

Review

The experience of community engagement for individuals: a rapid review of evidence

**Pamela Attree PhD¹, Beverley French PhD², Beth Milton PhD³, Susan Povall PhD³,
Margaret Whitehead PhD FFPH³ and Jennie Popay BA (Hons) MA^{1,*}**

¹Division of Health Research, School of Health and Medicine, Lancaster University, ²School of Nursing and Caring Sciences, University of Central Lancashire and ³Department of Health Inequalities and Social Determinants of Health, Institute of Psychology, Health and Society, University of Liverpool

Accepted for publication 24 October 2010

Correspondence

Pamela Attree
Division of Health Research
School of Health and Medicine
Bowland Tower East
Lancaster University
Lancaster LA1 4YT, UK
E-mail: p.attree@lancaster.ac.uk
*Principal investigator

What is known about this topic

- Community engagement is central to many health improvement programmes.
- Community engagement involves a range of strategies from simple consultation to community control.
- Evidence of the impact of community engagement on 'engaged' individuals is limited.

What this paper adds

- The majority of individuals perceive benefits from community engagement – for physical and psychological health, self-confidence and esteem, personal empowerment and social relationships.
- For some individuals there are unintended adverse consequences of community engagement, such as exhaustion and stress, which may pose a risk to well-being.
- Potential adverse consequences need to be considered by those planning community engagement initiatives.

Abstract

Community engagement is central to strategies to promote health and well-being and reduce health inequalities in many countries, particularly interventions which focus on improving health in disadvantaged populations. Despite the widespread use of community engagement approaches, however, there have been relatively few attempts to review the evidence on the impact that participation has on the lives of individuals involved. Drawing on a wider review of evidence carried out on behalf of the National Institute for Health and Clinical Excellence (NICE), this article reports on a rapid review of evidence of the effectiveness of initiatives which seek to engage communities in action to address the wider social determinants of health, to explore individuals' subjective experiences of engagement. The rapid review process was guided by NICE's public health methods manual, adapted to suit the diversity of the evidence. A total of 22 studies were identified containing empirical data on subjective experiences of community engagement for individuals. The findings of the rapid review suggest that the majority of 'engaged' individuals perceived benefits for their physical and psychological health, self-confidence, self-esteem, sense of personal empowerment and social relationships. Set against these positive outcomes, however, the evidence suggests that there are unintended negative consequences of community engagement for some individuals, which may pose a risk to well-being. These consequences included exhaustion and stress, as involvement drained participants' energy levels as well as time and financial resources. The physical demands of engagement were reported as particularly onerous by individuals with disabilities. Consultation fatigue and disappointment were negative consequences for some participants who had experienced successive waves of engagement initiatives. For some individuals, engagement may involve a process of negotiation between gains and losses. This complexity needs to be more widely recognised among those who seek to engage communities.

Keywords: evidence, health, inequalities, participation and empowerment

Introduction

Community engagement is an umbrella term that encompasses a range of different approaches to involving communities of place and/or interest in activities which aim to improve health and/or reduce health inequalities, ranging from the simple provision of information to full community control (Popay 2006). In this article, the term refers to community involvement in decision-making and in the design, governance and delivery of initiatives which aim to address the wider social determinants of population health and health inequalities. Community engagement is central to policy and practice across a wide spectrum of institutions in the public sector in the UK and other countries (Cook 2002, Clark *et al.* 2003, Anderson *et al.* 2006, Department of Health 2006a,b, Hogg 2007), and includes initiatives aimed at addressing the wider social determinants of health, such as neighbourhood regeneration (Social Exclusion Unit 1999, Electoral Commission 2005, Wallace 2007). A UK government white paper *Communities in control: real people, real power* proposed measures designed to shift power, influence and responsibility away from existing centres of power and into the hands of citizens (Department of Communities and Local Government 2008). In low and middle income countries community engagement (often described as 'empowerment') is increasingly seen as integral to public health, as a means of tackling the underlying social determinants of health (Commission on Social Determinants of Health 2008). Indeed, so solid is the consensus about the positive benefits of community engagement that it is now firmly ensconced in health and welfare policy documents, both in the UK and internationally (Social Exclusion Unit 1999, Electoral Commission 2005, Department of Health 2006a,b, Commission on Social Determinants of Health 2008).

Various methods are used to involve communities in health improvement initiatives, including (but not limited to) citizen juries, rapid appraisal techniques, neighbourhood committees, community forums and community champions. Models of engagement or involvement have been conceptualised as incorporating different levels, on a ladder or continuum, ranging from the provision of information to communities, through consultation, co-production, and delegated power, to full community control (Arnstein 1969, Popay 2006).

