Daydream

One day
People will touch and talk
Perhaps easily
And loving be natural as breathing and warm as sunlight
And people will untie themselves
As string is unknotted
Unfold and yawn and stretch and spread their fingers
Unfurl
Uncurl like seaweed returned to the sea
And work will be simple and swift
As a seagull settling
And the clocks will stop
And no one will wonder or care or notice
And people will smile without reason
Even in winter
Even in the rain

(A.S. J. Tessimond)

Rising to the Challenge:
Towards enhancing the wellbeing
of an urban community in New Zealand

by
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ABSTRACT

This thesis is about improving the mental health, wellbeing and quality of life of the people of an urban, diverse and disadvantaged community in Auckland, New Zealand. It was an attempt to facilitate greater connectedness and solidarity within that community so that they would be empowered to act together to achieve common goals.

The theoretical aspect of this study was motivated by the aspirational philosophy, principles and values articulated in the population mental health promotion (PMHP) paradigm. PMHP advocates trusting the innate resourcefulness of people to create supportive environments where individual and collective resilience may be realised.

The practice aspect of this study involved using a people-centred planning and evaluating procedural framework, the PEOPLE System, to establish and begin to evaluate a community-controlled community development project with the aim of enhancing the mental health and wellbeing of the whole community. This was done initially with a number of small Asian groups and later was extended to encompass the whole community. A central part of this second stage was a random household survey, to enable the people to identify their collective goals and priorities and to initiate actions to attain them.

The results indicate that the PMHP theoretical paradigm is a very workable one and that the PEOPLE System provides an effective practical guide within this paradigm. This particular combination of theory and practice is proposed as constituting a new approach, named the PMHP Model.

This thesis makes a unique contribution to existing knowledge by showing that the PMHP Model can be applied to a whole urban community and appears to be a highly promising approach to the enhancement of the mental health and wellbeing of that population. Because of the scale of the project, and the limited time frame of this study, it was not possible to apply the whole of the PEOPLE System; so any conclusions are tentative; however, the indications are that it is an approach that can meet the overall PMHP aims and can potentially be applied in many other communities in New Zealand and perhaps the world.

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Ehara taku toa,

he taki tahi,

he toa taki tini!

My strength is not mine alone,

but that of my whole community!

(Traditional indigenous New Zealand Maori proverb)

Thanks to these others who have kept me encouraged and strong:

- people and colleagues of the Glen Innes (GI) community
- staff, volunteers and board members of Ka Mau Te Wero Charitable Trust
- thesis supervisors (2002 – 2010):
    - John Raeburn; Samson Tse; David Thomas; Janine Wiles and Elsie Ho
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    - Christine; Gabrielle; Iutita; Jenny, Jo, Kathy and Tara
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    - Mum; Maria; Rose; Aggie; Michael; Julie; Bernie; Joey; Jeffrey and Dad
- current family members who kept the home fires burning:
    - Jack; Jason; Sarah and Bennett.... “Honeys, I’m home!!!”

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GLOSSARY OF ACRONYMS

AR	Action Research
CAR	Community Action Research
CBPR	Community - Based Participatory Research
CCB	Community Capacity Building
CD	Community Development
CDHP	Community Development Health Promotion
CYFS	Child, Youth and Family Services
EYN	Eastside Youth Network
GI	Glen Innes
GIDAG	Glen Innes Drug and Alcohol Working Group
GIRHS	Glen Innes Random Household Survey
IUHPE	International Union for Health Promotion and Education
KMTW	Ka Mau Te Wero
LFPR	Labour Force Participation Rates
MELAA	Middle Eastern, Latin American and African
MHP	Mental Health Promotion
MOH	Ministry of Health
PAR	Participatory Action Research
PEOPLE	Planning and Evaluation of People-Led Endeavours
PHM	People's Health Movement
PMHP	Population Mental Health Promotion
SCAF	Stronger Communities Action Fund
WHO	World Health Organisation
WROC	Wellbeing Resourcing of Communities

1 INTRODUCTION

Hutia te rito o te harakeke,
Kei hea te komako e ko?
Rere ki uta, rere ki tai.
Ki mai koe ki au:
He aha te mea nui o te Ao?
Maku e ki:
He tangata! He tangata! He tangata!

If the heart of the harakeke is removed,
Where will the bellbird sing?
You fly inland, you fly out to sea.
You ask me:
What is the most important thing in the world?
I would say:
It is people! It is people! It is people!

(Traditional indigenous New Zealand Maori proverb)

This research study is motivated by one main question: What are some ways of working with people of a disadvantaged urban community that will help facilitate their wellbeing?

The overall aim of the research described in this thesis is to apply the principles and values of the new Population Mental Health Promotion (PMHP) paradigm to a community development (CD) project, with the goal of improving the mental health, wellbeing and quality of life of that community's residents. To do this, a broadly participatory action research approach was taken with the 12,000 people of Glen Innes, a disadvantaged and diverse urban community in the city of Auckland, New Zealand.

A second research aim was to discover and document the potential for an ethical community-campus partnership that is empowering, people-centred and reciprocally beneficial. This arose from the fact that the community of interest here was that in which the researcher's campus was located (the Tamaki campus of the University of Auckland), and as purportedly the most powerful learning institution in the country, the nature of its relationship with that community is an important issue. Here, the aim was to develop a mutually beneficial partnership around the concept of community development, which could be seen as a model for other New Zealand universities. This issue was especially acute because the researcher had not been invited by the community to do this project; so there was a risk of its being perceived by the community as an unwelcome intrusion.

The third main aim of this study was to see if what was done in Glen Innes could be used as a demonstration project for this kind of PMHP approach, with a view to ultimately using this approach in communities around New Zealand. This was done on the basis that there is a perceived demand for wellbeing-enhancing strategies in New Zealand (MOH, 2002), and a community approach suggests itself as an optimal one. As yet, no easily disseminated, replicable approach for doing this has been developed in this country or, for that matter, internationally. As will be seen later, the opportunity to apply this approach on a wider scale arose during a later phase of this research, so this possibility has now become a reality.

In this chapter, some broad background considerations about the theory and practice of this study are covered. First, the broad field of community development is introduced, since this research takes a community development approach. Then, the concept of Population Mental Health Promotion (PMHP) is introduced as the "new" area of academic and practice interest in which this thesis is embedded. This is followed by a discussion of the PEOPLE System, a New Zealand procedural model for health-related community development projects widely used in this country which seems to fit well with the aims of PMHP. Next comes the introduction of the model to be tested in this thesis; called the PMHP Model, it is a marriage of PMHP principles with the praxis approach of the PEOPLE System and would seem to offer an optimal way of conceptualising and operationalizing the project under consideration here. Then, there is summary of the overall aims and objectives of the research. The rest of the chapter is taken up with a brief description of the background and history of the project itself, followed by a more detailed description of the community of Glen Innes, the location for this research. Finally, the structure of the rest of the thesis is outlined.

Community development

The project described in this research comes broadly under the category of “evaluated community development”. Although CD applied to a health context has been used to some extent internationally (Raeburn, Akerman, Chuengsatiansup, Mejia, & Oladepo, 2007), this study has a number of distinctive features. First, it is driven by the philosophy of PMHP, a 2005 paradigm advocating for trusting in the innate resourcefulness of people to remain resilient when they are in supportive environments. Second, although CD in the health area has been used since the 1930s, there are relatively few properly evaluated studies (Raeburn & Corbett, 2001). The number becomes even smaller when searching for those studies where the essential requirements of a PMHP approach are met. Here, the two most important requirements are that the CD processes were empowering and community-controlled. Third, the fact that the focus is on mental health, and on the wellbeing and quality of life of a whole community, is also relatively unusual, since most CD studies in the health area take a physical health focus. Although there are some community studies in the mental health promotion area (Helen Herrman, Shekhar Saxena, & Moodie, 2005), none adequately meet the criteria for being both empowering and community controlled, and few meet the criterion of being properly evaluated. Fourth, the study uses a procedural model developed and used widely in community health promotion projects in New Zealand, including being used with and by a variety of cultural groups; so it is an approach developed in the context in which it was applied. This procedural model, called the PEOPLE System (Raeburn, 1992), will be described more fully later. Finally, and perhaps most importantly, while it has been used many times in New Zealand ('Ofanoa, 2009; Raeburn & Rootman, 1998) its usage in the context of a whole urban, culturally mixed and disadvantaged community like Glen Innes is unique and is its most ambitious application to date.

Population Mental Health Promotion

PMHP has grown out of another relatively new discipline, that of Mental Health Promotion (MHP). This became visible in the academic area in the mid-1990s and was an attempt to adapt the principles of health promotion, especially as enunciated by the 1986 Ottawa Charter for Health Promotion (WHO, 1986), to the mental health area. Mental Health Promotion emerged as an international phenomenon in 1996, at a workshop on mental health promotion organised by the Centre for Health Promotion of the University of Toronto and the Mental Health Promotion Unit of Health Canada. Here, mental health was defined as “the capacity of each and all of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face” (Joubert and Raeburn, 1998, p16); mental health promotion was defined as “the process of enhancing the capacity of individuals and

communities to take control over their own lives and improve their mental health" (Joubert and Raeburn, 1998, p16).

This view of mental health and MHP frames mental health not merely as the absence of illness (Vaillant, 2003), but also as a positive sense of emotional and spiritual wellbeing that respects the importance of "culture, equity, social justice, interconnections and personal dignity" (N Joubert & Raeburn, 1998). In addition to reclaiming mental health as a term applicable to wellness (rather than mental illness), the authors' view was predicated upon the conviction that all individuals and communities inherently have the capacities, competencies and wisdom to deal with life's challenges and that these capacities allow for the ability of people and communities to "move away from pathologizing, victimization, and dependency on government and professions, and to establish a partnership that will allow for full recognition of their contribution and participation in all health and mental health activities" (Joubert and Raeburn, 1998, p15). It is this kind of philosophy that underpins the concept of PMHP.

PMHP was born a decade later when Lahtinen, Joubert, Raeburn and Jenkins wrote a chapter in a WHO book on MHP titled *Population Mental Health Promotion* (Helen Herrman, et al., 2005). In this, they asserted that MHP should be primarily concerned with *populations* as opposed to the usual health sector focus on individuals (Lahtinen, Joubert, Raeburn, & Jenkins, 2005). Here, populations were seen as being at three broad levels, labelled "macro" (whole populations, societal), "meso" (communities) and "micro" (smaller groupings, families).

However, the term "population mental health promotion" (PMHP) was not just limited to the size of the groups who were to benefit from it. It also was predicated on a very clear set of values and principles. These were described in general terms as being especially to do with "fostering the development of individual and community mental health, resourcefulness and capacity for well-being; and creating supportive or resourcing environments or life settings" (Joubert, 2009, p7). The following diagram shows the PMHP paradigm with its equation of its approach with the dual strategies of developing resourcefulness in individuals and creating resourcing and supportive environments.

Figure 1.1: Population Mental Health Promotion paradigm

Although PMHP may be conducted at macro, meso and micro levels, Lahtinen and colleagues (2005) argued that it is especially at the meso or community level that the most effective mental health promoting outcomes will be achieved. This is because community settings offer the most immediate and human scale environments for people's lived experiences. This pivotal level of engagement for PMHP "involves both policy and people components, equally and synergistically balanced" (Lahtinen *et al*., 2005, p.236). Macro policies or regulations impact on a daily basis on individuals and communities. At the same time, concerted actions by people in the community may be able to bring about changes in policies or regulations.

Community, therefore, is the particular focus of PMHP, with whole populations perceived as being comprised of multiple communities. In this context, "community" means the way the people describe how they see themselves, or are seen by others, as belonging together and as being connected by commonalities (Rubin, Rubin, & Doig, 2001). It follows, then, that communities are human groupings that make sense to their members, are naturally-occurring and contain the basic elements of social relationships and networks on which PMHP enterprises can build.

The whole domain of working with communities brings up the well-established principles and values associated with the ideals of CD and as represented by fields such as community psychology. The overriding principle of CD is that of empowerment, as articulated by writers such as Rappaport (Rappaport, 1981, 1992) and Minkler (Minkler & Wallerstein, 2005). Here, empowerment refers to "where the people are unambiguously in control and self-determining...fostered through developmental processes, which lead in turn to a direct experience of personal power by the people concerned" (Raeburn and Rootman 1998, p 78 – 79).

CD is essentially an empowering approach that seeks to build the capacity and social cohesiveness of communities to encourage collective action by the people to attain self-identified priorities and goals (Chile, 2007; Ife, 1999; Labonte, 2009). Although the community and its people are often seen as agents for social change in most CD undertakings, an equally important dimension to the CD approach is that of a well-connected community. Such a community can provide social support for its members and is therefore inherently a positive contributor to individual as well as collective mental health, wellbeing and quality of life. CD is a public good in and of itself (N Joubert & Raeburn, 1998; Lahtinen, et al., 2005; Minkler & Wallerstein, 2005).

The concepts of empowerment and community control on the one hand, and of social cohesion and social support on the other, represent the two quintessential features of PMHP. The former is to do with how people collectively cope with and manage their lives; the latter is to do with the power of a positive social context. Both dimensions are seen as contributing strongly to mental health and wellbeing and as the two equal "wings" of PMHP. There is good research support for such a way of looking at enhancing mental health and wellbeing. Health psychology research suggests that a psychological sense of control is possibility the single most important psychological ingredient for good health and wellbeing (Rappaport, 1981; Sarafino, 2006). Likewise, the concepts of "social cohesion", "social support" and "social capital" have decades of research behind them to show that they too are some of the most powerful ingredients for health and wellbeing (Eero Lahtinen, 2005; Herrman, 2001; Hughey, Peterson, Lowe, & Oprescu, 2008; Israel, Checkoway, Schulz, & Zimmerman, 1994). Both physical and mental health seem to benefit equally from these things.

PMHP, then, refers to promoting mental health and wellbeing by CD-type processes that foster a sense of control through community control and self-determined actions and by building networks and social support at the local level to enhance social health and wellbeing. Together, these elements are regarded as optimal for promoting a population's mental health, community by community.

The PEOPLE System

One of the practice models suited well to the aims of CD is the PEOPLE System (Raeburn, 1992). PEOPLE is an acronym for Planning and Evaluation Of People-Led Endeavours, and is based on a people-centred model of health promotion described by Raeburn and Rootman (1998) in a book of that name. The term "people-led" spells out the requirement for the community to be in control of their own CD projects. Empowerment is at the heart of this model, referring to the intention that not just the control but also the action part of community

projects should be undertaken by people and community groups themselves, in a participatory way. In such a context, the role of professionals is simply to enable and support these processes, not to control them or deliver them to the community.

In brief, the PEOPLE system, described more fully in Chapter 2, is a procedural model that guides the practitioner and community step by step as to the requirements of setting up and running successfully and sustainably, a community-controlled project. Initially, this process may require considerable input from a professional with expertise and experience in applying this approach; however, in time, the professional's role is "faded" (Raeburn, 1992), and the community itself can continue on its own (though still supported if they wish), using this powerful organizational approach to steer and govern their own community endeavours.

As will be relayed in more detail in Chapter Six later, PEOPLE Is also a mnemonic acronym reminding users of some of the System's guiding principles - People-centredness, Empowerment, Organisational and community development, Participation, Life quality and Evaluation (Raeburn & Rootman, 1998).
The following Figure 1.2 is a representation of the PEOPLE System steps.

Figure 1.2: The PEOPLE System steps

In some New Zealand community projects, this independent way of collective working together, based on the PEOPLE System approach, has survived and flourished for over two decades and even three decades for some projects (Raeburn, et al., 2007; Raeburn & Rootman, 1998). One of the major benefits of using this approach is that it has evaluation of both process and outcome types built into it, framed around the concept of goal-setting and goal attainment. It also uses other measures, in a cybernetic or self-correcting way. Thus, evaluation is an intrinsic part of PEOPLE System projects and is under the control of the

community itself, not researchers or professionals, in a way which is productive of sound and publishable research data (Raeburn & Rootman, 1998).

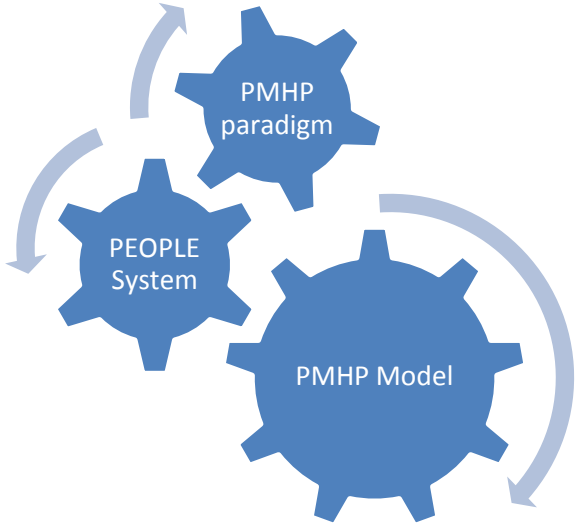
The PMHP Model

At the core of this thesis is a testing of what the researcher is calling "The PMHP Model". What this refers to is the combining of the PMHP philosophy and academic domain with a reflective practice guided by the PEOPLE System.

The researcher has long felt that the two elements are complementary, that is, both fit each other extremely well. In this thesis, they have been uniquely combined and have been brought to bear on an ambitious project – the raising of the mental health and wellbeing of a whole urban community, a community which because of its underprivileged status and cultural mix, is an especially challenging one. Given the time scale of the research and the complexity of the project, this study has not attempted to undertake a full "test" of the model, which would be likely to take several years to implement and evaluate fully. Rather, the aim was to take the PMHP model as far as it could go in the time available, to see whether it "worked", the latter being interpreted in a variety of ways.

The following Figure 1.3 shows the interrelatedness between the separate elements of the PMHP model. The philosophy underpinning the PMHP paradigm (represented by the top gear) helps turn the wheels of the PEOPLE System procedures (represented by the gear to the bottom left of the first), and together, the two theoretical and practice gears together effects the larger gear representing the PMHP Model.

Figure 1.3: PMHP Model used for the Glen Innes CD Project



One of the ways was to see whether it actually performed as expected and to what extent it seemed to be applicable in this context. Another was whether it led to actions that appeared to be fostering the overall long term goals of the project – that of enhancing mental health, wellbeing and quality of life of the whole community. The third test of the model's workability was whether the cherished values of PMHP, those of community control, empowerment and social support, were being achieved in a tangible and demonstrable way. In short, although this one study does not permit final conclusions about the whole approach and ultimate merits of the PMHP Model, it hopefully provides some strong information about process to indicate clearly whether this seems to be a good way of proceeding with such projects or not.

The research questions and contributions to knowledge

As stated at the outset of this chapter, the original research question driving this research study was: what are some ways of working with people of a disadvantaged community that will help facilitate their wellbeing?" Given that the main ways being tested here are based on the PMHP model, this question really became: did the PMHP Model work in this context? This in turn translates into the following issues: did the Model lead to actions that helped to enhance the mental health, wellbeing and quality of life for people in the Glen Innes community? Did it lead to a workable and sustainable organizational approach? Were the PMHP values of overall community control, empowerment and social support able to be achieved in visible ways?

In addition, my interest was to find out if the noble-sounding concepts of the PMHP paradigm could actually be translated into practical and successful ways of working and engaging with people that lived up to their rhetorical promise. Further, I wanted to see if the ways of working based on this model enabled the researcher to adopt a facilitative and supportive partnering role with the community, rather than a "top down" one, an approach that implicitly trusts the people as best judges of what works for them in their contexts. That is, did this approach lend itself to the professional taking a facilitating and supportive role, rather than a directive one?
I also wanted to look at the question of how a project of this nature could aid in the partnering of the university with the community. Although this was of lesser interest than the other questions, it remained as an evolving issue throughout the research.

Finally, I wanted to be able to assess whether this approach was transferrable to other communities, which in a sense was a test of the generalizability of the model.

Aims and objectives of the research

In summary, the overarching aim of this study is to initiate a researched community development project evaluating what seemed on the surface to be a good way of enhancing the mental health, wellbeing and quality of life of the community of Glen Innes – that is, the PMHP Model – to determine whether it appears to fulfill its promise: whether it is at least initially effective and sustainable and whether the experience in Glen Innes suggests that it seems like an approach applicable to other settings.

More specifically, the objectives of this study are:

1. To determine if the PMHP Model (which combines PMHP values and principles with the operational approach of the PEOPLE System) is applicable in the Glen Innes community, with the long term aim of enhancing the mental health, wellbeing and quality of life that whole community
2. To use information from this process to critically assess the merits and limitations of this model in the Glen Innes setting
3. To determine whether this project aids the development of a positive relationship and partnership between the Glen Innes local community and the university campus; and
4. To draw conclusions about the more general applicability of the PMHP Model, including its shortcomings, and see to what extent this research can add to the theory and practice of PMHP in a New Zealand context, with a view to potentially extending its application throughout New Zealand.

