A systematic review of evidence on the impacts of joint decision-making on community wellbeing

Technical report

FINAL report, August 2018

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1. Background

This report was commissioned by the What Works Centre for Wellbeing (WWC-WB). The WWC-WB is part of a network of What Works Centres: an initiative that aims to improve the way the government and other organisations create, share and use high-quality evidence for decision-making. The WWC-WB aims to understand what governments, businesses, communities and individuals can do to improve wellbeing. They seek to create a bridge between knowledge and action, with the aim of improving quality of life in the UK. This work forms part of the WWC-WB Community Wellbeing Evidence Programme, whose remit is to explore evidence on the factors that determine community wellbeing with a focus on the synthesis and translation of evidence on **Place** (the physical characteristics of where we live), **People** (the social relationships within a community) and, **Power** (the participation of communities in local decision-making).

During extensive stakeholder engagement (in workshops, an on-line questionnaire, community sounding boards, and one-to-one interviews), the Community Wellbeing Evidence Programme identified priority, policy-related topics within which evidence reviews were to be undertaken. One of the priority topics identified was community involvement in local decision-making. Stakeholders consistently raised community involvement and influence over local decisions, together with concepts such as empowerment and co-production, as key ingredients of community wellbeing (Community Wellbeing Evidence Programme, 2015).

The role of individuals and communities in shaping the material and social conditions in which they live is recognised as a potentially fundamental determinant of community wellbeing. Empowerment-based approaches, including the involvement of communities in local decision-making, were recommended by the World Health Organization Commission on the Social Determinants of Health, and the Strategic Review of Health Inequalities in England Post-2010 ('the Marmot Review'), which placed the empowerment of individuals and communities at the centre of necessary actions to reduce local, national and global inequalities in health and wellbeing (CSDH, 2008; Marmot, 2010). The concluding, key message of the Marmot Review was that greater power over decision-making within communities can enhance public service effectiveness, and improve outcomes:

'Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.'

Purpose of the systematic review, and place within the programme

This systematic review represents **Stage 2** of the Community Wellbeing Evidence Programme's examination of evidence on the wellbeing-related impacts of community involvement in local decision-making. Our previous Stage 1 scoping review focussed on evidence on community wellbeing-related impacts of co-production, and related concepts, located within previous **reviews** (Pennington et al., 2017). This Stage 2 systematic review provides a more in-depth examination of the evidence within individual/**primary level studies** on community involvement in local decision-making. See Box 1 for further information on the stages of evidence synthesis within the Community Wellbeing Evidence Programme.

Box 1: Stages of evidence synthesis within the Community Wellbeing Evidence Programme

Stage 1: 'Scoping' reviews to identify the current state of **review-level** evidence on the key community wellbeing topic areas identified by stakeholders. Designed to identify the strengths and weaknesses in existing knowledge and current gaps in the evidence-base, and to test the feasibility of conducting a systematic review of primary-level evidence in Stage 2.

Stage 2: A systematic review of primary-level evidence on the impacts of joint decision-making on community wellbeing.

Stage 3: based on the findings of Stages 1 and 2, identification of a 'roadmap' for future academic research, and 'frontline' evaluation.

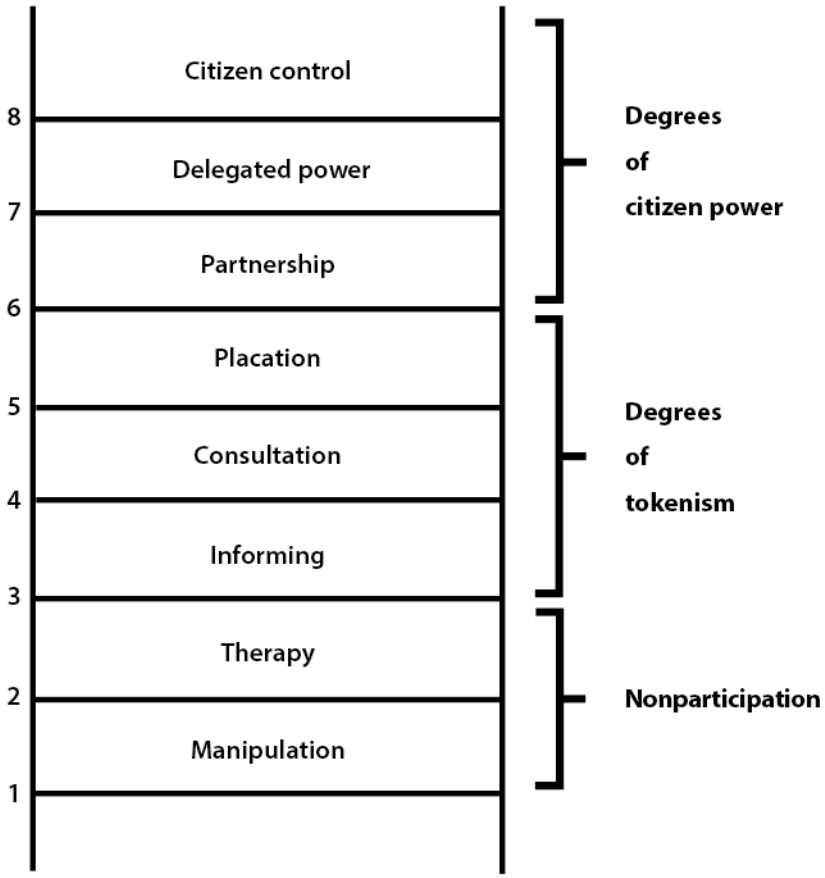
The wider context and focus of the review

The evidence contained within this review is focussed on an important gap within a large and broad body of existing evidence. The broader body of evidence is public or citizen participation (there are alternative phrases, such as community involvement). Participation can take many forms, and so the broader context extends from public involvement as volunteers, as consultees, through to public participation as instigators and managers of interventions in their communities. The broader body of evidence also includes observational studies not involving interventions, and evaluations of interventions in other settings. Nearly 50 years ago, Sherry Arnstein described and illustrated the broad range (or 'rungs') of public participation in her now famous[1] article *A Ladder of Citizen Participation* (Arnstein, 1969); the ladder is shown in Figure 1.[2]

[1] Cited in over 16,000 publications at time of writing (Google Scholar citation function) across a wide range of literatures including community development, public management, politics, and public health.

[2] The authors acknowledge that Arstein's Ladder has been the subject of many years of debate, conceptual development, and empirical research since 1969.

Figure 1. Eight rungs on the ladder of citizen participation (Arnstein, 1969)



At the extremes of the range, the bottom and top of the ladder, Arnstein identifies interventions where participants either have no power and are 'manipulated', or where they are in 'control' and have power over the decisions that affect their lives.

This review focusses specifically on current evidence from evaluations of interventions that are empowerment-based, i.e. the top three rungs of Arnstein's ladder ('Degrees of citizen power'). It only includes evidence from evaluations of interventions (policies, plans, programmes, or projects) that considered wellbeing-related outcomes (qualitative, or quantitative). It only includes evidence from evaluations of interventions set in the 'living environment' of communities, and does not include evidence from healthcare, education, or workplace settings, which have been covered quite extensively in other literature.

The authors have conducted previous reviews on this body of evidence (Whitehead et al, 2014; Pennington et al, 2017). This earlier work, including the Stage 1 scoping review, identified that there appeared to be a scarcity of evidence (or 'gap') specifically on the wellbeing-related impacts of

empowerment-based interventions in the living environment of communities. Review level evidence is, however, already available that considers:

i. The broad evidence on participation and wellbeing-related outcomes, but does not focus exclusively on empowerment-based interventions (i.e. the top three rungs of Arnstein's ladder).
ii. Evidence from observational studies on how different levels of control/power may be related to wellbeing, but not involving evaluations of interventions.
iii. Evidence only from other settings: healthcare, educational and other institutions (e.g. prisons), not the living environment of communities.

Traditional health promotion interventions (e.g. to address physical exercise, smoking, alcohol consumption, drug misuse) involving public participation have also been extensively researched and reviewed previously. They are also, therefore, excluded from this review.

Readers interested in reviews on the broader body of evidence on participation and wellbeing-related outcomes, evidence from non-living environment settings, or evidence on engagement in health promotion interventions will find references to 29 reviews of potential interest in Appendix 1.

The reviews conducted by the Community Wellbeing Evidence Programme, including this review, focus only on evidence from evaluations conducted in OECD countries. This is designed to maximise the potential transferability of research findings to UK settings, populations, and interventions.

Building on the Stage 1 scoping review

The previous, stage 1 **scoping review** (Pennington et al., 2017) identified important issues and gaps in existing *review* level evidence. These included:

1. Previous reviews contained lots of studies of interventions (policies, programmes, projects) that did not *meaningfully* involve communities in decision-making – local people were often just 'consulted' about decisions or helped to deliver projects, received little or no feedback on how they had made a difference, or had little or no real opportunity to shape them.
2. Reviews (and their included studies), often confused and conflated concepts such as consultation, volunteering, engagement, and empowerment. This may have led to the perception that there was more evidence on the impacts of 'true' empowerment interventions in communities than currently exists.

3. There were surprisingly few studies that attempted to evaluate the impacts of interventions on the wellbeing of those involved or on the wider community – when people *were* meaningfully involved in decision-making, most evaluations went no further than measuring whether or not people had been empowered.
4. Studies that have evaluated wellbeing-related impacts of interventions that meaningfully involved communities in decision-making are hidden within large bodies of related evidence (many thousands of studies) – they are scarce and hard-to-find.
5. Previous reviews identified few studies that had attempted to examine potential negative/adverse effects of involvement, and fewer still that looked at how impacts were distributed differently across population sub-groups, for example, by socioeconomic status, gender, ethnicity or disability.

To tackle some of these issues and gaps, this Stage 2 **systematic review** looked at all potentially relevant individual/'primary' evaluation studies (not just previous reviews as in stage 1) conducted in high income countries between 1980 and 2016.

Definitions of concepts used within this review

This review examines the potential relationships between two key concepts: joint decision-making in communities, and community wellbeing. They are multifaceted concepts that are frequently used in social policy discourse. Both refer to complex phenomena that can be understood and measured in a variety of different ways.

Joint decision-making in communities

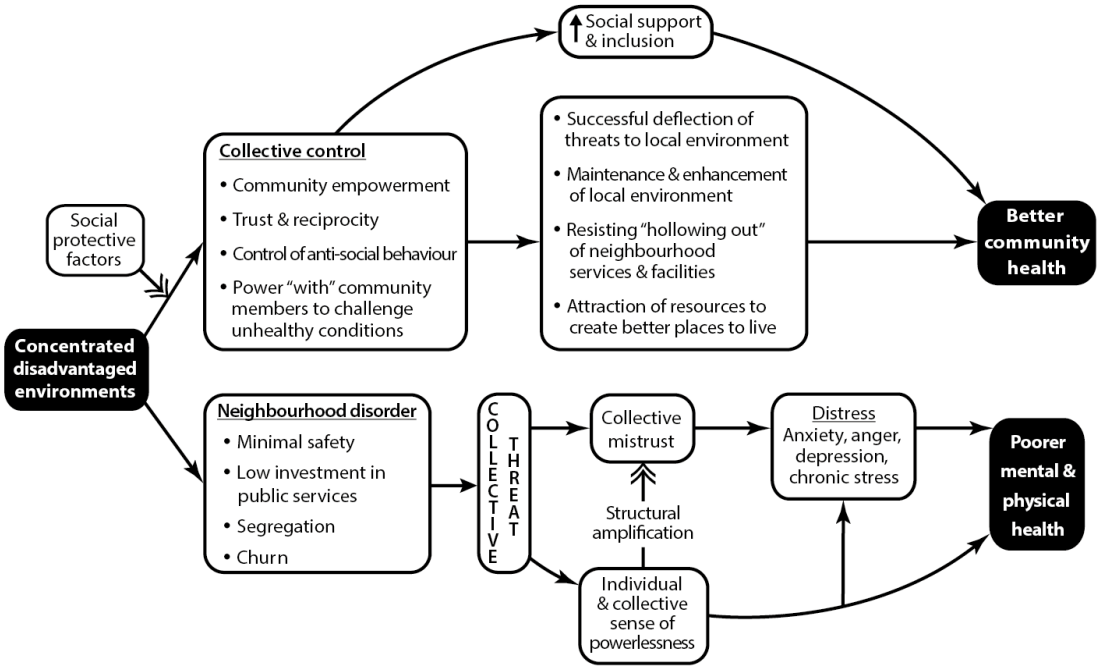
For this review, we define joint decision-making in communities as:

'The **meaningful** involvement of local people in decisions that protect, maintain, or enhance the material and social conditions in which they live.'

The definition is based on a critical review and synthesis of theories on community level pathways from socioeconomic inequalities in control/power to health and wellbeing outcomes (Whitehead et al., 2016). The community level pathway model is depicted in Figure 2. The model focusses on disadvantaged neighbourhoods. We acknowledge, however, that disadvantaged individuals and groups often live within more affluent communities. Poor/disadvantaged people living in relatively

affluent communities may be doubly disadvantaged. First, as a direct result of lower levels of access to key resources for health and wellbeing (for example, nutrition, healthcare, housing, education). Second, as a result of their experience of living in unequal communities, that have been linked to adverse health and wellbeing outcomes through psychological mechanisms and associated behaviour (Wilkinson and Pickett, 2009; 2018). A model showing potential relationships between low control for individuals and inequalities in health and wellbeing is included for further information in Appendix 2 (Figure 6) (Whitehead et al, 2016).

Figure 2. Theoretical pathways from community control to socioeconomic inequalities in health and wellbeing in disadvantaged neighbourhoods



Source: Whitehead et al., 2016.

The extent of **meaningful** involvement of community members in decision-making differs within and across contexts. While we acknowledge that all initiatives striving to involve community members in local area decision-making will aim to do so meaningfully, in certain circumstances, and for a variety or complex reasons, this does not or cannot happen.

Here we assert that the extent of meaningful involvement in practice is a key factor in determining the wellbeing-related outcomes of these initiatives - both positive and negative. It is therefore critical that we set out, with clarity, what we believe the most meaningful involvement looks like.

With the aim of moving the ethos and practice forward and so that we review an evidence base that conforms to the highest level of joint decision-making practice, we offer the following definition:

The most meaningful involvement in joint decision-making practice is where:

1) Power is agreed and acknowledged as being held jointly across constituents and that this is acted upon over time.

2) There is active and full involvement in all decisions made that are relevant to, or impact upon, the intervention being planned.

3) Potential barriers to accessing and participating in decision-making for certain individuals and groups (for example based on income, education, experience, illness and disability, language and culture, or caring responsibilities) are acknowledged and tackled (inequalities are addressed).

4) There is, when appropriate and desired by the community, full and active involvement in the implementation of the intervention in place/ community.

There are a range of related, empowerment-based concepts which will also be considered in the review, including:

- Co-production in local decision-making/service design/planning/production/policy-making.
- Shared community decision-making/service design/planning/production/policy-making.
- Lay involvement in local decision-making.
- Co-design, co-production in local service design.
- Community participation in local decision-making.

Wellbeing

Wellbeing is now increasingly being used as a measure of the success of communities and nations. Inspired by the work of Amartya Sen, Martha Nussbaum and others, in their attempts to identify measures of the quality of life within and across communities, the use of the term wellbeing as a political goal is, in part, a rejection of perceived inadequacies of solely economic measures such as the use of Gross Domestic Product (GDP) at national levels (Nussbaum and Sen, 1993). Whilst there are many well-known and widely used measures and scales of wellbeing at an individual level, wellbeing is currently less well defined at a community level.

For the purpose of this review we adopted the Office of National Statistics (ONS, 2015) definition of wellbeing:

'***Wellbeing***, put simply, is about "how we are doing" as individuals, communities and as a nation and how sustainable this is for the future. We define wellbeing as having 10 broad dimensions which have been shown to matter most to people in the UK as identified through a national debate. The **dimensions** are:

- The natural environment
- Personal wellbeing
- Our relationships
- Health
- What we do
- Where we live
- Personal finance
- The economy
- Education and skills
- Governance' (ESRC, 2014).

Community wellbeing

The definition of community wellbeing developed during the collaborative development phase of the Community Wellbeing Evidence Programme was also considered:

'***community wellbeing*** *is about strong networks of relationships and support between people in a community, both in close relationships and friendships, and between neighbours and acquaintances*' (Community Wellbeing Evidence Programme, 2015).

In addition, concepts related to community wellbeing such as 'social wellbeing', 'social capital', 'social cohesion', 'social inclusion', and 'community resilience' were also considered (Elliot et al., 2013).

When we refer to 'community wellbeing' throughout this document, this includes the wellbeing of individuals and groups, and determinants of their wellbeing, as components of community wellbeing.

Further information on conceptualisation and measurement of community wellbeing can be found in two WWC-WB Community Wellbeing Evidence Programme reviews:

- Atkinson et al. (2017) What is Community Wellbeing? *Conceptual review*.
- Bagnall et al. (2017) Systematic scoping review of indicators of community wellbeing in the UK.

Wellbeing inequality

For the purpose of this review, we define wellbeing inequality as:

'variations in levels of wellbeing within and across population sub-groups, that are typically avoidable, unfair and unjust, including by area, socioeconomic status, age, gender, health and disability status, sexuality, and religion.' (Based on Whitehead, 1991).