There is evidence that community involvement in decision-making and in the design, governance and delivery of public services can enhance ownership and empowerment amongst 'engaged' lay people, and make policy initiatives more accountable to users (Gillies 1998, Rifkin *et al.* 2000, Gustaffson & Driver 2005, Wallerstein

2006). In theory, different approaches to community engagement may have differential impacts on a number of outcomes for individuals taking part. The assumption underlying programmes is that the more that community members are supported to take control, by being involved in the design, development and implementation of activities, the more likely their health (and a range of other outcomes) might be expected to improve. Alternatively, greater engagement may be experienced as burdensome, and have negative consequences for the individuals and communities involved if they are inadequately supported or if their expectations are not met (Popay & Finegan 2006, Dinhm 2007, Greene 2007). Despite the widespread use of community engagement as an element of initiatives aiming to improve health, there have been relatively few attempts to review the evidence on the impact that community engagement has on the lives of individuals actively involved.

This article draws on a wider review of evidence, carried out between 2006 and 2007, to inform the work of the National Institute for Clinical Health and Excellence (NICE) community engagement programme development group. In this article, we focus on the impact of community engagement on individual members of communities who were actively engaged in initiatives which aimed to address the wider social determinants of health (rather than healthcare or health services), such as regeneration projects, time banks, service planning, and other civic and community groups.

Methods

The rapid review process was guided by the NICE methods manual for the development of public health guidance [NICE (National Institute for Clinical Health and Excellence) 2006]. This was not a traditional, 'Cochrane-style' systematic review, however. The literature on complex social initiatives includes a broad range of types of evidence, particularly qualitative and mixed-methods research, which do not fit neatly into standard review frameworks. Methods used were therefore adapted accordingly (in agreement with NICE) for the purposes of reviewing and synthesising diverse evidence sources. Studies were included in the review if they provided evidence on the experience of community engagement for individuals active in initiatives which sought to address the wider social determinants of health and were primary evaluative research or reviews of such research. No particular community of place, interest or identity was excluded. Further details of the study methods, including full inclusion and exclusion criteria, can be found at <http://guidance.nice.org.uk/page.aspx?o=432684>.

Search strategy

Between February and December 2006, literature searches were carried out in nine electronic databases: Medline, the Applied Social Science Index of Abstracts, PsycInfo, the Cochrane Database of Systematic Reviews (CDSR), the Database of Abstracts of Reviews of Effects (DARE), Social Science Citation Index, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Embase (Excerpta Medica), and the National Research Register (NRR). Other web-based databases and websites searched included the Research Findings Register, EPPI Centre databases, Joseph Rowntree Foundation Findings, and Renewal.net. Additional studies were identified by external stakeholders and members of the review team. In all, 22 studies were identified which included data on the subjective experience of community engagement for individuals (see Table 1 below).

Data analysis and synthesis

A data extraction pro-forma formed the basis of the thematic data analysis and data synthesis. In addition to collating details of individual studies (for example, study aims, sampling details, details of data collected etc.) this contained a series of outcome categories and subcategories which were developed as the article were read and re-read and the themes identified by the study authors extracted, initially by one member of the team (although all members of the research team contributed to the final evidence synthesis). In this article those categories are presented which emerged most strongly from the original authors' analyses, as viewed through the reviewers' lens.

Findings

Three main categories of community engagement initiatives were identified in the review (with, inevitably, some degree of overlap): area-based initiatives, such as Sure Start and New Deal for Communities, which target socially and economically deprived localities (Edwards 2002, Attree 2004, Cole *et al.* 2004, Ziersch & Baum 2004, Callard & Friedli 2005, McInroy & MacDonald 2005, Office of the Deputy Prime Minister/Neighbourhood Renewal Unit 2005); 'person-based' schemes, such as the Community Champions Fund, Residents' Consultancy Initiative and time banks, which seek to actively engage 'vulnerable' groups, such as low-income residents, older people, unemployed people, Black and minority ethnic communities, young people, those with physical disabilities and people with mental health problems (Matarasso 1997, Matthews 2001, Church & Elster 2002, Seyfang & Smith 2002, Johnstone & Campbell-Jones 2003, Seyfang

2003, Winters & Patel 2003, Office of the Deputy Prime Minister 2004, Watson *et al.* 2004, Gunn 2005, Bolam *et al.* 2006, Boyle *et al.* 2006, Chau 2007); and initiatives which involve particular interest groups, such as poverty and environmental organisations (del Tufo & Gaster 2002, Bickerstaff & Walker 2005, McInroy & MacDonald 2005).

Types of community engagement described in the studies included in the review ranged from consultation only, to delegated power for decision-making in the planning and design of services, through to co-governance or co-production of services (see Table 1). No initiatives were identified that were controlled solely by community members.

The subjective experience of engagement

Overall, the findings of this review suggest that the majority of individuals who were actively involved in initiatives utilising community engagement approaches experienced positive benefits, in terms of physical and emotional health and well-being, self-confidence, self-esteem, social relationships and individual empowerment (defined as the feeling that they are being useful to others, feeling in control of events, being able to express ideas and having an awareness of individual rights). There was also evidence, however, that community engagement was not inevitably a positive experience for participants in all circumstances.

