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Title

Theorising lifestyle drift in health promotion: explaining community and voluntary sector engagement practices in disadvantaged areas

Abstract

The past two decades have seen an increasing role for the UK community and voluntary sector (CVS) in health promotion in disadvantaged areas, largely based on assumptions on the part of funders that CVS providers are better able to engage ‘hard-to-reach’ population groups in services than statutory providers. However, there is limited empirical research exploring CVS provider practices in this field. Using ethnographic data this paper examines the experiences of a network of CVS providers seeking to engage residents in health promoting community services in a disadvantaged region in the North of England. The paper shows how CVS providers engaged in apparently contradictory practices, fluctuating between an empathically informed response to complex resident circumstances and (in the context of meeting externally set targets) behaviourist lifestyle approaches to health promotion. Drawing on concepts from figurational sociology, the paper explains how lifestyle drift occurs in health promotion as a result of the complex web of relations (with funders, commissioners and residents) in which CVS providers are embedded. Despite the fact that research has revealed the impact of targets on the work of the CVS before, this paper demonstrates more specifically the way in which monitoring processes within CVS contracts can draw providers into the neoliberal lifestyle discourse so prevalent in health promotion.

Key words

Community and voluntary sector; neoliberalisation; figurational sociology; community engagement; health inequality; disadvantaged areas

Introduction

The past two decades have seen an increasing role for the UK community and voluntary sector (CVS) in the delivery of public services and in health promotion activities in particular (Macmillan, 2010; Milligan & Conradson, 2006; Rees & Mullins, 2016), a trend mirrored in other high income countries (Eikenberry & Kluver, 2004; Lovell, Kearns, & Prince, 2014). The range of organisations operating in this field has expanded over this period to include faith groups, social enterprises and advocacy groups, ranging in size and organisational structure, but sharing commonality in operating on a not-for-profit basis (Portillo et al., 2015). The UK Health and Social Care Act (Department of Health, 2012) set out a more prominent role for the sector in delivering community services and current public health guidance advocates CVS leadership in community engagement, particularly in areas of higher socioeconomic disadvantage (National Institute for Health and Care Excellence, 2016). The CVS has a well-established history in public health activity in many high income countries (Wilson, Lavis, & Guta, 2012), but the expansion of market principles within the health sector has seen a surge of CVS involvement in a broad range of health promoting services in the UK, including employment support programmes (SCOPE, 2016) and physical activity programmes (Walking for Health, no date). These developments have been underpinned by government rhetoric that, in contrast to the statutory and private sector, people within the CVS have a better understanding of so-called ‘hard-to-reach’ communities (Cabinet Office, 2010; Department of Health, 2016). This view has been endorsed by many CVS bodies, largely because they claim that their members are better placed to gain the trust of marginalised groups (Association of Chief Executives of Voluntary Organisations, 2010). These claims are premised on the belief that residents are more likely to respond to people in the CVS who might share their life experiences (House of Lords Select Committee on Science and Technology, 2011, p. 146). However, such claims have not been subject to empirical interrogation (Borzaga & Fazzi, 2014; House of Commons Public Administration Select Committee, 2008; M. J. Roy, Donaldson, Baker, & Kerr, 2014).

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The limited body of work exploring CVS delivery of health promotion in high income countries is largely taken from the perspectives of people within the CVS, much of it focussed on perceived provider characteristics (such as apparent compassion) and perceived psychological barriers to service use among target groups (Flanagan & Hancock, 2010; Portillo et al., 2015; Wilson et al., 2012). Baggot and Jones (2014) argue that a more dynamic view of the sector is needed to better understand CVS practices in light of the increasingly marketised context in which providers are working. There is increasing evidence, for example, that engagement of the CVS in the provision of former statutory services, often through closely monitored partnership arrangements between CVS and statutory providers (Rees, Mullins, & Bovaird, 2012), is increasing bureaucracy and professionalisation of staff (Fyfe, 2005). Participation in competitive markets for the delivery of health services is encouraging business strategies that differ little from those of private organisations, including competition between CVS providers (Powell, Thurston, & Bloyce, 2014) and formal performance management of staff (Borzaga & Fazzi, 2014). Others have described a process of CVS ‘mission drift’ (Macmillan, 2010, p. 7), with evidence that organisations have adapted organisational goals (Cairns, Harris, & Hutchison, 2006), the remit of their work (Shared Intelligence, 2009), and working practices (Chew & Osborne, 2009) to fit with the requirements of a new set of funders. Indeed, Martikke and Moxham (2010) argue that the constraints of contracts devised in partnership with statutory bodies limit the responsiveness of the sector to the needs of its users. Hupe and Hill (2007, p. 279) have shown that front-line professionals, so-called ‘street-level bureaucrats’, are steered simultaneously by the demands of colleagues, managers and policy makers and consequently, they argue, implementation of public policy is best understood with reference to the social networks in which practitioners are embedded.