Initial comments on the history of this study

The study began in 2002. Initially, my intention was to engage a small number of Asian community groups in Glen Innes to undertake mental health promotion action projects using the PEOPLE system; six of these action projects were carried out between June 2002 and June 2004. As the research proceeded, I became increasingly involved in the wider Glen Innes community and, in July 2004, I was offered employment as the manager of a local CD project, Ka Mau Te Wero.

In the first stage of the research (Asian groups), the PMHP Model was applied mainly in the relatively limited context of these groups, although the intention had been to build these groups into a network and gradually to expand the purview of this approach into the wider community. The shift of the researcher's focus to the whole community meant that the Model could now be applied on a much wider scale.

In practice, this meant that where the PEOPLE System had been applied within small groups, to facilitate the steps required to set up and run an effective group, it could now be applied to the planning and implementation of the whole community Project. This meant in effect that the PEOPLE System would be used at two levels – one within the smaller group context (and most project activities take place through the operation of small to medium sized groups) and the other at the level of the overall Ka Mau Te Wero Project. The Project was an amalgam of all the smaller action projects, plus the overall governance and organizational structures and processes required to operate a whole community project of this scale. As will be seen in what follows, this two-tier application of the PEOPLE System was retained throughout; so part of the research is to ascertain the extent to which it works at both these levels.

The first step of the PEOPLE System involved a multiplicity of discussions and actions, required to get community consensus around the PMHP values and principles, and creating the organizational infrastructure to get the Project operational. The second step involved a formal needs/wishes assessment process. Once the research project was extended to involving the whole community, the major initial undertaking was moving to this second step, which involved undertaking a community-wide random household survey to identify community needs and priorities. This happened in 2005.

This survey represents a major component of the research presented in this thesis and is the framework around which the whole future Ka Mau Te Wero Project is built. After the survey in 2005, most of the work of the Project involved processing the information and participating in a community process of coming up with action goals, the third step required by the PEOPLE System. This coincided with setting up a more formal governance and resource base for the Project (Step 4) and led to the beginning of action on the goals ascertained from the survey. It was this action group work (Step 5) that occupied the remainder of the work, right up to the conclusion in 2009 of the research reported here; part of this was to set up the review and evaluative systems, which represent the final two steps of the PEOPLE System.

This thesis reports on these various stages, each of which has its own evaluative component, which in turn feed into the overall assessment made to draw conclusions about the efficacy of this approach.

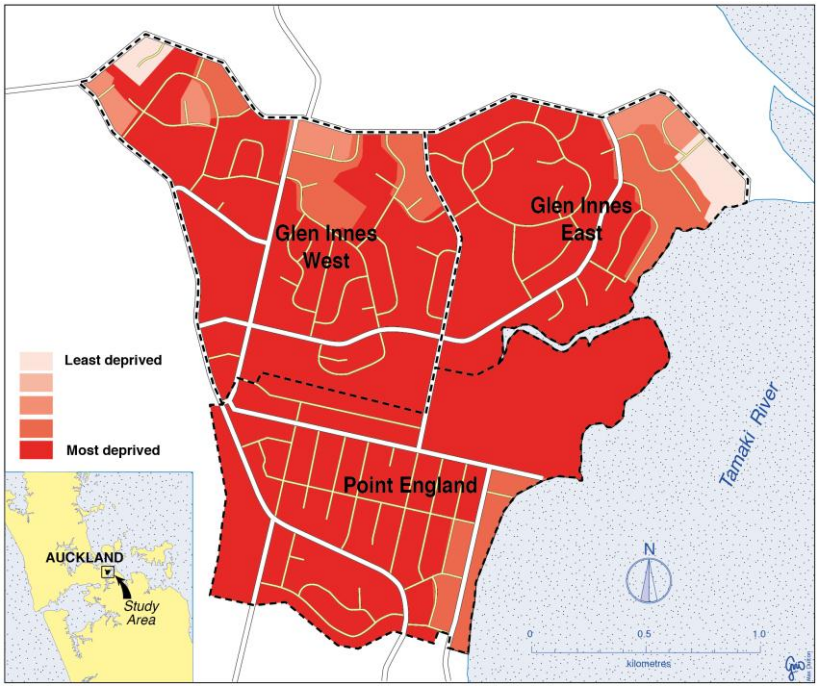
The community of interest: Glen Innes

At the heart of this research is the community of Glen Innes. This section gives an introduction to the nature of this community. It is a suburb of Auckland, New Zealand's largest city. For the purposes of this research, Glen Innes is made up of three census areas: Glen Innes West, Glen Innes East and Point England (see Figure 1.1). Located approximately nine kilometres to the east of the city centre, the area is ethnically, linguistically and culturally diverse.

Glen Innes developed in the 1950s as a state housing area and was one of the first comprehensively planned town centres in Auckland. The population of the area increased during this time as a result of the post-war baby boom, the migration of Maori to Auckland, and the influence of local planning policies. During the 1950s and 1960s, the New Zealand government tried to reduce the cost of state housing and started to build more multi-unit dwellings using cheaper materials. Recently, in an effort to improve housing, and as part of the area's community renewal initiative, these buildings were demolished and replaced with mostly apartment style dwellings. Presently, state housing makes up approximately 60 - 70 percent of housing in Glen Innes (Auckland City, 2004).

The deprivation index in 2006 (NZDep2006) indicates that the majority of households in this area are among the most deprived in New Zealand (White, Gunston, Salmond, Atkinson, & Crampton, 2008), as shown in the following Figure 1.4.

Figure 1.4 Glen Innes, including deprivation levels, 2006

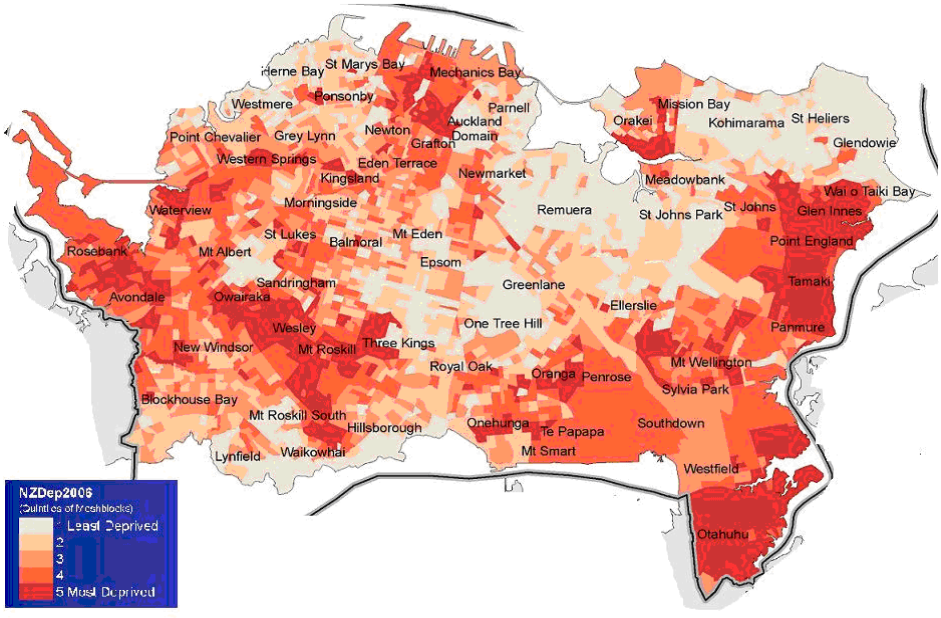


The NZDep2006 is a small census area-based index of deprivation derived from eight variables from the 2006 census. These include, in decreasing importance: income, home ownership, support (single-parent families), employment status, qualifications, living space, communication (access to a telephone) and transport (access to a car). Small area scores are usually grouped into deciles or quintiles (quintile 1 = least deprived; quintile 5 = most deprived).

At the time of the 2006 census, the population of usual residents in Glen Innes was 11,727, accounting for 0.90 percent of Auckland's population. Using the specific indicators for measuring deprivation in the population as mentioned earlier, Glen Innes is not only of interest to the government because of its real deprivation levels, it is of huge concern also because of its relative deprivation levels. Glen Innes is surrounded by communities that are far less deprived. The gradient of deprivation for Glen Innes is among the steepest experienced in the country.

In fact, these iniquitous ways of how Glen Innes is portrayed in national statistics and the media are contributors to the scepticism and suspicion often expressed by people living and working there towards external stakeholders e.g. government agencies, researchers. Glen Innes people share their annoyance about how "outsiders see what we don't have and have no interest at all in what we do have" (Liew, 2002 - 2010) The following figure might serve to give an added context for where Glen Innes situates in relation to the rest of Auckland City, in terms of the 2006 deprivation levels.

Figure 1.5: Auckland City, including 2006 deprivation levels and Glen Innes



Glen Innes is characterised by ethnic and cultural diversity. Nearly half the population in 2006 were made up of Pacific Peoples (46.0 percent), while 29.4 percent were New Zealand European and 21.0 percent were of Maori descent. A further 8.4 percent were Asian, 0.9 percent of Middle Eastern, Latin American and African ethnicity and approximately 4 percent of other ethnicities (Table 1.1). In line with previous censuses, people could identify with more than one ethnicity; therefore, these percentages add up to over 100 percent. It should also be noted that in 2006 the category "New Zealander" was created, and these responses were reported in the New Zealand European count.

Table 1.1: Selected characteristics of Glen Innes and New Zealand, 2006

	Glen Innes		*New Zealand Total*	
	Number	Percent	Number	Percent
Total population	11,727	100	4,027,947	100
Gender				
Male	5,727	48.8	1,965,618	48.8
Female	6,000	51.2	2,062,329	51.2
Ethnic group				
NZ European	3,444	29.4	2,609,592	64.8
Maori	2,457	21.0	565,326	14.0
Pacific Peoples	5,394	46.0	265,974	6.6
Asian	981	8.4	354,552	8.8
Middle Eastern, Latin American & African (MELAA)	111	0.9	34,743	0.9
Other	420	3.6	430,881	10.7
Age group				
Under 15	3,447	29.4	867,573	21.5
15-29	2,718	23.2	813,615	20.2
30-64	4,602	39.2	1,851,150	46.0
65+	960	8.2	495,609	12.3
Country of birth				
NZ-born	7,851	66.9	3,148,404	78.2
Overseas-born	3,567	30.4	841,365	20.9
Not elsewhere included	309	2.6	38,178	0.9
Years in NZ (for people born overseas)				
0-9	1,668	46.8	414,345	49.2
10-19	846	23.7	149,727	17.8
20+	1,053	29.5	277,293	33.0

	Glen Innes		*New Zealand Total*	
	Number	Percent	Number	Percent
Language				
No language	252	2.1	75,195	1.9
Maori, English and/or NZ Sign Language	9,831	83.8	3,684,861	91.5
Other languages only	663	5.7	70,701	1.8
Not stated	981	8.4	197,190	4.9
Religion				
No religion	2,187	18.6	1,297,104	32.2
Buddhist	237	2.0	52,362	1.3
Christian	6,753	57.6	2,027,418	50.3
Hindu	60	0.5	64,392	1.6
Islam/Muslim	195	1.7	36,072	0.9
Judaism/Jewish	24	0.2	6,858	0.2
Maori Christian	429	3.7	65,550	1.6
Other / Not elsewhere included	1,842	15.7	478,191	11.9

(NZ Statistics, 2006 Census data from www.stats.govt.nz)

Table 1.1 above gives an overview of selected characteristics of the Glen Innes community from the 2006 census and provides a comparison with the total population of New Zealand.

When compared to the total population in New Zealand, these statistics are quite striking. Pacific Peoples made up 46 percent of the Glen Innes population compared to only 14.4 percent in the wider Auckland area and 6.6 percent of New Zealand's total population in 2006. Conversely, less than one-third of the Glen Innes population were of European descent compared to over half in Auckland and nearly two-thirds of the New Zealand population (Table 1.1). Glen Innes also had a higher proportion of Maori (21 percent) when compared to both Auckland (11.1 percent) and New Zealand (14.0 percent).

A breakdown of ethnicity statistics shows that the majority of Pacific peoples in Glen Innes were Samoan, Tongan or of Cook Island Maori descent, while those from Asia were mostly Chinese. As a whole, the population is young, with over half (52.6 percent) aged under 30 years in 2006. Another 39.2 percent were aged between 30 and 64, and 8.2 percent were aged 65 and over. This is compared to New Zealand as a whole where 41.7 percent of the population were less than 30, nearly half were aged between 30 and 64 years (46 percent), and 2.3 percent were aged over 64 years (Table 1.1).

Across ethnicities, Maori and Pacific Peoples living in Glen Innes in 2006 were younger than European and Asian residents. Conversely, European and Asian residents of Glen Innes were significantly older than the Maori and Pacific residents, with 13.4 percent of European people aged 65 and over, and 11.3 percent of Asian people in this older age bracket. In terms of gender, 48.8 percent of the population of Glen Innes in 2006 were male and 51.2 percent were female (Table 1.1); this parallels the overall New Zealand male-female ratio.

Table 1.1 also shows that the suburb of Glen Innes is a mixture of both New Zealand-born residents and those who were born overseas. Two-thirds (66.9 percent) of the population in 2006 were born in New Zealand. This is compared with 78.2 percent of New Zealand-born in the total population. Not surprisingly, the majority of European and Maori residents were born in New Zealand, while just over half of Pacific Peoples were born here. Only one in five Asian residents in Glen Innes was born in New Zealand. These Asian migrants were more recent arrivals than those from the Pacific Islands, with 61.5 percent entering into New Zealand less than ten years ago.

Reflecting its ethnic diversity, Glen Innes is a multi-lingual community. Many of its residents speak more than one language. Some (5.6 percent) speak neither English nor Maori (nor New Zealand sign language), in comparison to 1.8 percent of the New Zealand population (Table 1.1). Within the community, Asian people are the most likely to speak only in their native language (26.8 percent). In the Pacific community, this figure stood at 6.8 percent. Many of the people who do not speak English are older and thus less likely to learn the language. Research has shown that lack of English proficiency can lead to isolation and loneliness among migrants, which in turn can lead to depression and mental health issues (Ho, Au, Bedford and Cooper, 2002).

In addition to ethnic diversity, a variety of religious beliefs are held by Glen Innes residents. Indeed, it is a community in which faith plays a major role in people's lives. Only 18.6 percent of the population in 2006 stated that they did not hold any religious beliefs (Table 1.1). This is compared with 32.2 percent of the New Zealand population as a whole. Over half (57.6 percent) of Glen Innes population was Christian; however, for Pacific peoples this percentage was much higher (78.2 percent). Other religions included Maori Christian, Buddhism, Muslim and Hinduism.

The labour force participation rates (LFPR) and unemployment rates of residents living in Glen Innes and in New Zealand in 2006 are shown in Table 1.2. Overall, Glen Innes residents had lower labour force participation rates, and higher unemployment rates, than the

total population in New Zealand. In 2006, LFPR for Glen Innes stood at 54.4 percent, while the Auckland LFPR was 68.6 percent (Auckland Regional Council, 2007) and the New Zealand LFPR was 66.2 percent. Across ethnic groups, Asian residents had the lowest labour force participation rates (42.9 percent), followed by the Middle Eastern, Latin American and African (MELAA) residents (53.6 percent).

Table 1.2: Labour force participation rates, unemployment rates, income levels and sources of income, for people aged 15 years or over, living in GI and NZ, 2006 (percentage not shown if number is under 30)

	Glen Innes	New Zealand Total
	Percent	Percent
Labour force participation		
NZ European	62.3	68.7
Maori	59.2	69.3
Pacific Peoples	55.4	65.0
Asian	42.9	62.2
MELAA	53.6	62.4
Other	76.6	77.3
Total	54.4	66.2
Unemployment		
NZ European	7.0	4.0
Maori	15.5	11.0
Pacific Peoples	13.1	10.7
Asian	…	8.5
MELAA	…	11.4
Other	…	2.7
Total	10.4	5.1
Income		
Less than $5,000	15.0	12.1
$5,001-$10,000	10.4	7.2
$10,001-$20,000	18.3	19.5
$20,001-$30,000	12.3	13.8
$30,001-$50,000	15.9	21.1
$50,000+	7.6	16.2
Not stated	20.4	10.2

	Glen Innes	New Zealand Total
	Percent	Percent
Sources of income		
No source	8.8	5.6
Wages, salaries etc	45.0	56.2
Self-employed	6.0	15.6
Interest, dividends etc	7.1	22.6
NZ Super or Veterans Pension	8.0	13.9
Unemployment benefit	7.4	2.9
Sickness benefit	5.5	2.2
Domestic purposes benefit	6.4	2.9
Student allowance	2.8	2.0

(NZ Statistics, 2006 Census data from www.stats.govt.nz)

With regard to sources of income, 45 percent of people residing in Glen Innes in 2006 gained their income through wages or salary, which was lower than the national percentage of 56.2 percent (Table 1.2). Compared to the total population in New Zealand, the proportion of people who were on unemployment, sickness and domestic purpose benefits were significantly higher (19.3 percent compared to 8 percent).

As can be seen from the above socio-demographic statistics, Glen Innes is a multi-ethnic and multi-cultural community, made up of large proportions of relatively young, Pacific and Maori people, who generally live in below average housing and survive on very small incomes. Mental health risk factors include youth unemployment, crime, drug and alcohol abuse and health disparities. Despite these issues, opportunities exist for fostering community resourcefulness and empowering people to make positive changes for themselves and their families.

Structure of the thesis

The remainder of the thesis is organized in six chapters. Chapter 2 provides a review of the literature on PMHP and CD, from which the theoretical framework of this study has been developed. Chapter 3 describes the research methodology used to conduct the Asian community action project groups, the community random household survey, the Glen Innes community development action projects and how these relate to the wider whole community CD Project. The development, progress and outcomes of the three phases of the study are

presented in Chapters 4 to 6; the factors that contributed to, or constrained, the planning, implementation and evaluation of the community mental health promotion sub-projects in each phase are also reviewed and discussed. Finally, Chapter 7 considers the theoretical, methodological and practical implications of the study, including future directions for PMHP and suggestions for future research.

2 LITERATURE REVIEW

Naku te rourou, nau te rourou
ka ora ai te iwi.
With your food basket and my food basket
the people will thrive.
(Traditional indigenous New Zealand Maori proverb)

This chapter provides an overview of the main literature on health promotion, mental health promotion and community development to establish the theoretical context for this research. I will trace the development of the "new public health" movement of the late 1970s which aimed to improve the health of people by addressing determinants of health outside the health care system, rather than focusing on the diagnosis, treatment and cure of diseases of individuals as in traditional biomedical approaches. I will also consider how the World Health Organization (WHO) built upon the public health approach to promote an inclusive definition of health and formulated strategies to protect and promote Health for All that call for multi-sectoral actions and collaboration. This part of the literature review seeks to position population mental health promotion within the broader context of health promotion and public health. The second part of the chapter introduces the population mental health promotion paradigm and the community development approach and considers the key principles and values for promoting the mental health of communities and populations.

Evolving concepts and practices of public health

Health is a concept that is understood differently by people over time (Baum, 1998; Tones & Tilford, 2001). While it has been used in a positive manner, as when describing a state of personal wellness or capacity to cope with difficult health conditions, it has been used more often in a negative manner by focusing on its absence during experiences of illness or disease (Naidoo & Wills, 2000).

Traditionally, the biomedical model was the most dominant and influential paradigm for shaping our understanding of health. The biomedical model places an emphasis on diagnosing and treating the body when it succumbs to physiological dysfunction, viral

infections, genetic abnormalities or injuries (Lupton, 1995; Naidoo & Wills, 2000). It assumes that diseases, when properly understood and diagnosed, can be treated and cured (Senior and Viveash, 1998); therefore, health has been about understanding and managing human pathology and ways of administering the proper therapy and cure to restore the body and its various parts to a more manageable state of being disease-free (Seedhouse, 1986). Following on from that position, public health has been about preventing the spread of diseases in the general population.

The success of the biomedical model of health, with its focus on human pathology and the ensuing medicalisation of health, renders people as relatively passive and helpless victims of invading pathogens and unsanitary living circumstances. Although few would argue about the importance of these factors, others point to the limitations of this simplistic cause-effect model (Armstrong, 1987) and propose that psychological and social factors also play a significant role in the context of disease or illness (Good, 1994; Mishler, 1981; Werner and Malterud, 2003).

A biopsychosocial model has been proposed as a more holistic approach to health, one which takes into account a combination of biological, psychological and social factors rather than purely biological factors (Engel, 1977). Here, the medical experts adopt a more compassionate and empathic interest in patients and their living circumstances, mediating the traditionally mechanistic stance of applying diagnosis and treatment regime to the symptoms of the condition (Borrell-Carrio, Suchman, & Epstein, 2004). Critics of this approach assert that it is still essentially subscribing to the traditional biomedical model (Armstrong, 1987). Up until the 1960s this narrow focus on the physical, chemical and biological environment constituted the primary aim for public health.