The health impacts of engagement

The evidence suggests that people who were actively involved in a range of community activities perceived physical health benefits from their involvement (Matarasso 1997, Ziersch & Baum 2004, Callard & Friedli 2005, Bolam *et al.* 2006, Boyle *et al.* 2006, Chau 2007) including improved physical fitness, healthier nutrition, and reduced cigarette and alcohol consumption (Matarasso 1997, Bolam *et al.* 2006). For example, an individual from a time bank initiative (organisations which link people on a local basis, to exchange time and skills without money changing hands), involving people from disadvantaged groups explained that:

I walk more and I go to a gym, an hour's swimming and an hour's gym a week. I eat more healthily now...because through fruit barrows and all that you are promoting health, so you want to do that. (Boyle *et al.* 2006, page 20)

In addition, peer educators taking part in an information technology project for people from disadvantaged groups reported that participation helped them to cope with the consequences of illness (Bolam *et al.* 2006). Evidence from an estates-based community arts project also suggested that, as a consequence of their involvement in

Table 1 Characteristics of studies which include data on the subjective experience of engagement for individuals (*n* = 22)

Reference	Type of intervention	Type of community engagement	Key characteristics of study population
Attrie (2004)	Sure Start	Service delivery, co-production Sure Start is an area-based programme involving local families in building community capacity. The project trains community support workers to provide services for parents and carers of pre-school children	Community support workers drawn from local families in wards marked by social and economic deprivation
Bickerstaff & Walker (2005)	Transport planning	Consultation Case study 1: Leafleting campaign. Round table meetings with key stakeholders (representatives of interest groups). Focus groups with sectors of the population thought to have distinctive views on transport (disability, young people) Case study 2: Consensus-building methods involving a cross-section of stakeholders – representatives of particular interest groups – through formal meetings and community groups	Interest group representatives including business, user groups, civic groups, residents' groups and environmental interest organisations
Bolam <i>et al.</i> (2006)	CityNet – an Information Communication Technology (ICT) project	Service delivery, co-production The CityNet project works with local people to design web interface and content, and recruits and trains Ambassadors (peer educators) to train others in ICT	People from disadvantaged groups, for example older people, unemployed people, those with a limiting long-term illness or disability or mental health difficulties
Boyle <i>et al.</i> (2006)	Time banks	Service delivery, co-production Time banks involve community members as partners in the delivery of services in the public and voluntary sector, using a co-production model	Time bank participants, who are local people drawn from some of the least prosperous wards in the UK
Callard & Friedli (2005)	Community arts	Co-production 'Imagine East Greenwich' was an estates-based arts and health project which provided opportunities for people to work together to produce displays, books, a calendar, film, artworks and other health-related material	Residents drawn from the estate
Chau (2007)	Service planning	Consultation, delegated power Working groups set up in three case study areas adopted different methods to influence service areas of their choice, including research with users	Chinese older people
Church & Elster (2002)	Sustainable development	Service delivery, co-production Engagement in sustainable development projects varies across case studies – the majority use volunteers to organise or deliver their services	Volunteers from socially and economically deprived areas
Cole <i>et al.</i> (2004)	New Deal for Communities (NDC)	Consultation, delegated power Resident involvement in formulating plans to tackle low demand and unpopular housing in their local areas Engagement techniques ranged from consultation to membership of a Housing Task Group	Residents of some of the most deprived wards in the UK
del Tufo & Gaster (2002)	Poverty commission	Consultation, delegated power Lay people were involved in the Commission on Poverty, Participation and Power, set up by the UK Coalition Against Poverty (UKCAP)	'Grass-roots' commissioners with direct experience of poverty

Table 1 (Continued)

Reference	Type of intervention	Type of community engagement	Key characteristics of study population
Edwards (2002)	Single Regeneration Budget (SRB)	Consultation, delegated power The SRB project aimed to involve community groups/representatives in developing regeneration bids and contributing to the decision-making process	Although the SRB is a broadly based regeneration initiative, this article focuses solely on people with disabilities
Gunn (2005)	Local authority service planning	Consultation Young people (some looked-after) participated in local authority decision-making through surveys, conferences, youth councils and participation groups	Young people (some looked-after)
Johnstone & Campbell-Jones (2003), Watson <i>et al.</i> (2004)	Community Champions Fund	Service delivery, co-production The Community Champions Fund supports individuals by developing their skills, through formal or informal training, and providing access to information and wider networks. The primary aim is to encourage people to become involved in community cohesion and regeneration activities, via community groups. The scheme focuses in some instances on disadvantaged areas in the English regions	Primarily unemployed people (42% from BME groups and 40% aged >50). Young Champions mainly aged <25
Matarasso (1997)	Community arts	Consultation, co-governance Arts projects ranged from those controlled by professionals to those where lay people were actively involved in decision-making, administration and management	Local residents from areas with high levels of deprivation
Matthews (2001)	Youth councils	Consultation, delegated power The main focus of the scheme was young people's participation in local decision-making in different types of forums – e.g. a youth council set up to allocate funding to art-based projects	Young people aged 12–25
McInroy & MacDonald (2005)	Environmental regeneration	Consultation, co-production Engagement varied across Groundwork environmental regeneration sites – mainly consultation, but some resident involvement in regeneration, and local volunteers engaged in improving public spaces	Community members actively involved in regeneration projects in socially and economically deprived wards
Office of the Deputy Prime Minister (2004)	Residents' consultancy initiative	Consultation, co-governance Projects engage local residents (consultants) to support the regeneration of their own localities through promoting greater community engagement and more responsive local service delivery	Local residents in deprived areas of the UK
Office of the Deputy Prime Minister/Neighbourhood Renewal Unit (2005)	New Deal for Communities (NDC)	Consultation, co-production Community engagement is a key characteristic of the NDC programme – involving consultation with residents, building capacity and resident involvement in governance	Residents drawn from some of the most deprived wards in the UK
Seyfang & Smith (2002), Seyfang (2003)	Time banks	Service delivery, co-production Time banks involve community members as partners in the delivery of services in the public and voluntary sector, using a co-production model	Time bank members, from economically deprived groups (e.g. unemployed, low-income), with a high percentage belonging to ethnic minorities