The findings discussed above are indicative of a change in the webs of relations (and associated resources) between CVS providers, their funders and users, changes which reflect global processes

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of neoliberalisation in public policy, particularly in high income countries (Ward & England, 2007). For example, Eikenberry and Kluver (2004) have argued that increased resource dependency on the public sector in the United States has led to incorporation of the prevailing ideological practices of the state into the CVS, exemplified by the shift from traditional ‘advocacy’ to ‘service provision’ roles. Although not based on the CVS explicitly, tensions have been observed in health promotion in disadvantaged areas in New Zealand, where providers struggled to reconcile an understanding of the social determinants of health with a more individualising behaviourist agenda among their funders (Lovell et al., 2014). Popay, Whitehead and Hunter (2010) have documented the tendency for health promotion to drift from socioecological explanations for health inequalities to individualised behaviourist interventions, but there is as yet limited explanation as to why this occurs. Individualised approaches to health promotion have been supported by the ‘lifestylism’ that tends to dominate health promotion in high income countries, what Skrabanek (1994, p. 11) refers to as a moralist normalising of behaviour in the ‘pursuit of the chimera of health’. There is, therefore, a need for further empirical research that explores the ways in which neoliberalising processes and discourses in health promotion are shaping day-to-day practices of providers (Bell & Green, 2016; Schrecker, 2016), particularly CVS providers.

To this end, this paper presents an account of the experiences of front-line CVS providers seeking to engage residents in health promoting services as part of an area-based initiative in a disadvantaged area, Target Wellbeing (TW). The paper starts with the rationale for the theoretical underpinning of the paper, before providing a description of TW. Two key dimensions of CVS provider practices that emerged from the analysis of their work with residents are then presented: the development of supportive environments and the removal of perceived barriers to participation. Understanding the ways in which CVS providers work to promote health in a market context can provide some insights into the likely constraints and consequences of neoliberalising processes for the CVS. In this way we

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aim to theorise *how* CVS practice drifts towards a focus on lifestyle. The paper concludes with the implications of the findings for public health policy and practice involving the CVS.

A figurational case study of CVS health promotion

This research was informed by figurational sociology (Elias, 1978) which provided the framework for understanding the social context in which CVS provider practices developed. This framework, which has been used to examine organisational change within the National Health Service (Dopson & Waddington, 1996; Mowles, 2011), has not yet been applied to the field of health promotion but provides a means of exploring interconnections between front-line CVS practices and prevailing discourses in health promotion. Figuration (rather than society, social structure or system) is a concept proposed by Elias to represent a network of interdependent relations between mutually oriented people (Elias, 1978; van Krieken, 1998). Figurations are thus a temporary consequence of interweaving social actions, and are, therefore, in a constant state of flux (Elias, 1991). Thus, for the purpose of this research, we conceptualised TW providers as a figuration of interdependent people, acknowledging that they are simultaneously embedded within other figurations. Service providers commissioned to deliver community health promotion projects are, for example, likely to be constrained in their actions by the actions of public health policy makers, funders and the residents they target by virtue of their interdependence with them. Exploring interdependencies between providers, residents and other stakeholders in health promoting initiatives provides a means of connecting global economic and ideological trends with provider actions at the local level and enables us to examine, as Ayo (2012) recommends, the ways in which health promotion practices both reflect and influence prevailing political ideologies.

