. and M. White, *Developing Evidence Based Heatlh Promotion for Older People: A systematic Review and Survey of Heatlh Promotion Interventions*

Targeting Social Isolation and Loneliness among Older People. Internet Journal of Health Promotion, 1998.

148. Guggisberg, N., et al., *Stronger Families and Community Strategies*. Australian Institute of Family Studies. 2004, Melbourne.
149. Smith, V.C., et al., *A How to Guide of Child & Family Community Development for Mainstream & Vulnerable Communities*. 2005: Illawara Child and Family Community Development Project.
150. Hunt, J. *Capacity Building for Indigenous Governance: International development experience of capacity development:implications for Indigenous Australia?* in *CAEPR-Reconciliation Australia ICG Project Workshop with WA and Australian Government Partners*. 2005. Perth, WA.

Appendix 1

Identifying factors in practice

The Queensland Government's Department of Communities has established a large project aimed at increasing social connectedness for older Queensland residents. Its "Cross Government Project to Reduce Social Isolation of Older People" has drawn a list of factors thought to have an effect on the social isolation of older people (Queensland, 2004). The factors are classed according to the level on which they operate and include personal and social factors.

Individual

- Living alone;
- Health status - mental, physical, disability;
- Ability to use existing public and/or private transport;
- Being in the workforce;
- Engagement in meaningful activity;
- Resilience - the ability to recover and move on in the face of difficulty;
- Socio-economic advantage/disadvantage;
- Gender;
- Speaking English;
- Literacy;
- Attitude to and/or knowledge of technology;
- Perception of level of crime/violence in community;
- Receptivity to help;
- Level of self responsibility/self determination; and
- Attitude to life - positive/negative.

Social

- Loss of relationships through death or divorce;
- Family support;
- Loss of children when they leave home;
- Network of friends;
- Grandparenting;
- Relocation to new community;
- Loss of grandchildren if family moves away or following divorce;
- Being a carer;
- Availability of wide range of opportunities for meaningful social participation activities:
- social recreational/health promoting/ activities; and
- transport assistance to and from activities; and
- Access to learning and development opportunities.

Community - environmental and cultural

- Physical isolation:
- area of residence; and

- availability of public transport;
- Local infrastructure for healthy living/healthy ageing:
- safe and accessible walkways and bikeways;
- Public space available for community members to use;
- Accessibility of public buildings for those with a disability/frailty;
- Range of social and health services needed to meet needs of community;
- Access to information on services;
- Ageism, racism, sexism;
- Norms that stereotype older people