Table 1 (Continued)

Reference	Type of intervention	Type of community engagement	Key characteristics of study population
Winters & Patel (2003)	Drugs needs assessment for Black and minority ethnic (BME) populations	Service delivery, co-production This community-led project aimed to assess need for drug treatment, education and prevention within BME communities. A research framework was created to encourage and build on the capacity of 47 BME community groups and voluntary organisations who took part	Community researchers drawn from BME groups and voluntary organisations
Ziersch & Baum (2004)	Civil society groups	Consultation, delegated power Resident involvement in civil society groups, including voluntary associations, clubs, organisations and societies	Local residents from an ethnically mixed working-class area

the co-production of art works, individuals began to think more positively about health and well-being issues (Callard & Friedli 2005). The study authors did not report whether this resulted in subsequent changes in health behaviours, however.

There was some research evidence that participants perceived positive outcomes of engagement for their psychological health. Members of time banks drawn from economically deprived groups described ways in which problems such as depression, loneliness, anxiety and negative stress were reduced through improving social networks and gaining access to alternative therapies (Seyfang & Smith 2002, Boyle *et al.* 2006). Ziersch & Baum's (2004) study suggested that belonging to civil society groups had psychological benefits for a small number of individuals from an ethnically mixed working-class area, closely linked to increased social participation. For example, one informant explained:

I always considered it [the involvement] was, at least psychologically, very positive. I felt a lot better for it. I felt I was meeting lots of people, and getting involved in lots of things was making me feel happier generally. (Ziersch & Baum 2004, page 497)

In addition, two studies, one involving individuals from an area of high deprivation in community arts (Matarasso 1997), and another of time bank members drawn from economically deprived groups (Seyfang & Smith 2002), reported a positive impact of engagement on their quality of life. For example, 73% of participants questioned in Matarasso (1997) study said that they had felt happier since being involved in community arts projects, while qualitative evidence suggested that improvements in participants' quality of life were linked to increased social interaction and broadening social networks. However, the extent to which non-professional people were *actively* involved in decision-making,

administration and management of the scheme is unclear in this study.

The studies reviewed painted a complex picture of the impact of community engagement on individual health. Survey findings from one study, for example, pointed to an inverse relationship between involvement in a civil society group and physical health for individuals drawn from an ethnically mixed working-class area, and found no association between involvement and mental health (Ziersch & Baum 2004). A small number of individuals spoke of experiencing personal health benefits associated with involvement, but the majority reported negative physical and psychological health effects, such as exhaustion and stress. For example, one participant stated:

Sometimes I was pretty stressed, that even when I came home from [the housing co-operative] meetings I couldn't sleep for three days because it went through my head what went on. (Ziersch & Baum 2004, page 497)

As Ziersch & Baum (2004) note, however, the apparent association between involvement in civic activities and negative health outcomes may not be causal. It is possible that it reflects an increased tendency for people with poorer health to engage in voluntary work, as they may not be in paid employment and have more available time.

Two studies suggested that the physical and psychological demands of engagement, such as attending long meetings, were particularly onerous for people with disabilities (Matarasso 1997, Edwards 2002). For example, a respondent in Matarasso (1997) community arts study involving residents from estates with high levels of deprivation explained that, 'I'm a bit demoralised because I was far less able than anyone in my group and so found it quite stressful at times' (page 77). In another study, individuals with disabilities described feeling that meetings tended to be held for

the convenience of service organisations and failed to take their specific needs into consideration. As one respondent explained:

Everything is always at organisations' convenience... I'd like to go to more meetings, but I physically can't do them. Today I have a meeting at 2pm...that will take until 5pm, and for me that causes a problem, because sitting is a problem. If I don't spend between 12 and 14 hours a day lying down then I can't function. (Edwards 2002, page 132)