Significantly for Elias (1978, p. 131), ‘fluctuating balance of power is a structural characteristic of the flow of every figuration’. Interdependencies create uneven, but shifting power balances that give

some people greater control over the outcomes of interweaving actions; despite this, there will always be outcomes that no one has planned as power is never absolute. Immersion in more complex figurations of interdependent people (such as expanding networks of economic interdependency emerging out of neoliberal processes of globalisation) makes it increasingly difficult for people embedded within them to identify the constraints on their own actions (Elias, 1956). The concept ‘figuration’ can therefore be used to understand how planned human action – for example, CVS providers intending to work on the social determinants of health in disadvantaged communities – can give rise to unplanned outcomes, for example, CVS practice focusing on individual lifestyle factors. Elias (1978) proposed that unplanned outcomes are an inevitable consequence of the interweaving processes involving pluralities of people, and such unplanned outcomes are not unusual, but rather commonplace features of social life. A focus on the development of the figurations in which CVS providers are immersed enables us to better understand how relationships established to achieve particular goals might actually constrain providers’ ability to achieve those goals.

Elias’s (1956) concept of emotional involvement is used in the paper to help explain the ways in which CVS providers interpret resident engagement in health promoting services. Elias (1956) argued that the most adequate accounts of social phenomena might be developed through blending emotional involvement with emotional detachment from the objects of our observations; the degree of involvement or detachment that a person has from a situation, he argued, will shift as social pressures rise and fall. Some degree of emotional involvement is thus a consequence of being embedded in figurations in which power ebbs and flows. Examination of emotional interdependence provides a means of exploring the ways in which the personal priorities of CVS providers, in a changing policy and economic environment, might influence the development of health promoting practices. Of final relevance to the analysis is the way which providers’ location in particular

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networks of relations strongly influences disposition, tastes and ambitions. Elias (1991) used the term habitus to explain how a process of socialisation shapes people’s expectations and actions. Habitus can be described as a second nature, reflecting ‘taken-for-granted ways of perceiving, thinking and knowing’ about the world (Paulle, van Heerikhuizen, & Emirbayer, 2012, p. 71). Consequently, examining the origins of provider figurations as they relate to particular health promoting initiatives will be helpful for understanding the context in which CVS practices develop.

TW, delivered between 2008 and 2012 and funded by the National Lottery, was targeted at 10 areas of disadvantage across the north west of England, defined by levels of physical, mental and economic wellbeing. The main aims of TW were to increase levels of physical activity, promote healthy eating and improve mental wellbeing through a programme of projects in each area (Groundwork North West, no date). The TW programme in one town (referred to here as ‘Seatown’) formed the case for this research. Seatown had six TW projects delivered by six different CVS organisations and two projects delivered by the local primary care trust (PCT) (see Table 1). Targets were set by the co-ordinators of the initiative in Seatown (the public health team at the PCT) for the recruitment of residents to individual projects. Quarterly monitoring reports against these targets had to be submitted by providers to the PCT to send on to the funders. In their bid for Lottery funding, the regional co-ordinators of TW (a multisector partnership led by Groundwork North West) described their aim to develop the ‘well-being capacity’ of the CVS ‘to deliver mainstream public services’ (Northwest Wellbeing Partnership, personal communication, February 21, 2007, p.9).