Health

The term 'health' is used frequently throughout this document for three reasons:

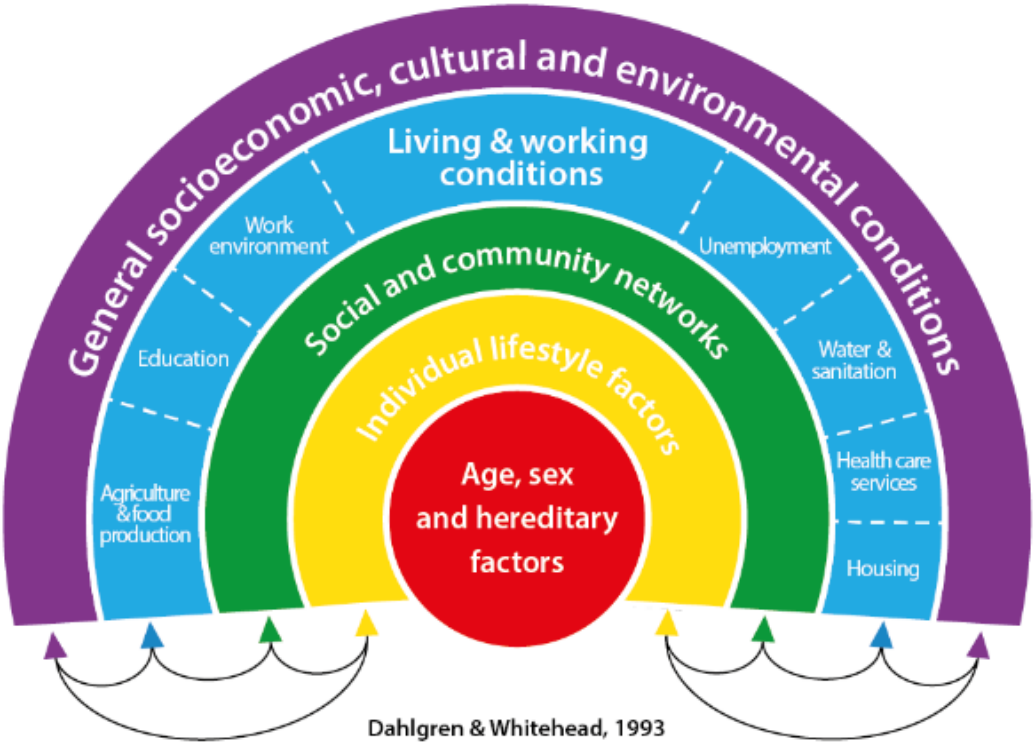
i. Physical and mental health are components/domains of our definitions and conceptualisation of wellbeing and community wellbeing.
ii. Overlaps in definitions of wellbeing and definitions of health can be found in most theoretical literature. The overlaps work in both directions, with some viewing health as an integral component of wellbeing, and others viewing wellbeing as an integral component of health.
iii. Many of the studies that measure *outcomes* relevant to wellbeing are to be found within public health, health inequalities, and social determinants of health literature. Other literatures, for example public management and community development, often fail to measure and report such outcomes.

We therefore also describe our conceptualisation of health here. We use the long-established, widely used, and broad definition of health from the constitution of the World Health Organization (1948):

'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'

In our conceptual framework for understanding *health*, we also use the Dahlgren and Whitehead (1993) Socio-environmental model of the determinants of health (widely known as the 'rainbow model of health') (Figure 3) that coincides with the domains/determinants of wellbeing used by the ONS (2015).

Figure 3 Socio-environmental model of the determinants of health (Dahlgren and Whitehead, 1993)



Theory of change

The Community Wellbeing Evidence Programme consortium has produced a working Theory of Change (South et al., 2017), in which power is proposed to have a mechanistic and cyclical relationship with community wellbeing. It is proposed that increased community power, exercised through meaningful participation in decision-making and governance will yield improved community conditions and individual benefits, eventually leading to increased community (and individual) wellbeing (Figure 4).

Figure 4. Theory of change of what works to increase community wellbeing (South et al., 2017)

2. Methods

This systematic review has used standard systematic review methodology, as described in the WWC-WB Methods Guide (Snape et al., 2017), and is reported following PRISMA and PRISMA-Equity guidelines (Moher et al., 2009; Welch et al., 2013).

Aims of the review

The aims of this systematic review were to locate, assess, synthesise, and describe the quality of, the available evidence on the impacts of joint decision-making interventions on community wellbeing, and to identify conditions that enable them to work effectively.

Review questions

The systematic review will address the following questions and sub-question:

1. What are the effects (beneficial and adverse) on community wellbeing of interventions to promote joint decision-making in communities?
    a. Is there evidence of differential distribution of effects across population sub-groups, including age, socioeconomic status, gender, ethnicity and disability status?
2. What conditions/factors determine (enhance or undermine) the effectiveness of interventions to promote joint decision-making in communities, or influence the distribution of impacts across population sub-groups?

Identification of evidence

The search strategy was developed by experienced systematic reviewers, including reviewers with experience in identifying hard-to-find evidence on complex social determinants of wellbeing (for example, control/power inequalities, community connectivity and cohesion). The aim of the search was to identify all evidence on joint decision-making interventions in communities that considered impacts on community wellbeing-related outcomes.

The following **electronic databases** were searched: MEDLINE and MEDLINE In-Process & Other Non-Indexed Citations, Social Sciences Citation Index, IDOX, PsycINFO. An example of the MEDLINE search strategy syntax is in Appendix 3.

Searches of **grey literature** were conducted via the Conference Proceedings Citations Index (CPCI), ProQuest Dissertations & Theses, OpenGrey, Google, Google Scholar, and through searches for, and inspection of, specialist websites and databases. Searches of CPCI and ProQuest were conducted using standard, advanced academic search syntaxes similar to the MEDLINE syntax (adapted to the specific database). Searches of the relatively smaller and less sophisticated database OpenGrey used simple searches for terms including and related to 'joint decision-making'. We conducted advanced searches in Google and Google Scholar. An example of the Google search strategy is in Appendix 4. Any potentially relevant websites were also manually searched for relevant articles or links to other relevant sources of evidence. A list of the websites/pages searched is contained within Appendix 5.

A **call for evidence** was issued by the WWC-WB. The call was also distributed to a mailing list of over 1300 **academics and practitioners** who expressed an interest in evidence on community wellbeing during the Voice of the User stakeholder engagement phase of the Community Wellbeing Evidence Programme, and shared on social media. We also distributed the call to a range of specialist academic and practitioner mailing lists via JISCMAIL, including groups specialising in evidenced-based health (www.jiscmail.ac.uk/EVIDENCE-BASED-HEALTH), health equity (www.jiscmail.ac.uk/HEALTH-EQUITY-NETWORK), town and country planning (www.jiscmail.ac.uk/PNUK), Health Impact Assessment (www.jiscmail.ac.uk/HIANET), and community empowerment (www.jiscmail.ac.uk/CEEN). In total our call for evidence was distributed to over 6,000 academics and practitioners with interests in health, wellbeing and community decision-making.

We also directly contacted **academic experts** on the health and wellbeing impacts of empowerment-based interventions in communities, from the fields of public health, health inequalities, human/social geography, public management, community development, psychology, politics, and local government studies.

In addition, we also scrutinised the background, and reference lists of included papers to identify additional studies through 'citation snowballing', and conducted forward citation searches on included studies through Web of Science forward citation searches.

Date of searches, search terms/syntaxes, database searched, number of hits, keywords and other comments were recorded, in order that searches are transparent, systematic and replicable as per PRISMA guidelines. The results of the searches were downloaded into Endnote reference

management software for deduplication (over three stages – one automatic, two manual), prior to export into EPPI Reviewer 4 systematic review management software.

Study selection

Studies were selected for inclusion through two stages (title and abstract screening, and full text screening), and screened using the criteria outlined below (Table 1) in EPPI-Reviewer 4 review management software (Thomas et al., 2010). A random 20% of all titles and abstracts were first screened independently by two reviewers, followed by a 'calibration' exercise to ascertain levels of agreement and to ensure consistency of subsequent coding. Once over 90% agreement was reached on whether to include or exclude studies, the remaining 80% of titles and abstracts were screened by a single reviewer. Full-text copies of potentially relevant studies were then independently screened by two reviewers. Any queries or disagreements in the screening process were resolved by discussion or recourse to a third reviewer. Appendix 6 contains a list of studies excluded at the full text screening stage, and reasons for exclusion.

Table 1 Inclusion and exclusion criteria

	Include	Exclude
Population / setting	Studies conducted in high-income OECD countries, on interventions set in the 'living environment' of communities. Any population.	Studies conducted in non-OECD countries, or on interventions in non-living environment settings (workplaces, healthcare, education or other institutional settings).
Intervention	Studies reporting evidence on the community wellbeing-related effects of interventions to promote joint decision-making in communities, and related empowerment-based concepts.	Interventions that are not empowerment-based, including interventions to promote co-implementation of initiatives that were not initiated or designed through the involvement of local communities/people.
Comparators	All studies, with or without comparators*	n/a
Outcomes	Outcomes related to any of the dimensions of community wellbeing (including 'intermediate outcomes', also known as 'determinants'), and subjectively or objectively measured individual or population outcomes. Individual and community health and wellbeing-related outcomes affecting participants, and the wider communities in which they lived.	Outcomes affecting agencies, actors, or population groups outside local areas/communities.
Study design & publication characteristics	Qualitative or quantitative primary studies. Published between 1980 and present day. Published in English language.	Opinion and discussion pieces. Studies conducted prior to 1980. Studies not published in English.

Essentially, studies were only included if they incorporated each of the following components:

A. Reported the involvement of local people in decision-making processes relating to the material or social conditions ('determinants') in which they lived.

B. Reported wellbeing-related impacts ('outcomes') on the participants, or the wider community.

C. Were conducted in a community ('living environment') setting in a high-income (OECD) country.

Studies that failed to incorporate all three components A to C, or that were published prior to 1980, were excluded. We also excluded studies not published in English as we lacked the skills within the team necessary to design and implement foreign language searches across academic and grey literature sources, or to interpret results reported in other languages. Finally, in a similar approach to Whitehead et al, 2014, we excluded studies of interventions that did not address a lack of power/control in potential pathways from control to wellbeing. We therefore excluded studies of the effectiveness of traditional health promotion activities, such as smoking cessation or obesity prevention interventions, that only employed community engagement to improve intervention effectiveness, i.e. where engagement was used in a utilitarian manner. The literature on community engagement in health promotion was examined previously in a comprehensive systematic review by O'Mara-Eves et al., 2013 (see Appendix 1).

Data extraction

Data from each included study were extracted into pre-designed and piloted forms. Forms were completed by one reviewer and checked for accuracy by another. A random selection was considered independently by two people for 20% of the studies. Data extracted included: study aims, study design, setting/country, type of intervention, comparator (if any), population, outcomes reported, main findings in relation to the review questions, limitations and conclusions specified by authors.

Study Quality Assessment

We conducted validity assessments of all studies using the appropriate checklist (Appendix 7), following the recommendations of the What Works: Wellbeing methods guide (Snape et al., 2017).

Unpublished studies (reports) from grey literature was assessed using the same criteria as used for published data. The tools provide an assessment of methodological quality that is based on the information reported within publications, or available companion documents (e.g. cited and available previous publications containing further detail on methodological approaches).
Each full paper or report was assessed by one reviewer and checked for accuracy by another. A random selection of 20% of the studies were considered independently by two reviewers. Any differences in grading were resolved by discussion or recourse to a third reviewer.

In this review we included studies that were assessed as being of 'low' quality and discuss the implications of including them.

Studies were assessed as 'low' quality if they met less than 4 out of 9 criteria on the validity assessment criteria on the qualitative checklist, or less than 11 out of 23 on the quantitative checklist; 'low-to-moderate' quality if they met between 4 and 5 criteria on the qualitative checklist, or between 11 and 14 criteria on the quantitative checklist; 'moderate-to-high' quality (**score 2**) if they met 6 out of 9 criteria on the qualitative checklist, or between 15 and 19 criteria on the quantitative checklist, and 'high' quality if they met 7 to 9 of criteria on the qualitative checklist, or between 20 and 23 criteria on the quantitative checklist.

As no tool was available for the assessment of mixed-methods studies, we assessed the quality of quantitative and qualitative components separately.

Data synthesis

Relevant study findings were narratively synthesised (Mays et al., 2005; Popay et al. 2003, 2006; Whitehead et al., 2014). This included:

- Thematic analysis of data based on the review questions.
- Exploration of relationships within and between studies.
- Identification of differential impacts in relation to gender, socioeconomic status, ethnicity, or disability status.
- Identification of the strength of evidence based on study design, and on the results of the quality assessment (for each type of design).
- Contradictions between findings were examined.

Any qualitative evidence that helped us to understand why interventions did or did not work was synthesised separately and narratively (following Popay et al., 2006) from quantitative data on overall intervention effects. Findings were grouped and are reported by review question and by intervention category, with evidence from higher strength studies being reported first and in more detail. Owing to the high degree of heterogeneity (diversity) of interventions, settings, populations, outcomes, and study designs within and across the intervention categories of this particular body of evidence (partly a result of interventions being design and delivered by the communities), we did not aggregate and present findings by outcome types (social relations, individual wellbeing etc). Statistical meta-analysis (to combine findings from quantitative studies) was also deemed to be inappropriate due to heterogeneity.

Transferability assessment

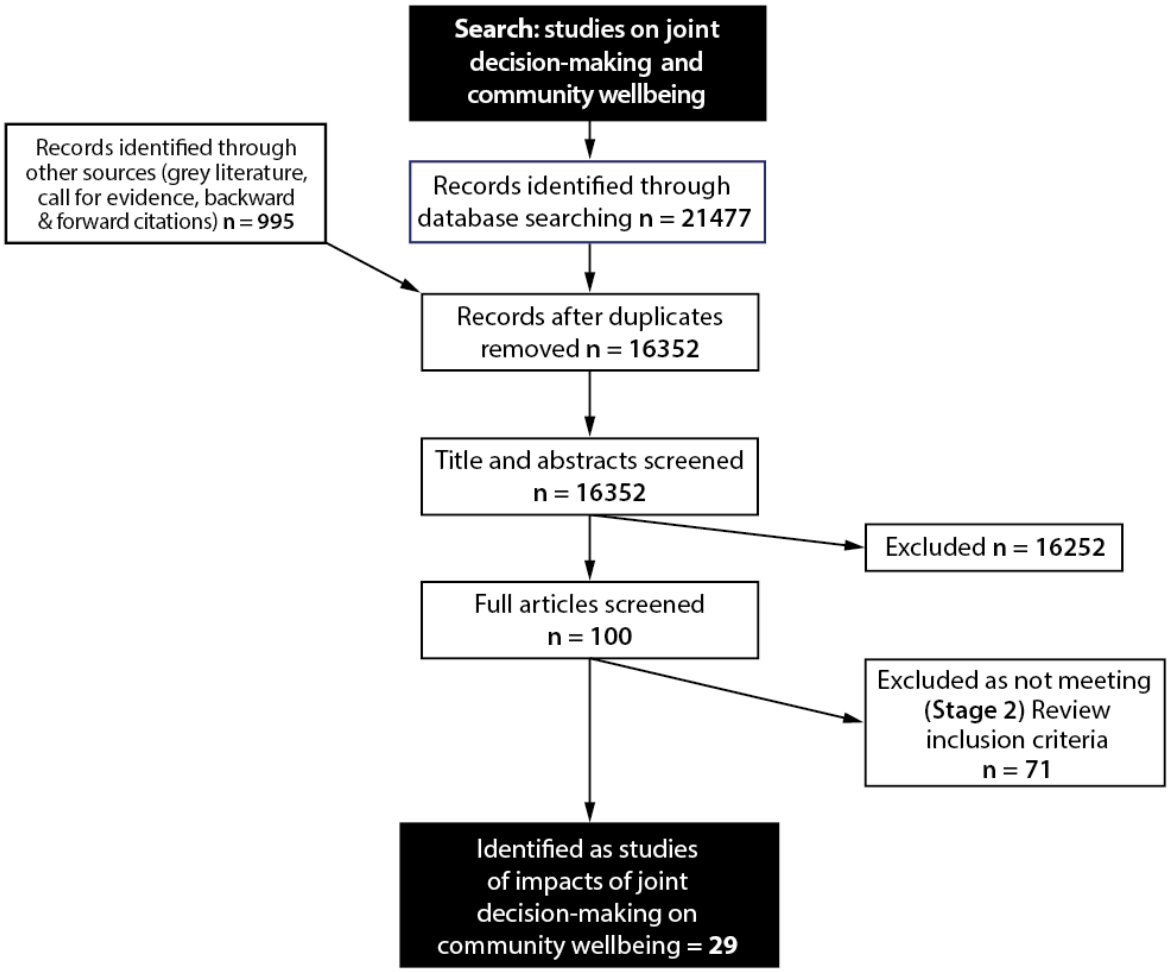
Interventions that were designed, implemented and evaluated in other countries and settings may not always map well to other living environments (Bagnall et al., 2016; O'Mara-Eves et al., 2013; Savage et al., 2010; South et al., 2010). Cultural and political climates, policies and programme funding may also change over time, and this may affect the relevance and transferability of research findings (Bagnall et al., 2016, South et al., 2016). The included publications contained very limited information on a range of factors of potential relevance to transferability, for example, virtually none of the publications reported information on set-up costs, operational costs, or sources of funding. We, therefore, limited the assessment of the potential transferability of interventions to information that was available for all the studies - whether the intervention settings and populations are common in the UK.

3. Results

Results of the literature search

From an initial 16,352 unique records, 29 publications that met our inclusion criteria were included. Figure 5 shows the progression of studies through the systematic review process.

Figure 5. PRISMA flow chart of the progression of studies through the review



Information on the reasons for excluding studies at the full text/article screening stage is within Appendix 6.

Description of included studies

A list of the 29 included studies is contained within Appendix 8. Key characteristics of the included studies are summarised below.

Country

Fifteen of the studies were from the UK, nine from the USA, three from Canada, one from Italy, and one from Israel, as shown in Table 2.

Table 2. Countries

Country	Studies
UK	Blades et al., 2016; Bovaird, 2007; Clift, 2008; Cole et al., 2004; Edwards, 2001; Haigh & Scott-Samuel, 2008; ODPM, 2004; ODPM, 2005; Lamie & Ball, 2010; Hawkins, 2012; Lawless & Pearson, 2012; Pill & Bailey (2012); Orton et al., 2017; Resources for Change, 2016; Popay et al., 2015
USA	Porter & McIlvaine-Newsad, 2013; D'Agostino & Kloby, 2011; DeGregory et al., 2016; Ohmer, 2007; Patton-Lopez et al., 2015; Semenza et al., 2007; Semenza, 2003; Semenza and March, 2009; Watson-Thompson et al., 2008
Canada	Blanchet-Cohen et al., 2014; Environics Research, 2015; Saville, 2009
Italy	Franceschini & Marletto, 2015
Israel	Itzhaky & York, 2002

Study design & timing of evaluation

Eleven studies were coded as solely **qualitative** (Blanchet-Cohen et al., 2014; ODPM, 2005; Porter and McIlvaine-Newsad, 2013; Orton et al., 2017; Hawkins and Egan, 2012; Lamie and Ball, 2010; Resources for Change, 2016; Haigh and Scott-Samuel, 2008; Cole et al., 2004; Pill and Bailey, 2012; Patton-Lopez et al., 2015).

Six studies were coded as solely **quantitative** (Itzhaky and York, 2002; Lawless and Pearson, 2012; Ohmer, 2007; Saville, 2009; Semenza et al., 2007; Semenza, 2003).

Eight studies were coded as **mixed-method** (Blades et al., 2016; Clift, 2008; Edwards, 2001; Environics Research, 2015; ODPM, 2004; Popay et al., 2015; Semenza and March, 2009; Watson-Thompson et al., 2008).