The move towards a "new public health"

In the 1970s, the dominance of medical-based public health models was challenged by a growing dissatisfaction with the mismatch between public health expenditure and public health outcomes, health inequalities found in different parts of the world's populations, and the advent of chronic diseases such as HIV and AIDS in Africa. A new approach to public health was needed to redress the limitations of pathologizing health and to help increase our understanding of other health determinants found in human behaviour, sociology, politics, economics and environments (Allegrante & Green, 1981; Brown & Margo, 1978; Freudenberg, 1984). Although the impact of these other determinants of health has been noted and traced back to intellectual writings from ancient Chinese, Babylonian, Hebrew and Greek civilizations (Green and Ottison, 1999), no major alternative to the biomedical

model of public health emerged until the mid-1970s when the Lalonde Report was published in Canada.

Marc Lalonde was the Canadian Minister of National Health and Welfare when he proposed that public health interventions should focus on addressing risk factors and determinants of health outside of the health care system (Lalonde, 1974). The Lalonde Report was built upon the earlier "health field" concept (Laframboise, 1973) and emphasized that personal lifestyle choices are partly responsible for the state of personal and public health; therefore, in order to improve their own health and the health of the public, people need to be educated and encouraged to make healthier choices in their lives (Lalonde, 1974).

The causes of disease and illness were no longer thought to be solely about genetics, germs, chemicals and accidents, but also about how people's behaviours can impact on their health. For example, people can enjoy better health if they undertake genetic counselling and screening, improve personal hygiene routines, avoid smoking and drugs, eat less fats and sugar, and get more physically active and fit. In a departure from the traditional doctor-as-scientist and person-as-patient model of public health, this approach highlights the importance of people as active decision-makers and architects of their own health.

What this approach didn't recognise is that an individual's health is not only influenced by their own lifestyle choices. There are many other key determinants of health that are not necessarily a matter of choice. For example, people cannot always choose to buy healthier fresh food that is free of chemical additives, sugar and fats, especially when healthier food costs much more than unhealthier bulk-produced items. Economics often dictate food choices. People cannot always choose the quality of air they breathe and the water they drink. Inequalities in health are related to a wide range of factors, not all of which (such as the characteristics of the physical environment) are factors that people have direct control over.

Although the personal lifestyle model of public health contributes to health education and the social marketing of healthier choices that can improve public health, it retains the limitations of the biomedical models by focusing on *individual* risk factors and individual's responsibility to take control over their health decisions and outcomes. The model is criticised for "blaming the victim" for choosing unhealthy lifestyle choices and for not really

addressing the wider economic, social and environmental determinants of health which require public health intervention from governments.

The importance of government and other societal actions to improve the health of populations was flagged at the World Health Assembly held in 1978. The Alma Ata Declaration on Primary Health Care called for urgent national and international actions to develop and implement primary health care throughout the world (WHO & UNICEF, 1978). As a result, public health is no longer just the business of doctors or health services or the lifestyle choices of people who are ill: it is everybody's business. The primary health care approach has since been accepted by member countries of the WHO as the key to achieving the goal of Health for All (WHO, 1981).

Building on the progress achieved with the Alma Ata Declaration, Health for All targets, and the increasing urgency for intersectoral health actions, the First International Conference on Health Promotion held in Ottawa in 1986 created a blueprint to spell out the scope of a "new public health" approach. This blueprint gave a more encompassing and holistic definition of health and called for the involvement of all sectors to work together in achieving world health ambitions. The Ottawa Charter named health promotion as the "new public health" and defined it as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986, p1). This "new public health" model is driven by both social and political considerations. Health promotion represents an attempt not only to protect and promote health, but also to reduce health inequalities experienced by populations and to increase their ability to control their own quality of life (Beaglehole, Irwin, & Prentice, 2003b);WHO, 1998).

Health inequalities are outcomes of social inequalities that are, in turn, outcomes of various socio-ecological factors that directly affect the lives of people (Marmot & Wilkinson, 1999). Populations experiencing these inequalities are represented by the poor and the disadvantaged sections in all nations, and their alleviation would constitute both a humanitarian as well as economic good (WHO, 2001). If the factors leading to poor or improved health can be identified and reduced or strengthened accordingly, then people would be better able to choose, control and promote their own health and wellbeing, individually as well as collectively. Such undertakings to manipulate these health determinants would involve changing fundamental social and political infrastructures and would require the combined will and resources of intersectoral and international efforts (Beaglehole and Bonita, 2003).

The Ottawa Charter for Health Promotion

The Ottawa Charter for Health Promotion adopts a socio-ecological model of public health. The aim of the Ottawa Charter is to provide a mandated and more holistic vision for public health that is supported by clear definitions of key concepts, strategies and actions.

Firstly, it champions health as a state of positive wellbeing that is more than the result of either health care or personal lifestyle choices. Secondly, it enumerates the basic requisites for health as the conditions and resources which are to be found in human contexts and which are subject to socio-political influences such as appropriate access to food, shelter, peace and income. Thirdly, it describes three main strategies for influencing socio-ecological health determinants in populations. Fourthly, it actively pushes the agenda for meaningful partnerships and collaborations among health interests to deliver on public health principles and goals. Fifthly, and perhaps most memorably, it outlines five streams of action for conducting local and global health promotion (WHO, 1986a). Each of the key features of the Ottawa Charter of Health Promotion will be discussed in more detail below.

Health as a positive state

The Charter reiterates the original WHO definition of health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1946; 1982). Healthy populations comprise people or groups that are able to "identify and to realize aspiration, to satisfy needs, and to change or cope with the environment" (WHO 1986; p1). This positive and inclusive health definition frames health as an important resource for everyday living in the presence or absence of illness or disability.

Fundamental prerequisites and determinants of health

The Charter identifies a list of fundamental pre-requisites for health such as peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. By so doing, it emphasizes the interrelated roles and responsibilities that governments, systems, organizations, communities as well as individuals have in achieving ecologies that contain those conditions and resources for positive health. Decisions made by any or all of those sectors will have consequences for population health, whether directly or indirectly. In this manner, the Charter is characterized by its insistence on leadership and efforts across all sectors to offset the hegemony of the

medical experts working in their independent disease-prevention, treatment and cure silos (Beaglehole, et al., 2003b).

Health promotion strategies

Having situated the responsibility for the provision of the health prerequisites with coordinated intersectoral efforts, the Charter proposes three strategies to guide health promoting workers and agencies in their work to create the living conditions that would favour population health, namely that of advocacy, enabling and mediation.

Advocacy work by all health promoters would focus on making sure relevant sector decisions are considered and assessed for their possible impacts on political, economic, social, cultural, environmental, behavioural and biological prerequisites and determinants of population health (WHO, 1986a). The strategy of enabling people and groups to achieve their fullest health potential in equitable ways should include due vigilance that ensures the public's appropriate and equal access to information, life skills and opportunities. In particular, people and groups experiencing the greatest disadvantage may be better able to make informed life choices that will give them more control over their own health.

The Charter took pains to point to the vulnerability of women as one of those disadvantaged communities (WHO, 1986a). Mediation strategies would focus on practical ways to work with and balance the inevitable tensions arising from the inherent differences between the constituent groups, cultures and systems. Mediating these differences successfully would increase the chances for sustainable and meaningful health solutions that are tailored more specifically to local aspirations and concerns (WHO, 1986a).

Partnerships and collaborations for health promotion

Following on from the above discussion about health-promoting strategies, governments, nongovernmental and voluntary sectors, industry, media, health and civil society have to involve themselves more purposefully in public health activities alongside the participation of individuals, families and communities. The end goal of the Health for All vision can only be achieved when there are commensurate local, national, regional and international joint efforts. Achieving that end would require coordinated will and effort in the form of dedicated associations, partnerships and coalitions.

One example of such a dedicated association is the Health Promoting Schools joint project led by the European Commission, the Council for Europe and the WHO European

office in 1991. The project identified the importance of sector linkages between education and health and aimed to connect all related health promoting efforts in Europe so as to maximize the impact of those efforts in that region. European members were urged to make sure that all school settings inculcated the health-promoting values of democracy, equity, personal empowerment and capacity-building. They were also encouraged to ensure they fostered healthy school environments by providing for appropriate curricula, quality teacher training, effective ways of measuring success, meaningful cooperation across all sectors, engaging all stakeholders, and sustainability.

Both the method and goal for the Healthy Schools project are combined under the heading ”partnerships“ and would occur within and across all levels and settings for health promotion activities such as individual students and school staff, families and communities, cities, regions, and countries (WHO, 1991). WHO launched the Global School Health Initiative in 1995, and versions of the original European project can now be found in regions including the Eastern Mediterranean, South East Asia and the Pacific. The spirit of coordinated efforts is maintained through international meetings and databases to mobilize, monitor and strengthen activities at global, regional, national and local levels (WHO, 1997).

Five health promotion action streams

Perhaps the most memorable characteristic associated with the Ottawa Charter is its clear enunciation of five recommended action streams for achieving the Health for All aspiration. The Charter architects saw the required actions to promote health as including those undertaken to build healthy public policy, create supportive environments, strengthen community action, develop personal skills and capacities, and reorient health services (WHO, 1986). After the first international conference which drafted and signed off on the Ottawa Charter, subsequent world assemblies were convened to focus on each of the action streams in turn to further solidify conceptual understanding and appropriate actions for the member nations.

1. Build healthy public policy

   Building healthy public policy was discussed extensively at the Second International Conference on Health Promotion in Adelaide in 1988. Public policies in all sectors influence the determinants of health and are a major vehicle for actions to reduce social and economic inequities, for example, by ensuring equitable access to goods and services as well as health care. The Adelaide Recommendations on Healthy Public Policy called on policy makers working at

various levels (international, national, regional and local) to commit to both increasing health investments and to assessing the impact of their decisions on public health (WHO, 1988). Four priority areas for action were identified: supporting the health of women; improving food security, safety and nutrition; reducing tobacco and alcohol use; and creating supportive environments for health.

2. Create supportive environments

   One of the priority areas identified at the Second International Conference, creating supportive environments for health, became the focus of the Third International Conference on Health Promotion in Sundsvall, Sweden in 1991. Political conflict, rapid population growth, inadequate food, lack of means of self-determination and degradation of natural resources are among the ecological factors identified at the conference as being damaging to health. The Sundsvall Statement on Supportive Environments for Health emphasized the importance of sustainable development and urged social action at the community level, with people as the driving force of sustainable development (WHO, 1991). In the following year, 179 member nations at the Rio Earth Summit acted upon the Sundsvall advice which resulted in the genesis of Agenda 21, a United Nations' master plan for global transformation and creation of a sustainable planet for the twenty-first century (UNEP, 1992).

3. Strengthen community action

   The Fourth International Conference on Health Promotion held in Jakarta, Indonesia in 1998 undertook a review of the Ottawa Charter's impact on public health as well as the status of its objectives to addressing health inequities and improving life quality (WHO, 1998). That conference was the first of the four International Conferences on Health Promotion to be held in a developing nation. There was good evidence to show that the health promotion strategies advocated since 1986 did indeed contribute to preventing diseases and improving health in all participating countries; however, it was also clear that those strategies and practices needed to be more effectively communicated to communities in developing countries in order for health gaps and inequities in those nations to be reduced further.

   Strengthening community action may be achieved by adopting assets-based approaches to community development that would effectively utilize all existing

resources in communities to enable people to set their own priorities, make decisions and plan and carry out collective action. Such public participation and management of health-promoting activities would demand ongoing resourcing and flexible access so that people and communities can have the useful information and appropriate educational, training and funding opportunities needed to be able attain their health goals. Accordingly, this includes involving the private sector in the collective pursuit of population health, in recognition that it represents an increasingly visible and vital link in the public health equation (WHO, 1998).

4. Develop personal skills and capacities

   The Fifth Global Conference on Health Promotion in Mexico City looked more closely at inequalities within and between nations and explored how to translate health promotion “Ideas into Action” and to monitor local and global progress more closely (WHO, 2000). Attendant actions included ways to increase people’s capacities to exert more choice and control over their health and to live as well as possible with illness, disability and other negative circumstances. Processes which develop practical skills and capacities for health promotion, which encourage leadership for health, and which support the emergence of social entrepreneurs in communities were considered vital for the continued development and implementation of health promotion ideas and actions. At the conference, attention was also called to the role of the United Nations in the international health arena. Specifically, the UN was to review and monitor how its own developmental efforts in the various regions of the world must also include thorough assessment of their resultant effects on the health, wellbeing and quality of life of the people concerned.

5. Reorient health services

   The sixth International Conference on Health Promotion in 2005 provided an opportunity to address the issue of health promotion in a globalised world. The Bangkok Charter for Health Promotion in a Globalised World was drawn up at this conference (WHO, 2005). The conference concluded that, whilst important progress had been made, health promotion must take into account the implications for the world context generated by the effects of globalization. As such, health promotion should be an integral part of all health services (WHO, 2005). In addition, reorienting health services also requires strong attention to health research as well as changes in professional education and training. This must lead

to a change of attitude and organisation of health services, which refocuses on the total needs of the individual as a whole person.

The contribution of the WHO to health promotion

The Seventh International Conference on Health Promotion in Nairobi, Kenya in 2009 identified new challenges to health promotion, including the inexorable growth of non-communicable diseases and illnesses in developing countries, worldwide financial crises, terrorism threats, global warming and climate change, and potentially catastrophic pandemics (WHO, 2009). Delegates at the conference acknowledged that these new challenges compounded the developmental problems which have yet to be solved and that the internationally agreed public health outcomes appeared increasingly unattainable. In the wider public there had also been concern for some time that the Ottawa Charter's vision and ideals were not being met for many of the world's populations, in spite of the huge resources expended on the provision of those health services (Hayes and Dunn, 1998).

The International Union for Health Promotion and Education (IUHPE) and the Canadian Consortium for Health Promotion Research put out a report in 2007 which warned of escalating inequalities in population health both within and between countries, including developed nations. Causative elements of this phenomenon were attributed to global events such as growing globalisation and consumerism and their varying effects on health determinants across national boundaries on the environment, people and communities (IUHPE, 2007). The IUHPE health and education professionals reflected that the Ottawa Charter's call for greater intersectoral coordination and implementation of strategies and recommended action streams have made progress with regard to health policies specifically targeting risk and disease reduction but that what was missing was an international policy that would integrate actions to improve health and social and economic conditions across all relevant sectors (IUHPE, 2007).

Some critics also pointed out that the Charter was based predominantly on the views of the industrialized and European states and did not acknowledge nor account for the health promotion work that has been going on in the United States of America, western Pacific or Asia (Green, 1986; Green and Raeburn, 1988). The People's Health Movement (PHM) was created at the first People's Health Assembly in India in 2000, and was a coordinated radical response to the burgeoning inequalities in health, especially among developing nations. The group famously called for "Health for ALL NOW" in a direct challenge to the original vision of Health for All articulated at Alma Ata in 1986.

The PHM calls for a revitalisation of the principles of the Alma Ata Declaration which promised Health for All by the year 2000. They insist that the Alma Ata Primary Health Care model could have been realised on target and on time, but the inequitable allocation of priorities and resources had prevented equal access of all people. The PHM accuses WHO of being unwilling to go far enough in addressing the unacceptable level of human suffering and privation because of its inadequate approaches to overturning the conservative thinking and neoliberal economics which pervert the social justice that was to be realised (PHM 2000). The group believes that WHO does not lack the funds, human resources or expertise to deliver health for all, but lacks political will and courage (PHM, 2005; 2009). They argue that genuinely people-centred initiatives must be strengthened to increase pressure on decision-makers, governments and the private sector to ensure that the vision of the Alma Ata becomes a reality. They also call for a complete revision of international and domestic policy that has been shown to impact negatively on health status and systems.

Notwithstanding criticisms about the WHO's inadequate provisions and actions, in the period spanning from the Ottawa Conference in 1986 through the seven global conferences to Nairobi in 2009, a body of evidence and experience has been accumulating about the importance of health promotion as an integrative and cost-effective strategy. Some thinkers believe that the focus of public health has shifted from disease prevention and an individual risk factor approach to addressing the determinants of health and empowering people to participate in improving the health of their communities (Kichbusch, 2003). However, in spite of perceptible changes in rhetoric and policy, much of public health practice remains oriented towards prevention and much work needs to be done to promote health and address the social determinants of it (PHM 2005; 2009).

The expectation that public health may only be achieved successfully through the collaborative and joint efforts of all the diverse sectors of human society, from individuals, communities, nations to the entire planet, has contributed to the growth of many health and related cooperative initiatives. This participatory health promotion model attends also to the need to build up individual and collective capacities and skills so that access to health resources might be shared equitably and political power might be returned to people who have been relegated passive roles as public health consumers.

The WHO definition of health frames it as a resource that is created in the context of everyday life. It relates health to a state of wellbeing that can co-exist with the presence of

disease or infirmity; furthermore, health is a fundamental human right to be protected and ensured without prejudice. Recognition of the state's role in health care provision in cooperation with its citizens is important as it acknowledges the fact that many of the social and environmental protective factors of health lie outside the control of most people but that people should be partners in decisions regarding their health. It is equally important that attention has been drawn to the implicit social justice view that inequalities among states is a danger and that every state's ability to protect and promote health increases the health of every other state. In short, no state is an island unto itself, and all states are connected on the surface of this planet in terms of how each affects every other in some way.

Along with the enthusiasm for promoting health as a public health priority, the interest in promoting mental health has grown over the past 20 years (Secker, 1998; Tudor, 1996; WHO, 1981; 2002). Mental health is increasingly seen as fundamental to physical health and quality of life (Helen Herrman, et al., 2005). The importance of mental health promotion takes on urgency especially since the WHO prediction that mental illness will be the second biggest global health load by the year 2020, measured in terms of human productivity losses due to death and disability (Murray & Lopez, 1997). Similar predictions are made of the mental health situation in New Zealand (Browne, Wells, Scott, & McGee, 2006).

In the next section, a new paradigm of population mental health promotion is presented. This paradigm attempts to address how the self, others and the environment can work together more effectively to achieve positive mental health in individual people and populations.

The population mental health promotion paradigm

The resonance between population health and mental health was made clear in the 2005 report to the World Health Organization on *Promoting Mental Health* where relevant evidence and tools were shared to position mental health as a priority goal within the wider canvas of population health promotion agenda (Helen Herrman, et al., 2005). The report also presented strong arguments and evidence of the relationship between people's mental health status and the protection of basic human rights. Having repeatedly asserted that "there is no health without mental health", it was fitting and logical that WHO became responsible for the formal launching of the population mental health promotion (PMHP) paradigm and was credited with adopting, guiding and supporting the process of

developing it as a natural next step in the development of health promotion (Natacha Joubert, 2009a). PMHP represents the culmination of the increasing interest and enthusiasm for promoting mental health that has been sparked since the recognition of its inextricable relationship to general health (Friedli, 2002; Secker, 1998; Trent and Reed, 1992, 1996); Tudor, 1996; WHO, 1981; 2002).

In the inaugural issue of the *International Journal of Mental Health Promotion*, Natacha Joubert and John Raeburn explained how they define mental health promotion:
Mental health promotion is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity (Joubert and Raeburn, 1998, p 16).

Population mental health promotion is a strengths-based approach for promoting mental health in whole populations. It aims to help individuals and communities gain greater power over and control of the status of their mental health and, ultimately, their lives and destinies (Lahtinen, Joubert, Raeburn and Jenkins, 2005). In 2009, Joubert further elaborated that population mental health promotion is based on:

> … a set of principles and local, national and/or global actions that focuses on ... fostering the development of individual and community mental health, resourcefulness and capacity for well-being ... creating supportive or resourcing environments or life settings (Joubert, 2009, p 7).

Joubert advocates for trusting and respecting people and communities and believes that both are inherently resourceful (Joubert 2009). PMHP acknowledges the importance of treatment and cure for those who are ill and stresses the need to apply the key principles of positivity, building strength and resilience, and empowering individuals and communities in all mental health promotion, treatment and recovery protocols. Effective PMHP solutions can include the entire array of interventions including health promotion, education, therapy and recovery (Lahtinen *et al*, 2005). Mental health promotion is an enterprise to build strength and capacity with the ultimate aim of life quality for everyone (N Joubert & Raeburn, 1998).

Micro, meso and macro level PMHP interventions

As an integral part of health promotion theory and practice, mental health promotion can be applied at three broad levels (i.e. individual or micro, community or meso, and

population or macro), and across a range of contexts and settings (N Joubert & Raeburn, 1998; Lahtinen, et al., 2005).