As the above quotation suggests, the physical and mental health benefits of community engagement for some participants were diluted by the stresses and strains associated with involvement. For example, a study of older people from the Chinese community, who took an active role in planning local authority services, described how participation drained their energy levels, as well as their time and financial resources (Chau 2007). In areas of the country, often those with high levels of deprivation, where there were a number of concurrent initiatives, individuals spoke of experiencing consultation fatigue (Cole *et al.* 2004, Bickerstaff & Walker 2005, Gunn 2005). A lay respondent from a transport planning group involving representatives of interest groups (primarily in consultation exercises) explained that, from his perspective:

The government have gone crazy on plans. People are absolutely inundated with plans on every subject under the sun and people are getting plan fatigue really. I think if you have too many of them people just go and lose interest and they're not going to be worth the effort really... (Bickerstaff & Walker 2005, page 2136)

Lack of continuity in engagement opportunities, together with the failure to embed projects into community organisations (often associated with the short-term nature of the resources available to develop initiatives) were sources of disappointment for a number of participants and could act as a disincentive for future engagement (Bolam *et al.* 2006). Moreover, people spoke of becoming disillusioned when their suggestions for service improvement were not acted upon (Chau 2007). In such cases, there was a danger that community engagement could be seen as 'tokenistic' in nature (Branfield *et al.* 2006).

The psychosocial consequences of engagement

Evidence from this review suggests that active engagement in community initiatives may have valuable psychosocial benefits for participants, in terms of bolstering self-confidence and self-esteem (Matarasso 1997, Matthews 2001, Church & Elster 2002, Johnstone & Campbell-Jones 2003, Winters & Patel 2003, Attree 2004, Watson *et al.* 2004, Bolam *et al.* 2006). An evaluation of the

Community Champions Fund (a scheme which encouraged individuals, primarily drawn from unemployed and disadvantaged groups, to get involved in community cohesion and regeneration activities), for example, found that 78% of respondents said that they had developed more confidence since participating in the initiative (Watson *et al.* 2004). For Young Champions (aged under 25) increased self-confidence was the most frequently reported benefit of involvement (Watson *et al.* 2004). The following quotations, from individuals involved in the Community Champions Fund and Youth Councils respectively, illustrate the type of changes experienced:

When people back you, you've got that bit more confidence... you feel as though you're worthy. (Johnstone & Campbell-Jones 2003, page 68)

I have gained something personally...confidence...it was a good experience. (Matthews 2001, page 307)

In addition, some studies suggested that community engagement could have a positive impact on individuals' perceptions of personal empowerment (variously defined as feeling useful to others, feeling in control of events, being able to express ideas and having an awareness of individual rights) (del Tufo & Gaster 2002, Attree 2004, Cole *et al.* 2004, Callard & Friedli 2005, Bolam *et al.* 2006).

The positive effect of community engagement on participants' social relationships was a recurring theme of the studies in the review (Matarasso 1997, del Tufo & Gaster 2002, Seyfang 2003, Watson *et al.* 2004, Office of the Deputy Prime Minister/Neighbourhood Renewal Unit 2005, Bolam *et al.* 2006, Boyle *et al.* 2006, Chau 2007). A survey conducted as part of a time bank evaluation, found, for example, that individuals from economically deprived groups who were actively involved in the project experienced personal benefits which included getting out into the community more often, greater involvement in local groups, getting to know more people, meeting like-minded people; and making new friendships (Seyfang 2003). Moreover, a qualitative study of time banks found that participants talked about being enabled to build a network of social contacts in a 'domino effect' (Boyle *et al.* 2006, page 29). Across several studies, individuals from different social, economic and cultural backgrounds described the positive differences that the social aspects of engagement in initiatives ranging from community arts to service planning had made to their lives, such as making new friends and gaining an appreciation of other people's points of view (Matarasso 1997, Seyfang & Smith 2002, Ziersch & Baum 2004, Chau 2007).

Experiential evidence also suggests that community engagement may benefit a community more widely, in

terms of increasing mutual trust and understanding between different population groups (Matarasso 1997, Seyfang & Smith 2002, Seyfang 2003, Callard & Friedli 2005). Three projects involving Young Champions were specifically designed to increase cultural awareness between different ethnic groups (although at the time of evaluation it was too early to assess impact) (Watson *et al.* 2004). A majority of respondents in the Seyfang (2003) study of time banks said that they felt that they had helped to improve their community as a place to live, a key element of which was bringing people together who would not normally meet.

However, community engagement could also be seen as a potentially divisive factor within communities. A number of Chinese older people engaged in service planning, for example, reported that they had experienced disapproval, criticism and even bullying from other community members, who assumed that their primary motive for involvement was financial (Chau 2007). A participant stated, for example:

This might be human nature. When it involves money people start to think differently...We put our trust in someone and in return make ourselves targets of bullying. (Chau 2007, page 19)

Discussion

This rapid review of evidence suggests that active community engagement may have benefits for individuals' physical health, psychological health and psychosocial well-being. The findings of the review are paralleled by research drawn from other fields. For example, user involvement in a mental health facility was found to have a therapeutic value for individuals (Truman & Raine 2001) and in cancer care, service users reported gains in self-confidence and self-esteem as a result of participation in decision-making groups (Cotterell *et al.* 2008).