Four studies were coded as descriptive **case studies** (post-intervention) (Bovaird, 2007 [all 3 included case studies]; D'Agostino and Kloby, 2011; DeGregory et al., 2016; Franceschini and Marletto, 2015).

Of the studies using quantitative approaches (including within mixed-methods), the majority used single time-point **cross-sectional** designs, with post-intervention only measurement (10 of 16 studies using quantitative approaches). Five used **repeated measures** designs, including observations before and after intervention (Itzhaky and York, 2002; Semenza et al., 2007; Watson-Thompson et al., 2008; Lawless and Pearson, 2012; Popay et al, 2015). Only one study was coded as **longitudinal**, having repeatedly measured the same respondents before and after the intervention (Saville, 2009).

Studies coded as 'post-intervention' include some that were conducted during the intervention/post-commencement. Some mixed-methods studies were coded into more than one category, reflecting the mix of methods (so numbers do not sum to 29).

Study methods

Within the various study designs described above, the evaluations use a range of quantitative and qualitative methods to collect and organise data, which included: face-to-face, telephone, postal and online surveys and interviews (quantitative and open-ended qualitative), focus groups, participant observation, geographical data mapping (in GIS), and analysis of documentary records (e.g. from meetings).

Setting

Twenty-three of the 29 included studies were conducted in urban settings, the vast majority in socioeconomically deprived areas (studies listed in Table 3). One study was conducted in a socioeconomically deprived suburban community. One study was conducted solely in a 'low-income' rural setting. One study evaluated a large number of (1092) intervention projects in lower SES areas (in the bottom 30% of the UK Indices of Multiple Deprivation) across a mix of urban, suburban and rural locations. One other study described interventions in a mix of settings (three case studies in urban, suburban and rural areas with low or high levels of affluence). One study covered a large territory (East Scotland). One study provided insufficient information to determine setting.

Table 3. Study settings

Setting	Studies

Urban	Clift, 2008; Cole et al., 2004; D'Agostino & Kloby, 2011; DeGregory et al., 2016; Edwards, 2001; Environics Research, 2015; Franceschini & Marletto, 2015; Haigh & Scott-Samuel, 2008; Hawkins, 2012; Itzhaky & York, 2002; Lawless & Pearson, 2012; ODPM, 2004; ODPM, 2005; Ohmer, 2007; Orton et al., 2017; Patton-Lopez et al., 2015; Pill and Bailey, 2012; Popay et al., 2015; Resources for Change, 2016; Semenza, 2003; Semenza et al., 2007; Semenza and March, 2009; Watson-Thompson et al., 2008
Suburban	Saville, 2009
Rural	Porter & McIlvaine-Newsad, 2013
Mixed (urban, suburban, rural)	Blades et al., 2016 (1092 projects); Bovaird, 2007 (3 case studies: urban, rural, suburban)
Large territory	Lamie & Ball, 2010 (East Scotland)
Insufficient information	Blanchet-Cohen et al., 2014 (5 unspecified communities)

Intervention

Interventions were coded in two ways, (i) by the type of intervention category/s the communities sought to influence through involvement in decision-making, and (ii) by the broad nature of community involvement (Table 4).

(i) Intervention type

We identified eight types (categories) of interventions:

1. ***Urban design, development, or renewal*** ('urban renewal') – the design, development, renewal/regeneration, or alternative use of infrastructure, places and spaces – such as housing, transport, meeting places, and/or neighbourhood facilities.
2. ***Protecting community facilities*** – community residents working together and/or with partners to save local facilities from closure (e.g. local post office/store).
3. ***Participatory budgeting*** – local people deciding how some of the budgets of public authorities are spent in their communities.
4. ***Natural disaster recovery planning*** – communities working with public and other agencies to develop reconstruction/redevelopment plans *after* a natural disaster such as a flood, storm, earthquake, or fire. This is distinct from community disaster preparedness planning – in which communities work with authorities to prepare for such events *before* they happen.

5. ***Integrating public sector service design/delivery*** – community members working with service providers to better integrate local services, for example, through partnerships between health, social care, and emergency services.
6. ***Crime prevention*** – coordinated programmes to prevent and reduce residents' fear and experience of crime through improvements to the design and maintenance of buildings and shared spaces, improved policing and security, and increased community cooperation and cohesion.
7. ***Community development*** – community members working in (typically) multifaceted programmes to improve material or social conditions, including access to housing, business and economic development, youth development, community planning, neighbourhood beautification, and leadership development.
8. ***Citizens' juries*** – a group of people who are chosen to represent their community. They are presented with information and evidence about potential policies or projects before deciding whether and how they *should* be implemented.

(ii) Nature of community involvement

Community members were involved in decision-making *processes* in all 29 included evaluations (e.g. planning, design, participating in budget decisions). This does not necessarily mean that their involvement resulted in changes that they desired, or that they were satisfactorily informed about how their involvement made a difference. Community members were also involved in the *delivery* of interventions they had helped to shape in 16 of the interventions (Table 4).

Table 4. Interventions, and nature of community involvement

Study	Intervention aim*	Nature of Community involvement
* All included studies had the explicit aim of increasing community involvement in decision-making.		
Cole et al., 2004	Urban renewal	Decision-making
DeGregory et al., 2016	Urban renewal	Decision-making
Edwards, 2001	Urban renewal	Decision-making
ODPM, 2005	Urban renewal	Decision-making
Patton-Lopez et al., 2015	Urban renewal	Decision-making
Lawless & Pearson, 2012	Urban renewal	Decision-making
Popay et al., 2015	Urban renewal	Decision-making
Environics Research, 2015	Participatory Budgeting	Decision-making
Hawkins, 2012	Participatory Budgeting	Decision-making
D'Agostino & Kloby, 2011	Natural disaster recovery planning	Decision-making
Lamie & Ball, 2010	Integrating public services	Decision-making
Blanchet-Cohen et al., 2014	Community development	Decision-making
Franceschini & Marletto, 2015	Citizens' jury	Decision-making
Haigh & Scott-Samuel, 2008	Citizens' jury	Decision-making

Pill and Bailey, 2012	Urban renewal	Decision-making
Bovaird, 2007 CASE STUDY 1	Urban renewal	Decision-making; delivery
Bovaird, 2007 CASE STUDY 2	Urban renewal	Decision-making; delivery
Clift, 2008	Urban renewal	Decision-making; delivery
Itzhaky & York, 2002	Urban renewal	Decision-making; delivery
Porter & McIlvaine-Newsad, 2013	Urban renewal	Decision-making; delivery
Semenza et al., 2007	Urban renewal	Decision-making; delivery
Semenza, 2003	Urban renewal	Decision-making; delivery
Semenza & March, 2009	Urban renewal	Decision-making; delivery
Orton et al., 2017	Urban renewal	Decision-making; delivery
Resources for Change, 2016	Urban renewal	Decision-making; delivery
Bovaird, 2007 CASE STUDY 3	Protecting (and enhancing) community facilities	Decision-making; delivery
Saville, 2009	Crime prevention	Decision-making; delivery
Blades et al., 2016	Community development	Decision-making; delivery
Ohmer, 2007	Community development	Decision-making; delivery
Watson-Thompson et al., 2008	Community development	Decision-making; delivery
ODPM, 2004	Urban renewal	Decision-making; delivery

Population

The codes used to describe populations taking part in the studies, or targeted by the interventions, and the number of relevant studies are shown in Table 5. The codes most frequently used to describe a population of interest related to people living in economically disadvantaged areas (in 24 studies), followed by children/adolescents (7 studies), ethnic groups (7 studies), working age people (4 studies), older people (4 studies), residents in moderate or higher income areas (4 studies), and people with a limiting long-term illness or disability/s (3 studies). In addition, two studies were coded as relating to homeless people, and one study related explicitly to women. Two studies appeared to cover general populations, by virtue of the geographical scale, coverage and/or of interventions. No studies were coded as our other predefined population groups, including people with particular religious beliefs, people with particular political beliefs, gypsies and travellers, or whole families.

Table 5. Population characteristics (participants & intervention recipients)

Population category	Nº of studies	Studies (first author, year)
People living in economically disadvantaged areas	24	Blades, 2016; Blanchet-Cohen, 2014; Bovaird, 2007 (case study 2); Clift, 2008; Cole, 2004; D'Agostino, 2011; De Gregory, 2016; Edwards, 2001; Haigh, 2008; Hawkins, 2012; Lawless & Pearson, 2012; ODPM, 2004; ODPM, 2005; Ohmer, 2007; Orton et al., 2017; Patton-Lopez,

		2015; Pill & Bailey, 2012; Popay et al., 2015; Porter, 2013; Resources for Change, 2016; Saville, 2009; Semenza and March, 2009; Semenza, 2007; Watson-Thompson, 2008
Children and/or adolescents	7	Blades, 2016; Blanchet-Cohen, 2014; De Gregory, 2016; ODPM, 2005; Patton-Lopez, 2015; Porter, 2013; Semenza, 2007
Racial and ethnic groups (particularly minority groups)	7	Blades, 2016; D'Agostino, 2011; De Gregory, 2016; Itzhaky, 2002; Patton-Lopez, 2015; Semenza, 2007; Watson-Thompson, 2008
Working age people	4	Blades, 2016; Franceschini, 2015; Haigh, 2008; Semenza, 2007
Older people	4	Blades, 2016; Haigh, 2008; ODPM, 2005; Porter, 2013;
Residents in moderate or higher income areas	4	Bovaird, 2007 (case study 1); Bovaird, 2007 (case study 2); Semenza, 2003; Semenza and March, 2009
People with long-term illness or disability/s	3	Blades, 2016; Edwards, 2001; Porter, 2013
Homeless people	2	Blades, 2016; D'Agostino, 2011
General population (determined by large geographical area, or many sites)	2	Environics Research, 2015; Lamie, 2010
Gender (women)	1	Blades, 2016

Transferability

A basic assessment of the potential transferability of interventions to the UK was conducted based on whether the setting and population are common in the UK. The included publications contained very limited information on other factors, for example, set-up costs, operational costs, and sources of funding.

Table 6 shows that the 16 studies set in the UK also involved interventions conducted in settings, and on populations, that are common in the UK. Of the 13 studies conducted outside the UK, only two were conducted in setting, and on populations, that are not common in the UK. All of the included studies incorporated joint decision-making, often relating to similar interventions (urban design and renewal, improving social relations) on similar population groups (typically low SES, and other characteristics associated with vulnerability or disadvantage), and this may have resulted in a high level of similarity between the studies and transferability to UK settings and populations. The two studies with lower levels of transferability (bottom of Table 6) came from studies of an unusual

event (natural disaster recovery in New Orleans) and in a dissimilar setting (a town in the centre of Israel) to the UK (though extreme weather events are on the increase, large-scale natural disasters, such as Hurricane Katrina, are not common in the UK).

Table 6. Transferability

Study	UK?	Is the setting & population common in UK?
Blades et al., 2016	Yes	Yes
Blanchet-Cohen et al., 2014	Yes	Yes
Bovaird, 2007	Yes	Yes (all 3 case studies)
Clift, 2008	Yes	Yes
Cole et al., 2004	Yes	Yes
Edwards, 2001	Yes	Yes
Haigh & Scott-Samuel, 2008	Yes	Yes
Hawkins, 2012	Yes	Yes
Lamie & Ball, 2010	Yes	Yes
Lawless & Pearson, 2012	Yes	Yes
ODPM, 2004	Yes	Yes
ODPM, 2005	Yes	Yes
Orton et al., 2017	Yes	Yes
Pill & Bailey, 2012	Yes	Yes
Popay et al., 2015	Yes	Yes
Resources for Change, 2016	Yes	Yes
Environics Research, 2015	No (Canada)	Yes
Saville, 2009	No (Canada)	Yes
Franceschini & Marletto, 2015	No (Italy)	Yes
DeGregory et al., 2016	No (USA)	Yes
Patton-Lopez et al., 2015	No (USA)	Yes
Ohmer, 2007	No (USA)	Yes
Porter & McIlvaine-Newsad, 2013	No (USA)	Yes
Semenza, 2003	No (USA)	Yes
Semenza et al., 2007	No (USA)	Yes
Semenza and March, 2009	No (USA)	Yes
Watson-Thompson et al., 2008	No (USA)	Yes
D'Agostino & Kloby, 2011	No (USA)	No
Itzhaky & York, 2002	No (Israel)	No

Study quality assessment

The validity assessment revealed that the majority of the included studies were of 'low' or 'low-to-moderate' methodological quality. Appendix 10 contains summary results of the quality assessments.

Six of the qualitative studies (or the qualitative components of mixed-method studies) were graded as 'high-quality' (Clift, 2008; Blanchet-Cohen et al., 2014; Porter, McIlvaine-Newsad, 2013; ODPM, 2005; Orton et al., 2017; Popay et al., 2015), two were graded as 'moderate-to-high' methodological quality (Edwards, 2002; Watson-Thompson et al., 2008), four were graded as 'low-to-moderate' quality (Hawkins and Egan, 2012; Resources for change, 2016; Lamie and Ball, 2010; Patton-Lopez et al., 2015), and the remaining eight were graded as 'low' quality (Haigh, Scott-Samuel, 2008; Cole et al., 2004; Pill and Bailey, 2012; ODPM, 2004; Blades et al., 2016; Lawless and Pearson, 2012; Semenza, March (2009); Environics Research, 2015).

Three of the quantitative studies (or quantitative components of mixed-methods studies) were graded as 'moderate-to-high' methodological quality (Popay et al.,2015; Watson-Thompson et al., 2008; Lawless and Pearson, 2012). Three were graded as 'low-to-moderate' quality (Itzhaky and York, 2002; Semenza et al., 2007; Clift, 2008). The remaining eight were graded as 'low' quality (Blades et al., 2016; Semenza and March, 2009; Ohmer, 2007; Semenza, 2003; Edwards, 2001; ODPM, 2004; Saville, 2009; Environics Research, 2015). Only three studies used comparator groups (Lawless and Pearson, 2012; Popay et al, 2015; Semenza et al., 2003).

Many of the validity assessment criteria were answered 'unclear' as insufficient details of the methodology were reported by the study authors. Unclear or 'missing' information has the same effect on the grading as a negative score.

Complex social interventions often have high degrees of heterogeneity as interventions are adapted for different population groups and settings. This is particularly the case for interventions designed and delivered by empowered communities – in deliberate attempts to relate interventions to local needs and context. Therefore, all the quantitative studies, and the quantitative components of mixed-methods studies, were coded as 'not applicable' (n/a) for intervention 'fidelity' (there being no valid alternative).

All of the descriptive case studies were graded as of 'low' methodological quality.

Findings

Table 7 provides an overview of the study findings together with the results of the relevant quality assessments. This includes information on categories of intervention, wellbeing domains, observed outcomes and who experienced them (participants or wider community), and results of the quality assessments grouped by broad category of design (qualitative, quantitative, mixed-methods, descriptive case studies). Appendix 9 contains a summary of outcomes table. Higher methodological quality studies are presented first (within the broad study design categories).

This section is structured by intervention type, and findings are presented together with the results of the quality assessments for individual studies.

Table 7. Summary of findings table (category of intervention, wellbeing domains, identified outcomes [statistically significant outcomes only, for quantitative studies), who affected, adverse effects, QA levels)

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
Qualitative								
Blanchet-Cohen et al., 2014	Community development	Social relationships, individual wellbeing	Increased personal empowerment; increase group consensus, cooperation, and cohesion; enhanced personal development (emotional, social, confidence, friendship, organisational and financial skills of youth participants); increased sense of belonging.	√	√		High	n/a
ODPM, 2005	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing	Improved physical environment; improved services (tailored to needs of residents); increased sense of pride in area; increased personal empowerment. Reduced trust in public agencies.	√	√	√	High	n/a
Porter & McIlvaine-Newsad, 2013	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing	Increased personal empowerment; increased availability, affordability & access to healthy foods, increased social activity & connectivity; reduced social isolation (older people); increased knowledge & skills; improved physical environment; increased access to green space.	√	√		High	n/a
Orton et al., 2017	Urban renewal	Socio-environmental determinants, social	Improvements to physical environment (e.g. general regeneration activities,	√	√	√	High	n/a

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
		relationships, individual wellbeing, community wellbeing	formation of gardening club); increased social connectivity and cohesion; increased confidence, sense of pride, feeling of 'making a difference'. Some reported issues relating to tensions and disagreements between participants, and concerns that only certain interests (of "the more 'middle class' side of the ward") were being addressed.					
Hawkins & Egan, 2012	Participatory Budgeting	Social relationships, individual wellbeing, community wellbeing	Increased social connectivity & cohesion; increased personal and collective empowerment; increased trust, respect, and reciprocity between communities and public agencies.	√			Low-to-moderate	n/a
Lamie & Ball, 2010	Integrating public services	Individual wellbeing	Disempowerment; frustration and disappointment with the processes of involvement, and with perceived lack of tangible outcomes.	√		√	Low-to-moderate	n/a
Resources for Change, 2016	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing	Improvements to physical environment and service provision/facilities; improvements to learning, skills, employment; increased confidence, aspirations, happiness; increased enthusiasm, school attendance, and improved behaviour (school children); increased social connectivity (including	**√**	**√**	**√**	Low-to-moderate	n/a

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
			intergenerational), and social cohesion; increased sense of community. Some participants suspected the (Big Local) interventions were causing local authority resources to be directed elsewhere. Some participants became disheartened about rate or lack of change.					
Haigh & Scott-Samuel, 2008	Citizens' Jury	Individual wellbeing	Increased sense of pride and belonging. Frustration and disappointment with processes of involvement, and with perceived lack of feedback from public agencies; consultation fatigue.	√		√	Low	n/a
Cole et al., 2004	Urban renewal	Socio-environmental determinants, individual wellbeing	Improvements to physical environment (housing); increased personal empowerment (for some). Increased frustration, distress, discomfort, disappointment, distrust, consultation fatigue.	√	√	√	Low	n/a
Pill & Bailey, 2012		Socio-environmental determinants, individual health, individual wellbeing, community wellbeing	Increase skills and confidence; improved service delivery; improved health (unspecific); increased trust between residents and local agencies.	√	√		Low	n/a
Patton-Lopez et al., 2015[iii]	Urban renewal	Socio-environmental determinants, social	Improvements to physical environment (park/play facilities); improvements to	√	√		Low	n/a