With regard to the personal or micro level, PMHP postulates the need to trust that all people inherently possess the potential to be aware, solve problems, seek help and adapt in order to cope with negative or stressful life circumstances (N Joubert & Raeburn, 1998; Lahtinen, et al., 2005). Because of the attrition of these attributes due to repeated or prolonged exposure to those negative conditions, this resourcefulness is subject to erosion over time and must be replenished or constantly maintained. At this level of mental health promotion activity, appropriate strategies would involve teaching, supporting and enabling people to access their inner resources or capacities. These may include life and communication skills such as how to plan, set goals, self-review and assess progress towards improving self-care or personal relationships with others, cultivating a sense of humour and optimism for the future, tolerance of diversity and participation (Antonovsky, 1979; Bernard, 1991; Bernard and Sharp-Light, 1999; Carver, Scheier and Weintraub, 1989;)

Health promotion at the individual level of action may also overlap with prevention activities. Since mental health is possible in the presence or absence of illness, it is entirely appropriate that both the domains of mental health promotion and prevention activities would cross over and affect each other (Hosman and Jane-Llopis, 2005; US Institute of Medicine, 1994).

The meso or intermediate level is where PMHP strategies and actions are developed and lived out on a daily basis. This sub-population level of “community” would include families and kin, schools and workplaces, groups and organizations, and other population aggregates where people are connected along lines of geography, ethnicity, identity, interests or other similarities. The community level mediates between the global/national (macro) and individual (micro) contexts and is where the considerable and negative impacts from contextual factors such as substance abuse, stressful work conditions, discrimination, insecurity, hopelessness, physical ill-health, rapid social change and poverty can be shown to take their toll on mental health (Costello *et al.*, 2003; Desjarlais *et al.,*1995; Durning, 1989; Parker *et al*, 2003; Patel and Kleinman, 2003; Pransksy, 1998; Rutter, 2003;). Joubert (2009) argues that PMHP conducted in communities is central to the paradigm’s effectiveness because these are the best contexts for sharing knowledge and skills that may lead to the creation of groups or organizations to support people’s growth and transformation.

At the macro level or the level of societies or nations, mental health promotion is about ensuring that the writing and implementation of public health policies are in line with the principles, values and objectives for promoting population mental health. Well-integrated policies should be based on accurate analyses of priorities and goals, clear outlines and descriptions of roles and responsibilities, comprehensible strategies and tasks, agreed processes of review and feedback, and commensurate and adequate resourcing of activities to facilitate their success. Examples of these would be policies relating to education, environment and economics such as those governing access to products and services, workplace conditions, public housing and transport, childcare and parental leave, regulations and legislation regarding discrimination, domestic violence and immigration, amongst others. They should also ideally attract the widest range of stakeholders' involvement and commitment (Funk, Gale, Grigg, Minoletti and Yasamy, 2005; HEA, 1997; Lahtinen *et al*, 1999). According to PMHP, the most important stakeholders in this collaborative approach would be people and communities, and the work for mental health promoters is to advocate, mediate and enable their active and meaningful participation (Jenkins, 2004; Joubert, 2001; Joubert and Raeburn, 1998; Lahtinen *et al.,* 2005).

There are examples of successful collaborations where the public have been involved in policy development with the desired effect of improved processes and outcomes for people (Lowe, Schellenberg and Shannon, 2003; MacKinnon, 2003; Marmot, 1997, 2003; Marmot and Wilkinson, 1999; Phillips and Orsini, 2002). Policies that encourage such positive ways of enabling people to be involved and participate in decisions that affect their lives will certainly contribute to increased population mental health and wellbeing (Funk *et al.,* 2005).

Population mental health promotion at the community level

Rubin and Rubin (2008) describe communities as the way people consider themselves or are considered by others as connected and sharing some common identity or destiny. In their well-known typology and classification system, Rothman and Tropman (1987) suggested three kinds of communities comprising those designated by place or locality (streets, neighbourhoods and cities), common interests (sports, politics and social networks on the World Wide Web) or identity (ethnicity, culture, sexual orientation or culture). Each one of these communities provides a nexus or connecting central reason for members to consider themselves united along some common goal or intention. For example, it may be neighbours on a street lobbying for road humps to reduce speed and increase safety for children, soccer players working together to increase game skills and

promote the sport, or members of ethnic groups gathering to keep their languages, cultures and rituals alive.

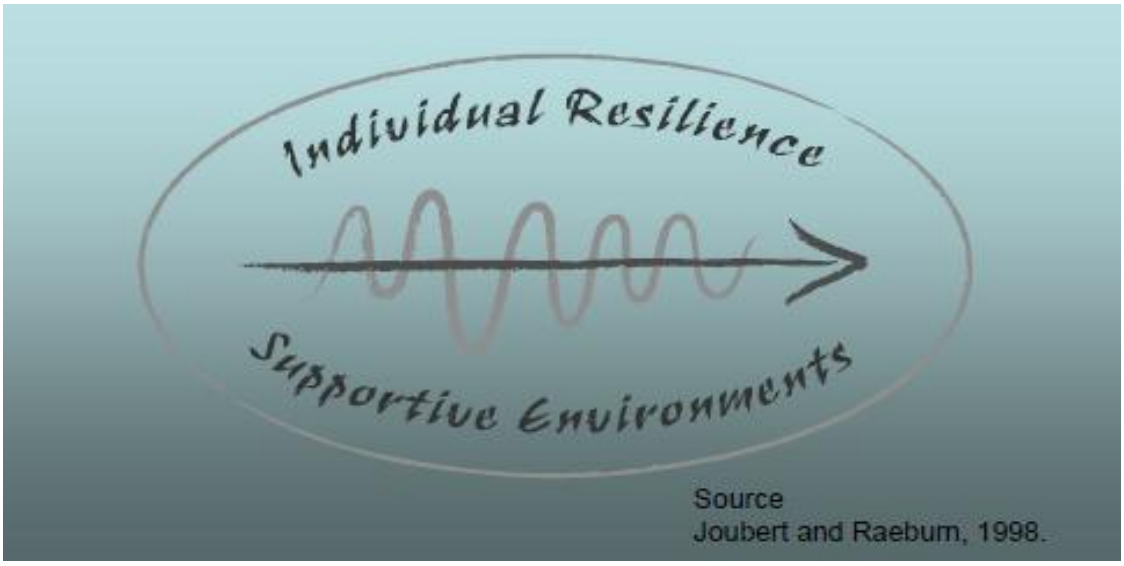
In the PMHP paradigm, it is the locality definition of community that is being considered as the most appropriate context for promoting mental health. A community of place is the optimal context for interventions because a strong sense of place is regarded as being of huge significance for mental health and wellbeing, and community is where and how social support and networks are set up, exist and function (Joubert and Raeburn, 1998; Lahtinen *et al*, 2005; Raeburn, 2001; Williams, 2001).

Joubert and Raeburn (1998) argued that the key for PMHP success is to find ways to foster and strengthen individual resilience within a supportive and resourcing community environment. This individual-environment relationship is reflected in the resourcefulness/ resourcing approach adopted by PMHP and may be illustrated by the following illustrative equation:

> PMHP = Individual and community **R**esourcefulness + **R**esourcing environments
> (Joubert, 2009, p13)

Below is a reproduction of the original 1998 diagram from the Joubert and Raeburn article that illustrates the set of relationships just described by the authors.

Figure 2.1: The Resourcefulness/Resourcing approach



(Adapted by Joubert and reproduced from Joubert and Raeburn, "Mental Health Promotion: People, Power and Passion", International Journal of Mental Health Promotion, Inaugural Issue 1998, p 15 – 22)

Individual resilience refers to the ability people possess to use their inner resources such as strengths, knowledge, wisdom, life skills, and sense of humour to cope with on-going challenges and stresses of living (represented above by the up-and-down wriggly line), learn from these experiences and to "bounce back", or resile from them with increased resourcefulness for future reference (represented by the forward arrow). This positively ascribed capacity is what is meant when PMHP practitioners use the terms "resilience" or "resourcefulness". (N Joubert & Raeburn, 1998; Seligman, 1991).

Communities may also be attributed with this resilience and resourcefulness collectively when their members work and learn together, pooling their capabilities and resourcefulness to respond to events that affect them all (Natacha Joubert, 2001). When people and communities have access to the appropriate means (e.g. education, spirituality, motivation and health status) to identify their own priorities and aspirations, they are best-placed to take control over decisions on the most appropriate ways to achieve positive outcomes for themselves (Natacha Joubert, 2009b).

Of course, there are situations when people suffer from severe disabilities, illnesses or social deprivations (e.g. loss of limbs or functioning, generational poverty, chronic abuse or neglect), in which cases, their inner resources may be more limited. This is also true for communities. Even so, these individuals and communities would still possess resources that can be accessed and strengthened in a resourceful and resourcing environment that subscribes to inclusion and social justice (Natacha Joubert, 2001). The wellness and strengths-based approaches of both PMHP and community development mean that such cases are included within their scope of meaningful engagement. No matter the quality or quantity of resilience and resourcefulness, all can get tested and depleted and replenished over time as people and communities interface and negotiate their way through the vicissitudes of life (Joubert and Raeburn, 1998; Joubert 2009; Raeburn, 2009). The next section discusses in greater detail what the community development approach is and how it is considered to be complementary with the PMHP enterprise in theory and in practice.

The community development approach

The term "community development" has been variously taken to mean the same thing as what colleagues in the United States call "community organisation" and those in Australia term "community building". Other similar appellations include "community work", "community action", "community practice", "community change" and the entire plethora of terms referring to social services and practices prefixed by "community-based" (Ife, 2002; 2005). Some commentators think that such inconsistent or uncritical usage of related

terms might and does contribute to the failure of the sector to capitalise on the pool of diverse resources, skills and experience that exist and that this state of affairs presents a fundamental flaw that might even work against benefits for the health and wellbeing of all our communities (Boutilier, Cleverly and Labonte, 2000; Brennan, 2007; Labonte, 2005; Laverack, 2007).

In a review of definitions of “community action”, reference was made of the international variations in usage (Hancock, Sanson-Fisher *et al*, 1997). Those particular authors identified those interventions that actively involve people or the communities at all stages as “community development” (Australia, Canada and the United Kingdom) or “community organization” (United States) in the community action continuum, while those where people or communities were only involved in tokenistic or consultative activities as “community-based”. A few specific definitions are discussed below.

A definition from the United States sees community organisation as “the process by which community groups are helped to identify common problems or goals, mobilize resources, and in other ways develop and implement strategies for reaching the goals they have set” (Minkler, 1990, p.257). A more radical version of community organisation has been championed by Saul Alinsky in America. It is seen as a process of dis-organising communities to expose the inherent systemic inequities and then mobilising the informed communities to re-organise themselves in order to agitate for change through politicised actions such as boycotts and strikes (Alinsky, 1971). A definition from Canada considers community development as referring to the efforts made to create new groups or organisations that are often supported by professionals from outside the community (Rothman, 2001). A couple of Australian practitioners suggest that community building is “working together to build and strengthen communities through the empowerment of local people” (Murphy and Cauchi, 2002, p.1).

In New Zealand, community development (CD) has been defined as

> a process whereby local groups would be assisted to clarify and express their needs and objectives and encouraged to take collective action to attempt to meet them...emphasized the involvement of the people themselves in determining and meeting their own needs (Shirley, 1979, p 64).

More recently, the term has also been defined as an academic discipline and professional practice that “intervenes through distributive strategies to enhance social justice and economic equity between groups and communities locally, nationally and internationally”

(Chile, Munford and Shannon, 2006, p.400). Although New Zealand was not included in the review of definitions undertaken by WHO cited earlier, it would be accurate to say that the term “community development” as used in New Zealand would be placed on the same side of the community action continuum as our Australian, Canadian and United Kingdom colleagues (Raeburn & Corbett, 2001).

All the different ideas espoused above share more overlaps in intent, process and desired outcomes than not. Writers like Jim Ife (2002) from Australia resolved the issue of lexical and definitional diversity by suggesting that CD should be more properly regarded as an approach rather than an enterprise with specific prescribed theory or application. Likewise, McNeely (1999) suggests that community building is a new approach that works by
building community in individual neighbourhoods: neighbours learning to rely on each other, working together on concrete tasks that take advantage of new self-awareness of their collective and individual assets and, in the process, creating human, family, and social capital that provides a new base for a more promising future and re-connections to America’s mainstream (p.742).

In a similar attempt to be generally inclusive in its definition, Bhattacharya (2004) described CD as a process whereby agency and solidarity is created or increased. In the PMHP article in 2005, CD was also defined as an approach that
draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters” and that CD “requires full and continuous access to information, learning opportunities for health, as well as funding support (Lahtinen *et al*, 2005, p.236).

For the purpose of this thesis, CD refers to an approach or way of working with the people and their communities intentionally to ensure that their unique contexts, needs, concerns and aspirations are acknowledged and addressed equitably in the pursuit of enhanced health and wellbeing. It focuses on respectful ways of working with people in their communities to facilitate the improvement of health and quality of life through various means. This approach is particularly appropriate for PMHP interventions, which must be centred on, designed, led and controlled by the people concerned at all times (Joubert and Raeburn, 1998; Lahtinen *et al*, 2005; Raeburn and Rootman, 2001). The CD approach is chosen for this study because of its focus on empowerment, building community capacity, connectedness and control.

A participatory community practice model

Having established that the quintessential context for PMHP is at the meso or community level of a population and that a people-centred community development approach would be the most appropriate one to adopt for the purposes of enhancing population health and wellbeing, I will now describe what such a practice model would look like.

First described operationally in 1979 by Raeburn and Seymour, the early version of the PEOPLE system was a generic approach that provides practical and comprehensive guidance for any interested community group or population to bring about a program for desired social change. The model was designed to be simple to understand and use, as well as being flexibly adaptable to most settings (Raeburn and Seymour, 1979). The systems-based planning and evaluation model contained a theoretical aspect that emphasises the complex interrelatedness of all the component parts of the ecology of a system to each other (can include community, processes, environment, politics, communications, infrastructure etc.), as well as a practical aspect that outlines a series of procedural steps to be undertaken (setting goals, allocating resources, continuous feedback to self-correct) in order to successfully achieve goals and priorities (Raeburn, 1992).

The main inspiration for Raeburn came from the General System Theory propagated by Ludwig von Bertalanffy, a biologist, who considered the traditional reductionist scientific method of trying to understand a whole system by analysing its component parts *in vacuo* to be a shortcoming (von Bertalanffy, 1968). An example of this is trying to reduce an individual's body weight by prescribing pills and diets without taking into account their life circumstances that might be controlling the causative and motivational factors. Bertalanffy thought such an approach neither bore true witness to the real complexities and interconnectedness of constituent parts to the whole system nor considered how the different constituent parts impact on and affect each other in turn.

Bertalanffy's General System Theory proposes that all systems are subject to laws of nature and that these laws can be used to help our understanding of other similar systems. One example of such a law that is applicable to community development is the law of equilibrium. The law of equilibrium explains that most systems (such as communities) are resistant to change because they seek to maintain stasis, a dynamic state or balance or equilibrium. Feedback regarding changes or deviations from component parts of the system enables it to adjust itself accordingly; however, the law of equilibrium also allows for the possibility of gradual systemic changes when these are

done by continuous inputs of appropriate strength, much like incremental changes to communities from intentional and on-going community development activities. In the earlier example of our fictional obese person who might not want to go to the gym every day or cut out fatty foods, effective weight loss might be achieved by walking the dog with a friend for ten minutes a day or exchanging butter for a low fat margarine.

Another source of inspiration for Raeburn came from Charles Churchman's Systems Approach that advocated creating a systematic and sequential series of operations or procedural steps that break potentially complex or complicated goal-attainment activities into manageable chunks for the people involved (Churchman 1968). Churchman was driven by a sense of moral outrage that sections of the world continued to be plagued by war, malnutrition, poverty and so on. He believed that committed interdisciplinary collaborations using system analytical methods could render all the great problems of the world ultimately soluble (Churchman, 1980; Jantsch, 1972). The application of critical intellect to solve complex problems because it is the moral, just and ethical thing to do is a theme that will be revisited later in the last chapter of this thesis.

Raeburn developed his systems-based model over a 20-year period in New Zealand (and also in Canada) to incorporate all the relevant values and principles underpinning health promotion activities into a unitary operational system that would make the task more manageable. Initially used to build and plan programmes for his adult psychiatric patients in a public hospital to rehabilitate them for life outside the institution, he adapted it to be applicable to whole-of-communities as well. In keeping with his professional affiliations, he incorporated community psychology principles such as "community control, empowerment, deprofessionalisation, positive strength-building, a social systems/ecological perspective and programme evaluation" (Raeburn, 1992, p 38). Later in 1998, the PEOPLE system was offered as a specific tool for conducting people-centred health promotion activities (Raeburn and Rootman, 1998). Most recently, it was described in the WHO 2005 Report on Mental Health Promotion (Lahtinen et al).

Although the model was not named as such back then, the seven steps described in 1979 were recognisable as those later outlined as the PEOPLE System in 1992 and 2005 (Raeburn, 1992; Raeburn and Seymour, 1979, WHO, 2005).

Reproduced below is a figure illustrating the PEOPLE System steps in the familiar segmented arrow, surrounded by some of the main principles embedded in the PEOPLE acronym.

Figure 2.2: The PEOPLE System steps and main embedded principles

The 2005 PEOPLE (Planning and Evaluation of People-Led Endeavours) System component steps in their basic sequence are as follows:

1. Objectives and values statement: this will be the outcome of discussions with community people regarding their aims, objectives and values;
2. Needs/wishes assessment: this will be an undertaking of an agreed process to help the community identify their needs or wishes and to prioritise them;
3. Goal setting: this would involve agreeing on what the community intends to achieve within a time frame of their choosing;
4. Organisation and resource arrangements: this would include a consideration of resources and appropriate organisational structure needed to help the group meet their collective goals efficiently;
5. Action: this would be where requisite activities, tasks or projects are allocated to different members for carrying out;
6. Reviews: these are when nominated people report back to the community on progress of their tasks or projects, when any difficulties or challenges encountered will be shared, and when the community will engage in problem-solving to address them; and
7. Periodic outcome assessments: this would involve scheduled time frames for the group to conduct overall evaluations of their progress, to ascertain if the whole enterprise is still on track for achieving intended outcomes, and to make decisions about the need to reshape or realign tasks or projects accordingly.

(Lahtinen, et al., 2005; Raeburn, 1992)

I am arguing that the inclusion and use of ongoing reviews and periodic outcome assessments into the PEOPLE system would provide important feedback and input back into the community development project, thus enabling participants to monitor or adjust their activities to keep on track in achieving collective goals. This is one of the main reasons for choosing the planning and evaluation PEOPLE model for the research study in Glen Innes.

Over the years since the model was first employed in the early 1970s, several examples of its application have emerged. One of the earliest and very ambitious uses of it for that time was the 1975 Birkdale-Beachhaven Community Project undertaken by one of Raeburn's doctoral students (Seymour, 1978).

Raeburn and his colleagues were approached by the community's school principals who were concerned about the growing social problems encountered within the population of 13,000. The residents were mainly lower to middle-income young families, with more than half of their numbers being children of school age or under, and many were living in a new housing development that lacked the requisite facilities and amenities to cater to their needs. Raeburn and Seymour spent over a year getting an overview of the context by engaging in preliminary planning and groundwork with the community before Seymour undertook a formal needs assessment using a random household survey method. Community goals were agreed, based on the findings from the needs assessment, and the community was mobilised to contribute to 17 projects, with attendant tasks and activities identified to meet the collective community goals. Evaluations of the Birkdale-Beachhaven Community Project were based on annual goal attainment and community participation rates on projects, and these concluded that it was a huge success for its people. For example, at the end of their first year, 15 of the 17 annual goals had been achieved (Raeburn and Seymour, 1978).

Other New Zealand examples of projects using the generic model and principles of the PEOPLE system were outlined in a 1998 book by Raeburn and Rootman (Chapters 12 and 13, p 167 – 195). As well, similar international examples of community projects subscribing to like principles and approaches have been reported and documented by Natacha Joubert to establish the overall efficacy of the generic model (Joubert, 2009). Although not all the examples in the literature identify as PEOPLE projects, the main point is that they subscribe to the same principles and process and demonstrate the general effectiveness of such people-centred and systematic approaches to promote health and wellbeing in all kinds of settings (rural, urban and organisations) and with diverse cultures

and people. Two more New Zealand examples that used the PEOPLE model specifically are described below.

The first is the North Shore Community Health Network that started in 1983 in Northcote, a suburb of about 12,000 on Auckland's northern shore, by one of the ex-coordinators of the Birkdale-Beachhaven PEOPLE project. This case shows the impact that the transformational leadership of one individual, Glennys Adams, had when she applied her community development experience to help build an organisation which is funded by public health but run by community people. The other example is The Other Way project that started in 1993 in Thames, a provincial service town of 6000 people, to find innovative community solutions to address rising unemployment and its social impact on the lives of community people. It showed how an intervention introduced into a community that has not asked for it may nevertheless be an effective people-centred and community-owned undertaking. The success factors included adherence to PEOPLE principles such as cultural inclusion, empowerment, community participation, and facilitated delivery by a worker, Jane West, who was sensitive to and passionate about their implications for practice (Raeburn and Rootman, 1998, chapter 14, p 196 -213).