Methodology

The figuration of providers, stakeholders and residents that emerged over the course of TW in Seatown was examined ethnographically. Ethical approval for the study was obtained from a regional National Health Service Research Ethics Committee in May 2009, when fieldwork (carried out by the lead author) began, ending in May 2012. Fifty two events and activities were purposively and progressively sampled for observations according to the potential they afforded to explore provider-resident dynamics (Bryman, 2012). Documents relating to the initiative (such as publicity materials and meeting minutes) were examined to explore changes over time in communications between residents and providers. Semi-structured interviews were conducted with 15 staff working face to face with residents (referred to here as ‘providers’) in each of the eight TW projects in Seatown. Four of these providers were employed by a statutory organisation and 11 by the CVS. Five regional and local TW co-ordinators (referred to here as ‘co-ordinators’) were also interviewed, three from the statutory sector and two from the CVS. Five providers, purposively selected to explore emerging themes, were interviewed a second time (6 months later), to explore changes over time. Interviews were also conducted with 10 TW service users (including nine users of CVS-run projects and one user of a statutory-run project). Interviews explored residents’ lives in Seatown, their relations with other residents and with service providers. Consistent with a figural perspective, sampling sought out events and participants deemed to be interdependent, exploring, for example, the people and activities connected to a particular TW resident recruitment strategy. A field diary was kept to record the fieldworker’s response to events, which, along with discussion with the co-authors, encouraged greater reflexivity and detachment with regard to the lines of enquiry that were developed (Bryman, 2012; Perry, Thurston, & Green, 2004). Figural ideas were used as sensitising concepts in an analysis process driven by grounded theory to support a ‘constant interplay’ between generating new ideas directly from collated data and testing existing explanations (Elias, 1978, p. 34).

Findings

Two distinct, and apparently contradictory, practices were visible among providers. The first practice revolved around seeking to develop socially accessible environments, which tended to be underpinned by a relatively detached and empathically informed understanding of the context and meanings associated with residents’ use of services. The second practice focussed on the removal of what providers identified as practical barriers to participation, which was based on a form of lifestyleism, a view that residents should want to participate in health promoting services. These different practices (described in more detail below) were visible amongst all providers regardless of the sector in which they were employed, but were found to emerge in different contexts, reflecting the complex networks of interdependency that providers occupied and the degree of emotional involvement that providers had. The origins of these networks are described in the paragraph below. Interview and documentary quotations used to illustrate the findings are labelled with participant roles, using pseudonyms where necessary.

When TW was introduced to Seatown, 12 lower super output areas (LSOAs) in the town were amongst the 20% most ‘deprived’ LSOAs in England, four of which were within the 10% most deprived LSOAs in England (Communities and Local Government, 2010). Providers and residents described Seatown residents as having a historical mistrust of local service providers that was particularly entrenched in the more deprived wards. There was a perception that the town had been ‘forgotten’ by service providers and funders (Statutory co-ordinator 01), a view partly shaped by the closure of a large industrial plant in the 1980s and the decline of shopping and leisure facilities in the town centre. Local government integration with a nearby city was also described by some residents as a reflection of their decreasing influence over local service provision: ‘We’re in with [the city] now; we’ll get nothing’ (TW user 04). Service co-ordinators and residents described resident hostility

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towards recent initiatives, particularly those instigated by local government. According to co-ordinators, TW was intended to change the ways in which residents in the most deprived wards engaged with services, and involvement of the CVS was expected to ensure that services reflected the needs and interests of local residents (Seatown TW bid, February 2007).

Blending involvement and detachment: the development of socially accessible environments

CVS and statutory providers from a range of projects described the development of relations with residents as a complex process requiring long-term strategies to understand and build trust from residents. During interviews, providers presented rich descriptions of residents’ lives and the complex reasons why they might not engage with services. One provider at an employment project described how emotional and physical abuse within personal relationships might affect residents’ low sense of self-worth and, subsequently, their confidence in seeking work. This provider perceived that working with residents to understand their family and personal experiences, past and present, was important as this revealed the ‘psycho-social issues’ affecting their ability to work (CVS provider 08). This sort of insight was informed by empathic understanding gained through immersion in professional networks supporting particular client groups over many years, blending emotional insight with a more detached assessment of resident circumstances. TW providers identified the specialist focus of their work as an aid to developing insight into residents’ lives, reflecting empathically informed interpretations of the complex contexts that shaped resident use of services. One CVS provider, who had worked with clients experiencing mental health issues for over 10 years, described this experience as important in supporting residents’ needs:

It’s always been clients at the centre [of our work]... So we know what... our clients want to achieve, and work that way. (CVS provider 09).

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Shared experiences with residents enabled providers to identify particular ways of working that they deemed more suitable. A provider at a mental health project described how her own experiences as a teenager with mental health issues, along with insight from former project users turned volunteers, helped her team to understand why some residents might fail to attend scheduled appointments. This insight helped to inform the language that providers used when corresponding with people who missed appointments, seeking to encourage reengagement at a future date.