Other research suggests that the social outcomes of community engagement may be particularly important for 'at risk' population groups, such as residents in poor social and economic circumstances, and older people, who tend to be less 'well-connected' socially (Glennerster *et al.* 1999, Scharf *et al.* 2001). Moreover, there is a substantial body of evidence that suggests that social integration can have a protective effect on physical and psychological health and health-related quality of life (Rosengren *et al.* 1993, Achat *et al.* 1998, Berkman & Glass 2000, Cohen *et al.* 2000, Cohen 2004).

Set against the benefits, however, the findings of this rapid review suggest that community engagement can have unintended negative consequences for the physical and emotional health of participants. For some people

engagement may involve a process of negotiation between gains and losses and weighing the potential risks to well-being.

There are several limitations of the review and the studies identified which need to be taken into account. Firstly, it was not possible in the time available to include all the potentially relevant studies identified. It is possible that this resulted in a biased selection of evidence. Secondly, the UK focus of the review may limit its generalisability to other contexts. Thirdly, although types of community engagement can be categorised under broad headings (such as consultation and co-production) the majority of included studies did not provide detailed descriptions of the approaches and methods employed, making them less useful for planning new initiatives. Finally, it is likely that assessing the impact of community engagement for individuals is affected by the 'directness' of the involvement. However, the reporting of initiatives often failed to distinguish between *active* community engagement in decision-making that may affect their lives – such as involving lay people in service planning, design, delivery or governance – and simply engaging them in activities that may be health or life enhancing. The terminology used in research articles to describe community engagement often conflates these two meanings. Thus, identifying the individual effects of community engagement, in the sense of active involvement in decision-making processes that affect people's lives, is difficult. It would be helpful if those planning, commissioning and conducting such research in the future were to attempt to tease out these differences.

Furthermore, studies provide evidence of an *association* between the initiative being evaluated and the individual outcomes identified, but it is not possible to say how community engagement *per se* has contributed to these outcomes. No studies used research designs that would have enabled direct attribution of outcomes to community engagement. It cannot be claimed with certainty that the type of outcomes described in this article would not have occurred in the absence of initiatives because of other influencing factors in the lives of individuals. The limitations of the evidence also meant that, in the main, it was not possible to analyse the extent to which participants' individual characteristics impacted on the extent to which individuals derive benefit from engagement. This would require further research.

Conclusions

This rapid review of community engagement in initiatives which aim to address the wider social determinants of population health has demonstrated that the 'engaged' individuals in the studies included in the review perceived a range of positive benefits in terms of

physical and psychological health and psychosocial well-being. It was also found, however, that community engagement could pose risks for personal well-being, and that the potential gains may be unevenly distributed. Importantly, for some 'vulnerable' groups, such as disability and older people, the negative consequences of engagement may outweigh the perceived benefits. It is important therefore that those planning such initiatives are sensitive to users' specific concerns and support requirements, comprehensively addressing their requirements throughout the process of participation (McDaid 2009).

Moreover, lack of continuity in opportunities for involvement, limiting engagement to consultation exercises without conceding power to lay people, 'tokenism' on the part of public organisations, failure to act on service users' suggestions and consultation fatigue, mean that engagement can prove a dispiriting experience for some community members and may ultimately lead to withdrawal from participation.

While the evidence suggests that for some individuals there are a range of clear and identifiable benefits from community engagement, across the review studies the range of methods and approaches used varies and are not consistently replicated across all settings and initiatives to allow the evidence to demonstrate which is the most successful. It is difficult, therefore, to attribute specific benefits to any one approach or method. Evidence from a number of studies (Cole *et al.* 2004, Bickerstaff & Walker 2005, Chau 2007) does suggest, however, that individuals are less likely to find community engagement a positive experience where *consultation* is the main method employed by professionals and no real power to effect change is ceded to community members.

Whilst the failure of practice to match up with the rhetoric of community engagement is widely recognised, the potential for this failure to have negative consequences for the health and well-being of the lay people involved is not widely acknowledged. Combined with the good quality evidence that community engagement, when done well can have significant health benefits, this strengthens the case for greater investment to improve practice in this area.

Acknowledgements

We would like to acknowledge members of the Centre for Public Health Excellence team at NICE, including the director Professor Mike Kelly, Antony Morgan, Melanie Iddon and Lorraine Taylor, for their contributions to the report on which this article is based. We would also like to thank members of the research team Deborah Hornby, Nancy Simpson and Ute Kowarzik for their invaluable input into the

review, Julie Glanville, Jo Akers and Kate Light of the University of York, for carrying out a number of literature searches and the two anonymous reviewers for their comments on an earlier draft of this article.