I was particularly interested in using the PEOPLE system as a practice model for the research in Glen Innes because it is a simple framework that embodies all the important principles and values espoused by the population mental health promotion paradigm. It is at once comprehensive in its scope and specifically adaptable to local and cultural contexts; it is strengths-based; it takes into account all the complexities and inter-relatedness of contextual variables to be found in any human community; it is model developed in New Zealand; it supports learning through reflective practice praxis; and it offers guidance for an uninvited professional, such as myself, who is venturing into a community that might be viewing me with some measure of scepticism and suspicion.

There is also a discernible and specific dearth of documented research in the literature for CD and health promotion (CDHP) projects that meet the single most definitive criteria of the approach - that of community control. Various writers have highlighted the propensity for many projects ostensibly labelled CD, HP or CDHP that default to being top-down, deficits-based or dealing with risk and prevention factors instead of building on strengths, capacities or resilience as their appellations may dictate (Kretzmann and McKnight, 1993; Raeburn and Rootman, 1998; Rappaport, 1992). In their scan of the literature to find evidence for the effectiveness of CDHP outcomes, Raeburn and Corbett argued that any interventions deserving of the appellation must be able to demonstrate evidence of

meeting the ideal criteria of the “3 Cs – community control, community building and capacity building” (Raeburn and Corbett, 2001, p 9).

Applying this standard, they devised a system of categorising the articles about community projects they found in the literature according to the degree to which their outcomes met the 3 Cs criteria: A types were the ones where the primary focus of the processes and outcomes has to do with either treatment or recovery outcomes; B types were primarily working on prevention outcomes; C types were the ones to do with promoting general health and wellbeing outcomes and, therefore, the ideal that meets the 3 Cs criteria in accordance with our PMHP and CDHP interest. Of the 24 articles they found over a five-year period that purported to measure effectiveness, only one met the CDHP criteria of the 3 Cs.

The situation is not much changed today as can be evidenced by the 2007 review conducted on behalf of the WHO (Raeburn, et al., 2007). That study was undertaken to review the impact and effectiveness of community capacity building (CCB) on health promotion. Although they concluded that there was strong support for the effectiveness of CCB on health promotion outside academic literature, the authors found that “there is as yet little formal academic research on the effectiveness of CCB in terms of randomized control trials or systematic evaluative or qualitative studies” (p 87).

This research in Glen Innes is a step towards adding to the academic literature for a systematically evaluated empirical study. By using the PEOPLE system’s planning and evaluation procedures, the intent it to demonstrate that PMHP in a CD context does work, that engaging in reflective practices with the diverse and multicultural community of communities that is Glen Innes will create a resourcing and supportive environment that is culturally competent, will increase community connectedness and capacities, and will put community in control of project processes and outcomes.

This community participatory action research project will seek to be led and controlled by community wishes and aspirations via the particular mechanism of the random household survey. The last is a tool that offers every community householder an equal chance to be selected to have their input recorded to guide the project goals and outcomes. As outlined in Chapter 1, the uniqueness of the project lies in its status as the first CD project to use the PMHP Model to put the community in absolute control. I will discuss some key principles and values that will be guiding the community participation research that I undertook in Glen Innes.

Key principles and values of PMHP in communities

This review has supported the suggestion that Population mental health promotion (PMHP) is an approach that advocates trusting in people's innate resilience and coping resources, and commits to helping to create supportive environments that will sustain and replenish those individual and collective resources (Lahtinen *et al*, 2005). I have argued that PMHP is best-served by adopting a community development (CD) approach to meet its delivery outcomes. Both PMHP and CD are optimally suited for application at the meso level of ordinary social intercourse because they are people-centred, are framed to build upon the strengths and assets that the people and communities possess, and adhere to working in ways that are respectful and socially just.

Because communities are uniquely different from each other, methodology must be specifically tailored to suit their particular characteristics. This complex nature of interacting personal, social and environmental factors, within and between, communities make huge demands on the ability of PMHP practitioners to be and remain flexible, effective and innovative through the duration of these community participatory engagements. I have previously discussed the finding that many projects that start out with community development and health promotion intentions end up defaulting to a top-down process that favours those in power such as project managers, academics, professionals, funders or government departments (Murphy & Cauchi, 2006; Raeburn & Corbett, 2001). Also, such defaults invariably mean that the outcomes that are meaningful to community often get displaced by outcomes driven by external parties. Many of these projects centre on treatment, recovery or prevention and neglect the population health promotion agenda that should be central.

In an effort to avoid such a default possibility, I will now go on to outline some of the key principles and values that I use to review and evaluate the Glen Innes project to ensure it remains true to the PMHP vision and purpose. The principles and values are discussed in pairs to illustrate the way they overlap and affect each other in terms of their processes and outcomes. Although the list is by no means exhaustive, it shows that when one or more of these related principles or values are advanced, it improves the chances for others to be similarly served as well.

Empowerment will be discussed first because it is the most important factor to ensuring community control, and it is linked in with equity to advocate for social justice in our PMHP enterprise. The discussion about participation underscores PMHP and CD emphases on involving community people in our pursuit of mental health, wellbeing and quality of life,

Further to that, partnership is seen as one important way to acknowledge the fact that most disadvantaged and underserved communities need support and help to bring about social change. Finally, the values of connectedness and culture will be discussed in recognition of the importance of social and cultural support to sustain mental health.

Empowerment and equity principles

Community empowerment has been defined as

a process by which people increase their assets and attributes to gain more power over their lives and has the explicit intent of bringing about social and political change, usually by affecting public policies, decision-making authority and resource allocation (Laverack, 2007, p. 20).

This sense of power and control over life outcomes is demonstrably related to a corresponding sense of health and wellness (Karasek *et al*., 1981; Lachman and Weaver, 1998; Marmot and Smith, 1991; Schnall, Landsbergis and Baker, 1994; (Sarafino, 2006; Seligman, 1975)). This principle of control by people is internationally sanctioned by the Ottawa Charter (WHO, 1986) and is predicated upon the foundational assertion that health is a fundamental human right to which all people should have equitable access (WHO, 1946). The empowerment process is applicable equally to individuals as well as to small groups, communities or wider populations, such as countries. Empowered people experience a sense of personal strength, confidence, effectiveness and control; it is this feeling of being or having control that is deemed by psychologists to be vital for individual health and resilience to stress (Raeburn, 1998; Sarafino, 1998; Steptoe and Appels, 1989 (Sarafino, 2006)).

In a statement in the *2006 World Development Report*, the WHO stated that “By equity we mean that individuals should have equal opportunities to pursue a life of their choosing and be spared from extreme deprivation in outcomes” (WHO, 2006, p 2). This meaning of equity requires that the distribution of heath resources to people must be fair and dependent on their specific needs. The pursuit of this ideal principle in health remains a high priority for the international community as evidenced by reiterations of them in their various publications (WHO, 1998, 2005, 2006, 2009). Subscribing to the WHO agenda of Health for All, any PMHP activities that are described as demonstrating the empowerment principle must, of necessity, also be operating to increase equity health outcomes as well to ensure every person has their fundamental human right to health restored. In other words, the principles of empowerment and equity are irrevocably linked to each other, and the honouring of one will also deliver positive effects for the honouring of the other.

In adhering to both empowerment and equity principles, the health promotion paradigm can be considered a social as well as a political enterprise that values reducing health inequities and gaps found in different populations and reinstating a more balanced and socially just allocation of health resources for achieving population health for all (Dahlgren and Whitehead, 1992; Whitehead, 1990; WHO, 1996; Wilkinson, 1996). There is ample evidence to show that such empowering and equitable health promotion and community development interventions are effective at many levels and that they have contributed to increased equity in health for people (Benzeval *et al*., 1995; Black and Mittelmark, 1999; Raeburn et al 2007).

Laverack (2007) alludes to and cautions about the many types of "community-based interaction" practices in the literature that are mistakenly conceived as being equivalent to that of community empowerment. He argues that though many different kinds of community-based interactions share common characteristics expressed by the concept of empowerment, such as being people-centred strategies and actions for reducing health inequalities, each kind calls for quite different actions on the part of health promoters. He ranged the various related concepts along a continuum of eight stages of community interaction from "readiness" to "empowerment". All comprise the twin elements of community empowerment and community capacity for action together.

Laverack believes communities move from being relatively passive participants in community activities ("community readiness", "community participation") to becoming increasingly more concerned and interested in identifying and addressing the socio-environmental determinants on their lives ("community engagement", "community organization"), through to undertaking to increase capacity for action ("community development", "community capacity") to finally gearing up for political action to take charge and control of those determinants to improve personal and communal life ("community action", "community empowerment"). For empowerment practitioners, Laverack (2007) prescribes an initial directive and instructional role when the community is just starting out; a second facilitative one assisting the community to discover some self-identified goals; and a third properly empowering one where practitioners fully engage and collaborate with the community to effect social, systemic and political change. He sees the community empowerment concept as an essentially political one because it is to do with the redistribution of power or, as I would see it, restoring equity to people. It was the intention of this research to show that when a health promoting community development project engages in good on-going reflective practices, then all participants will have accurate information about the most optimal roles for each of them, community members as well as

health promoters, depending on the goals and outcomes that they have collectively agreed to work on.

Another potential challenge for PMHP practitioners working in disempowered communities is dealing with the impact of real or perceived power differentials and inequities between health professionals and the people working jointly in these communities. Of course, these inequities also exist between different members and groups within the community as well. How these differentials are perceived, managed and resolved will affect the quality of the interactions and outcomes accordingly. Taking the time and effort to build trust and rapport with community people remains a potent way to enable honest communications about mutual expectations and equitable outcomes in collaborations among equals (Israel, et al., 1994; N Joubert & Raeburn, 1998; Lahtinen, et al., 2005; Minkler & Wallerstein, 2005). Thus, all participants must believe that every person has strengths and capacities that can be accessed and developed (empowerment principle), and collective resources are able to be utilised for the common good (equity principle). In this way, members are enriched by the assets that others possess and bring to the enterprise, and all benefit from improved health and wellbeing outcomes of every individual as well as the collective whole.

Participation and partnership principles

In their discussion regarding people-centred health promotion, Raeburn and Rootman pointed out that community participation is most useful when the following conditions are met:

- it involves as many people as possible;
- the people involved are representative of the community's diversity;
- community initiatives are based on the needs and aspirations of the people;
- the participatory experience contributes to increased unity and solidarity among people

(Raeburn and Rootman, 1998, p 29 - 34)

In terms of involving as many people as possible (participation principle), there is the challenge of making sure their participation is not just tokenistic and that we are not merely counting off the numbers. The people involved must become true partners of the PMHP enterprise and be engaged in every aspect of the developmental work (partnership principle) from design and planning to implementation and review. The necessary balancing act is to include as many people with as diverse interests as possible (equity principle) while ensuring their participation retains the integrity of the mission to build on

and utilise their individual strengths and goals (empowerment principle) in meaningful ways. This inclusion also helps promote the “fit” of goals and outcomes for everybody.

With regard to representativeness, PMHP honours and celebrates the fact of community diversity because it resonates with the equity principle, as previously discussed, and is a positive value for the wealth of community life experiences that it may bring with it. There are the added challenges of avoiding “agenda capture” by vocal or more populous interest groups, of ensuring that the activities do not replicate the prejudices or discrimination that exist in any human society and of making sure that all interested members are included, irrespective of gender, age, ethnicity, health status and so on. The way PMHP practitioners advertise and promote activities, the days and times they are held, the venues, the food provided, the types of activities and so on all affect the ability and willingness of people from different backgrounds to participate. For example, activities during the day might have to include the provision for transport and childcare if minority women with young children are to be involved; activities for youth might have to be held in the latter part of the day to include those who attend school, and so on. Once again, ongoing reflective practice will uncover any emergent challenges and issues that arise in the process of our community development work, and cooperative enquiry and problem-solving will enable these to be properly addressed.

The other condition stipulated by Raeburn and Rootman (1998) for participation is about ensuring the community activities are actually led and driven by the people themselves. Practically, it is to ensure these activities are intrinsically motivating, fun to participate in, and culturally-attuned to include diverse participants. To fulfil this criterion, health promoters must be vigilant about making the efforts to listen actively to what people want, to plan for these activities cooperatively and to strenuously avoid defaulting to doing things for the sake of expedience. Engaging in the PEOPLE System’s embedded review activities would allow participants to ascertain to what extent their actions are, in fact, guided by the agreed priorities and goals.

Since the Alma Ata Declaration, community participation has been mandated for the provision of health services that are tailored to suit the particular needs of the people these services are meant for (WHO, 1978). In reality, the partnership models used by health agencies in communities frequently do not contribute to the vision for greater empowerment and health improvements of people (Murphy & Cauchi, 2006; Neuwelt, 2007). PHM 2000

Himmelman (2001) suggests that there are four different kinds of community health partnerships; they are networking, coordinating, cooperating and collaborating. Each is different in terms of the way communities participate and in terms of the amount of actual say they have in making activity decisions.

In a similar vein of explaining the models used in reality, Sheryl Arnstein (1969) used a ladder analogy to describe different levels of community partnerships and participation, in relation to the amount power and control people can actually exert on the partnership processes and outcomes. The bottom rung is where the typical “top-down” and external stakeholder-led health activities are: these invite no real community participation nor do they offer to share any control at all; people participate merely as users and consumers. The next rung up is where information is offered, and participation is by way of people being passive recipients of this. Other ascending rungs describe activities to do with community consultations and advice; the topmost rung is where there is complete community control and decision-making power.

PMHP practitioners strive for communities to be participating and partnering at the topmost rung, and this useful model provides us with a means of measuring PMHP activities against salutogenic empowerment, control, participation and partnership principles. It can also help us identify the gaps and distances to be covered for achieving authentic community-stakeholder participation and partnership. In yet another review of partnership effectiveness, Gillies (1997) found that these are most likely to happen when the community is most empowered to set and drive the agenda for health promotion themselves. Further, these true partnerships can provide opportunities for sharing skills and other resources, as well as building strengths and resilience for dealing with environmental stressors.

In New Zealand, our own national framework for health promotion, the *Building on Strengths* document (Ministry of Health, 2002) identifies participation as one of the primary determinants of public health. Others include valuing our country’s diversity and creating safe and cohesive communities. The framework adopts a population health promotion orientation and aims at reducing mental health inequalities, creating supportive environments, and improving individual and population resilience. It puts out a call for close partnerships between the stakeholders to better coordinate mental health promotion activities including active participation by people in communities, government, and health, education, corporate and civil sectors. Emulating the WHO initiatives before and since, *Building on Strengths* echoes what PMHP is all about; its focus on participation makes it a

good example of an effective strategy for promoting mental health in this country and elsewhere.

One more point to make on the principles of participation and partnership that is of special interest for the New Zealand context is the inclusion of the indigenous Maori people into health promoting endeavours. This is not just because of their vulnerable health status as a marginalised sub-population, but it is also because of the provision under our country's founding document, Te Tiriti O Waitangi (The Treaty of Waitangi), to promote, protect and partner with Maori in all aspects of nationhood which most definitely includes population health. We not only wish for full partnering and participation of Maori people in community health promotion activities but also want their participation in the health sector as practitioners, teachers and researchers.

Operating on the principles of participation and partnership contributes to creating a sense of empowerment and control in the people and communities involved and, as such, these remain some of the main mechanisms for guiding PMHP and related activities (Lord and Farlow; Marmot, 2003; Rissel, 1994). As such, all the four principles just discussed are clearly and inextricably linked with each other.

Connectedness, culture and values

The value of connectedness has to do with acknowledging that, as social beings, most people want to have a sense of community and belonging that affords some perception of meaningful human relating, mutual support and shared fates (Chavis and Pretty, 1999; McMilan and Chavis, 1986; Sarason, 1986). The communication channels and structures that people use to relate and connect with each other in society are recognized as a collective resource that creates social safety and unity, and this resource is what is generally meant when academics discuss the concept of social capital (Baum, 1999; Cox, 1995; Grootaert and van Bastelaer, 2001; Putnam, 1993). Putnam is generally associated with the popularization of the concept of social capital and suggested that, while it is essential for strong civil societies and democracies, the creation of this resource takes time, effort and on-going commitment. Putnam also stated it remains an ongoing challenge to ensure that these demands on resources are not such that the creators of them suffer from exhaustion and burnout (Putnam, 1993; 1995).

Cox (1995) described four kinds of capital as including financial, physical, human and social, and criticized the dominance of the first three over the last one. She thought the focus on finances, environmental impact, human labour and productivity has taken away

from paying more deserved attention to social capital. Cox also argued that social capital allows for collective action for public good, builds cohesion and trust and can be used to measure social links and their resilience (Cox, 1997). Connecting people in a community helps create increased quantity and quality of social capital resources with all its attendant values of social cohesion, sense of belonging and egalitarianism and is, therefore, a great activity and outcome for PMHP

The process of building social capital and connectedness within any community, by definition, creates strong relationships and ties that facilitate mutual trust and reciprocity and offers its members protection from isolation and crime (Baum, 1999; Putnam, 1995; Woolcock, 1998). What is less often recognised is the possibility that the ties that build strong connectedness among members can act to exclude people who are not considered members. This is especially a challenge for culturally diverse communities because each culture views, understands and communicates their experiences very differently from each other.

Culture “includes the technology and organization that people employ to provide food, shelter and clothing within various physical and social environments” (Gesler & Kearns, 2002). Although it is a concept that is notoriously difficult to define, it has been used frequently in the literature as if all users share a common and uncontested understanding. Provocatively, one writer even went on to famously assert that “There’s no such thing as culture” (Mitchell, 1995, p 102) and that it was far more important to focus on how the idea of culture is used to control production and reproduction rather than on what it might mean.

When writing about the relationships between culture and health, Gesler and Kearns (2002) offered some explanations as to how the complexities involved in trying to tie down a precise definition of the term came to be. They cautioned that culture is not a thing and that its meaning is not independent of the people who possess and experience it. Although culture is inherited and passed on through the generations, it can also stagnate or change with how people practise it or not. Culture is situated within relationships and is affected by factors to do with the history, economics, politics, place, society and so on of the individual and the group. The concept of culture can be applied to any human grouping, however small or large (Gesler and Kearns 2002); hence, a small group of young people who are admirers of a Hollywood celebrity may be considered to possess a culture as much as an entire country whose populace may share a common history, language, religion or aspiration does.

The problems about defining it notwithstanding, it is indisputable that culture affects the way individuals and communities view, understand and participate in the social world they live in. The cultural pluralism that exists in our communities today, therefore, logically leads to a matching pluralism in the views, values, aspirations and experiences that affect people's ideas and practices about every aspect of life, including that of health and wellbeing.

Continuing on our PMHP paradigm of trusting in the resourcefulness of community and its peoples, we trust in the depth and wealth of the extant cultural resources the people in our diverse communities will bring to our community development and health promotion undertakings. In the particular case of the diverse community of Glen Innes, it is about ensuring that those multicultural resources are harnessed and used to maximize the participation of the population so as to improve the health outcomes of all of them. These include the most vulnerable cultural groups that experience the biggest inequities: indigenous Maori, Pacific Peoples, refugee, migrants, youth, elderly, disabled and other community minorities (Gesler & Kearns, 2002; Tiatia, 2008). This particular and inclusive community vision resonates with the one articulated by the *Building on Strengths* framework for mental health promotion in our country (Ministry of Health, 2002).

Connectedness through culture is an effective way of progressing PMHP if we can work at building on the strengths and resources that exist in the different cultures to weave a population health narrative that is inclusive and meaningful (Gesler & Kearns, 2002; Raeburn & Rootman, 1998) Ofanoa 2010; Asian Health Report 2002) We do this practically by cultivating cultural respect when working with all the various community groups, including as many representatives of them into our activities as possible, increasing opportunities to build cross-cultural relationships and celebrations, and building an environment that thrives on and values community connectedness and cultural diversity. In doing so, the Glen Innes community will be co-creating a unique Glen Innes "culture" with its own ways of working to promote the health and wellbeing of the Glen Innes population.

Chapter summary

In this chapter, I have placed the proposed community participatory research project within the context of health promotion and community development literature. The World Health Organisation was described as championing a socio-ecological focus on the environmental impacts on population health and the Ottawa Charter as embodying an

international mandate for multilevel collaboration to advocate, enable and mediate social determinants for populations to promote “new public health”. Although the WHO’s holistic definition of health includes the mental component, appropriate attention to this suffered from neglect of the public health sector.

PMHP is a new paradigm that seeks to redress that situation by proposing that resiliency can be fostered within individuals and populations by creating supportive and resourcing environments that are community-led and controlled. This resourcefulness/resourcing model promotes culture, community connectedness, capacity-building and control. I have argued that the PEOPLE system, with its simple and comprehensive framework for guiding interested people to plan, organize and act to achieve common goals, is an appropriate way to promote population mental health at a community level.