Empathic understanding informed providers’ attempts to develop what they described as socially accessible environments for residents. One of the ways in which they sought to do this was to spend time, and be seen doing so, in places used by residents in more deprived wards. Early in the programme, one provider at an employment project described how his personal experience of living in what he described as a ‘deprived’ area influenced his strategy of visiting a local pub to develop familiarity with locals as the following quotation illustrates:

Local people who work around here ... said, “Oh don’t go in The Stag for a drink; it’s full of [trouble makers]. If they know you’re not from Seatown, you might be in trouble.” So, we went in there on our first week ... we go in rougher places than The Stag ... we just had a word with the landlord there to tell him what we were doing. We’ve been in there a couple of times since and they see us here when we’re promoting the programme. (CVS provider 01).

As part of the same project, a resident described how she was employed to speak informally to other local people to promote the project using opportunities that arose in her day-to-day life in the school playground or at a bus stop. Another provider explained how the location of her organisation on a housing estate, and its appearance as a home, helped to convey to residents that they were welcome:

We’re based here for a purpose, not just because, “Oh, we’ll go and base ourselves here.” The door’s open, it’s not locked. People can walk in. ... It looks like a house... We use community venues for that reason. (CVS provider 08).

Other long-term strategies were described by CVS and statutory providers as a means to build trust: such as repeatedly visiting care homes to chat informally with older people who might want to engage in physical activity projects. These practices conveyed providers’ views that it would take time to build the trust of residents, given the historical issues that influenced residents’ participation in services in the town. These views were endorsed by resident descriptions of their relationships with providers. One resident with mental health issues described how she felt that TW providers understood what she was going through partly as a result of her long-term relationship with them:

Sometimes ... I could speak to Peggy or Mary about ... my illness ... and how it’s affecting me ... because I’ve known them for a long time ... and because I’ve got that trust with them and that understanding, I know I could put to them ... what’s going on in my head ... whereas I might not be able to go and do that to somebody who doesn’t know me as well. (TW user 10).

In a different context many of the same providers and co-ordinators presented a less detached view of resident participation, which leads us to a discussion of lifestylism within the TW figuration.

Relative involvement: lifestylism and barrier removal

When seeking to explain apparently low project participation rates, providers drew on individualised, moralising accounts of resident attitudes towards potentially health-enhancing lifestyles, views which could be seen as a form of lifestylism. Such views were expressed more frequently over the course of the initiative and reflected the pressure on providers to meet targets

set by co-ordinators for the participation of residents in each TW project. Describing how she would assess the success of TW, one TW co-ordinator said: ‘We predominantly will use [monitoring tools], particularly around [resident] numbers’ (Statutory co-ordinator 01). These views and the TW target reporting processes contributed to expectations among TW providers that they needed to explain low turn-out at some activities. Over time, a narrative emerged among many TW providers and co-ordinators that residents in Seatown were ‘hard to reach’ (CVS provider 08) and that this explained apparently low participation. Reflecting their dependency on TW co-ordinators to interpret the success of their TW project for funders and future commissioners, TW providers drew directly on the description of residents as ‘hard to reach’ to explain unmet targets; as one TW provider said, ‘Seatown, it’s hard to get your targets, you know, it really is a hard-to-reach area’ (Statutory provider 02).

Providers used the term ‘hard to reach’ as a pejorative term to describe resident attitudes towards what they deemed to be healthy lifestyles. Providers commonly voiced the opinion that Seatown residents were ‘stuck in a rut’ (CVS provider 03) in relation to physical activity and diet, as one provider said:

People don’t really want to diet and they don’t want to exercise do they?

(Laughs) And ... I would imagine that there’s a lot of people in Seatown who don’t

do a lot of that so it’s a very difficult area to get change. (CVS provider 04).