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
		relationships, community wellbeing	physical activity (types); increased social connectivity and cohesion.					
Mixed-methods								
Clift, 2008	Urban renewal	Socio-environmental determinants, individual wellbeing, community wellbeing	Increased skills; increased social connectivity; increased personal empowerment. Disappointment and dissatisfaction with process; increased tension and stress; disempowerment; frustration with perceived lack of influence; conflict across community groups and public agencies.	√	√	√	High	Low-to-moderate
Popay et al., 2015	Urban renewal	Social relationships, Individual health, individual wellbeing, community wellbeing	Increased trust and social cohesion; improved mental health.	√			High	Moderate-to-high
Watson-Thompson et al., 2008	Community development	Socio-environmental determinants, individual wellbeing	Improvements to policies and services (in relation to housing, youth, crime and safety, economic development); increased skills; increased pride. Frustration or dissatisfaction with process or its impacts.	√	√	√	Moderate-to-high	Moderate-to-high
Edwards, 2001	Urban renewal	Individual wellbeing, individual health	Increased physical & psychological 'strain' and fatigue from involvement processes. Higher levels of adverse	√		√	Moderate-to-high	Low

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
			impacts for disabled people, in comparison to non-disabled.					
ODPM, 2004	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing	Increased skills, experience and career development; increased employment opportunities; increased self-confidence; increased social connectivity & cohesion; improved services; increased access to services for previously 'excluded' groups (low income, BME); increased trust in public agencies	√	√		Low	Low
Semenza & March, 2009	Urban renewal	Socio-environmental determinants, social relationships, individual health, individual wellbeing, community wellbeing,	Improved physical environment; enhanced sense of place, sense of belonging, sense of community; increased physical activity; increase social connectivity. Increased conflict; increased concerns about safety (roads, pavements); concerns about potential gentrification and associated tax increases.	√	√	√	Low	Low
Environics Research, 2015	Participatory Budgeting	Individual wellbeing, community wellbeing	Increased personal and collective empowerment; increased trust in public agencies; increased social connectivity, and cohesion. Frustration and disappointment with process of involvement; concerns about feedback from public agencies.	√		√	Low	Low

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
Blades et al., 2016	Community development	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing, individual health	Improvements to physical environment (including availability of, and access to, green spaces and play areas); reduced social isolation and loneliness; increased confidence and optimism; increased social connectivity; increased sense of belonging; increased happiness; reduced anxiety and depression; increased skills, experience and career development; increased personal and collective empowerment; improved lifestyle. Frustration and disappointment with process and some outcomes.	√	√	√	Low	Low
Quantitative								
Lawless & Pearson, 2012	Urban renewal	Socio-environmental determinants, individual wellbeing,	Improvements to physical environment, 'feeling safe', trust in local agencies, involvement in local organisations, and perception of local area.	√			n/a	Moderate-to-high
Itzhaky & York, 2002	Urban renewal	Socio-environmental determinants, individual wellbeing, community wellbeing	Increased individual mastery & self-esteem; improved family wellbeing; improved service delivery; increased collective control/empowerment.	√	√		n/a	Low-to-moderate
Semenza et al., 2007	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing	Improvements to levels of depression, sense of community, and social capital.	√	√		n/a	Low-to-moderate

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
Ohmer, 2007	Community development	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing	Improvements to physical environment; increased self-efficacy; increased collective efficacy; increased sense of community.	√	√		n/a	Low
Semenza, 2003	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing, individual health	Improvements to physical environment; increased social capital; increased social connectivity; increased satisfaction in local area; reduced levels of depression; improved levels of perceived general health.	√	√		n/a	Low
Saville, 2009	Crime prevention	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing	Improvements to physical environment; reduced fear of crime; reduced crime rates; increased social connectivity and cohesion.	√	√		n/a	Low
Case studies								
Bovaird, 2007 Case study 1	Urban renewal	Socio-environmental determinants, social relationships, community wellbeing	Improvements to physical environment; improved service provision; increased social connectivity.		√		Low	
Bovaird, 2007 Case study 2	Urban renewal	Socio-environmental determinants, social relationships, individual wellbeing, community wellbeing, individual health, community health	Improvements to physical environment; increased access to green spaces; improved service provision; lower levels of depression; lower use of primary and social care services (from reduced need); increased school attendance; reduced crime; increased trust in public agencies, reduced social isolation.	√	√	√	Low	

Study	Intervention	Wellbeing domains	Outcomes	On participants[i]	On wider community	Adverse effects[ii]	QA level Qual.	QA level Quant.
			Increased conflict (participants 'occasionally faced reprisals from other residents').					
Bovaird, 2007 Case study 3	Protect & enhance community facility	Socio-environmental determinants, social relationships, community wellbeing	Improvements to local facilities & services; increased social connectivity & cohesion.		√		Low	
D'Agostino & Kloby, 2011	Natural disaster recovery planning	Individual wellbeing	Frustration and disappointment with process of involvement; concerns about feedback from, & impacts of, public agencies.	√	√	√	Low	
DeGregory et al., 2016	Urban renewal	Socio-environmental determinants	Improvements to physical environment, improved relations between public & public agencies.		√		Low	
Franceschini & Marletto, 2015	Citizens' jury	Individual wellbeing	Frustration with process of involvement; concerns about feedback from public agencies	√		√	Low	

i. Evidence of effects on one or more outcomes.
ii. Adverse effects on study participants from involvement in decision-making processes, for example, frustration, conflict, fatigue.
iii. Although Patton-Lopez et al. (2015) was a mixed-methods study, they used only qualitative methods to assess impacts of community involvement – the study was therefore coded as qualitative.

Review question 1: What are the effects (beneficial and adverse) on community wellbeing of interventions to promote joint decision-making in communities?

In addition to other project aims (e.g. urban renewal), all 29 included studies had the explicit aim of increasing community involvement in decision-making. Sixteen of the studies also involved local people in the implementation of interventions (e.g. volunteering to help build or renew a local facility, or working in a facility after completion). Following the reporting of evidence by category of intervention, a brief overview of evidence on potential negative/adverse impacts from across the included studies is additionally grouped and summarised together, as this evidence relates specifically to the processes of community involvement in decision-making, despite being distributed across a wide range of intervention categories and studies.

The intervention categories below are ordered (ranked) by the number of relevant studies included, with categories containing the largest number of relevant studies presented first. A brief description of each intervention category is provided. Evidence from higher quality studies is reported first and in greater detail than evidence from lower quality studies (where possible). Outcomes described as 'significant' are all statistically significant ($p \leq 0.05$).

1. Urban renewal (17 studies)

Urban design, development, or renewal interventions (henceforth: 'urban renewal' interventions) may involve communities in the design, development, regeneration, or alternative use of infrastructure, places and spaces – such as housing, transport, meeting places, and/or neighbourhood facilities. They involve residents in decentralised structures of area management such as local forums and area committees that work with public agencies and/or other service providers.

Eighteen studies evaluated impacts from the involvement of local communities in decisions that helped to shape urban renewal interventions (Bovaird, 2007; Clift, 2008; Cole et al., 2004; DeGregory et al., 2016; Edwards, 2001; Itzhaky & York, 2002; Lawless & Pearson, 2012; ODPM, 2004; ODPM, 2005; Orton et al., 2017; Patton-Lopez et al., 2015; Pill and Bailey, 2012; Popay et al., 2015; Porter & McIlvaine-Newsad, 2013; Resources for change, 2016; Semenza, 2003; Semenza et al., 2007; Semenza and March, 2009).

Three qualitative studies (ODPM, 2005; Porter & McIlvaine-Newsad, 2013; Orton et al., 2017) and two mixed-methods studies (Clift, 2008; Popay et al., 2015) graded as '**high-quality**' (for qualitative methods) found evidence of community wellbeing-related impacts of community-led urban renewal interventions. The qualitative evidence suggests that the interventions had beneficial effects on participants and their wider communities by increasing levels of personal empowerment (ODPM, 2005; Porter & McIlvaine-Newsad, 2013; Clift, 2008); increasing social activity, connectivity, and cohesion (Porter & McIlvaine-Newsad, 2013; Clift, 2008; Orton et al., 2017; Resources for change, 2016; Popay et al., 2015); reducing social isolation (Porter & McIlvaine-Newsad, 2013); improving elements of the physical environment, such as local housing, and communal spaces (ODPM, 2005; Porter & McIlvaine-Newsad, 2013; Orton et al., 2017; Resources for Change, 2016); improving local service provision (ODPM, 2005; Resources for Change, 2016; Pill and Bailey, 2012); increasing trust (Pill and Bailey, 2012; Popay et al., 2015); increasing pride in the local neighbourhood (ODPM, 2005; Orton et al., 2017); increasing the knowledge, skills and experience of participants (Resources for Change, 2016; Pill and Bailey, 2012); increasing sense of community (Resources for Change, 2016); increasing individual wellbeing (e.g. confidence, happiness, enthusiasm) (Orton et al., 2017; Resources for Change, 2016; Pill and Bailey, 2012); improving mental health of individuals (Popay et al., 2015); increasing the availability and affordability of healthy foods, and increasing access and use of local greenspace (Porter & McIlvaine-Newsad, 2013).

A **high**-quality ethnographic study of a community garden in a vacated area of land in an economically disadvantaged rural area of Illinois USA, found evidence that the intervention which was initially designed to improve food availability, affordability and security, subsequently led to a wide range of wellbeing-related benefits. In addition to environmental improvements, increases in food security, and increases in use of greenspace, the community garden increased social activity and social connectedness (Porter and McIlvaine-Newsad, 2013):

'over time, that shyness falls away and people who might never have social contact with each other begin to talk and socialize as gardening for food security gives way to expressions of leisure'. (Community resident, participant: Porter and McIlvaine-Newsad, 2013).

Intergenerational social connectedness and cohesion were increased:

'My two grandkids were so excited about helping that we had to check the garden every time they came out to see if it was growing... My daughter would always say "Can we water the garden?" and .

. . my grandson made sure he'd have his overalls on . . . he turns five in December. He said he loved it.' (Community resident, participant: Porter and McIlvaine-Newsad, 2013).

Participants developed skills not limited to horticulture, that could be transferred into other activities or occupations, including increased confidence, personal empowerment, group working and organisational abilities (which eventually led to full-time employment for one gardener in a non-gardening role):

'And I'm looking forward to next year, and I hope the group decides to put me on the committee because I would like to be, and we'll see what happens . . . I took the lead just because I feel I'm a leader . . . If I know what I'm doing, I'm going to be right in there getting my hands dirty and enjoying myself as much as the next guy . . . You know so . . . being the leader . . . somebody has to do it, and, and I felt I had nothing but time on my hands.' (Community resident, participant: Porter and McIlvaine-Newsad, 2013).

Another **high**-quality ethnographic study conducted an evaluation of an area-based empowerment initiative (Orton et al., 2017). The Big Local programme was designed to support residents in 150 areas in England in making their area a better place to live (the evaluation focussed on 10 of the areas). There in-depth analysis revealed improvements to social relations as residents and partner organisations came together to develop a shared vision for their areas. The partnerships identified and addressed a variety of local priorities and initiated a wide range of projects, for example, a dog show to promote responsible dog ownership following a series of dog attacks, cooking events to promote healthy eating, gardening projects to increase physical activity and enhance the urban environment, and music/dance and community arts projects. All of the projects where under the control of residents, and they all helped to promote social interaction (including intergenerational) and social cohesion. In addition to benefits to individuals through increased levels of confidence and pride, residents involved in steering the projects also gained skills and experience seen as beneficial to the community in the long-term:

'It's provided some people with the skill sets to be able to implement this kind of work locally … It's kind of professionalised them in a way. They've had to put in rules of governance, and I think that that, those kind of skills will be like long lasting and will leave a legacy in the area, so I think that's quite important in terms of them being active citizens and making decisions about their area.' (Local councillor, participant: Orton et al., 2017).

Some tensions were also identified, with some participants reporting concerns that the interests of certain groups were over represented ('the more middle class') and about conflict/disagreements between participants (Orton et al., 2017).

Another '**high**' quality qualitative study (ODPM, 2005) identified a range of potential benefits from community participation in urban renewal programme decision-making, including improvements to local physical environments (e.g. housing, and neighbourhood design), improvements to local services, increased personal empowerment, and an increased sense of pride in the local area. This study also identified some potential adverse effects involving reduced trust in public agencies, for example, from concerns about a lack of transparency about financial and funding arrangements, and a perceived shortage of information on the delivery of projects.

The highest quality mixed-methods study included in this review (graded as '**high**' for qualitative, and '**moderate-to-high**' for quantitative approaches), by Popay et al. (2015), was the only study that attempted to make comparisons between different approaches to community involvement/empowerment. They constructed a typology to approaches to community engagement in a large government-led regeneration programme – the New Deal for Communities (NDC). They identified four types of approaches (A. an empowering resident-led approach that involved residents in many decisions; B. an approach that was initially empowering but became instrumental over time; C. a balanced empowerment and instrumental approach; and D. an instrumental professional-led approach). Although they identified few significant differences in outcomes between the different types of community engagement approaches, they concluded that the most empowering approach, type A, appeared to have the greatest benefits in terms of resident's perceptions of improvements to local areas, levels of trust, and self-reported mental health, followed to a lesser degree by types B and C which appeared in turn to have greater benefits than the least empowering approach – type D. For example, after adjusting for demographic and socioeconomic factors, they identified significant increases in trust in neighbours over time, with greater increases for the most empowering approach (type A). More empowered residents were also more likely to participate in NDC events than less empowered residents.

While Clift (2008), in mixed-methods study (graded as '**high**' quality for qualitative, and '**low-to-moderate**' for quantitative approaches), found some evidence of beneficial impacts (increased skills, empowerment, and social connectedness), she also found evidence of a range of potential adverse

impacts from participant's experience of Community Empowerment Networks (CENs) in London. Potential adverse impacts identified included increased tension and stress, conflict between community groups and public agencies, disempowerment, disappointment and dissatisfaction with involvement processes, and frustration with perceived lack of influence. One participant, for example, stated:

'I have never felt that I could exert any influence through them. I wrote to HarCEN after an event about some ideas that I had, but I never heard from them, I did not get any feedback, and nothing really happened from that. Since then I have been invited to various different events, but quite honestly I am not sure what they are all on about.' (Community resident, participant: Clift, 2008).

In a mixed-methods study (graded as '**moderate-to-high**' quality for quantitative and '**low**' quality for qualitative approaches) Lawless and Pearson (2012) also investigated the impacts of the NDC programme. Quantitative elements of the study were based on a randomised before and after design. Compared to 'non-involved' residents, people who were involved in the programme reported significantly greater improvements to outcomes including fear and experience of crime, trust in local agencies, and perceptions of improvements to their local area.

Two '**low-to-moderate**' quality quantitative studies found evidence that community-led urban renewal was associated with increased levels of personal mastery and self-esteem, enhanced family wellbeing, increased collective empowerment, improvements to local service delivery (Itzhaky & York, 2002), enhanced sense of community and social capital, and reduced levels of depression (Semenza et al., 2007).

Semenza et al. (2007) report findings from a before and after study of the health and wellbeing impacts of a programme that involved community members and public authorities in decisions and activities which restored public squares in Portland USA. They reported post intervention reductions in (Center for Epidemiological Studies Depression-scale 11) depression ($p = 0.03$), increased sense of community ($p=0.01$), and an overall expansion of social capital ($p = 0.04$).

Based on a series of repeat cross-sectional surveys during and after an intervention to improve community services and empower an economically deprived community in Israel, Itzhaky and York (2002) reported that participants' mean levels of mastery increased by 19% between 1990 and 1993, and self-esteem increased by approximately 18% between 1990 and 1993 ($p<0.01$). Mean family

empowerment levels increased by approximately 27% (from 2.24 in 1992 to 2.84 in 1997, p<0.01), service delivery empowerment increased by 8% (from 3.49 in 1992 to 3.78 in 1997, p<0.01) and community empowerment increased by approximately 5% (from 3.73 in 1992 to 3.91 in 1997).

Six '**low**' quality studies of various designs also found evidence of potential beneficial impacts of community decision-making in urban renewal interventions including, improvements to physical environments (Cole et al., 2004; Semenza and March, 2009; Patton-Lopez et al., 2015; Semenza, 2003); increased social connectivity, capital or cohesion (Semenza & March, 2009; Patton-Lopez et al., 2015; Semenza, 2003); increased personal empowerment (Cole et al., 2004); increased sense of belonging or place, satisfaction, or pride in local area (Semenza & March, 2009; Semenza, 2003); increased skills and confidence (Pill and Bailey, 2012); increased trust in public agencies (Pill and Bailey, 2012); reduced levels of depression, and improved levels of self-reported general health with, for example, 86% of respondents reporting excellent or very good general health in the intervention neighbourhood, compared with 70% in the adjacent (control) neighbourhood (P< .01) in Semenza's 2003 evaluation. In addition, three '**low**' quality descriptive case studies also identified a range of potential positive impacts including, improvements to physical environment; improved service provision, increased social connectivity and reduced social isolation, lower use of primary and social care services (from reduced need), lower levels of depression (maternal and general), increased school attendance, reduced crime, and increased trust in public agencies (DeGregory et al., 2016; Bovaird, 2007 - case studies 1 & 2). It was difficult to identify whether there were impacts on community-level physical or mental health/ill health, as the studies used small population groups and measured health at the level of individuals. We, therefore, only identified one study as having shown a potential impact on 'community health' by reducing pressure on local (population wide) health services (Bovaird, 2007 – case study 2).

Three of the '**low**' quality studies also found evidence of a range of potential adverse impacts on community wellbeing-related outcomes resulting from participants involvement in decision-making processes. In a qualitative study Cole et al. (2004) found evidence of distress, frustration, discomfort, distrust, and consultation fatigue amongst participants. Bovaird, 2007 (descriptive case study 2) states that participants 'occasionally faced reprisals from other residents'. In a mixed-methods study, Semenza and March (2009) found evidence of increased conflict between participants in decision-making and delivery, and some residents expressed concerns about potential reductions in safety (on roads, and pavements) resulting from the community-led urban renewal programme.

Some residents expressed concerns about potential gentrification of the area, and concerns about potential, subsequent effects on local property tax levels (increases).

2. Community development (4 studies)

Community development interventions involve community members working in (typically) multifaceted programmes to improve material or social conditions, including access to housing, business and economic development, youth development, community planning, neighbourhood beautification, and leadership development.

Four studies evaluated the impacts of community-led community development programmes (Blades et al., 2016; Blanchet-Cohen et al., 2014; Ohmer, 2007; Watson-Thompson et al., 2008).