The PEOPLE System is a practice model that includes a review component in its functions, and is adaptable for the multicultural and underserved Glen Innes community. The proposed PMHP Model is the result of using the PEOPLE System to apply the PMHP paradigm in Glen Innes.

Finally, I outlined some important principles and values that must inform the Glen Innes research to ensure that it is led, driven and controlled by the Glen Innes people themselves. The proposed study particularly seeks to discover if the CD and PMHP empowerment ideals may be actualized with the community in Glen Innes. I envisaged a community-campus partnership that will model an ethical way of working where the community retains control of the project processes and outcomes, reciprocal benefits may be realized, and Glen Innes people experience greater mental health, wellbeing and quality of life.

The next chapter on methodology will describe the ways I embarked on this undertaking as an uninvited academic intent on collaborative research with the Glen Innes population. I will start by using the PEOPLE System to begin initial engagements with some Asian groups in Glen Innes, then move on to a wider whole-of-community participatory research project that will build on the learning from the Asian projects and improve their individual and collective health and wellbeing by employing the PMHP Model.

3 RESEARCH METHODOLOGY

It is necessary to help others,
not only in our prayers, but in our daily lives.
If we find we cannot help others,
the least we can do is to desist from harming them.
(The Dalai Lama)

This study aimed to promote and improve the mental health of a disadvantaged urban community by applying the PMHP Model, a combination of the PMHP paradigm and the PEOPLE System mechanism. This chapter presents the research approach and methods used in the series of sub-studies that comprise the whole thesis research project. The first section presents the overall community participatory action research methodology used in the study, an approach which is compatible with the principles of PMHP and community development. The methodological approach was developed by integrating elements from action research, participant action research and community-based participatory research methodologies. The remainder of the chapter introduces the three phases of the research process and the methods used in each of those phases.

Overall research approach

The series of research studies that make up this thesis together constitute what could be considered a demonstration project, coming out of a broadly community psychology way of working (Raeburn and Seymour 1979; Raeburn 1986; Raeburn and Rootman 1999; Duffy and Wong 2000). In other words, there is an overall and novel naturalistic situation into which various assessment and change processes are introduced, and this constitutes a project where the research task is to evaluate the processes and impacts associated with these as precisely as possible, using a variety of quantitative and qualitative methodologies. On the basis of triangulating all these data and appraising the overall project, conclusions can be drawn as to its efficacy and processes, and how well it meets the values statements identified in the previous chapter. The knowledge component arising from this comes from seeing whether the model used for planning and implementing the project (in this case the PMHP model) appears to be a workable and effective one.

This composite approach has been used for many years in projects involving the PEOPLE system. In this thesis, the author, in association with John Raeburn, have coined "Community Action Research" or CAR, to denote the unique research approach used to fit this kind of environment and research situation. Although it is in one sense unique, it actually uses aspects of a number of well-accepted methodologies in social and community research, specifically: action research (AR), participatory action research (PAR), community-based participatory research (CBPR) and systems-oriented evaluation approaches. Each of these is discussed briefly here.

Action research has been in existence for over fifty years. In 1946, social psychologist Kurt Lewin first introduced the term "action research" to describe a way of doing research that transcends pure knowledge creation and involves finding practical solutions to social issues. Lewin (1946) saw this kind of research as a way to help restore democratic values and processes in a post Second World War environment (McNiff, 1988; Robson, 1993). Typically, AR is problem-focused and involves a cyclical series of steps that include stating the problem to be addressed, devising an appropriate plan of action to address the problem, carrying out the plan, evaluating the results from the plan, and using the findings and knowledge arrived at to resolve the issue or devise a more appropriate plan (Brown and Tandon, 1983; Cunningham, 1976; Peters and Robinson, 1984; Wadsworth, 1998). Early undertakings of AR were primarily led and controlled by researchers and scientists. Study participants remained passive and had action research done for them, to them and at them, rather than with them (Peters and Robson, 1984).

Participatory Action Research (PAR) is a subsequent derivative of AR which offers a more equal and democratic relationship with those being studied in a research project. PAR has an action or problem-solving focus similar to action research, but it also places an emphasis on the active participation of the people at all times and for all parts of the research process, from social issue identification, to planning for action and implementing action, to evaluating outcomes (Reason, 1998). Based on democratic and social justice principles, PAR aims to co-create knowledge that will drive effective action for the people and share power through building on their own capacities to make social change possible (Reason, 1998; Whyte, 1991). Ideally, participants become co-researchers and the research activity becomes an exercise in equal and reciprocal cooperation (Reason and Bradbury, 2001; Robson, 1993; Stringer, 1999).

PAR differs from most other approaches to public health research because it is based on reflection, data collection and action that aim to improve health and reduce health

inequities through involving the people, who, in turn, take actions to improve their own health (Baum et al., 2006). The process of PAR should be empowering and lead to people having increased control over their lives.

In the way PAR has just been described, a huge philosophical and practice debt is also owed to the work of people like Brazilian educator, Paulo Friere, and Colombian sociologist, Orlando Fals-Borda, in Latin America. Both were working in the 1970s to try to resolve some of the pressing social, economic and political problems experienced by people living in underprivileged and exploited communities, and writing about the processes and outcomes they experienced with those disenfranchised communities.

Paulo Friere developed his brand of critical pedagogy while working with deprived communities in South America, and in response to how he saw traditional education systems and models being used to keep those people passive, marginalised and oppressed. His brand of active education was a praxis model where his adult students were encouraged and actively participated in asking important questions regarding the inequitable social circumstances they find themselves in, and then using the knowledge gained through that process to reflect on how they might act to change those oppressive circumstances. Using these reiterative cycles of asking and doing, these adult students would be empowered to mobilise themselves and work together to instigate and advocate for social and political change (Freire, 1972).

Building on Friere's work, Orlando Fals-Borda promoted PAR worldwide by using lessons learnt from empirical field studies conducted in Nicaragua, Colombia and Mexico in Latin America (Fals-Borda, 1987) to describe a way of improving societies. Fals-Borda saw his use of PAR as a pertinent approach for promoting radical changes from the grassroots level of the disadvantaged people in self-determined and nonviolent ways. These include "scientific research, adult education and political action combined" (p 329). His vision postulated delivering education and knowledge in ways that people may "articulate their own socio-political position on the basis of their own values and capacities and act accordingly to achieve their liberation from the oppressive and exploitative forms of dominations imposed by opulent (capitalist) foreign powers and local consular elites and thus create a more satisfactory life for everyone" (p 331).

At about the same time in the developed Northern hemisphere, the community-based participatory research (CBPR) methodology progresses the community involvement in research direction by emphasising a collaborative and empowering relationship with the

participants, who are typically members of a community being researched by community psychologists, community development workers and the like. CBPR is a generic term for a variety of research approaches that have in common the fact that they include community participants as collaborators in the research process (Tandon and Kwon, 2009). The quintessential feature that distinguishes this from other types of Western action-orientated research is that the research activities in CBPR arise directly from the needs of the community (Park, 1999). CBPR also has specific relevance to working with vulnerable, disempowered and underserved populations, and has a commitment to addressing health inequalities and restoring wellbeing and quality of life as fundamental human rights (Baum *et. al*., 2006; Trinh-Shevrin, Islam and Mariano, 2009; Wallerstein and Duran, 2010). In that regard, CBPR demonstrates a parallel concern with alleviating the inequities experienced by less advantaged communities and enabling these populations to rise up to effect socio-cultural changes as was evidenced by the work of Friere and Fals-Borda in Latin America discussed earlier.

CBPR also differs from the traditional focus for social research in communities that have a deficits-based approach, with its emphasis on building on assets, strengths and resources within the community and developing social and health solutions that are empowering, strengths-based, equitable and transformative (Dalton, Elias and Wandersman, 2001; Kretzmann and McKnight, 1993; Rappaport and Seidman, 2000). In this kind of research setting, attention is trained on what exists in the community rather than what is absent or lacking. Further, the role of the researcher is what is termed a “participant-conceptualiizer” who becomes integrated into the fabric of that community, while still retaining a degree of separation that enables her to conduct herself in a way appropriate to the fulfilment her research tasks. It is this CBPR approach to research, along with the general concept of action research of a participatory nature, especially inspired by the radical developments in Latin America, that most informs the CAR approach used here.

The other component of CAR, systems-based evaluative approaches, is derived from general and operational systems concepts (Churchman, 1968; von Bertalanffy, 1968; B. Williams & Imam, 2006) in the planning and evaluation of community (and other) types of projects, and the very name “PEOPLE System” indicates that it comes from this perspective. Here, the concept of cybernetics systems is particularly pertinent, where a large, whole system, such as a community project, is defined in terms of its overall goals and objective, and evaluation is done in terms of the achievement of these goals, both short term (as in process evaluation) and long-term (as in outcome evaluation). This approach can provide both hard and soft data for evaluation purposes and is especially

distinguished by its use of “feedback loops” from reviews of progress towards goal-attainment; these are used to appraise management systems and to correct parts of the operation that might otherwise be taking the system off-target (“negative feedback”) and affirming operations that keep it on-target (“positive feedback”). In short, it creates a self-optimising system, which is exactly the kind of system one wants for something like a complex CD project.

In this research, the PEOPLE System frames the whole operational enterprise in terms of such a review/feedback/self-optimising kind of system, and this provides some of the main data for research analysis. In order to distinguish the whole community Project from its component sub-projects (the PEOPLE System being applied at both these levels of project), the first will be referred to as the “Project” (with a capital P), and the others will be referred to as “action projects”, since they represent the vehicle through which the overall Project is operationalised.

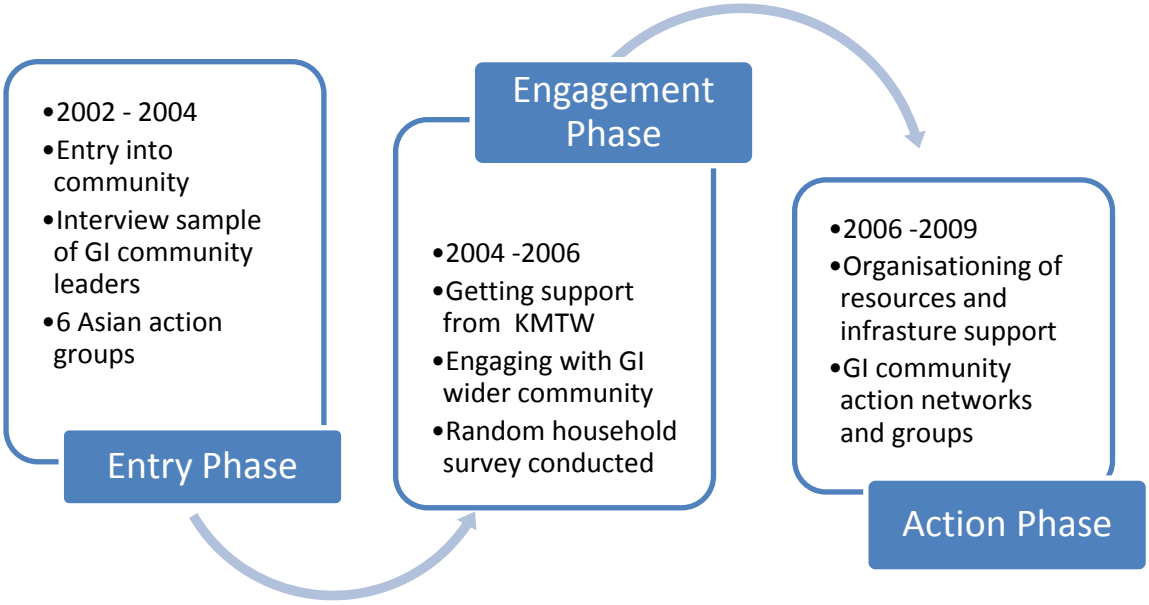
In a similar vein, Fetterman’s empowerment evaluation approach was developed specifically to give all programme participants active roles in identifying their own objectives and ways to achieve the same (Fetterman, 1994). In his words, “Empowerment evaluation is the use of evaluation concepts and techniques to foster self-determination. The focus is on helping people to help themselves. This evaluation approach focuses on improvement, is collaborative, and requires both qualitative and quantitative methodologies.” (p 1). Fetterman adds value to our work in Glen Innes by offering insights into how the empowerment evaluation approaches may be incorporated in how we train, facilitate, advocate, understand and liberate ourselves and the people we work with.

Three phases of the research study

All of the above approaches contributed to the way the entire Glen Innes CAR research study was conducted to different extents. As mentioned previously, this thesis reports on a study that consists of a series of smaller projects and stages. The study stages can be divided into three main phases namely: Entry (2002 – 2004), Engagement (2004 – 2006), and Action (2006 - 2009). These phases of the CAR Project are also able to be related to the concurrent PEOPLE System steps and this relationship is shown in the following table. The following figure is a process diagram giving an overview of the study undertaken between 2002 and 2009 in relation to the CAR Project phases. It is intended to facilitate the subsequent narrative describing the researcher’s entry into the community and

subsequent research activities undertaken there, integrating the vital role of participant-conceptualizer into the fabric of the CAR process in Glen Innes.

Figure 3.1: Process diagram illustrating the three phases of the GI CAR Project.



The following table provides a description of what happened in each of the three phases in relation to the five PEOPLE System steps.

Table 3.1: Aligning Glen Innes CAR study phases with CD activities and PEOPLE System steps

Research Study Phases	Description	PEOPLE System steps
Entry Phase: 2002 – 2004	Building relationships in Glen Innes (GI); Introducing research project to 14 community stakeholders and leaders; Interviewing 18 Asian community leaders and stakeholders about possible interest in participating in research project; Recruiting six Asian action projects; Completing first few steps of PEOPLE System with Asian action projects	1. Values and objectives statement regarding the GI Project (The six Asian groups trialed the PEOPLE System steps with the original aim that each one would complete the first three steps to the goal setting stage)

Engagement Phase: 2004 – 2006	Introducing whole-of-community Project; Conducting the GI random household survey project in the community; Setting community priorities and goals;	2. Needs/wishes assessment 3. Goal setting
Action Phase: 2006 - 2009	Confirming/setting up governance and organizational structures; Seeking resources and planning; Facilitating the creation or strengthening of appropriate community action groups: Facilitating the creation or strengthening of community networks; Supporting action projects to work together on community goals	4. Organization and resource arrangements to implement goals 5. Action groups arising from goals

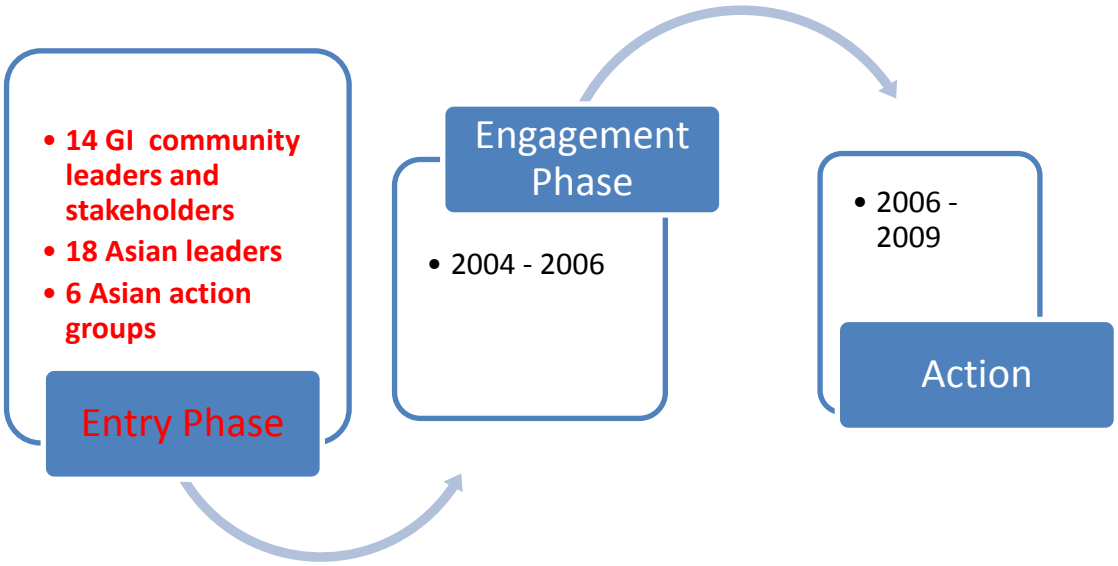
The rest of this chapter provides a description of the projects undertaken in each phase and the methods used in each of these phases.

Phase 1 Entry: 2002-2004

The entry phase consists of several aspects including initial entry into the Glen Innes community, relationship building and introducing the research project to the community; Asian stakeholder interviews; and setting up and running the Asian action projects. The initial aim when I entered this community in 2002 was to begin building positive relationships with stakeholders in Glen Innes to elicit and gauge their interest in the proposed research project.

The first methodological step, then, was to establish and build on the nature of the relationship I wished to have with the community. As the various methodological approaches outlined above suggest, the nature of this relationship is crucial, especially from a trust perspective, and in terms of the partnership/ participatory/ collaborative philosophy driving those approaches. Specifically, these relationships would facilitate getting the information needed to complete the first step of PEOPLE System's Objectives and values statement.

Figure 3.2: Process diagram highlighting Entry Phase and Asian projects



Entry into community, building relationships, introducing research project

From the university's point of view, my entry to the community was facilitated by the university's support for staff and students undertaking projects that engaged with its neighbouring Glen Innes community. For example, in 2002, the then Pro Vice Chancellor of the Tamaki Campus held an inaugural "University/Community Liaison Group" forum to start conversations about how interested parties from both university and community might work together for mutual benefits.

From the community's point of view, my introduction into the community was by way of going along to attend several of the GI community network meetings to get a sense of the rhythm of community life and to assess possible community responses to a participatory research Project to be undertaken. These meetings always began with an introduction round, and I took the opportunity at every meeting I attended to introduce myself as being a university student interested to conduct a community research project with the people in GI. Some of the attendees had been invited to and attended the university/community liaison group meetings set up by the Pro Vice Chancellor. At some of these meetings, caution or even hostility was expressed by some community members who had had previous interaction with researchers, consultants and academics undertaking projects in GI. These community people were concerned that those past projects did not help them to increase their understanding of their community and doubted that these types of projects would benefit them.

I was fortunate to have worked as a volunteer with an early childhood service in GI and had even attended one of the GI monthly network meetings with some parents to get support to resolve a safety situation at the early childhood centre; so, when I returned to the network meetings some months later in my researcher role, I was able to remind them of their previous help to me and the centre parents and so managed to get some acceptance that way. Notwithstanding some perceptible scepticism, a few network members did venture to give me the benefit of doubt, some recommendations and advice. Based on that, I was able to create a list of likely community people and agencies to whom I could introduce myself and my research proposal.

In response to some of the understandable wariness expressed by GI people at the network meetings, I also undertook several practical strategies to increase the chances of my successful entry into the GI community. One was to give very clear information about the philosophy and values underpinning the people-centred feature of the research project and to reiterate the ability of community participants to withdraw from any part of the project at any time without having to give any reasons. Another strategy was to cultivate credible community champions who would be willing to promote the project as well as provide advice on the best ways to proceed with it. Yet another, related to the previous, was to take note of the members who expressed the most critical reservations about the project and to explore ways to mediate their reluctance. A fourth strategy was to focus on working initially with some smaller Asian migrant groups in GI. In the end, I used all of them. The fourth option was appropriate because I am Chinese, and I believed that my ethnicity and previous work with Asian families there might help me gain easier access to the Asian communities that would later facilitate my venture into the wider GI community.

Sampling of GI stakeholders

To select key community people to talk to about my project, I used a few different techniques. First of all, I identified some key people at the community network meetings who seemed to have personal influence and the respect of the other members. I made personal contact with four of them to see if I could set up a further meeting, for 15 to 20 minutes each, to talk a bit more about my research project. They all agreed to meet with me within the week. With each one of them, I also referred to the list of community contacts given out at the network meetings and asked if they thought any of those listed people would be able or willing to help me. I also asked them if they knew of any other people who may not be on the list who might be good for me to contact. Using these stratified, networking and snowballing techniques, a total of 14 community people were selected to be interviewed and to start building relationships with.

Not all of the stakeholders lived in GI, but those who do not live there do work there, and were very involved in community life. They were also mainly Europeans, as the majority of people attending the GI community network meetings then tended to be agency or other paid workers. These network meetings had a focus on service providers and agencies sharing information about what was happening in the community; ordinary residents do not usually attend unless there were specific requests for information or help, such as when I first attended with a group of local parents. The GI community network was set up in 1987 by a group of concerned residents and is the oldest such community network in Auckland. The original cohort of GI residents who set it up wanted the services and agencies to work in more coordinated and efficient ways and to keep community people informed. Several of them still attend these meetings regularly. The following Table 3.2 summarises some selected characteristics of these GI community stakeholders.