Another TW provider identified individual ‘inclination’ as a key problem in terms of engaging residents in physical activity, suggesting that such a problem was ‘very hard to get over’ when trying to build relations (CVS provider 03). The term ‘hard to reach’ also reflected a view that residents had a ‘lack of aspiration towards ... education attainment’ (Statutory co-ordinator 02) and ‘no aspirations of getting work’ (CVS provider 09). There was a tendency to see residents as tolerating, and

consequently perpetuating, some of the difficult circumstances in their lives. The following quotation from a TW provider at a mental wellbeing project captures this well:

Their personal lives are just in chaos, absolute chaos some of them, they come from very difficult relationships where *they allow themselves* to be in difficult relationships, again because they don't think that they're of any worth. (CVS provider 08).

TW providers and co-ordinators firmly believed that involvement with TW activities would lead to improvement in the lives of residents; consequently, they interpreted non-participation as a signal that some residents did 'not want to improve their lives, they might actually be quite happy with the way they are' (Statutory co-ordinator 01). These partly defensive accounts of resident participation reflected providers' unwillingness to be blamed for a project's apparent lack of success. These moralising accounts, which presented Seatown residents as deviating from normalised health enhancing behaviours, can also be seen to reflect TW providers' emotional involvement in particular health promotion fields. TW providers designed and delivered activities that reflected their own interests and experiences and, consequently, believed that the activities had intrinsic value. A range of providers described how their expertise in physical activity, nutrition or mental health, developed over many years, had influenced the activities that they had designed for TW. Given their beliefs that the activities were worthwhile, TW providers sometimes found it difficult to account for the fact that some residents did not engage and consequently drew on individualised explanations that blamed the attitudes of residents for non-participation.

Having invested in explanations for low participation that were rooted in lifestylism, providers subsequently worked to address what they perceived to be practical barriers to participation. In response to missed targets, changes were made to activity timings, venues and pricing in anticipation that this would make it easier for residents to attend. When such changes had little

impact on engagement targets, this reinforced the ‘hard to reach’ narrative. One TW provider described the changes made to physical activity sessions, suggesting that if they were a practical possibility for residents, non-attendance could only be explained by individual inclination:

We’ve focused on things in the day ... but of course ... some of them are caregivers ... so some of them would be better off with an evening class ... If you remove every other barrier [like transport] and people still aren’t going, it must be because they don’t want to or they don’t feel the need to. (CVS provider 03).

TW providers justified the practical changes made in terms of the need to meet resident recruitment targets. In some instances, such changes meant that providers worked with residents outside of the more deprived, target wards and often with residents who had established relationships with existing statutory services. One TW provider in a physical activity project described how the need to focus on targets had encouraged her to deliver physical activity sessions within an established leisure centre rather than community walks within more deprived wards that were benefiting only a relatively small number of residents:

You can’t keep flogging the dead horse, if only one person is turning up for a walk, that’s good for them but we’ve still got to meet targets, so we’ve got to look at other ways of attracting [residents]. (Statutory provider 02).

As the initiative developed, providers drew increasingly on methods to increase resident participation numbers, reflecting the pressure they felt to meet project targets.

Discussion

The findings in this study can be used to theorise the way in which lifestyle drift develops within CVS health promotion practices. The apparently contradictory views that providers held simultaneously

about residents’ use of services can be explained by the fluctuating degrees of emotional involvement they had in residents’ participation. These fluctuations were influenced by the dynamic and interweaving networks of economic and personal relations between providers, residents, funders and policy makers. In some circumstances, providers sought to develop socially accessible environments in which residents might wish to participate, which was informed by a blend of involvement and detachment that gave rise to a nuanced interpretation of the influences on residents’ participation. The embodied experiences of TW providers working with specific resident groups over long time periods, and the similarities between the personal circumstances of some providers and residents, facilitated more adequate understanding among providers of residents’ lives. Harris et al. (2015) found that peer support programmes for health promotion work better when providers have experiences in common with the participants. This paper shows how these experiences contributed to a more adequate understanding of resident circumstances which was reflected in the ways in which providers worked to develop residents’ trust. Outreach was one way in which providers sought to develop, over the longer-term, socially accessible environments in which residents might participate. In this respect, providers could be seen to be responding to the ways in which residents might be constrained to participate in TW by their historical distrust of services.