Source of funding

This review was funded by the National Institute for Health and Clinical Excellence (NICE), London, UK. This article represents the views of the authors, not of NICE.

Conflict of interests

None

References

- Achat H., Kawachi I., Levine S. *et al.* (1998) Social networks, stress and health-related quality of life. *Quality of Life Research* 7, 735–750.
- Anderson E., Shepherd M. & Salisbury C. (2006) 'Taking off the suit': engaging the community in primary health care decision-making. *Health Expectations* 9, 70–80.
- Arnstein S.R. (1969) A ladder of citizen participation. *Journal of American Planning Association* 35 (July), 216–224.
- Attrie P. (2004) 'It was like my little acorn, and it's going to grow into a big tree': a qualitative study of a community support project. *Health and Social Care in the Community* 12, 155–161.
- Berkman L.F. & Glass T. (2000) Social integration, social networks, social support, and health. In: L.F. Berkman and I. Kawachi (Eds) *Social epidemiology*, pp. 137–173. Oxford University Press, New York.
- Bickerstaff K. & Walker G. (2005) Shared visions, unholy alliances: Power, governance and deliberative processes in local transport planning. *Urban Studies* 42, 23–44.
- Bolam B., McLean C., Pennington A. & Gillies P. (2006) Using new media to build social capital for health – a qualitative process evaluation study of participation in the CityNet project. *Journal of Health Psychology* 11, 297–308.
- Boyle D., Clark S. & Burns S. (2006) *Hidden work: Co-production by People outside Paid Employment*. The New Economics Foundation and the Joseph Rowntree Foundation, York.
- Branfield F. & Beresford P., with *et al.* (2006) *Making User Involvement Work: Supporting Service User Networking and Knowledge*. Joseph Rowntree Foundation, York.
- Callard F. & Friedli L. (2005) Imagine East Greenwich: evaluating the impact of the arts on health and well-being. *Journal of Public Mental Health* 4 (4), 29–41.
- Chau R.C.M. (2007) *The Involvement of Chinese Older People in Policy and Practice: Aspirations and Expectations*. University of Sheffield and the Joseph Rowntree Foundation, York.
- Church C. & Elster J. (2002) *Thinking Locally, Acting Nationally: Lessons for National Policy from Work on Local Sustainability*. Joseph Rowntree Foundation, London. (WWW document) URL <http://www.jrf.org.uk/bookshop/eBooks/1842631381.pdf> (last accessed 21 April 2010).

Clark M.J., Cary S., Diemert G. *et al.* (2003) Involving communities in community assessment. *Public Health Nursing* **20**, 456–563.

Cohen S. (2004) Social relationships and health. *American Psychologist* November, , 676–694.

Cohen S., Gottlieb B. & Underwood L. (2000) Social relationships and health. In: S. Cohen, L. Underwood and B. Gottlieb (Eds) *Measuring and Intervening in Social Support*, pp. 3–25. Oxford University Press, New York.

Cole I., Hickman P. & McCoulough E. (2004) *The Involvement of NDC Residents in the Formulation of Strategies to Tackle Low Demand and Unpopular Housing*. Research Report 40. Sheffield Hallam University, The Centre for Regional Economic and Social Research, Sheffield, UK. (WWW document) URL <http://extra.shu.ac.uk/ndc/downloads/reports/RR40.pdf> (last accessed 21 April 2010).

Commission on Social Determinants of Health. (2008) *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. Final report of the Commission on Social Determinants of Health. World Health Organisation, Geneva.

Cook D. (2002) Consultation for a change? Engaging users and communities in the policy process *Social Policy and Administration* **36**, 516–531.

Cotterell P., Harlow G., Morris C. *et al.* (2008) *Identifying the Impact of Service Users Involvement in the Lives of People Affected by Cancer*. Final Report. Macmillan Cancer Support, London, UK.

Department of Communities and Local Government (2008) *Communities in Control: Real People, Real Power*. Cm 7427. The Stationery Office, London.

Department of Health (2006a) *A Stronger Local Voice: A Framework for Creating a Stronger Local Voice in the Development of Health and Social Care Services*. Department of Health, London.

Department of Health (2006b) *Our Health, Our Care, Our Say*. Department of Health, London.

Dinham A. (2007) Raising expectations or dashing hopes?: Well-being and participation in disadvantaged areas. *Community Development Journal* **42**, 181–193.

Edwards C. (2002) Inclusion in regeneration: a place for disabled people? *Urban Studies* **38**, 267–286.

Electoral Commission (2005) *Social Exclusion and Political Engagement*. Research report. The Electoral Commission, London.

Gillies P. (1998) Effectiveness of alliances and partnerships for health promotion. *Health Promotion International* **13**, 99–120.

Glennerster H., Lupton R., Noden P. & Power A. (1999) *Poverty, Social Exclusion and Neighbourhood: Studying the Area Bases*. CASE paper 22. Centre for Analysis of Social Exclusion, London School of Economics, London.