Table 3.2: Selected characteristics of 14 GI people contacted and interviewed

Characteristics	Number
Gender	
Female	9
Male	5
Ethnicity	
NZ European	7
Maori	3
Pacific Island	2
Asian	2
Sector involvement	
Community agency worker	4
Health or education worker	4
Government or agency worker	4
Other	2
Residence	
Glen Innes	5
Not Glen Innes	7

Introducing research project to 14 community stakeholders

To make sure that the stakeholders were very clear about the aims and objectives of the proposed research project, I offered each one who agreed to meet with me some background material to peruse. These packages included the Joubert and Raeburn article "Mental Health Promotion: People, Power and Passion" (N Joubert & Raeburn, 1998), the PEOPLE System graphic (Raeburn, 1992), the "Resilience in supportive environment" PMHP graphic (N Joubert & Raeburn, 1998), a copy of the Ottawa Charter's Five Action Streams (WHO, 1986b) and my business card with contact details in case they had any questions before the meeting with me.

Interview process with 14 community stakeholders

To acknowledge the value of their time with me, I always turned up to the meetings punctually and finished no later than the agreed time unless the other party asked to extend it. The meetings were kept to a standard template and were summarised on a cue card for my easy reference as follows:

1. Greet them appropriately and thank them for agreeing to meet;
2. Ask for permission to make notes of meeting;
3. Introduce self and project objectives again;
4. Ask if they have read over the background material;
    a. If yes, ask if they have any questions;
    b. If no, give them a quick summary;
        i. Go over PMHP's "Resilience In Supportive Environments" graphic;
        ii. Go over PEOPLE System graphic;
        iii. Go over Ottawa Charter action streams;
        iv. Go over rationale in beginning with some GI Asian groups;
5. Ask if they have any more questions, comments or advice;
6. Ask if they thought there was any other person or group I should contact;
7. Ask if they want any more material left with them;
8. Ask if they wish to be kept informed about what happens next;
9. Thank them for their time and help.

Outcome of interviews with 14 GI community stakeholders

The participants were mostly very positive about the project. Most of them agreed that it was a reasonable strategy for me to start with Asian groups although several suggested that some non-Asian groups might be interested in taking part as well. All of them liked the PMHP and PEOPLE models, and some were very familiar with the Ottawa Charter already. They also thought that mental health was not well served for GI people and

confirmed that there was general reluctance to talk about mental health in the community as those conversations would tend to be about mental illness. They generally supported the idea of promoting mental health, instead of focussing on preventing or treating mental illness, but many also wondered out loud if that would “solve the problem”. A few of them reminded me that my research needed to “do something practical” instead of “just talk about good ideas”.

All of them offered me at least one Asian community stakeholder to contact, and several of them also volunteered to contact some likely Asian groups on my behalf to set up meetings for me. Through this initial interview and personal referral process with the original 14 community stakeholders, I managed to get a total of 18 Asian community contact people to follow up on.

Sampling of 18 Asian community stakeholders

To progress to the next stage of interviewing the 18 Asian community stakeholders, I made a list of their known demographic details to work through. These included as much as I knew about their ethnicity, background, occupation, role in GI Asian communities, and any other information that could be gathered from those making the referrals.

There were four who were not Asians, but they worked very closely with GI Asian communities and were important stakeholders in the context of their influence and familiarity. For example, a couple of them were English language teachers who took classes with Asians, and the other two were community service providers for Asian clients and groups.

These stakeholders were made up of a range of Asian ethnic groups including Indian, Sri Lankan, Pakistani, Burmese, Afghani, Chinese, Taiwanese and South-East Asian (Table 3.3 below). They were community residents and volunteers, agency and council workers, health professionals and university researchers. Some were born in New Zealand, but the majority were migrants (including the two Europeans) and ex-refugees. All of them were members of or connected to some Asian community groups in GI.

Table 3.3: Selected characteristics of 18 Asian community stakeholders, 2002

Characteristics	Number
Ethnicity	
Afghani	1
Burmese	2
Chinese	5
Indian	2
Pakistani	1
Sri Lankan	2
Thai	1
NZ European	2
Indigenous Maori	2
Occupation or role	
Community health professionals (doctors, nurses, counsellors)	5
Local council or government agency staff	3
Non-government agency staff	3
Social service providers and workers	4
Volunteer community workers	3
Residential status	
Born in New Zealand	3
Established migrant (resident in NZ for 10 years or more)	9
Recent migrant (resident in NZ for under 10 years)	4
Refugee background	2

Introducing research project to 18 Asian community stakeholders

Initially, I contacted each Asian stakeholder on the list by telephone or electronic mail with a brief introduction of myself and the proposed research project. I explained how I got their contact details and requested a short meeting of about 15 to 20 minutes if they were interested in finding out or talking more about the project. I also offered to send hard or soft copies of related documents prior to the meeting if desired, just as I had with the earlier group interviewed. Some of those with electronic mail requested the information

packs to be sent that way, and some indicated a preference for the information to be mailed to them, or dropped off to them in GI. All of the 18 contacted stakeholders agreed to a first meeting, and some had, in fact, been contacted by the earlier interviewees and knew something about the project. Two of them were also involved in postgraduate studies at the university.

Interview process with 18 Asian community stakeholders

Before each meeting, I utilised the information collected regarding the interviewee's background to maximise my chances of making a credible first impression with them. Whenever possible, for example, I learnt to greet each interviewee in their first languages and used some of their biographical data to facilitate interest and communication, for example, congratulating someone who had just completed their postgraduate degree and another who had recently received an award from the city council. I endeavoured to build a personal relationship with the interviewee as I expected each one to be a potential champion over the course of the Asian action projects. During the meeting, I explained that the purpose of the interview was to gauge interest in participating in the proposed health promotion project, provide any needed information and to gain introduction to their or other potential Asian community groups who might be interested in participating.

The template for these meetings resembled the one I had used with the earlier group with some amendments.

1. Greet them appropriately in their first language and make any connections from biographical information (for exam[le, time spent in my home country);
2. Thank them for agreeing to meet, and ask for permission to make notes of meeting;
3. Introduce self, Asian background and project objectives again;
4. Ask if they have read over the background material;
    a. If yes, ask if they have any questions;
    b. If no, give them a quick summary;
        i. Go over PMHP's "Resilience In Supportive Environments" graphic;
        ii. Go over PEOPLE System graphic;
        iii. Go over Ottawa Charter action streams;
        iv. Go over rationale for Asian action projects;
5. Ask if they have any comments, questions and advice regarding project;
6. Ask if they thought they or their groups might be interested in participating in action projects;
    a. If yes, thank them and ask what the next steps would involve;

b. If no, thank them and ask if they were happy to share any concerns;

7. Review decisions and agree on next steps;
8. Thank them for their time and help.

Outcome of interviews with 18 Asian community stakeholders

All the interviewed stakeholders thought the proposed health promotion project would be good for Asian groups to participate in; although they cautioned me regarding cultural prejudice regarding the topic of mental health as it was usually associated with the culturally-sensitive and taboo topic of mental illness. Two of the stakeholders were directly involved in mental health and were fully supportive of me working with their group of Asian members who had experience of mental ill health. The four who were working with Asians from refugee backgrounds emphasised the importance of engaging with their innate resilience and motivation to be and stay well. Most of them commented on the vulnerability of elderly Asians who were missing their traditional support systems and networks. Many of these senior members were experiencing loneliness, and needed to "get more involved in community life". A couple of community health workers were keen for me to convene a group for some Asian women who were experiencing violence in their homes.

All of the stakeholders thought it was very important for Asian people in GI to be more connected with the rest of community. They thought this increased connectedness would serve to mediate some common ethnic or racial prejudices built up due to negative anti-immigration narratives in the media and political agenda during that time nationally. The latter plus the recent influx of Asian refugees into state housing in the GI area had stoked local perceptions that these "people off the boats" were exacerbating the already extreme shortage of state housing for GI people and were unfairly housed before needy locals.

They all thought it was "about time that the university up the hill made itself useful to the community down the hill". By the completion of the 18 Asian stakeholder interviews, there was enough interest to begin the next stage of setting up and running the Asian action projects in GI.

Setting up and running the Asian action projects

The study aim here was to help set up and run some action groups where the PEOPLE System approach could be used to help people in the groups determine what they wanted for themselves, and how they could be supported to take appropriate actions to get what they wanted. I had initially wanted to work with two or three Asian project groups but, on

the basis of the successful Asian stakeholder interviews, a total of six Asian action groups were "formed" (Table 3.4).

Four of these Asian action groups were already functioning as part of bigger groups in the GI community and were meeting regularly for group activities. I made the choice to leverage and build on these existing infrastructures to work through the first three PEOPLE System steps with their members to help them achieve common goals. Two of the action groups were formed specifically for the purpose of this research study. One was an Asian women's group that was convened to provide members with a new learning forum for sharing common parenting issues and finding appropriate solutions to these. The other was a group of Chinese seniors who lived in GI but who were meeting as members of a bigger Chinese group in a neighbouring suburb. They consented to participate in the project by creating a new and smaller GI Chinese group.

Sampling of six Asian community groups

There were a total of 81 Asian members in the six Asian action projects, not including the interpreters that some of them had to help facilitate communications with their non-English speaking members and myself. Except for the women's group, there were male members in all of the groups, with the Indian seniors' group having the largest proportion of a two-thirds male membership. All the groups had mixed adult ages except the two groups of seniors who were all over 65 years. Children sometimes attended the meetings but were not counted as participants.

Table 3.4: Characteristics of the 6 Asian action projects

Asian action projects	No. of participants	Meeting	Duration of project
Burmese refugee group	20 members (+ 3 interpreters)	Weekly	June 2002 - June 2004
Women's support group	5 members	Weekly	March - May 2003
Indian seniors' group	30 members	Weekly	June 2003 - June 2004
Chinese mental health group	12 members (+ 2 interpreters)	Fortnightly	October 2003 - June 2004
Chinese elderly group	9 members (+ 2 interpreters)	Weekly	March - June 2004
Afghani refugee group	5 members (+ 2 interpreters)	Various	March - June 2004

Each of the six Asian action groups is briefly introduced below to give a background for what they had been doing up to the time of their involvement in the health promotion action projects.

1. Burmese refugee group

A Burmese physician had originally set up this community group for Burmese refugees to help them settle well into their host community. Most of the members had only been resident in New Zealand for a year and had multiple needs to be met. These included on-going health issues as well as issues in dealing with the various social services and related bureaucratic structures, in understanding the local customs of the culturally and ethnically diverse GI community, in supporting their children in school, in finding employment and learning how to communicate using the foreign English language. Because the physician was moving to a new role, he would have less time to personally work with this group. At the time of meeting with me, he was mentoring a Burmese volunteer as a replacement facilitator. They both thought the proposed participatory project was consistent with the group's desire to improve the health and wellbeing of themselves and their families and were keen to sign up.

2. Women's support group

Two local Asian stakeholders that I had interviewed raised concerns that some women with experience of domestic violence had been reluctant to discuss their situation with strangers. The stakeholders thought some supportive, safe and culturally-appropriate intervention might help these women. I took this opportunity to offer to run a parenting course for Asian mothers that had been identified as a priority by the stakeholders, and asked for their help to recruit the women they mentioned earlier. The intent was to provide these women with opportunities to talk about and share their own ideas and concerns in the context of the cooperative learning forum to enhance their parenting skills. As it happened, all of them disclosed their experiences of domestic violence by the second group meeting.

3. Indian seniors' group

This Indian seniors' group met weekly to socialise, to "get out of the house" and to "learn new things to keep the brain working". The stakeholders who connected me to them thought that this ethnic group was especially vulnerable to health issues such as cardio-vascular disease, gout, diabetes and depression. Members of this group included retired professionals and academics; they were easily convinced to participate in the research project. They considered the project would present them with the opportunity to talk more

intentionally about how to improve their own health and wellbeing. They were also appreciative of the work involved in completing a doctoral degree and were keen to help me to accomplish this task

4. Chinese mental health group

Two Chinese health professionals had started this group for their Chinese clients who lived in or close to the GI community. The group was created as a way to provide support to mental health clients and their families. The proposed mental health promotion research was welcomed by the health professionals because they both thought participation in it would enhance recovery of their charges and facilitate members to interact with other people in the wider GI community. My ethnicity also made me a less threatening presence to the group than if I were from a different ethnic group. The fact that I was also a psychologist added to the group's willingness to engage.

5. Chinese elderly group

The members of this group were regular attendees of a larger Chinese group (the largest Chinese assembly in Auckland) that held its twice-weekly meetings in a community hall in the suburb of Panmure, just outside of GI. Before our meeting, these GI residents did not have much to do with the GI locals and, in fact, it was a local Maori community worker who was keen to use the proposed research as an opportunity to encourage her Chinese "neighbours" to participate in the community activities in GI. Her own family of origin had lived in the area for over five generations and had experienced very positive relationships with the earlier GI Chinese residents. Those residents were mainly market gardeners who gifted vegetables to their large family of nine children. These Chinese vegetable farmers had to move out of GI when the land was needed for providing more state housing. She was saddened by the lack of connectedness with the newer Chinese migrants who did not seem to speak much English and who were observed to "keep themselves to themselves".

I presented the proposed project to the group and the members agreed to participate as a GI group. What helped to get the project underway was my ability to converse with them in two of the most common Chinese languages, Mandarin and Cantonese. Also, the group was very interested and moved to learn that members of the local Maori community were keen to support them to become more included in their community.

6. Afghani refugee group

This Afghani group had just started meeting weekly at the GI Ruapotaka Marae (a traditional Maori meeting places that includes a meeting house, compound and related

buildings for conducting cultural activities); the Burmese group also held their meetings there. The Afghani group was set up for the same reasons as those of the Burmese group - to help their new migrants to settle well in the receiving GI community. By the time I approached the group, the coordinator had already known about the Burmese action project and was happy to get his group involved as well. He thought that participating in the project would help his members build their confidence and increase their sense of belonging in the GI community.

Introducing the PEOPLE System to six Asian action projects

To ensure the groups were well-informed about the work that they were about to do, I began my first formal meetings with each of the groups with a presentation of the PEOPLE System. These included the key principles and values underpinning the overall philosophy and the procedural steps, especially those of empowerment, community control and building connectedness and capacity. These presentations were conducted verbally and assisted by visual props as well as the help of the first language interpreters where they were needed. Although all the group facilitators had prior knowledge of the contents of these presentations, they all thought that it would be useful for me to present them because that would help the members to get to know me better and vice versa. Once again, I prepared for these presentations by making up my information pack containing the components that had proved useful in earlier interviews and meetings. Although the presentations followed a standard format, I would adapt each one to be more culturally appropriate for the audience. For example, I learnt and practised greetings in first languages and prepared some useful resources that I thought might interest them. These included promotional materials for upcoming events in the community and information about possible resources they might be eligible to apply for.

Resources for meetings

These included suitable venues for meetings, printed hand-outs, large sheets of paper or whiteboards for recording group feedback and comments, stationery for writing on paper or whiteboards, materials to use for attaching paper sheets to the walls safely, stationery for participants, and appropriate contributions for group refreshments.

Fortunately for me, the majority of the groups already had suitable meeting venues that they were using and many of these included whiteboards or blackboards. For the two groups that did not have prior venues (the women's and the GI Chinese groups) I managed to get permission to use an early childhood education centre for the first and a room in the local library for the second. I also provided other stationery that might be useful – such as extra paper and oil pastels/crayons for occupying any children who

attended the meetings - and used the university facilities for printing hand-outs and other relevant resources. For those participants who wanted one, a small notebook and pen or pencil was available for them to keep a record of their own notes and thoughts over the course of the projects.

Most of the groups also had on-going provisions for refreshments when they met, as in shared member contributions or group refreshments funded out of grants some them managed to secure. I kept a box of light refreshments" in case these were needed.
The printed hand-outs for the first meetings included the following resources:

- PMPH graphic
- PEOPLE System graphic
- Mental Health Promotion article by Joubert and Raeburn (1998)
- Participant Information Sheet (in Appendix A)

Procedures for meetings

To make certain that all groups would be given consistent messages, a standard template for these first meetings was created as a guide for me. The following is a summary of the aspects I would cover, with the help of interpreters where appropriate:

1. Greet them appropriately in their first language, then Maori and then English;
2. Thank them for agreeing to participate in the project;
3. Introduce myself and go over project objectives again;
    a. Go over PMHP's "Resilience In Supportive Environments" graphic;
    b. Go over PEOPLE System graphic and explain the steps;
    c. Go over Ottawa Charter action streams;
    d. Go over rationale for Asian action projects;
4. Ask if they have any comments or questions regarding project;
5. Go over the Participant Information Sheet and the project protocols;
    a. Emphasize how their control of the project will be ensured;
    b. Emphasize their freedom to participate or exit at any point;
    c. Ask if they any questions or concerns about the project;
    d. Invite them to sign the Consent Form (in Appendix B);
6. Confirm subsequent meeting venues and times;
7. Thank them for their time and contributions to the meeting.

This standard presentation was made to each of the six participant groups with help from bilingual facilitators as appropriate. Any relevant feedback and comments from group members were noted by the researcher or the interpreters on the whiteboards,

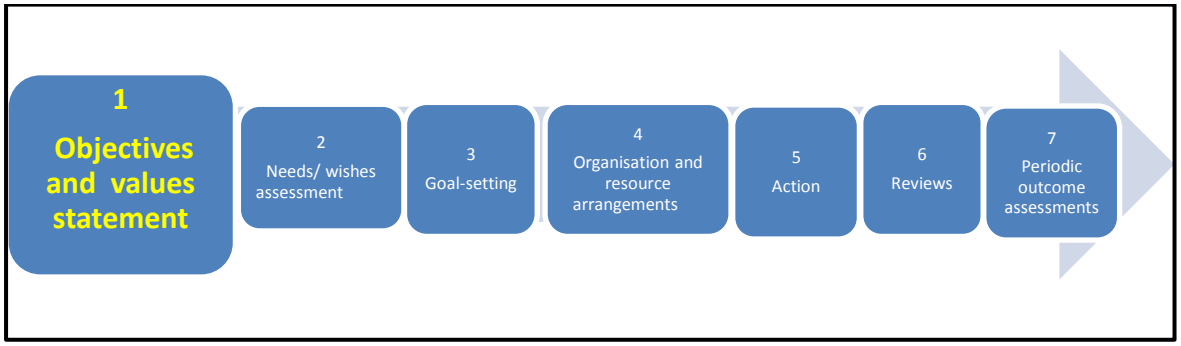
blackboards or large sheets of paper that were displayed where these could be seen by all easily. All the group members signed their forms; the venues and times for the following meetings were also noted and confirmed.

To keep all our processes clear and accountable to each other, each group nominated at least one facilitator who would work closely with me. These group facilitators or coordinators would meet with me either just before or after each meeting to 'catch up with the play' and to discuss any emergent or anticipated issues. These were normally carried out on a face-to-face basis although we would conduct these over the phone or via the internet as agreed and needed. I kept notes of all proceedings in my journal as well for reference. The Asian action groups were now all set up to run with the PEOPLE System steps.

PEOPLE System Step 1: Objectives and values statement

The following is an enhanced version of the PEOPLE System steps to remind us of the context of the narrative to come regarding the Asian projects completing this first step.

Figure 3.3 Step 1 of the PEOPLE System



This important first PEOPLE System step involves getting all the members of the group to share and discuss their values, objectives and, generally, what they wanted for themselves and what were the ways of working together that would get them there. This process helps to create common purposes and builds connectedness among the members if it is done sensitively and skilfully. It was also important to somehow link the conversations to the overall aim of the research project, which was to improve the participants' mental health, wellbeing and quality of life. To remain mindful of the cultural sensitivity around the concept of mental health, a holistic health concept was used so that after establishing the fundamental components of overall health, I did not initiate any talk about "mental health" unless it was in direct response to a request. Over time, as the

Asian participants and groups became more comfortable with me and my professional training as a psychologist, some of them would ask direct questions regarding mental health and mental illness.

Resources for Step 1

These remained the same as for the first meetings (meeting venues, equipment, stationery, refreshments) with the addition of particular hand-outs, learning aids and topics for group discussions. For this specific session, they included

- World Health Organization's definitions of "health"
- Cultural examples of health definitions especially examples relevant to the groups
- Visual and other learning aids relating to health, wellbeing and quality of life
- A collection of interactive and fun games or icebreakers that might be appropriate to use with the groups to move things along and to build cohesiveness

The various group facilitators were hugely valuable to me as resource people to advise me regarding the appropriateness of what was planned for the meetings as well as the learning aids (photos of or real health and medical equipment, pictures of people and places, flowers, rocks, feathers, fruit, cans). They contributed their own ideas and props to the collection as well. The internet was a useful vehicle for gathering information and old copies of the National Geographic magazines, in particular, provided high quality visual support to illustrate cultural expressions of health, wellbeing and quality of life. The group decided on the sequence of the meeting components and who would be responsible for conducting each part. It was agreed that I would participate in these presentations, including those for the non-English speaking groups. The relevant group facilitators thought the members would benefit from my presentations in English and that would help build their personal relationships with me.