One qualitative study graded as '**high**' quality found that a youth-led community development grant programme across five communities in Canada may have led to a range of improvements to community-wellbeing related outcomes that included enhanced emotional, social, friendship, organisational and financial skills for youth participants; increased self-confidence; increased personal empowerment; increased sense of belonging; and improved group cooperation and cohesion (Blanchet-Cohen et al., 2014).

The authors provide a range of qualitative quotes that illustrate the development of the youth participants, for example, in terms of learning to understand differing view-points, to cooperate, and to reach consensus:

'Even if there is one person in the group who disagrees and everyone else is positive we don't just grant it, we take the time to look at that reason and understand that perspective.' (Youth participant: Blanchet-Cohen et al., 2014).

'Everybody has their own views and everybody's going at it from a different angle, but I think the diversity is really helpful because it's not just one demographic or two demographics making all the decisions.' (Focus group participant: Blanchet-Cohen et al., 2014).

'Usually we each read over and take it in and then ask each other questions and talk about it from different angles . . . So we discuss and then go through the criteria… we are not so set in our ways.' (Youth participant: Blanchet-Cohen et al., 2014).

One mixed-method study graded as '**moderate-to-high**' quality (for both qualitative and quantitative methods) provides evidence of both beneficial and adverse impacts of involvement in two community development programmes led by community coalitions in economically disadvantaged neighbourhoods in Kansas City USA. Watson-Thompson et al. (2008) provide evidence that the coalitions made improvements to a range of policies and services (in relation to housing, youth, crime and safety, economic development), increased the skills of participants, and increased pride in the local community. One of the coalitions recorded 100 instances of community changes to policies and services, and 78% of participants surveyed indicated that they were satisfied with involvement in decision-making processes. The other coalition, however, was less successful and only managed to secure 19 changes. Interviews with members suggested the timing of the intervention may not have been appropriate while the (latter) coalition was dealing with internal conflicts.

One '**low**' quality mixed-methods study (Blades et al., 2016) and one '**low**' quality quantitative study (Ohmer, 2007) identified a wide range of potential benefits associated with involvement in community-led community development interventions. Blades et al. (2016) provide evidence of improvements to physical environments (e.g., access to, green spaces and play areas), reduced social isolation and loneliness, increased confidence and optimism, increased social connectedness, increased sense of belonging, increased happiness, reduced anxiety and depression, increased skills and experience, increased personal and collective empowerment, and improved (healthier) lifestyles. They also, however, provide evidence of potential adverse impacts including, frustration and disappointment with the decision-making processes and concerns about outcomes for some participants. Ohmer (2007) provides evidence of increased levels of self and collective-efficacy, and increased sense of community for participants.

3. Participatory budgeting (2 studies)

Participatory budgeting interventions involve local residents in deciding how some of the budgets of public authorities are prioritised and spent in their communities.

Two studies evaluated the impacts of community involvement in local authority budget decisions (Environics Research, 2015; Hawkins, 2012). One '**low-to-moderate**' quality qualitative study found evidence of positive impacts including increased personal and collective empowerment, increased levels of social connectivity and social cohesion, and increased trust, respect, and reciprocity between communities and public agencies (Hawkins & Egan, 2012).

Enthusiasm for the community's involvement in decision-making was highlighted by one of the members of the participatory budgeting group:

'the group … started because of the severe problems that were in Govanhill … it brought most of the community groups in the area together to form GoCA [Govanhill Community Action]… it was a very positive step, incredibly positive.' (GoCA member, community participant: Hawkins & Egan, 2012).

One '**low**' quality mixed-methods study found that community involvement in local authority budget decisions increased public trust in public agencies, led to reports of higher levels of personal and collective empowerment, and increases in reported levels of social connectedness and cohesion (Environics Research, 2015).

Some study participants, however, expressed disappointment and frustrations with the process of involvement, with poor communication being a prominent concern:

"the printed material that was mailed out was not clearly set out and could easily be taken as an advertisement to be thrown out". (Community resident, participant: Environics Research, 2015).

4. Citizens' juries (2 studies)

Citizens' Jury interventions involve a group of local residents who are chosen to represent their community. They are presented with information and evidence about potential policies or projects before deciding whether and how they should be implemented.

Two '**low**' quality studies (one qualitative, one descriptive case study) examined the impacts of community involvement in citizen's juries – one in Liverpool UK, and one in Bari Italy (Haigh & Scott-Samuel, 2008; Franceschini & Marletto, 2015, respectively).

Haigh and Scott-Samuel (2008) found qualitative evidence of both beneficial (increased sense of pride and belonging among participants) and adverse impacts (frustration and disappointment, consultation fatigue, and a perceived lack of feedback from public agencies) resulting from the processes of involvement in the jury. Franceschini and Marletto (2015) only found evidence of potential adverse effects (frustration, and concerns about a lack of engagement and feedback from public agencies).

5. *Protecting community facilities (1 study)*

Protecting community facility interventions involve local residents working together and/or with partners to save local facilities (for example, a local post office/store) from closure or from takeover by 'outside' commercial interests.

One '**low**' methodological quality case study describes the impact of a local community's work to save a local shop and post office from closure, and their ongoing collaborative work enhancing it as a local supplier of goods and services, and as a community hub. The case study describes a range of beneficial impacts from the community intervention including, improvements to local facilities and service provision, and improvements to social connectedness, particularly for older residents (Bovaird, 2007 – case study 3).

6. *Natural disaster recovery planning (1 study)*

Natural disaster recovery planning interventions may involve communities working with public and other agencies to develop reconstruction/redevelopment plans *after* a natural disaster such as a flood, storm, earthquake, or fire. This is distinct from community disaster preparedness planning – in which communities work with authorities to prepare for such events *before* they happen.

One '**low**' quality descriptive case study examined the impacts of community involvement in disaster recovery planning following the Hurricane Katrina natural disaster in New Orleans in 2005. This study only identified adverse impacts that resulted from community frustration and disappointment with the process of involvement, together with public concerns about a perceived lack of feedback and action from public agencies who were responsible for involving the community in recovery planning, and for implementing the recovery programme (D'Agostino & Kloby, 2011).

7. *Integrating public sector service design/delivery (1 study)*

Integration of public sector service design and delivery interventions may involve community members working with service providers to create more joined-up local services, for example, by enhancing partnerships between health, social care, and emergency services.

One '**low-to-moderate**' quality qualitative study evaluated the impacts of community involvement in a partnership that attempted to better integrate public sector services such as health, education, social care, police, ambulance, and fire services. This study only found adverse impacts from public

involvement in the decision-making processes. The study provides evidence that the community representatives found attempts at collaboration with public agencies frustrating and disappointing, and they expressed concerns that the public-sector partner's approach was tokenistic:

'We are not involved from the beginning and, therefore, do not know what stage in the process things are at; we are expected just to nod in agreement.' (Local community planning group/resident, participant: Lamie & Ball, 2010).

Participants were concerned about a general lack of feedback and action from the public-sector partners, and some reported the effects of consultation fatigue (Lamie & Ball, 2010). This study was a 'borderline' include in this review as although the intervention aimed to meaningfully involve communities in decision-making, delivery fell short of this intention.

8. Crime prevention (1 study)

Crime prevention interventions attempt to prevent and reduce residents' fear and experience of crime through improvements to the design and maintenance of buildings and shared spaces, improved policing and security, and increased community cooperation and cohesion.

One '**low-to-moderate**' quality before and after quantitative study evaluated the impacts of community involvement in a crime prevention programme in a 'troubled' apartment block area of Toronto, Canada. The intervention was associated with reductions to crime and fear of crime rates, and with increased social connectedness and social cohesion.

Significant changes in some violent crime rates were reported – a 60.5% drop in sexual assaults, and a 49.9% drop in violent crime rates overall over four years (between 2002 and 2006). A significant fall in motor vehicle theft of minus 67.1% was also associated with the intervention over the same time period ($p < 0.05$), although changes in some other crime rates were not statistically significant, and some increased (e.g. personal theft). The study also reports large reductions in fear of crime, for example the percentage of people feeling unsafe walking at night fell from 47% in 2002 to 20% in 2006. Some measures of the percentage of people making contact with neighbours also increased, for example, contact a few times each month increased from 10% to 17% between 2002 and 2006 ($p < 0.001$), although weekly and daily contacts did not change significantly (Saville, 2009).

Evidence of potential adverse effects

In summary, just over half the included studies (15 of 29) provide evidence that the involvement of communities in decision-making processes may lead to a range of adverse impacts on those participating. This included evidence from studies at all quality levels (high to low), and all study designs. Studies providing evidence of adverse impacts frequently cite similar themes or outcomes that include disappointment, frustration, dissatisfaction, loss of trust in public agencies, conflict amongst participants and with other actors/agencies, disempowerment, perceived lack of feedback and evidence on the impacts of their involvement, tension and stress, and consultation fatigue. The adverse impacts reported clearly relate to the *processes* of involvement.

Review question 1a: Is there evidence of differential distribution of effects across population sub-groups, including age, socioeconomic status, gender, ethnicity and disability status?

Although the vast majority of the included studies focussed on a socially disadvantaged group or groups, predominantly people who were economically disadvantaged or who lived in an economically disadvantaged area, very few of the studies attempted to examine the distribution of impacts from involvement in community decision-making across different socioeconomic, ethnic, or other potentially disadvantaged groups.

One higher quality mixed-methods study made deliberate attempts to assess the distribution of impacts (inequalities) across different socioeconomic groups (Popay et al., 2015). They concluded, however, that '*there was no firm evidence that any one approach to CE* [community engagement] *was more successful than the others in engaging more or different social groups, or that the different approaches to CE had differential impacts on health inequalities or their social determinants*.'

None of the quantitative studies stratified results by socioeconomic status, ethnicity, gender, religious, or health or disability status. Only one study focussed on the experiences of disabled people in comparison to non-disabled people (Edwards, 2001). In a mixed-methods study graded as '**low**' methodological quality, Edwards (2001) found that people with disabilities were more likely to experience the adverse impacts of involvement including, consultation fatigue, distress and frustration, and from the physical and psychological strain of accessing and participating in decision-making processes for people with disabilities, in comparison to non-disabled people.

Few of the studies attempted to adjust for confounding by socioeconomic status (Semenza, 2007; Ohmer, 2007; Popay et al., 2015). This provides another indication of the relative low-quality of the body of quantitative evidence, in comparison to other evidence on the health and wellbeing-related impacts of inequalities in control/empowerment at the *individual level* (Whitehead et al., 2014).

Given the limited attention to inequalities in the included studies, our findings are only able to provide an insight into which type of interventions are likely be associated with impacts (beneficial and/or adverse) on community wellbeing-related outcomes. Questions relating to the distribution of impacts across important population groups remain unanswered.

Review question 2: What conditions/factors determine (enhance or undermine) the effectiveness of interventions to promote joint decision-making in communities, or influence the distribution of impacts across population sub-groups?

Only one included study made comparisons between different approaches to community involvement in decision-making. This higher methodological quality study (graded as 'high' for qualitative, and 'moderate-to-high' for quantitative approaches) compared four types/levels of empowerment of residents in New Deal for Communities areas (Popay et al., 2015). They concluded that the most empowering approach appeared to have the greatest benefits in terms of residents' perceptions of improvements to local areas, levels of trust, and self-reported mental health. Their analysis, however, was limited to comparisons between four basic typologies/levels of empowerment, e.g. an empowering resident-led approach that involved residents in many decisions (the most empowering approach), in comparison to an instrumental professional-led approach (the least empowering approach), and not more specific conditions or factors.

Ten of the 29 studies included in the review focussed solely on the outcomes of joint decision-making and related interventions. Nineteen of the included studies did, however, identify conditions or factors that may enhance the effectiveness of interventions to promote joint decision-making in communities (Blades et al., 2016; Blanchet-Cohen et al., 2014; Bovaird, 2007; Cole et al., 2004; D'Agostino, 2011; Edwards, 2001; Environics Research, 2015; Franceschini and Marletto, 2015;

Harkins and Egan, 2012; Lamie and Ball, 2010; ODPM, 2004; ODPM, 2005; Ohmer, 2007; Orton et al., 2017; Patton-Lopez et al., 2015; Porter and McIlvaine-Newsad, 2013; Resources for Change, 2016; Semenza and March, 2009; Watson-Thompson et al., 2008). Information on the factors was typically presented as recommendations pertaining to 'lessons learnt' or 'barriers and enablers' to effective and inclusive involvement in the discussion sections of the publications. The precise empirical support for these recommendations, particularly for comparisons between approaches, is therefore unclear.

Factors identified as potentially promoting more effective joint decision-making interventions are summarised in Table 8 (presented as recommendations as within the studies). They are also grouped into four categories of action (1. Communication and transparency; 2. Organisational culture and commitment to empowering communities; 3. Timing and accessibility of involvement; 4. Training and support). In addition, the 15 studies that found evidence of adverse impacts of involvement in decision-making processes also provide an insight into potentially common barriers to involvement resulting from issues relating to accessibility and communication for some participants.

Table 8. Included study authors recommendations on factors that may promote more effective involvement of communities in joint decision-making interventions

Category of action/recommendation	Recommendation	Study
Communication and transparency	Create clear and transparent arrangements for partnership working.	Environics Research, 2015; Lamie and Ball, 2010; Resources for Change, 2016; Watson-Thompson et al., 2008
	Be open and realistic about what can and cannot be achieved, and about how long delivery may take.	Cole et al., 2004; D'Agostino, 2011; Environics Research, 2015; Lamie and Ball, 2010; Patton-Lopez et al., 2015
	Ensure good communication and monitoring and provide feedback to participants on what has and has not been delivered.	Blades et al., 2016; Environics Research, 2015; Harkins and Egan, 2012; Lamie and Ball, 2010
	Share learning and examples of best practice.	Blades et al., 2016
Organisational culture and commitment to empowering communities	Promote full commitment to partnership working at all levels of organisations and make it a responsibility for all.	Cole et al., 2004; Lamie and Ball, 2010
	Allow the community participants greater control over the 'rules' and processes of participation.	Cole et al., 2004
	Trust the process of involvement and the ability of participants and be prepared to relinquish control to communities.	Blanchet-Cohen et al., 2014; Cole et al., 2004; Bovaird, 2007; Lamie and Ball, 2010; ODPM, 2005
	Deliver the plans that communities helped to develop.	D'Agostino, 2011

Timing and accessibility of involvement	Involve communities from the start, so they are involved in key decisions and to promote a sense of ownership and maintain involvement of both communities and public agencies throughout.	Franceschini and Marletto, 2015; ODPM, 2005; Patton-Lopez et al., 2015; Watson-Thompson et al., 2008
	Identify and address barriers to communication and involvement for all participants (for example, physical and spatial barriers; financial barriers; literacy, numeracy and language barriers; cultural barriers; barriers relating to caring responsibilities and time/availability to participate) and identify any adverse impacts on participants with a view to addressing them.	Edwards, 2001; Environics Research, 2015; Harkins and Egan, 2012; Franceschini and Marletto, 2015; ODPM, 2005; Orton et al., 2017; Porter and McIlvaine-Newsad, 2013; Semenza and March, 2009
	Allow community participants greater flexibility to engage.	Cole et al., 2004; Watson-Thompson et al., 2008
Training and support	Provide training and ongoing support to community participants and staff from public agencies engaged in joint decision-making.	Blades et al., 2016; Bovaird, 2007; Cole et al., 2004; Edwards, 2001; Environics Research, 2015; Franceschini and Marletto, 2015; Harkins and Egan, 2012; ODPM, 2004; ODPM, 2005; Ohmer, 2007; Watson-Thompson et al., 2008

Implications for practice arising from these recommendations are considered in the Discussion section.

4. Discussion and conclusions

From over 16,000 papers and reports, identified through comprehensive searches, we identified and included 29 primary studies that explored the relationships between empowerment-based joint decision-making interventions and community wellbeing-related outcomes. This is the first systematic review to include a substantial body of studies conducted in high-income (OECD) countries that: **A**. report the meaningful involvement of local people in decision-making processes, **B**. report wellbeing-related impacts, and **C**. were conducted in a community/living environment setting. It is the first systematic review that has specifically examined the community wellbeing-related impacts of empowerment-based participatory interventions consistent with Arnstein's 'degrees of citizen power'. All of the interventions were designed with the intention of empowering community members to take greater control of decisions that affect their lives, although some fell short of this intention during delivery. Given the often-stated intentions of international organisations, national and local governments, and 'frontline' organisations and practitioners to empower communities and improve wellbeing, it is surprising that evidence on the impacts of interventions that seek to meaningfully involve communities in decision-making is still limited nearly 50 years after publication of the Ladder of Citizen Participation (Arnstein, 1969). This review can be used as a starting point for understanding and addressing limitations and gaps in the current evidence base.

Despite limitations, which are common in evidence on the impacts of complex social determinants of health and wellbeing, the available evidence clearly demonstrates that there are a wide range of potential benefits from community involvement in decision-making, which include benefits to both participants and wider their communities.

The review findings are consistent with the upper (positive/beneficial) pathway of Whitehead et al.'s (2016) model which links increased levels of 'collective control' to better community health and wellbeing. The included studies provide evidence that joint decision-making interventions can be successful in helping to deflect threats to the local (living) environment and in resisting 'hollowing out' of neighbourhood services and facilities (Bovaird, 2007; ODPM, 2004, 2005; Watson-Thompson et al., 2008), in maintaining and enhancing local conditions, and in attracting resources to create better places to live (Blades et al., 2016; Bovaird, 2007; Cole et al., 2004; DeGregory et al., 2016; Lawless & Pearson, 2012; ODPM, 2005; Ohmer, 2007; Patton-Lopez et al., 2015; Porter & McIlvaine-

Newsad, 2013; Resources for Change, 2016; Semenza & March, 2009; Semenza, 2003). There is also evidence that the interventions led to increased trust and reciprocity (Hawkins & Egan, 2012; Pill & Bailey, 2012; Popay et al., 2015; ODPM, 2004; Environics Research, 2015; Lawless & Pearson, 2012; Bovaird, 2007), control of anti-social behaviour (Saville, 2009), and power 'with' community members to challenge unhealthy conditions (Blades et al., 2016; Blanchet-Cohen et al., 2014; Clift, 2008; Cole et al., 2004; Environics Research, 2015; Hawkins & Egan, 2012; Itzhaky & York, 2002; ODPM, 2005; Porter & McIlvaine-Newsad, 2013). The beneficial impacts identified were on a wide range of established determinants of health and wellbeing (consistent with Dahlgren and Whitehead's socio-environmental model, 1993), including the physical conditions in which people live, social relationships, individual physical and mental health, community health, individual wellbeing, and community wide levels of wellbeing.