Greene S. (2007) Including young mothers: community-based participation and the continuum of active citizenship. *Community Development Journal* **42**, 167–180.

Gunn R. (2005) Young people's participation in social services policy making. *Research Policy and Planning* **23**, 127–137. (WWW document) URL <http://www.ssrsg.org.uk/publications/rpp/2005/issue3/article1.pdf> (last accessed 21 April 2010).

Gustaffson U. & Driver S. (2005) Parents, power and public participation: Sure Start, an experiment in New Labour governance. *Social Policy and Administration* **39**, 528–543.

Hogg C.N.L. (2007) Patient and public involvement: what next for the NHS? *Health Expectations* **10**, 129–138.

Johnstone D. & Campbell-Jones C. (2003) *Skills for Regeneration: Learning by Community Champions*. Educe and the Department for Education and Skills, London.

Matarasso F. (1997) *Use or Ornament? The Social Impact of Participation in the Arts*. Comedia Stroud, Gloucestershire.

Matthews H. (2001) Citizenship, youth councils and young people's participation. *Journal of Youth Studies* **4**, 299–318.

McDaid S. (2009) An equality of condition framework for user involvement in mental health policy and planning: evidence from participatory action research. *Disability and Society* **24** (4), 461–474.

McInroy N. & MacDonald S. (2005) *From Community Garden to Westminster: Active Citizenship and the Role of Public Space*. Centre for Local Economic Strategies, Manchester.

NICE (National Institute for Clinical Health and Excellence). (2006) *Methods for Development of Nice Public Health Guidance*. NICE, London. (WWW document) URL <http://www.nice.org.uk/page.aspx?o=299970> (last accessed 21 April 2010).

Office of the Deputy Prime Minister (2004) *Evaluation of the Residents' Consultancy Pilots Initiative*. Research Report 10. Office of the Deputy Prime Minister, London.

Office of the Deputy Prime Minister/Neighbourhood Renewal Unit (2005) *Views of New Deal for Communities – Focus Group Report*. Office of the Deputy Prime Minister, London. (WWW document) URL http://extra.shu.ac.uk/ndc/ndc_reports_01.htm (last accessed 21 April 2010).

Popay J. (2006) *Community Engagement, Community Development and Health Improvement*. A background paper prepared for the National Institute for Clinical Health and Excellence, London.

Popay J. & Finegan H. (2006) *Learning about Effective Community Engagement from Selected National Initiatives*. Working Paper 5, Lancaster University, National Collaborating Centre for Community Engagement, Lancaster, UK.

Rifkin S., Lewando-Hundt G. & Draper A. (2000) *Participatory Approaches in Health Promotion and Planning*: A literature review. Health Development Agency, London.

Rosengren A., Orth-Gomer K., Wedel H. & Wilhelmsen L. (1993) Stressful life events, social support, and mortality in men born in 1933. *British Medical Journal* **307**, 1102–1105.

Scharf T., Phillipson C., Kingston P. & Smith A.E. (2001) Social exclusion and older people: exploring the connections. *Education and Ageing* **16**, 303–320.

Seyfang G. (2003) Growing cohesive communities one favour at a time: Social inclusion, active citizenship and time banks. *International Journal of Urban and Regional Research* **27**, 699–706.

Seyfang G. & Smith K. (2002) *The Time of Our Lives: Using Time Banking for Neighbourhood Renewal and Community Capacity Building*. New Economics Foundation, London.

Social Exclusion Unit (1999) *Bringing People Together: A National Strategy for Neighbourhood Renewal*. HMSO, London.

Truman C. & Raine P. (2001) Involving users in evaluation: the social relations of user participation in health research. *Critical Public Health* **11** (3), 215–229.

del Tufo S. & Gaster L. (2002) *Evaluation of the Commission on Poverty, Participation, and Power*. Joseph Rowntree Foundation and YPS, York. (WWW document) URL <http://www.jrf.org.uk/bookshop/eBooks/1842630822.pdf> (last accessed 21 April 2010).

Wallace A. (2007) 'We have had nothing for so long that we don't know what to ask for': New Deal for Communities and the regeneration of socially excluded terrain. *Social Policy and Society* **6**, 1–12.

Wallerstein N. (2006) *What is the Evidence on Effectiveness of Empowerment to Improve Health?* Health Evidence Network, WHO, Europe.

Watson A., Owen G., Crowder M. & Ellis B. (2004) *Evaluation of the Community Champions Fund*. ASW Consulting, Department for Education and Skills, London. (WWW document) URL <http://www.dfes.gov.uk/research/data/uploadfiles/RR550.pdf> (last accessed 21 April 2010).

Winters M. & Patel K. (2003) *The Department of Health's Black and Minority Ethnic Drug Misuse Needs Assessment Project*. Centre for Ethnicity and Health, University of Central Lancashire and the Department of Health, London.

Ziersch A.M. & Baum F.E. (2004) Involvement in civil society groups: is it good for your health? *Journal of Epidemiology and Community Health* **58**, 493–500.