Interwoven with these views, provider descriptions of residents as ‘hard to reach’ were influenced by their emotional involvement in participation targets and their ingrained views about the value of particular activities. Elias (1978) argued that greater levels of emotional involvement in social phenomena inhibit a more adequate understanding of their causes and consequences, and in the emotive context of meeting targets, providers fell back on individualised accounts of resident motivation for ‘healthy’ activities: the unintended outcome of being constrained to work towards quantified targets. Significantly, the lifestylism inherent in provider accounts fostered a particular approach to working with residents: seeking to remove apparent barriers to participation. Others

have concluded that the CVS is well equipped to remove barriers to service use among so called ‘hard-to-reach’ groups (Flanagan & Hancock, 2010). However, the metaphor of removing ‘barriers to change’ (Checkland, Harrison, & Marshal, 2007, p. 95) is inadequate in explaining the complex social processes shown in this study to affect service use. The lifestylism expressed in TW provider accounts reflected a less adequate understanding of participation and in many ways reflected their position within a wider figuration of practitioners whose livelihoods depended on the promotion of health-enhancing behaviours. The ‘hard to reach’ narrative shifted the blame for failing to meet targets away from providers towards the behaviour of the residents. Explanations for ill health that focus on irresponsible lifestyles and a failure to use local services were useful to providers in explaining apparently low participation rates that posed a threat to future funding for their organisations and potentially their own employment.

Individualised explanations for a range of social problems are hegemonic in high income countries (Elias, 1994) and their centrality within the healthism used to explain participation of lower socio-economic groups in health enhancing activities is no exception (Crawford, 2006). In the context of health promotion in neoliberalised states, Ayo (2012, p. 103) has defined individualised responsibility as a highly value-laden code of ethics, ‘an obligatory duty of citizenship’ that overrides the need for collective action to address the social determinants of health. Providers in this study were strongly influenced by the prevailing lifestyle explanations for poorer wellbeing in their target areas because, as a consequence of the stakeholder networks in which they were embedded, they needed to account for their lack of apparent success in engaging residents in activities. The CVS and statutory providers in this study also had a long-term professional commitment to health promoting activities that made lifestyle explanations more appealing. Such commitment was born of the established careers of providers in the fields of diet, physical activity and mental health. As Elias (1991) argued, one’s place in a figuration, such as a professional network, strongly influences

dispositions. When discussing targets, the providers in this study drew on taken-for-granted views that residents should want to engage in health promotion activities, informed by their professional habitus. Such processes of occupational socialisation are well documented in other professional spheres (Mordal-Moen & Green, 2014) and this study indicates that CVS provider practices are influenced by similar processes. Warr, Mann and Kelaher (2013) have noted a similar phenomenon in health promotion in disadvantaged areas in Australia, whereby government health providers shift between empathetic understanding of residents’ lives and implementation of standardised informational approaches to health promotion endorsed by a neoliberal government. Amin (2005, p. 629) has suggested that community engagement approaches in neoliberalised states risk ‘pathologization of areas facing hardship’ by localising disadvantage through a community deficit approach. This study helps to explain how socialisation into particular health roles can translate neoliberal discourse into CVS practices and can become useful to health promotion providers in a market culture. The study also revealed the circumstances in which an appropriate blend of emotional involvement and detachment tended to flourish and inform providers’ interpretations of and practice with residents, which suggests that working conditions can be developed to foster this. This is endorsed by Roy (2016) who saw that, in the context of asset-based community development, workers in Scotland were able to exploit the neoliberal agenda and work around it by supporting communities to work together to mitigate the effects of poverty. Figurations of social relations are in a constant state of flux (Elias, 1991), highlighting the fact that practices can and do shift under changing circumstances.

This interpretive account explains provider practices within health promotion in terms of simultaneous social influences, reflecting the complexity of the networks in which they were embedded. The established professional networks of which providers were a part (relating to their particular fields of expertise) sometimes influenced providers’ ability to think and act using an

appropriate blend of emotional involvement and detachment to try to better meet the needs of residents. At the same time, their immersion into emerging networks of dependency with funders and commissioners constrained providers to think in ways that shifted responsibility for participation in health promotion onto residents. Conceptualising providers’ practice as simultaneously constrained by their immersion in a complex figuration of residents, other providers, commissioners and funders provided a way of explaining why some of them held apparently contradictory beliefs about residents’ participation in services at different points in time. Fluctuating degrees of involvement and detachment influenced providers’ ability to use their insight into resident circumstances. A figurational analysis of the power dynamics shaping CVS provider practices in health promotion therefore provides a means of explaining the ways in which empathic understanding might be utilised or constrained within particular social figurations of policy makers, funders and providers.