A key finding of this review was that 15 of the 29 included studies provided some evidence of potential adverse impacts for those participating. It is, however, important to note that the adverse impacts were associated with problems in joint decision-making intervention implementation processes. There was no evidence that the participants made 'poor' decisions leading to negative effects. Adverse impacts appear to be associated with poorly designed and implemented interventions, involving insufficient support and guidance to public agency staff, community participants, and poor feedback and communication between public agencies and communities. Fortunately, the apparent causes of these adverse outcomes are amenable to change and improvement through more careful and considerate design and implementation of the joint decision-making processes; some approaches to which are outlined below (see: 'implications for practice'). Designing and implementing interventions based on the specific characteristics and needs of all participants appears to be essential. Further (comparative) research is, however, required on the relative effectiveness and wellbeing-related effects of different approaches to implementation of joint decision-making interventions, as only one included study attempted to make comparisons between broad approaches, and no studies made comparisons between more specific methods of practice. This could build on studies in the public management and community development literatures that examine *how* to effectively empower communities, but currently fall-short of measuring wellbeing-related outcomes and therefore failed to meet our inclusion criteria (for examples, see Voorberg et al.'s 2015 review).

Implications for practice

Communication and transparency

Most of the 15 included studies that found evidence of adverse effects of community decision-making interventions identified failings in communication between public actors/agencies and participants. In particular, failures of public agencies to communicate how community involvement had made a difference to programmes or projects were frequently highlighted. Nine studies made recommendations about the importance of clear and transparent communication of information in joint decision-making interventions (Blades et al., 2016; Cole et al., 2004; D'Agostino, 2011; Environics Research, 2015; Harkins and Egan, 2012; Lamie and Ball, 2010; Patton-Lopez et al., 2015; Resources for Change, 2016; Watson-Thompson et al., 2008). This included the need for:

a. Explicit partnership working arrangements (Environics Research, 2015; Lamie and Ball, 2010; Resources for Change, 2016; Watson-Thompson et al., 2008).
b. Open communication about what can and cannot be realistically achieved by the partnerships, and about how long programme and project outputs will take to deliver (Cole et al., 2004; D'Agostino, 2011; Environics Research, 2015; Lamie and Ball, 2010; Patton-Lopez et al., 2015).
c. Effective communication to participants and wider communities about delivery (what has and has not been delivered as a result of their participation, and about the general progress of programmes and projects) (Blades et al., 2016; Environics Research, 2015; Harkins and Egan, 2012; Lamie and Ball, 2010).
d. Monitoring and sharing the learning from good and bad examples of community involvement in decision-making interventions (Blades et al., 2016).

Organisational culture and commitment to empowering communities

Six studies made recommendations relating to the need for public and private sector organisations to embrace the empowerment of communities (Blanchet-Cohen et al., 2014; Bovaird, 2007; Cole et al., 2004; D'Agostino, 2011; Lamie and Ball, 2010; ODPM, 2005) by:

a. Making clear strategic commitments to empowering communities (Cole et al., 2004; Lamie and Ball, 2010).

b. Trusting the process of joint decision-making and the ability of community participants to make informed decisions (Blanchet-Cohen et al., 2014; Cole et al., 2004; Bovaird, 2007; Lamie and Ball, 2010; ODPM, 2005).
c. Allowing community participants to take control over the mechanisms of 'power' and the 'rules'/processes of participation such as the setting of meeting agendas, deciding on the location and timing of meetings, and any rules of voting (Cole et al., 2004).
d. Delivering the plans developed by community and public or private sector partnerships (D'Agostino, 2011).

Timing and accessibility of involvement

Eleven studies made recommendations relating to the timing and involvement of communities in decision-making (Cole et al., 2004; Edwards, 2001; Environics Research, 2015; Franceschini and Marletto, 2015; Harkins and Egan, 2012; ODPM, 2005; Orton et al., 2017; Patton-Lopez et al., 2015; Porter and McIlvaine-Newsad, 2013; Semenza and March, 2009; Watson-Thompson et al., 2008). The implications for practice are that:

a. Communities should be involved in decision-making from initial or early planning stages, to ensure that communities have a say in all key decisions, and to increase community sense of ownership. Involvement should also be maintained by all parties throughout the decision-making process (Franceschini and Marletto, 2015; ODPM, 2005; Patton-Lopez et al., 2015; Watson-Thompson et al., 2008).
b. Physical access barriers may prevent some groups, for example, for older people, and people with limiting long-term illnesses or disabilities, from accessing facilities. Barriers to accessibility of venues and decision-making processes should be proactively identified and addressed, along with any potential adverse impacts of involvement within and across population groups so that involvement processes can be made more inclusive, and any adverse impacts are reduced or eliminated (Franceschini and Marletto, 2015; Edwards, 2001; Environics Research, 2015; Harkins and Egan, 2012; ODPM, 2005; Orton et al., 2017; Porter and McIlvaine-Newsad, 2013; Semenza and March, 2009). Consideration of accessibility should take account of the needs of the widest possible range of participants, including those with disabilities (hidden and visible, mental and physical), and adaptions should be made if necessary, and/or other forms of support offered (Edwards, 2001; Porter & McIlvaine-Newsad, 2013). Physical access adaptations may include locating meeting venues near to public transport - to enable easier access for people without cars (including larger proportions of people on fixed or low incomes, compared to those on higher incomes; and

young and older people, compared to working age people). Meetings and events should be held in venues with good physical access and facilities for people with disabilities. Parking charges and membership fees should be avoided or minimised wherever possible. Location of events should be as close to communities as possible (Environics, 2015). Other factors such as language, literacy and numeracy, hearing and visual impairment, and culture may also act as barriers to involvement (Edwards, 2001). Invitation materials, and regular information should be made available in a variety of accessible formats, potentially including audio, large text, language translations; and ideally be based on an examination of the population profile of the local community (Local Authority population health profiles in the UK contain relevant demographic information, and they are readily available on most local authority websites). Materials should be written or recorded in plain and accessible language (of whatever language is required). The timing of meetings or events should also be considered, for example, so that working age people and people with childcare responsibilities, are able to attend. Allowing participants greater flexibility to engage as and when they please may reduce demands on participants and increase participation across communities (Cole et al., 2004; Watson-Thompson et al., 2008).

Training and support

Eleven studies made recommendations on the importance of providing training and adequately resourced ongoing support to community participants and staff from public/private agencies engaged in joint decision-making interventions (Blades et al., 2016; Bovaird, 2007; Cole et al., 2004; Edwards, 2001; Environics Research, 2015; Franceschini and Marletto, 2015; Harkins and Egan, 2012; ODPM, 2004; ODPM, 2005; Ohmer, 2007; Watson-Thompson et al., 2008).

Taking part in joint decision-making programmes may be a daunting experience for some, particularly for those with little experience of working with public or private-sector actors and agencies. Initial and ongoing training of participants (potentially including public and private-sector representatives) may help to reduce the stress of involvement and make participation more fruitful for all parties. Experienced facilitators may also help to allay the fears of participants, guide them through new processes, and make sure that everyone has a chance to contribute. Training and facilitation may help maximise the benefits of participation, while reducing or eliminating any adverse effects (for example, Hawkins, 2012; Edwards, 2001).

Transferability

Transferability was assessed in terms of whether the setting and population were common to the UK. Based on our, albeit basic, assessment of transferability, many of the studies included in this review appear to be relevant and transferable to UK settings and populations. Most were conducted in the UK, and those conducted elsewhere were in settings and on populations common in the UK.

Limitations in the review

We used quality assessment tools (checklists) that assessed the quantitative and qualitative elements of mixed-methods studies separately, as no quality assessment tool for mixed-methods studies was available (there is currently no consensus about the best approach). Eight of the included studies used mixed-methods designs. Reporting limitations in the papers, and complexity and heterogeneity of interventions, methods, and outcomes, together with logistical (time) constraints made assessment of methodological quality by each outcome unfeasible. Results from separate assessments of quantitative and qualitative approaches may have failed to reflect the complex and sophisticated designs, and potential strengths, of some of the included mixed-methods studies. Low-quality gradings may be in-part due to the failure of the quality assessment tools to account for the strengths of mixed-method approaches, despite such approaches being designed to offset potential weaknesses of both quantitative and qualitative methods; particularly within the context of research on complex social determinants of wellbeing, such as community participation in decision-making (Cresswell and Plano Clark, 2006). We also assessed the quality of unpublished studies (reports) from grey literature using the same criteria as used for peer-reviewed, academic, published studies. While this is appropriate, there being no established alternative, we have to acknowledge that many grey literature reports are intended for different audiences than academic publications (or academic grey literature reports). This may limit the inclusion of information on, for example, the theoretical underpinnings of methodological approaches, which may result in lower gradings of methodological quality (for example, see final question, criterion 3, QA tool in appendix 7). Current quality assessment tools, originally developed for use on precisely-defined (standardised) clinical interventions in healthcare settings, also fail to account for deliberate variations in (non-standardised) approaches to implementation of complex social interventions in community settings, particularly community-led interventions tailored to the needs of local contexts (Hawe et al., 2004). The studies included in this review may have received lower quality gradings as a result of the inability of the tools to account for this deliberate lack of intervention fidelity.

Studies that *only* measured or observed empowerment as an outcome were excluded. We acknowledge that empowerment, and related concepts such as self-efficacy and agency, are potentially fundamental determinants of community wellbeing and important wellbeing-related outcomes in their own right. We excluded studies that measured no other wellbeing-related outcomes, however, for three reasons. First, studies that use levels of empowerment as both independent (relating to the intervention 'input') and dependent (the outcome of interest) variables provide limited insight into pathways between interventions and outcomes. Second, we are interested in the broad spectrum of potential impacts of empowerment-based interventions. Third, the sheer volume of studies that only examine empowerment as an outcome would have made this review logistically unfeasible.

We also excluded studies on community ownership/asset transfer. Community asset transfer interventions clearly involve the transfer of decision-making powers to communities, they are not however joint decision-making interventions (although they are close to our area of interest). A separate review of the evidence on the wellbeing-related impacts of such interventions is required, including to investigate potential wider and longer-term issues surrounding the transfer of assets previously owned by the public sector to individuals or small groups within communities, for example, social housing tenants or social enterprises.

Limitations in the included studies

The review has identified important gaps and limitations in the current evidence base.

The majority of the included (solely) quantitative studies used study designs that were either inherently weak, or there were serious shortcomings in the reporting of methods. There was, however, some high-quality qualitative evidence, and some moderate-to-high-quality quantitative evidence. Most of the quantitative or mixed-methods studies used single time-point cross-sectional methods that are only able to establish whether there is an association between variables, and the strength of any association. They provide no insight into temporal relationships (if a change in one variable proceeds and potentially leads to changes in another, or the other way around). Six studies, however, used inherently stronger 'before and after' designs, including five repeat cross-sectional studies (participants not being linked when measured before and after the intervention, and with some differences in participation) and one (stronger) longitudinal study that measured the same individuals throughout (Saville, 2009; Itzhaky & York, 2002; Watson-Thompson et al., 2008; Popay et al., 2015; Lawless & Pearson, 2012; and Saville, 2007 respectively). Longitudinal studies help to

establish causal inference (cause and effect). There is a need for further and high-quality longitudinal studies with carefully selected comparator groups. An investigation into *why* the quality of current quantitative evidence is of lower quality may be useful. Such an investigation could seek to identify why researchers selected lower quality study designs (e.g. for logistic, training, or methodological reasons) and how methods could be improved over time. An exploration of the potential role of frontline practitioners in contributing to data collection and evaluation may also lead to useful and additional resources for evaluations.

While most of the studies focussed on low socioeconomic status groups, only one study attempted to compare how impacts were experienced differentially across lower and higher socioeconomic groups; although its findings on socioeconomic distribution of effects (inequalities) were inconclusive (Popay et al., 2015). Only one study made a comparison between the experiences of disabled and non-disabled people (Edwards, 2001). No evidence pertaining to the distribution of impacts across sub-populations by gender, ethnicity, religion, sexuality or other characteristics was located. This is a surprising and important finding given the sheer scale of research into the social determinants of inequalities in health and wellbeing, and the attention drawn to the potential fundamental role of power inequalities in shaping population outcomes in seminal public health publications such as the Final Report of the Commission on the Social Determinants of Health (CSDH, 2008), and the Strategic Review of Health Inequalities in England Post-2010 ('the Marmot Review') (Marmot et al., 2010).

Further research on the potential health and wellbeing-related impacts of joint decision-making interventions in communities is needed. Future studies should pay attention to data collection, disaggregation, stratification and analysis of the distribution of impacts of joint decision-making and related empowerment-based interventions within and across population sub-groups, including socioeconomic, gender, ethnic, age, and disability groups. Forthcoming research and publications from the Big Local/Communities in Control study funded through the National Institute for Health Research School for Public Health Research may go some way towards providing this.

Only three of the included studies used comparator groups, which limits the conclusions that can be drawn as to whether any observed impacts were due to the intervention being evaluated, or whether they were the result of other changes going on in the communities at the same time (Lawless & Pearson, 2012; Popay et al, 2015; Semenza et al, 2003). Future studies should use carefully selected comparator groups to tackle this issue. Self-section bias (for example when more

empowered people or those with higher wellbeing choose to participate) may also be addressed in some situations, most likely larger scale evaluations, with random or cluster sampling methods.

The wider body of knowledge on community participation

This evidence does not sit in isolation - it is part of a broader body of knowledge on the role of control/empowerment in determining health and wellbeing that extends across and beyond community settings, and into workplace, healthcare and other institutional settings. The wider body of knowledge also indicates that increasing the power of individuals and communities to influence the decisions that impact on their daily lives can be beneficial to their health and wellbeing (examples of reviews of the wider body of evidence are within Appendix 1).

In situations where the 'best' or high-quality evidence (through research methods such as Randomised Controlled Trials) on the effects of a policy or intervention does not exist, it is established best-practice in evidenced-based decision-making to base decisions and action on the '**best available evidence**'. This approach is endorsed, for example, by the Health Evidence Networks of the World Health Organisation Europe. Despite limitations in the current evidence, this review has identified the 'best available evidence'. It should, therefore, be used to inform policies and practice alongside other considerations. The limitations should be recognised, and future research should focus effort on addressing the specific limitations of this particular evidence (relating to sample sizes, selection, randomisation, comparators, distribution of impacts, and temporal design/causality). Future research should also focus on *how* empowerment-based interventions can be implemented most effectively.

The evidence included in this review shows that communities can initiate, design and deliver change for the benefit of community wellbeing through well designed and implemented joint decision-making interventions. Policy makers and practitioners should promote and support *meaningful* empowerment-based involvement of communities in decision-making. Inequalities in access to decision-making for certain individuals and groups should be explicitly acknowledged and addressed, so that benefits to participants and wider communities are maximised and any adverse effects are reduced or eliminated.

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5. Appendices

Appendix 1 - Broader context of evidence on wellbeing-related outcomes of participation

Examples of review-level evidence across settings, including workplace, healthcare, health promotion, and types/levels of participation.

1. Andrews J, Newman S, Heath J, Williams L, Tingen M (2012) Community-based participatory research and smoking cessation interventions: a review of the evidence. The Nursing Clinics of North America, 47(1):81-96.

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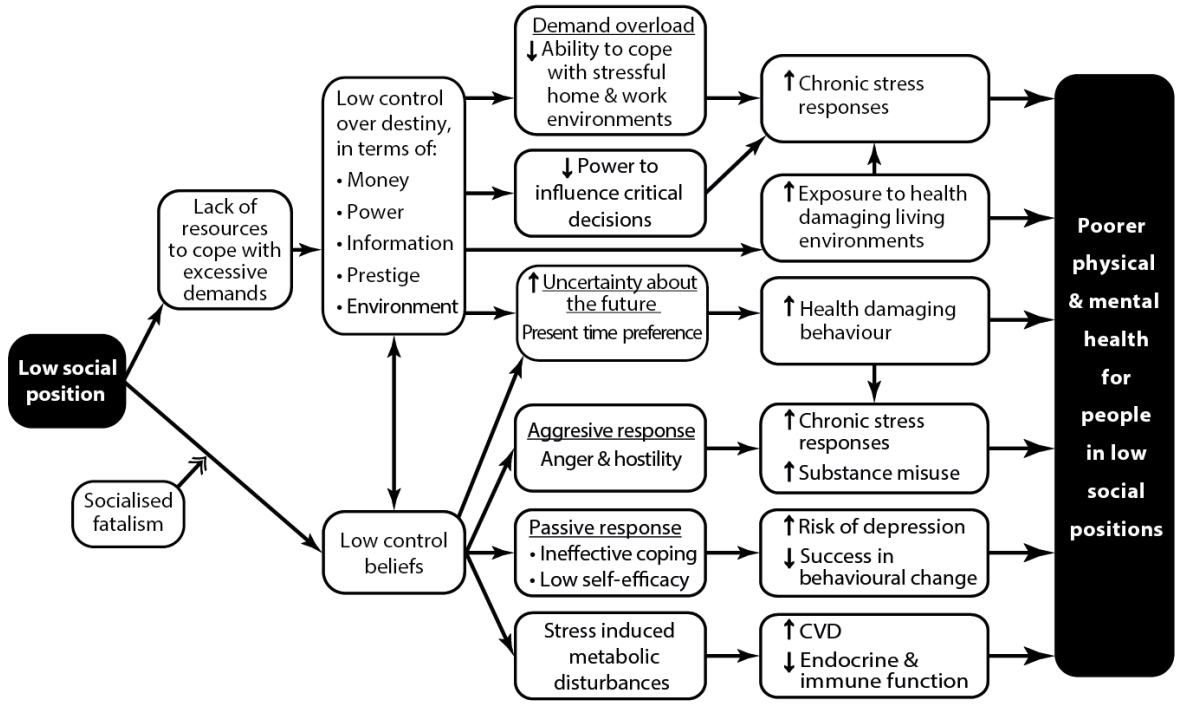
Appendix 2 - Model of potential pathways between low control and socioeconomic inequalities in health and wellbeing at the level of individuals (micro)

Figure 6. Theoretical pathways at the Micro/personal level leading from low control to socioeconomic inequalities in health.



Source: Whitehead et al., 2016

Appendix 3 - Example academic database search strategy

MEDLINE and MEDLINE In-Process & Other Non-Indexed Citations - Via OVID

1	((co-production or co-design or co-creation or coproduction or codesign or cocreation or joint or shared or lay or communit*) adj2 (decision-making or decision making or policy-making or policy making or service design or planning or governance)).ti,ab.
2	Charrette or citi?ens jury.ti,ab.
3	OR 1 - 2
4	limit 3 to (English language and humans and years 1980 to Current)

Appendix 4 - Grey literature search strategy (Google)

1. (co-production | co-design | co-creation | coproduction | codesign | cocreation | charrette | joint | shared | lay | community) (decision-making | “decision making” | policy-making | “policy making” | “service design” | planning | governance)

2. (“citizen jury” | “citizens jury” | “citizens’ jury” | “participatory budgeting”)

3. (co-production | coproduction) (community | communities)

4. (empowered | empowerment) (community | communities)

Appendix 5 - Websites searched

Websites/pages identified via Google search (Google Scholar was also searched, separately)

	Title	URL
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408.	Stroud Micro Dairy – a look at the new community-led enterprise.	*www.stroudnewsandjournal.co.uk/.../15049907.Stroud_Micro_Dairy_____a_look_at...*
409.	Successful webinar session on governance for community co-operatives	www.plunkett.co.uk/news/successful-webinar-session-on-governance-for-community-co-operatives
410.	Task Force for Creating Opportunities for Shared Governance for Co ...	www.ohiohighered.org/content/task_force_creating_opportunities_shared_governance_co_located_campuses_0
411.	The challenges of participatory budgeting - OpenBudgets	openbudgets.eu/post/2016/04/26/challenges-around-participatory-budgeting
412.	The Co-operative Group - Wikipedia	*https://en.wikipedia.org/wiki/The_Co-operative_Group*
413.	The Design of Crowdfunding Mechanisms for Participatory Budgeting	www.kd2lab.kit.edu/92_114.php
414.	The Effects of Participatory Budgeting on Municipal Expenditures and ...	www.sciencedirect.com/science/article/pii/S0305750X13000156
415.	The failure of HBOS plc - Bank of England	*www.bankofengland.co.uk/pra/Documents/publications/reports/hbos.pdf*
416.	The Naturesave Trust - Green Insurance by Naturesave	*www.naturesave.co.uk/the-naturesave-trust*
417.	The Participatory Budgeting Project - Home | Facebook	www.facebook.com › Places › Brooklyn, New York › Organization
418.	The Plymouth Plan: The new plan for South Hams, West Devon and…	*https://plymswdevonplan.co.uk*
419.	The West Midlands Mental Health Commission Citizens Jury	www.wmca.org.uk/.../wmca-mental-health-commission-citizens-jury-report.pdf
420.	Towards Co-Production in Research with Communities - Arts and ...	*www.ahrc.ac.uk/...communities/towards-co-production-in-research-with-communities...*
421.	Towards Co-Production in Research with Communities | Connected ...	*https://connected-communities.org/.../towards-co-production-in-research-with-commu...*
422.	Unlocking the potential of participatory budgeting - Nesta	www.nesta.org.uk/sites/default/files/your_local_budget.pdf
423.	Urban planning and co-creation | Playsign | Playsign	*www.playsign.net/urban-planning-and-co-creation*
424.	using participatory budgeting to improve mental capital at the local level	www.britac.ac.uk/.../kwame-mckenzie-using-participatory-budgeting-mental-capital-l...
425.	value co-creation in a project setting: a service-dominant logic ...	*www.arcom.ac.uk/-docs/proceedings/edb7e7176768bcb59ac66ec7d387b4e0.pdf*

426.	Value co-creation in Complex Engineering Service Systems ...	*https://business-school.exeter.ac.uk/documents/papers/management/2010/1004.pdf*
427.	Victoria's Citizens' Jury on Obesity - VicHealth	www.vichealth.vic.gov.au/programs-and.../victorias-citizens-jury-on-obesity
428.	Victoria's Citizens' Jury on Obesity | The Behavioural Insights Team	www.behaviouralinsights.co.uk/australia/citizens-jury
429.	Views on Alternatives to Imprisonment: A Citizens Jury Approach	www.lowitja.org.au/sites/default/files/.../Lowitja%20Alternatives-text-WEB.pdf
430.	VocalEyes Digital Democracy | Participatory Budgeting	about.vocaleyes.org/services/participatory-budgeting
431.	Vote for NYC Council Participatory Budgeting – District 22 : Events	www.longislandcityqueens.com/.../vote-for-nyc-council-participatory-budgeting-distr...
432.	Walsall Council	*www.walsall.gov.uk*
433.	Wealth Management, Pension And Retirement Planning.	*amberwealth.co.uk*
434.	welcome - nick wright planning	*nickwrightplanning.co.uk*
435.	Welcome to Shetland Islands Council	*www.shetland.gov.uk*
436.	We're all in this together: User and community co-production of public ...	*www.birmingham.ac.uk/Documents/college.../inlogov-co-production-chapter.pdf*
437.	West Carclaze eco-community - ECOBOS	*www.westcarclaze.co.uk*
438.	West of England Local Enterprise Partnership - Joint Transport Board	*westofenglandlep.co.uk/meetings/joint-transport-board*
439.	What is a Citizens' Jury - Civicus	www.civicus.org/documents/toolkits/PGX_B_Citizens%20JuryFinalWeb.pdf
440.	What is a Citizens' Jury all about? – Better Together	bettertogether.sa.gov.au/what-is-a-citizens-jury-all-about
441.	What is a Citizens' Jury? - newDemocracy Foundation	www.newdemocracy.com.au/library/what-is-a-citizens-jury
442.	What is co-creation? definition and meaning - BusinessDictionary.com	*www.businessdictionary.com/definition/co-creation.html*
443.	What Is Participatory Budgeting? – Intellitics	www.intellitics.com/blog/2013/03/07/what-is-participatory-budgeting
444.	What is Participatory Budgeting? – Revive and Thrive	reviveandthrive.co.uk/what-is-participatory-budgeting
445.	What is Participatory Budgeting? An Explainer – Rock the Vote - Medium	https://medium.com/.../what-is-participatory-budgeting-an-explainer-b592aceac713
446.	What is PB? - Participatory Budgeting Project	www.participatorybudgeting.org/what-is-pb
447.	What makes co-production different? - In more detail - Co-production ...	*www.thinklocalactpersonal.org.uk/co-production.../co-production/.../what-mak...*
448.	What Works in Community Profiling? - Glasgow Centre for Population ...	*www.gcph.co.uk/assets/0000/5539/Community-Profiling-in-West-Dunbartonshire.pdf*
449.	What Works Scotland – community empowerment	*http://whatworksscotland.ac.uk/category/topic/Community-empowerment/*
450.	What Works Scotland – co-production	*http://whatworksscotland.ac.uk/category/topic/co-production/*
451.	What Works Scotland – publications	*http://whatworksscotland.ac.uk/publications*
452.	Whitley And Eggborough Community Primary School - Home	*www.whitleyandeggboroughcpschool.co.uk*
453.	WHO | Track 1: Community empowerment	*www.who.int/healthpromotion/conferences/7gchp/track1/en*
454.	WHO | Track 1: Community empowerment	*www.who.int/healthpromotion/conferences/7gchp/track1/en*
455.	Why co-ops are better - The Co-operators	*www.cooperators.ca/en/About-Us/why-coops-are-better.aspx*
456.	Why co-production is an important topic for local government	*www.govint.org/fileadmin/user_upload/.../coproduction_why_it_is_important.pdf*
457.	York Community Stadium	*www.yorkcommunitystadium.co.uk*

Appendix 6 - Table of reasons for excluding studies during full text screening

Reasons for excluding studies during full text screening

	Study	Reason for exclusion
1.	Cyril S, Smith B J, Possamai-Inesedy A, and Renzaho A M. N. (2015). Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. Global health action, 8, pp.1-12.	Not primary study of Community Decision-making Intervention
2.	We the Citizens (2011) We the Citizens – Speak up for Ireland - Participatory democracy in action - a pilot. www.wethecitizens.ie/wp-content/uploads/2015/05/We-the-Citizens-2011-FINAL.pdf	Not primary study of Community Decision-making Intervention
3.	DemocracySpot (Undated) The Benefits of Citizen Engagement: a (Brief) Review of the Evidence. https://democracyspot.net/2012/11/24/the-benefits-of-citizen-engagement-a-brief-review-of-the-evidence	Not primary study of Community Decision-making Intervention
4.	The power Inquiry (2006) Power to the People – The report of Power: An independent inquiry into Britain's democracy. www.powerinquiry.org	Not primary study of Community Decision-making Intervention
5.	Citizen Participation Network (Undated) Tag Archives: participatory democracy. https://oliversdialogue.wordpress.com/tag/participatory-democracy	Not primary study of Community Decision-making Intervention
6.	Rai S (2008) Routes and barriers to citizen governance. York: Joseph Rowntree Foundation.	Not primary study of Community Decision-making Intervention
7.	Hughes T, Warburton D (2012) Revisiting past participants. London: Involve. www.involve.org.uk/resources/publications/project-reports/revisiting-past-participants	Not primary study of Community Decision-making Intervention
8.	Marcinkiewicz, Montagu I, Reid S (2016) Scottish Social Attitudes 2015: Attitudes to Social Networks, Civic Participation and Co-Production. https://tinyurl.com/ya2m4nxm	Not primary study of Community Decision-making Intervention
9.	Mayo M, Mendiwelsa-Bendek Z, Packham C (2012) Learning to take part as active citizens: Emerging lessons for community organising in Britain. Voluntary Sector Review, 3(2): 179-195.	Not primary study of Community Decision-making Intervention
10.	Atlantis Leisure (2009) Steps to Successful Community-Led Service Provision in Rural Areas. Fife: Carnegie UK Trust.	Not primary study of Community Decision-making Intervention
11.	EKOS Limited and Avril Blamey Associates (2017) Review of the community-led regeneration approach as delivered via the People and Communities Fund. Edinburgh: The Scottish Government.	Not primary study of Community Decision-making Intervention
12.	Hothi M (2012) Local 2.0: how digital technology empowers local communities London: The Young Foundation.	Not primary study of Community Decision-making Intervention
13.	Mguni N, Caistor-Arendar L (2012) Rowing Against The Tide: Making the case for community resilience. London: The Young Foundation.	Not primary study of Community Decision-making Intervention
14.	Aiken M, Cairns B, Thake S (2008) Community ownership and management of assets. York: JRF.	Not primary study of Community Decision-making Intervention
15.	Joseph Rowntree Foundation (2012) Community Asset Transfer in Northern Ireland. York: JRF.	Not primary study of Community Decision-making Intervention

16.	Carnegie Young People Initiative (2008) Empowering Young People. Dunfermline: Carnegie UK Trust.	Not primary study of Community Decision-making Intervention
17.	Woodall J, White J, South J (2013) Improving Health and Wellbeing through community health champions: a thematic evaluation of a programme in Yorkshire and Humber. Perspectives in Public Health. 133(2): 96-103.	Not primary study of Community Decision-making Intervention
18.	Satsangi M (2007) Land tenure change and rural housing in Scotland', Scottish Geographical Journal. 123(1): 33–47.	Not primary study of Community Decision-making Intervention
19.	Browning S (2007) Scottish Land Fund: Findings from our Evaluation. Big Lottery Fund Research. 34. www.biglotteryfund.org.uk/er_eval_slf_fi ndings.pdf	Not primary study of Community Decision-making Intervention
20.	Pogrebinschi T (2013) The Squared Circle of Participatory Democracy: Scaling-up Deliberation to the National Level. Rio de Janeiro: State University of Rio de Janeiro.	Not OECD
21.	Claridge T (2004) Designing social capital sensitive participation methodologies. Saint Clair, Dunedin: Social Capital Research.	Not OECD
22.	Joost Fledderus. (2015). Building trust through public service co-production. International Journal of Public Sector Management, (7), pp.550.	Not living environment
23.	Bryant Carol A, Forthofer Melinda S, Brown Kelli R. McCormack, Landis Danielle C, and McDermott Robert J. (2000). Community-based prevention marketing: The next steps in disseminating behavior change. American Journal of Health Behavior, 24, pp.61-68.	Not living environment
24.	Aarsaether N, and Ringholm T. (2011). The Rural Municipality as Developer Entrepreneurial and Planning Modes in Community Development. Lex Localis-Journal of Local Self-Government, 9, pp.373-387.	Not living environment
25.	Agarwal B. (2009). Gender and forest conservation: The impact of women's participation in community forest governance. Ecological Economics, 68, pp.2785-2799.	Not living environment
26.	Bovaird T, and Loeffler E. (2013). The role of co-production for better health and wellbeing: why we need to change. Co-ProduCE, , pp.20.	Not living environment
27.	Cleary J, and Hogan A. (2016). Localism and decision-making in regional Australia: The power of people like us. Journal of Rural Studies, 48, pp.33-40.	Not living environment
28.	Collins Brady Joseph. (2017). The boundaries of culture: Perceiving and experiencing place in multi-ethnic Los Angeles. . ProQuest Information & Learning.	Not living environment
29.	Cornelius N, and Wallace J. (2010). Cross-Sector Partnerships: City Regeneration and Social Justice. Journal of Business Ethics, 94, pp.71-84.	Not living environment
30.	Cyril S, Smith B J, Possamai-Inesedy A, and Renzaho A M. N. (2015). Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. Global health action, 8, pp.1-12.	Not living environment
31.	Fledderus J. (2015). Building trust through public service co-production. International Journal of Public Sector Management, 28, pp.550-565.	Not living environment
32.	Parrado S, Van Ryzin , G G, Bovaird T, and Loffler E. (2013). Correlates of Co-production: Evidence From a Five-Nation Survey of Citizens. International Public Management Journal, 16, pp.85-112.	Not living environment

33.	Roussos S T, and Fawcett S B. (2000). A review of collaborative partnerships as a strategy for improving community health. Annual review of public health, 21, pp.369-402.	Not living environment
34.	Alakeson V, Bunnin A, Miller C (2013) Coproduction of health and wellbeing outcomes: the new paradigm for effective health and social care. London: Office of Public Management.	Not living environment
35.	Knapp M, Bauer A, Perkins M, Snell T (2013) Building community capital in social care: is there an economic case? Community Development Journal. 48(2):313-331.	Not living environment
36.	Loeffler E. (2016). CitizenPoweredCities: Co-producing better public services with citizens. , , pp..	Not empirical
37.	Cilliers E J, and Timmermans W. (2014). The importance of creative participatory planning in the public place-making process. Environment and Planning B-Planning & Design, 41, pp.413-429.	Not empirical
38.	Cilliers E J, and Timmermans W. (2015). An Integrative Approach to Value-Added Planning: From Community Needs to Local Authority Revenue. Growth and Change, 46, pp.675-687.	Not empirical
39.	Deaton Ashley Spring Morgan. (2011). Increasing inclusive recreation opportunities for children with disabilities through community-based participatory intervention. . ProQuest Information & Learning.	Not empirical
40.	Sarkissian W. (2010). Engaging the Community in Decision Making: Case Studies Tracking Participation, Voice and Influence. Journal of Planning Education and Research, 30, pp.105-107.	Not available
41.	PriceWaterhouseCoopers (2001) URBAN Community Initiatives in Northern Ireland 1994–1999. Belfast: PriceWaterhouseCoopers.	Not available
42.	Perry, M. (2007) Inspiring rural communities unpublished slide presentation. Woodstock, Oxfordshire: Plunkett Foundation.	Not available
43.	Darien Lindsey Elizabeth Olivia. (2012). Social capital and new localism: a comparitive study of two parish councils. . University of Kent at Canterbury (United Kingdom).	No wellbeing outcome
44.	Beresford Peter. (1997). Citizen involvement in public policy. . Middlesex University (United Kingdom).	No wellbeing outcome
45.	Brown Louis D, Chilenski Sarah M, Ramos Rebeca, Gallegos Nora, and Feinberg Mark E. (2016). Community Prevention Coalition Context and Capacity Assessment: Comparing the United States and Mexico. Health Education & Behavior, 43, pp.145-55.	No wellbeing outcome
46.	Darien Lindsey Elizabeth Olivia. (2012). Social capital and new localism: a comparitive study of two parish councils. . University of Kent at Canterbury (United Kingdom).	No wellbeing outcome
47.	de Koninck de'tSerclaes, and Vanessa . (2017). Disruptions, transformations, and divisions: Negotiating joint management in northern Australia. . ProQuest Information & Learning.	No wellbeing outcome
48.	Dooris M, and Heritage Z. (2013). Healthy Cities: Facilitating the Active Participation and Empowerment of Local People. Journal of Urban Health-Bulletin of the New York Academy of Medicine, 90, pp.S74-S91.	No wellbeing outcome
49.	Jennings J. (2004). Urban planning, community participation, and the Roxbury Master Plan in Boston. Annals of the American Academy of Political and Social Science, 594, pp.12-33.	No wellbeing outcome
50.	Kenyon W, and Nevin C. (2001). The use of economic and participatory approaches to assess forest development: a case study in the Ettrick Valley. Forest Policy and Economics, 3, pp.69-80.	No wellbeing outcome

51.	Loeffler Elke, and Bovaird Tony. (2016). User and Community Co-Production of Public Services: What Does the Evidence Tell Us?. International Journal of Public Administration, 39, pp.1006-1019.	No wellbeing outcome
52.	Mitchell B. (2005). Participatory partnerships: Engaging and empowering to enhance environmental management and quality of life?. Social Indicators Research, 71, pp.123-144.	No wellbeing outcome
53.	O'Neill Claire. (2003). Citizens' juries and social learning: understanding the transformation of preference. . University of Bedfordshire (United Kingdom).	No wellbeing outcome
54.	Savini F. (2011). The Endowment of Community Participation: Institutional Settings in Two Urban Regeneration Projects. International Journal of Urban and Regional Research, 35, pp.949-968.	No wellbeing outcome
55.	Young Teresa Jane. (2007). Involving place based and interest based communities in urban regeneration: a temporal and spatial reading of community governance. . Lancaster University (United Kingdom).	No wellbeing outcome
56.	Hough J, Button D, and Coote . (2016). Evaluation of Local Conversations - Baseline data report. London: , pp.. .	No wellbeing outcome
57.	Bromley Elizabeth, Eisenman David, Magana Aizita, Williams Malcolm, Kim Biblia, McCreary Michael, Chandra Anita, and Wells Kenneth. (2017). How Do Communities Use a Participatory Public Health Approach to Build Resilience? The Los Angeles County Community Disaster Resilience Project. International Journal of Environmental Research and Public Health, 14, pp.1267.	No wellbeing outcome
58.	Berry C, Kaplan S A, Reid A, and Albert S. (2009). THE VIABILITY OF COMMUNITY PARTNERSHIPS INITIATED BY EXTERNAL FUNDERS. Public health reports, 124, pp.590-593.	No wellbeing outcome
59.	Butterfoss F D. (2006). Process evaluation for community participation. In: , ed., Annual review of public health. Palo Alto: Annual Reviews, pp.323-340.	No wellbeing outcome
60.	Michels A, De Graaf L (2010) Examining Citizen Participation: Local Participatory Policy Making and Democracy, Local Government Studies, 36(4), 477-491.	No wellbeing outcome
61.	Pound D, Reed M, Armitage L, Pound J (2016) Engaging and Empowering Communities and Stakeholders in rural land use and land management in Scotland. Edinburgh: The Scottish Government.	No wellbeing outcome
62.	Richardson L (2012) Working in Neighbourhoods, Active Citizenship and Localism: Lessons for Policy-makers and Practitioners. York: JRF.	No wellbeing outcome
63.	Ross C, Kerridge E, Woodhouse A (2018) The Impact of Children and Young People's Participation on Policy Making. Edinburgh: The Scottish Government.	No wellbeing outcome
64.	Berkley Patton, and Jannette Y. (2005). Evaluation of a comprehensive community effort to reduce substance abuse among adolescents in a Kansas community. . ProQuest Information & Learning.	Health promotion only
65.	Butterfoss F D, Goodman R M, and Wandersman A. (1996). Community coalitions for prevention and health promotion: factors predicting satisfaction, participation, and planning. Health Education Quarterly, 23, pp.65-79.	Health promotion only
66.	Darrow William W, Montanea Julie E, Fernandez Paula B, Zucker Ula F, Stephens Dionne P, and Gladwin Hugh. (2004). Eliminating disparities in HIV disease: community mobilization to prevent HIV transmission among Black and Hispanic young adults in Broward County, Florida. Ethnicity & Disease, 14, pp.S108-16.	Health promotion only