Lowe and Wilson (2015) have argued that payment by results for the delivery of public services encourages providers to work in ways that ignore the complexity of residents’ lives. This case study presents empirical evidence of this within the CVS and explains fluctuations in provider practices over time under the pressure to meet targets. The tendency for public health policy to drift from socioecological explanations for health inequalities to individualised behaviourist responses is well-documented (Popay et al., 2010) but not well theorised; this paper demonstrates that CVS providers are similarly susceptible to such lifestyle drift within health promoting practice and explains the processes through which this drift happens. A particular strength of this study was the processual approach to studying provider and resident relations; the extensive period of time spent in the field enabled examination of the ways in which relations between providers and residents changed over time. Figurational sociology provides a useful framework for theorising health promotion practices because it focuses on interdependent relations within complex networks, of which emotional

involvement with many people (commissioners alongside residents) is an important part. It is the varying degrees of emotional involvement which give rise to particular patterns of practice, which might be more or less based on empathic understanding or lifestylism depending on the power dynamics operating within provider figurations. Further work is needed to examine how relationships are developing between CVS providers and residents or service users in other areas of the health sector, particularly in the field of mental health treatment where the CVS is playing an increasing role.

These findings suggest that the role of the CVS in community health promotion needs more considered understanding. The assessment of CVS potential in this field has so far been based on a static understanding of provider characteristics and an assumption that CVS providers know what residents need (particularly in disadvantaged areas). More detailed assessment is needed of both the context in which CVS providers are operating in health promotion and the interpretive work that providers conduct to make sense of their work with residents. This study has shown that CVS providers often have skills and experiences that might inform their work with residents, but their immersion in figurations that extend beyond the CVS constrains them to work with residents in ways that might be reflected in other sectors, working to address short-term targets at the expense of longer-term strategies to build trust with residents. Neville (2010) has argued that CVS organisations can deal with the potentially conflicting demands of funder-defined contracts and complex user needs by refusing funding that challenges their organisational remit. This seems increasingly difficult in an environment of shrinking funding where CVS organisations are more dependent on public service contracts (National Council for Voluntary Organisations, 2016). A more realistic option, as others have argued, might be the removal of short-term targets for service delivery and a less directive role for statutory bodies in monitoring contracts (Harris & Young, 2010; Lovell et al., 2014; Roy, Donaldson, Baker, & Kay, 2013). Despite the fact that research has revealed the impact of targets on the work of the CVS before, this paper demonstrates more specifically the way in which

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monitoring processes within CVS contracts can draw providers into the lifestyle discourse so prevalent in health promotion. The assessment of success in health promotion on the basis of engagement targets can change the ways in which CVS providers define the communities that they work with, perpetuating the limiting view that some residents are unmotivated to respond to health promotion activities. Many practitioners in the CVS engage in practices that reflect empathic understanding towards residents but some of these practices, such as outreach, need more time to take effect. In order to facilitate this, CVS health promotion work needs to be funded to allow the development of practices that involve building trust over time. Encouraging CVS providers to work in ways that build on their personal and professional experiences might encourage the development of better engagement practices in health promotion that respond to the complexity of residents’ lives.

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Table 1: Target Wellbeing organisations and projects in Seatown

Organisation type	Organisational expertise	Project description
Statutory-funded health centre	Healthy lifestyles	Community walking project Subsidised fruit and vegetables/ School nutrition sessions
Charity	Environmental and social	Outdoor physical activity

	regeneration	project
		Food growing project
Charity	Mental health	Project supporting people with severe and enduring mental health problems into work
Charity	Older people	Physical activity project for older people
Community interest company	Mental health	Project supporting people who have been long-term unemployed back into employment
Charity	Work place health	Project supporting people experiencing work-related health problems