67.	Fawcett Stephen B, Collie-Akers Vicki, Schultz Jerry A, and Cupertino Paula. (2013). Community-based participatory research within the Latino health for all coalition. Journal of Prevention & Intervention in the Community, 41, pp.142-54.	Health promotion only
68.	Cohen D, Han B, Derose K, Williamson S, Marsh T, and McKenzie T. (2013). Physical activity in parks: a randomized controlled trial using community engagement. Am J Prev Med, 45, pp.590-597.	Health promotion only
69.	Darrow William W, Montanea Julie E, Fernandez Paula B, Zucker Ula F, Stephens Dionne P, and Gladwin Hugh. (2004). Eliminating disparities in HIV disease: community mobilization to prevent HIV transmission among Black and Hispanic young adults in Broward County, Florida. Ethnicity & Disease, 14, pp.S108-16.	Health promotion only
70.	Fawcett Stephen B, Collie-Akers Vicki, Schultz Jerry A, and Cupertino Paula. (2013). Community-based participatory research within the Latino health for all coalition. Journal of Prevention & Intervention in the Community, 41, pp.142-54.	Health promotion only
71.	Cohen D, Han B, Derose K, Williamson S, Marsh T, and McKenzie T. (2013). Physical activity in parks: a randomized controlled trial using community engagement. Am J Prev Med, 45, pp.590-597.	Health promotion only

Appendix 7 - Study Quality Assessment tools

Quantitative QA tool (based on Snape et al., 2017)

Category	Nº	Tab code	Criteria	Yes	No	Can't tell
Evaluation design	**1**	Fid	Fidelity: • The extent to which the intervention was delivered with fidelity is clear - i.e. if there is a specific intervention which is being evaluated, this has been well reproduced.			
	2	Meas1	Measurement: • The measures are appropriate for the intervention's anticipated outcomes and population.			
	3	Meas2	• Participants completed the same set of measures once shortly before participating in the intervention and once again immediately afterwards			
	4	Meas3	• An 'intent-to-treat' design was used, meaning that all participants recruited to the intervention participated in the pre/post measurement, regardless of whether or how much of the intervention they received, even if they dropped out of the intervention (this does not include dropping out of the study - which may then be regarded as missing data)			
	5	Count1	Counterfactual: • Assignment to the treatment and comparison group was at the appropriate level (e.g., individual, family, school, community)			
	6	Count2	• The comparison condition provides an appropriate counterfactual to the treatment group. Consider: o Participants were randomly assigned to the treatment and control group through the use of methods appropriate for the circumstances and target population OR sufficiently rigorous quasi-experimental methods (regression discontinuity, propensity score matching) were used to generate an appropriately comparable sample through non-random methods			

			○ The treatment and comparison conditions are thoroughly described.			
Sample	**7**	Rep1	Representative: • The sample is representative of the intervention's target population in terms of age, demographics and level of need. The sample characteristics are clearly stated.			
	8	Rep2	• There is baseline equivalence between the treatment and comparison group participants on key demographic variables of interest to the study and baseline measures of outcomes (when feasible).			
	9	Samp1	Sample size: • The sample is sufficiently large to test for the desired impact. This depends most importantly on the effect size; however, a suggestion could be e.g. a minimum of 20 participants have completed the measures at both time points within each study group.			
	10	Attr1	Attrition: • A minimum of 35% of the participants completed pre/ post measures. Overall study attrition is not higher than 65%.			
	11	Atrr2	• The study had clear processes for determining and reporting drop-out and dose. Differences between study drop-outs and completers were reported if attrition was greater than 10%.y			
	12	Attr3	• The study assessed and reported on overall and differential attrition			
	13	Equiv1	Equivalence: • Risks for contamination of the comparison group and other confounding factors have been taken into account and controlled for in the analysis if possible: ○ Participants were blind to their assignment to the treatment and comparison group			
	14	Equiv2	• There was consistent and equivalent measurement of the treatment and control groups at all points when measurement took place.			
	15	Measr1	Measures:			

			• The measures used were valid and reliable. This means that the measure was standardised and validated independently of the study and the methods for standardization were published. Administrative data and observational measures may also have been used to measure programme impact, but sufficient information was given to determine their validity for doing this.			
	16	Measr2	• Measurement was independent of any measures used as part of the treatment.			
	17	Measr3	• In addition to any self-reported data (collected through the use of validated instruments), the study also included assessment information independent of the study participants (e.g., an independent observer, administrative data, etc).			
Analysis	**18**	Analy1	• The methods used to analyse results are appropriate given the data being analysed (categorical, ordinal, ratio/parametric or non-parametric, etc) and the purpose of the analysis.			
	19	Analy2	• Appropriate methods have been used and reported for the treatment of missing data.			
Consistency	**20**	Consi1	• Are the findings made explicit?			
	21	Consi2	• Is there adequate discussion of the evidence both for and against the researcher's arguments?			
	22	Consi3	• Has the researcher discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)?			
	23	Consi4	• Are the findings discussed in relation to the original research question?			

Qualitative QA tool (based on Snape et al., 2017)

Criteria	Yes	No	Can't tell
1. Is a qualitative methodology appropriate? Consider: Does the research seek to interpret or illuminate the actions and/or subjective experiences of research participants? Is qualitative research the right methodology for addressing the research goal?			
2. Is the research design appropriate for addressing the aims of the research? Consider: Has the researcher justified the research design (e.g. have they discussed how they decided which method to use)?			
3. Is there a clear statement of findings? Consider: Are the findings made explicit? Is there adequate discussion of the evidence both for and against the researcher's arguments? Has the researcher discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)? Are the findings discussed in relation to the original research question?			
4. Was the data collected in a way that addressed the research issue? Consider: Is the setting for data collection justified? Is it clear what methods were used to collect data? (e.g. focus group, semi-structured interview etc.)? Has the researcher justified the methods chosen?			

Has the researcher made the process of data collection explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)? If methods were modified during the study, has the researcher explained how and why? Is the form of data clear (e.g. tape recordings, video material, notes etc)?			
5. Was the recruitment strategy appropriate to the aims of the research? Consider: Has the researcher explained how the participants were selected? Have they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study? Is there any discussion around recruitment and potential bias (e.g. why some people chose not to take part)? Is the selection of cases/ sampling strategy theoretically justified?			
6. Was the data analysis sufficiently rigorous? Consider: If there is an in-depth description of the analysis process? If thematic analysis is used, is it clear how the categories/themes were derived from the data? Does the researcher explain how the data presented were selected from the original sample to demonstrate the analysis process? Are sufficient data presented to support the findings? Were the findings grounded in/ supported by the data? Was there good breadth and/or depth achieved in the findings? To what extent are contradictory data taken into account? Are the data appropriately referenced (i.e. attributions to (anonymised) respondents)?			

7. Has the relationship between researcher and participants been adequately considered? Consider: Has the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location? How has the researcher responded to events during the study and have they considered the implications of any changes in the research design?			
8. Have ethical issues been taken into consideration? Consider: Are there sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained? Has the researcher discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)? Have they adequately discussed issues like informed consent and procedures in place to protect anonymity? Have the consequences of the research been considered i.e. raising expectations, changing behaviour? Has approval been sought from an ethics committee?			
9. Contribution of the research to wellbeing impact questions? Consider: Does the study make a contribution to existing knowledge or understanding of what works for wellbeing? e.g. are the findings considered in relation to current practice or policy?			

Appendix 8 - List of studies included in the review

1. Blades R, France J, Ahmed H, Diep M, Jackson O (2016) Active Communities Evaluation - Final Report. London: ECORYS UK.
2. Blanchet-Cohen N, Manolson S, Shaw K (2014) Youth-Led Decision Making in Community Development Grants. Youth & Society, 46: 819-834.
3. Bovaird T (2007)* Beyond Engagement and Participation: User and Community Coproduction of Public Services. Public Administration Review, 67: 846-860.
4. Clift S (2008) Governance, community participation and urban regeneration: a new role for third sector partners? Middlesex: Middlesex University.
5. 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: Sheffield Hallam University, Centre for Regional Economic and Social Research.
6. D'Agostino M J, Kloby K (2011) Building Community Capacity to Engage Government: Reflections of Nonprofit Leaders on Post-Katrina New Orleans. Administration & Society, 43: 749-769.
7. DeGregory S, Chaudhury N, Kennedy P, Noyes P, Maybank A (2016) Community Vision and Interagency Alignment: A Community Planning Process to Promote Active Transportation. American Journal of Public Health, 106: 654-7.
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Note: * Three case studies from Bovaird 2007 were included. The case studies were extracted and assessed individually.

Appendix 9 – Summary of outcomes identified

Summary of outcomes table (from process of involvement, and from the resultant interventions)

Study	On study participants	On wider community	Socio-environmental determinants	Social relationships	Individual wellbeing	Community wellbeing	Individual health	Community level health	Adverse effects
Blades et al, 2016	√	√	√	√	√	√	√		√
Blanchet-Cohen et al, 2014	√	√		√	√				
Bovaird, 2007 CASE STUDY 1		√	√	√		√			
Bovaird, 2007 CASE STUDY 2	√	√	√	√	√	√	√	√	√
Bovaird, 2007 CASE STUDY 3		√	√	√	√	√			
Clift, 2008	√	√	√		√	√			√
Cole et al, 2004	√	√	√		√				√
D'Agostino & Kloby, 2011	√	√			√				√
DeGregory et al, 2016		√	√						
Edwards, 2002	√	√			√		√		√
Environics Research, 2015	√				√	√	√		√
Franceschini & Marletto, 2015	√				√				√
Haigh & Scott-Samuel, 2008	√				√	√			√
Hawkins, 2012	√	√		√	√	√			
Itzhaky & York, 2002	√	√	√		√	√			

Study	On study participants	On wider community	Socio-environmental determinants	Social relationships	Individual wellbeing	Community wellbeing	Individual health	Community level health	Adverse effects
Lamie & Ball, 2010	√				√				√
Lawless & Pearson, 2012	√		√		√				
ODPM, 2004	√	√	√	√	√	√			
ODPM, 2005	√	√	√	√	√				
Ohmer, 2007	√	√	√	√	√	√			
Orton et al., 2017	√	√	√	√	√	√			√
Patton-Lopez et al, 2015	√	√	√	√		√			
Popay et al., 2015	√	√		√	√	√	√		
Porter & McIlvaine-Newsad, 2013	√	√	√	√	√	√			
Resources for Change, 2016	√	√	√	√	√	√			√
Semenza & March, 2009	√	√	√	√	√	√			√
Semenza et al, 2007	√	√	√	√	√	√			
Semenza, 2003	√	√	√	√	√	√	√		
Watson-Thompson et al, 2008	√	√	√		√				
Pill and Bailey, 2012	√	√	√		√	√			

Appendix 10 - Quality Assessment results - summary tables

Qualitative studies (or qualitative approaches within mixed-methods studies)

Study	Qualitative method appropriate?	Research design appropriate?	Clear statement of findings?	Data collection appropriate?	Recruitment strategy appropriate?	Rigorous data analysis?	Researcher relationship considered?	Ethical issues taken into account?	Contribution?	Level	Quality
Clift, 2008	Y	Y	Y	Y	Y	Y	Y	Y	Y	3	High
Blanchet-Cohen et al., 2014	Y	Y	Y	Y	Y	Y	?	Y	Y	3	
Porter, McIlvaine-Newsad, 2013	Y	Y	Y	Y	Y	Y	N	N	Y	3	
ODPM, 2005	Y	Y	Y	Y	Y	Y	?	N	Y	3	
Orton et al., 2017	Y	Y	Y	Y	?	Y	N	Y	Y	3	
Popay et al., 2015	Y	Y	Y	Y	Y	Y	N	Y	Y	3	
Edwards, 2001	Y	Y	Y	Y	Y	?	N	N	Y	2	Moderate-to-high
Watson-Thompson et al., 2008	Y	Y	Y	Y	Y	?	N	N	Y	2	
Hawkins & Egan, 2012	Y	Y	Y	Y	?	?	N	?	Y	1	Low-to-moderate
Resources for change, 2016	Y	Y	?	Y	Y	?	N	N	Y	1	

Study	Qualitative method appropriate?	Research design appropriate?	Clear statement of findings?	Data collection appropriate?	Recruitment strategy appropriate?	Rigorous data analysis?	Researcher relationship considered?	Ethical issues taken into account?	Contribution?	Level	Quality
Lamie & Ball, 2010	Y	Y	Y	Y	?	?	N	?	?	1	
Patton-Lopez et al., 2015	Y	Y	?	?	N	N	N	N	Y	0	Low
Haigh & Scott-Samuel, 2008	Y	?	?	Y	?	?	N	N	Y	0	
Cole et al., 2004	Y	?	Y	?	?	?	?	?	Y	0	
Pill & Bailey, 2012	Y	Y	?	?	?	N	N	N	Y	0	
ODPM, 2004	Y	?	Y	?	N	?	N	N	Y	0	
Blades et al., 2016	Y	?	Y	N	N	?	N	N	Y	0	
Lawless & Pearson, 2012	Y	?	Y	?	?	?	N	N	Y	0	
Semenza, March, 2009	Y	N	?	N	?	?	?	?	Y	0	
Environics Research, 2015	Y	N	N	?	?	N	N	N	Y	0	

Quantitative studies (or quantitative approaches within mixed-methods studies)

Study	Design						Sample											Analysis		Consistency				Level	Quality
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23		
	Fid	Meas1	Meas2	Meas3	Count1	Count2	Rep1	Rep2	Samp1	Attr1	Atrr2	Attr3	Equiv1	Equiv2	Measr1	Measr2	Measr3	Analy1	Analy2	Consi1	Consi2	Consi3	Consi4		
Popay 2015	n/a	Y	Y	?	Y	Y	Y	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	?	Y	Y	Y	Y	2	Moderate-to-high
Watson-T 2008	n/a	Y	Y	?	Y	Y	Y	Y	?	?	?	Y	n/a	Y	Y	Y	Y	?	?	Y	Y	Y	Y	2	
Lawless 2012	n/a	Y	Y	?	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	?	Y	N	?	?	Y	Y	Y	Y	2	
Itzhaky 2002	n/a	Y	Y	?	n/a	n/a	Y	Y	Y	?	?	N	n/a	Y	?	Y	Y	Y	?	Y	Y	Y	Y	1	Low-to-moderate
Semenza 2007	n/a	Y	Y	N	N	N	Y	n/a	Y	Y	?	N	Y	n/a	Y	Y	N	Y	?	Y	Y	Y	Y	1	
Clift 2008	n/a	Y	n/a	n/a	n/a	n/a	Y	n/a	Y	n/a	n/a	n/a	n/a	n/a	Y	Y	Y	Y	?	Y	Y	Y	Y	1	
Blades 2016	n/a	Y	n/a	n/a	n/a	n/a	Y	n/a	Y	n/a	n/a	n/a	n/a	n/a	Y	Y	Y	Y	N	Y	N	Y	Y	0	Low
Semenza 2009	n/a	Y	n/a	n/a	n/a	n/a	Y	n/a	Y	n/a	n/a	n/a	n/a	n/a	n/a	?	Y	Y	N	Y	Y	N	Y	0	
Ohmer 2007	n/a	Y	n/a	n/a	n/a	n/a	Y	n/a	Yes	n/a	n/a	n/a	n/a	n/a	Y	Y	N	Y	N	Y	Y	N	Y	0	
Semenza 2003	n/a	Y	n/a	n/a	Y	?	Y	Y	Y	n/a	n/a	N	N	?	?	n/a	N	Y	?	Y	N	Y	n/a	0	
Edwards 2001	n/a	Y	N	n/a	n/a	n/a	Y	n/a	Y	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Y	N	Y	Y	n/a	Y	0	
ODPM 2004	n/a	Y	n/a	n/a	n/a	n/a	N	n/a	Y	n/a	n/a	n/a	n/a	n/a	n/a	Y	Y	Y	N	Y	N	N	Y	0	

Saville 2009	n/a	Y	?	N	N	N	?	N	?	?	N	N	N	N	?	?	Y	?	N	Y	Y	?	Y	0	
Enviro nics 2015	n/a	Y	n/a	n/a	n/a	n/a	N	n/a	N	n/a	n/a	n/a	n/a	n/a	N	Y	N	Y	N	Y	N	N	Y	0	

Quality scoring

Studies were graded as 'low' quality (**score 0**) if they met less than 4 out of 9 criteria on the validity assessment criteria on the qualitative checklist, or less than 11 out of 23 on the quantitative checklist; 'low-to-moderate' quality (**score 1**) if they met between 4 and 5 criteria on the qualitative checklist, or between 11 and 14 criteria on the quantitative checklist; 'moderate-to-high' quality (**score 2**) if they met 6 out of 9 criteria on the qualitative checklist, or between 15 and 19 criteria on the quantitative checklist, and 'high' quality (**score 3**) if they met 7 to 9 of criteria on the qualitative checklist, or between 20 and 23 criteria on the quantitative checklist.