Procedures for Step 1

To get everyone talking about what their values and objectives were, the following session template was used as a guide for all group facilitators:

1. Begin session with an overall presentation about health and all the important components of it, including physical, mental and spiritual components;
    i. Ask them what they understand "health" to mean for them and have their responses written up or noted as appropriate;
    ii. Present the holistic WHO definition of health, ask for comments and have these noted as before;

iii. Present some other cultural definitions of health, ask for comments and have these noted as before;
iv. Ask how they think health is related to wellbeing and quality of life and have these comments and responses noted as before;

2. Conduct a group icebreaker to stimulate conversation around the themes of values and objectives for health, wellbeing and quality of life;
    i. Pass around the visual and other learning aids (or put in centre of the room); get each person to choose one that appeals;
    ii. Ask them why the chosen item was appealing to them in terms of values relating to health, wellbeing or life quality;
3. Ask them what they considered to be important reasons for working together as a group and have comments written up or noted as before;
4. Agree on the values of the group:
    i. Ask group members what were the most important values for them and write these up;
    ii. Get group members to discuss and debate on what they can agree on as common values for the whole group;
    iii. Get whole group to confirm the common group values and write these up on a fresh sheet of paper;
5. Agree on objectives of the group:
    i. Ask the group what they thought to be the most important group objectives and write these up;
    ii. Get them to discuss and debate what they can agree on as common objectives for the whole group to work towards;
    iii. Get group to confirm the common objectives and write these up on the fresh sheet of paper with the agreed group values;
6. Agree on how they will work together as an action project:
    i. Get the group to share their expectations of each other and themselves in terms of how they will work together as an action group to meet their agreed values and objectives;
    ii. Write up only the suggestions that everyone agrees to;
    iii. Get group to confirm the suggestions that have been written up to be the agreed ways of working together as an action group;
7. Ask the group to share how the session went and if there were any comments or feedback regarding the agreed values and objectives;
8. Review and summarize what was accomplished by referring to the notes and thank them for their contribution and participation.

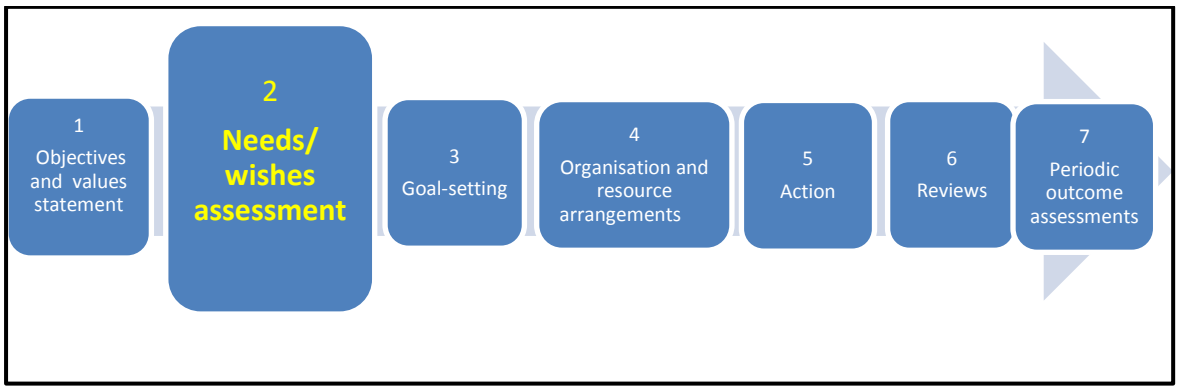
The above template served only as a general guide to the session proceedings to ensure all aspects were covered; it was not applied directly without reference to the actual context in which the meetings occurred. It might seem that the groups had to fit in with the template, but the template more often had to fit in with the group. What was considered important was that the group facilitators work with me closely to ensure that I was not imposing my expectations and ideas on the different action groups. I saw my role as facilitating the groups to undertake and complete each of the three PEOPLE System steps and that included creating suggested session templates to guide them to do so.

Another point is that each of these PEOPLE System steps was not expected to be completed over a single group session, although some groups certainly managed to do this. The group facilitators were able to amend and adjust any of the planned activities to suit the appropriate pace and needs of their members and the specific circumstance relating to the meetings at the time. In some instances, the group took a few meetings to complete each of the steps. It was very important that each group took as much time as was required to complete each one well and thoroughly. The facilitators were encouraged to guide me in this aspect of the group work. It was this honest and close working relationship that kept the action groups in control of how they conducted their activities while participating on the projects. This way of working with the Asian groups seemed to work well as they remained connected, engaged and animated during the sessions. The review and feedback round conducted at the end of every session offered another opportunity for concerns to be raised and addressed.

PEOPLE System Step 2: Needs/wishes assessment

This important next step really constitutes the basic driving power, or engine, of any action project because a group will keep working together, even through adversity, if the identified needs and wishes are truly what they really want for themselves to experience better lives. This is also where the empowerment principle comes to the fore by getting people to identify and choose the needs or wishes that will be their collective priorities. The needed skills are to get the whole group to agree on a process for identifying needs and wishes and then prioritizing them for collective actions.

Figure 3.4 Step 2 of the PEOPLE System steps



Resources for Step 2

The group facilitators and I all collected items that would help group members focus their thinking about needs and wishes. These including finding pictures relating to food, shelter, clothing, families, friends, education, jobs, leisure, faiths, incomes, natural features and so on. We also gathered pictures or graphics depicting people in different life situations such as people in a motor vehicle accident, the scene of the birth of a baby, children playing on the street, people queuing for a bus and a scene from an old people's home. We went through the collected items and checked that they were all culturally-appropriate and acceptable for using in the sessions as props to generate discussions.

As usual, the groups used different combinations of props and photos for their sessions; the choice was left to the group facilitators to make in consultation with their group members.

Procedures for Step 2

To keep everyone on task, the following template was agreed for working with the groups to assess their needs and wishes:

1. Begin session with a reminder to the group about their agreed values and objectives from the first PEOPLE System step;
2. Remind the group that the intended outcomes of the current step would be to identify their needs and wishes and then to cooperatively prioritize those;
3. Ask if they have any questions before proceeding;
4. Use the visual and other props collected by
    i. Getting members to choose which pictures appealed to them, especially what needs or wishes they represented for them, or
    ii. Getting members to discuss the different points of view with regards to what were the needs or wishes of different people in the life-situation pictures;

5. Get members to talk specifically about their own needs and wishes in terms of their current lives in GI
    i. Ask them what they liked or disliked about their current living situations in GI and have these written up or noted as appropriate for the group;
    ii. Ask them what changes they need or wish for to help improve their living situations in GI and have these written up or noted as appropriate for the group;
6. Get the group to discuss the needs or wishes that were written up and identify the ones they agreed were important for all of them; compare these preferences against what was written up earlier;
7. Ask them to decide on how the needs and wishes would be prioritized for the whole group;
8. Get the group to agree on the final list of ranked group priorities of needs and wishes;
9. Ask the group to go home and think about some possible ideas about how they can work together to meet those priorities for the next sessions;
10. Review and summarize what was accomplished and check if there are any questions or comments to make about what they have done;
11. Thank them for their contribution and participation and remind them of the next meeting times and any tasks they had agreed to do.

By this stage of the life of the Asian action groups, the group members were usually all very engaged and taking ownership of the group processes and outcomes. Also, the meetings were structured in such a way that some members began to feel comfortable about helping to run parts of them. For example, they sometimes chose to work in smaller groups of threes or fives and would facilitate themselves in these activities. They took notes or gave verbal reports in their own languages of what they had done to the bigger group; these were written down and noted as well.

PEOPLE System Step 3: Goal-setting

To get the groups to set clear goals based on their own prioritised needs and wishes, which is the main purpose of this Step, the groups have to agree on exactly what they need to do in order to meet those targets. The clearer these goals are, the more likely that they will be achieved successfully. Setting clear goals also ensures the whole group is confident about agreeing on whether or not specific goals have been met. Group goals may be set for the long, medium or short terms, depending on how complex or involved they are.

Figure 3.5: Step 3 of the PEOPLE System steps

For the Asian action groups, the group facilitators agreed that it was important to build up confidence by ensuring group members got to experience success quite quickly so that they could build on these and be motivated to create future successes for themselves. These group goals would serve to focus the collective energy of the members on how their group's philosophy, values and objectives could be translated into deciding on what they would work on together. Main group goals could also be broken into smaller sub-goals that can involve more members. Setting goals also enabled the groups later to review and evaluate the effectiveness of their work against attainment of the goals.

Resources for Step 3

The aim for this step is to get all the action groups to set goals that would be likely to be achieved successfully. To do that, different goal-setting resources (hand-outs, books, copies of other project group goals) were assembled to share with the groups. These included collected examples from different sources of

- Different decision-making models that are relevant to setting goals
    - Autocratic decisions by "leaders"
    - Democratic voting by all members
    - Inclusive consensus process
- How individual goals may be broken down into more manageable chunks
    - Time chunks for long term, medium term and short term goals
    - Separated into smaller sub-goals that required different skills or resources
- How to formulate SMART (mnemonic acronym for goals being specific, motivating, achievable, realistic and time-bound) criteria that would render them more likely to succeed in achieving their goals

Procedures for Step 3

These sessions were again guided by a template for completing this step with the groups; the props and resources would be used only as required and as determined by the group facilitators as the sessions progressed. If the groups were well on their way to setting the goals without these props, as some of them did, then it was all the better. Generally, most of the groups followed a similar sequence of activities for setting their goals.

1. Begin session with a reminder of the group's priorities regarding the identified needs and wishes completed with the second PEOPLE System step (make sure these are displayed clearly all through these group goal-setting sessions);
2. Ask if they have any questions or comments before proceeding;
3. Ask the group members if they have any ideas about the kinds of goals that could be set to achieve the agreed priorities and if these are offered, record these as usual;
4. If needed, use the examples and resources collected to
    i. Go over all the different ways people and groups can make decisions on goals;
    ii. Go over all the kinds of goals that can be set depending on circumstances and resources;
    iii. Go over the SMART tool for setting goals;
5. Get members to talk specifically about setting goals for each of the identified priorities in turn;
6. When complete, ask members to categorize or separate these into short, medium or long term goals, and write these up;
7. For each of the goals, get the group to decide the criteria for measuring its successful achievement and write these up;
8. For each goal, get members to volunteer or nominate people to take charge of working to achieve and make sure these are written up;
9. Get the group to agree on the schedule of yearly, monthly or weekly goals they will work on as well as review their progress;
10. Review what were the agreed goals, people responsible for tasks, time-lines and goal review cycles; get group to confirm these;
11. Thank them for their contribution and make arrangements to ensure the group decisions are all confirmed, recorded and saved for on-going reference.

The Asian action groups performed these three PEOPLE System steps in the ways that were most appropriate for them, and the results of these will be presented in the next Chapter.

Transitions

In July 2004, this part of the research with the Asian action projects came to an end, as a consequence of my being offered employment as the manager of the GI community development project, Ka Mau Te Wero – Stronger Communities Action Group. This led to the research taking a new direction, which will be described in the section on Phase Two. Because the goals of the larger Project were consistent with those of the Asian action projects, I was able to facilitate the transition of five of the Asian projects to the larger KMTW Project for those participants who wished to continue their groups or to participate in the wider Project. The women's support group did not continue meeting as a group beyond the first few weeks due to extenuating personal circumstances for some of the members. More details from this first phase of the research are provided in the following Chapter Four presentation of the results from the Asian action projects.

Other "entry" activities

My main aim in starting with the Asian groups was to get a point of entry into the wider community in due course; consequently, some of my time during these first two years was spent in creating general relationships with individuals and groups in the GI community and with external stakeholders who have an interest in the community. Wherever possible, I also spent some effort to build more personal relationships with individuals who seemed to share common interests such as building community capacity, connectedness, empowerment and participation. I also paid close attention to those individuals and groups who expressed scepticism or negative views about research projects, the university, Asians in the community or any aspect relating to my work in GI. My view was that their criticisms could be used as references to review and evaluate my work in terms of avoiding the mistakes those critics identified. Over time and with perseverance, some of those critics have become the GI Project's allies and promoters.

One of these "entry phase" activities was my being a point of contact for University of Auckland staff interested in working in the local community; this occurred through my participation in a Community-Campus Korero group ("korero" is the indigenous Maori word meaning "talk") that was formed in 2004, with the aim of fostering a partnership between the university and the community. The partnership would broadly be in the area of community development and the research project described here. Over this period,

several community-campus projects were undertaken, including a mentoring scheme that paired university students with local college students to help them with homework assignments and an Open Day at the Tamaki campus for community people to visit the new School of Population Health and its on-site clinical facilities.

One of the most important activities during this period was attending as many of the GI community network monthly meetings as possible. At those community network meetings, I participated in every introduction round by always sharing some new information regarding my work with the Asian groups, including asking for help and support such as, for example, asking for donations (beds, blankets, crockery) to help new refugee families settle in the community, inviting them to participate in cultural events (Burmese and Thai New Year, Asian Food Festival), and requesting ideas for resources (locating a local driving instructor who might be suitable for teaching people who spoke little English). This was my way to create an awareness of the community development research activity and the university's presence, connect the wider community with the Asian communities, get my contact details on their database, and also offer opportunities for the wider community representatives to ask questions or to give feedback.

In the early months, they mostly just listened to me (I kept to the same minute or so that everyone else took to do the introductions) when I spoke with not much feedback or questions. Over the later months, some of the 14 stakeholders I interviewed began making supportive comments about the community research work in the community and asked questions about specific events. This created more interest in the others. Also, as I was the only Asian at most of these meetings, they would ask me to comment on what I thought about some of the anti-Asian and anti-immigration narratives that were being presented in the media. I used humour and honesty as my basic ingredients to respond to these questions and think these responses helped habituate them to my presence in GI.

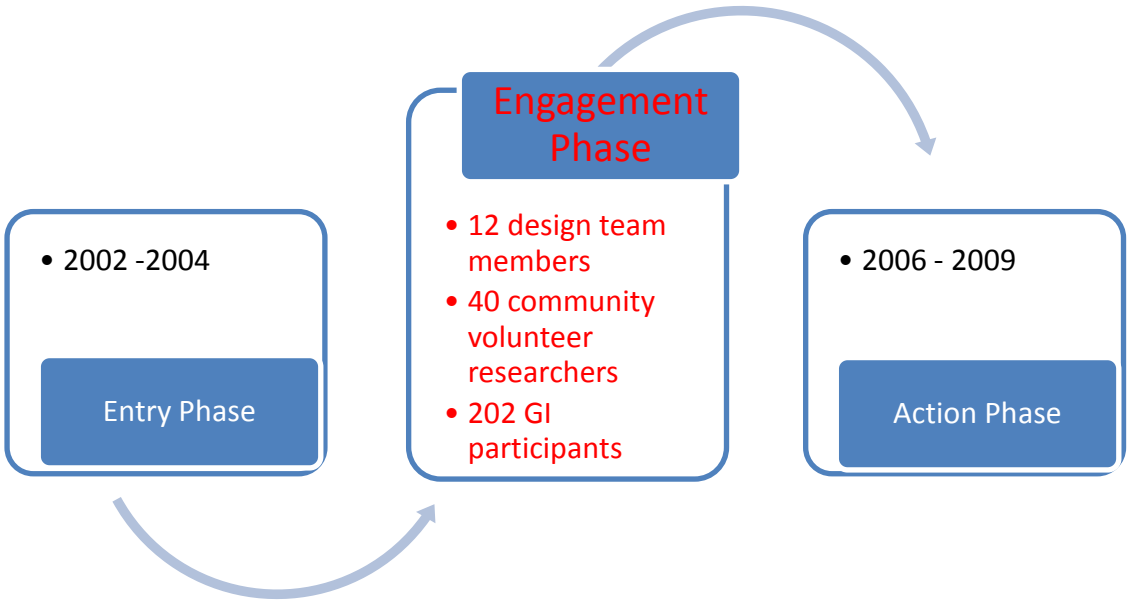
Almost a year after I first started attending these network meetings, I was asked to give the GI community network group a presentation about the participatory action research work with the six Asian groups in GI. I also volunteered to do little tasks for the network – phone up an allocated number of people on the database to remind them about the next meeting, put posters up in the town centre and find out answers to questions relating to anything the members thought were in my area of expertise, which included anything to do with the university, Asians and research.

The introduction rounds were great ways to get an environmental scan regarding who the key stakeholders and networks in GI were, and I used the information to attend other relevant meetings (like the local community board meetings, city council consultation meetings, GI Health project and so on) and to make personal contact with key stakeholders (such as local politicians, council officers, agency workers, cultural leaders). I also attended as many GI community events as possible (Christmas parade, Child Health Day, community submission meetings to the city council) and always tried to find opportunities to volunteer for jobs (e.g. washing dishes at the marae, making cups of tea, cooking sausages on the barbecue, painting children's faces). My aim was to become regarded as part of the GI social environment.

Phase 2 Engagement: 2004-2006

During this phase of the research, my role in GI changed quite dramatically – from that of a community researcher to that of a manager of a major community development project called Ka Mau Te Wero (KMTW), also known as the Stronger Communities Action Group.

Figure 3.6: Process diagram highlighting Engagement Phase



In this section, I will describe how the wider Project plan was introduced to the community and the KMTW governance board, and how that fitted the first step of an enlarged view of the use of the PEOPLE System – one that now involved a whole complex community project, rather than just providing the procedural system for smallish action groups in the Asian communities. I then describe what was done to implement the second step of the

PEOPLE System approach as applied to this wider Project – that of a comprehensive needs/wishes analysis. Following that, I will describe the methods used to implement the PEOPLE System's third step – that of goal-setting based on the ascertained needs/wishes.

First I will expand on the history of the KMTW project and my role in it, since that was the context of this Engagement phase of the research and had a strong bearing on how it was conducted. As a researcher, I was subject to the constraints of being the KMTW manager and immediately answerable to the governing board of the KMTW. As such, it was very important that I managed to get the board's support to undertake my managing role using the PEOPLE community development approach.

In 1998, the GI Family Centre (formed in the middle of the 1970s by some local women who wanted to improve the lives of local people and revitalise the community) collaborated with other GI groups and the Auckland City Council's Community Development Project Team to organise the GI Charrette event. This was a three-day community consultation exercise that sought to get the people of GI to help identify important issues and needs for them via a series of workshops, feedback forms and information booths. At a public meeting in 1999, a report on the Charrette findings was presented, and the community was invited to give feedback on the suggested community projects and to get involved. These projects related to health, transport, housing, employment, safety and capacity building.

The Ka Mau Te Wero – Rising to the Challenge - Strategy was the most ambitious of the initiatives in the report. It comprised the KMTW Health, KMTW Refugee, KMTW Employment, and the KMTW Community Development strands. The Auckland City Council received funding for the first three strands and looked for resources to address the fourth. In 2000, the Council successfully put in an application to nominate GI for selection as a pilot site for a new government funding initiative for CD in communities with high socio economic needs.

The Stronger Communities Action Fund (SCAF) was set up to trial a devolved approach to setting priorities and allocating funding to communities (CYFS, 2004). To do the trial, the Child, Youth and Family Services (CYFS) department of the Ministry of Social Development would provide funding for seven SCAF pilot sites spread out through New Zealand. The overall aim of the SCAF initiative was to improve outcomes for children, young people and their families. These seven pilot sites were contracted to achieve four main objectives for CYFS; these were to:

- Encourage the seven pilot communities to identify their own needs
- Support innovative ideas from within those communities to address their needs
- Test this new approach to devolved decision making in the seven communities
- Increase the strength and capacity of the seven communities

(CYFS, 2004)

The funding criteria for successful selection as a pilot site included

- Particular socio-economic needs of the community
- Specific focus on "small disadvantaged communities located within wealthier areas"
- Availability of a credible local organisation to manage the funds
- Demographic characteristics to provide a representative sample of New Zealand communities (including rural, urban, provincial and kin based settings)

In the 2001 – 2003 SCAF funding round, GI was successfully selected as one of the seven pilot sites with the Auckland City Council as the "credible local organisation" to ensure good financial management of the government funds. The KMTW governance board was the "community representative" charged with complying with the SCAF contractual objectives described above. The KMTW Project manager was co-managed by both the KMTW board and the Council's CD Team manager, and was charged with the task of reporting to both SCAF contract partners. In 2005, by request of the GI community to the Council's CD Team, the "KMTW" identifier was dropped from the other strands of the original council strategy for GI, and only the CD strand is now identified by the Ka Mau Te Wero "brand". The SCAF scheme ended in 2006, and KMTW became a legally-incorporated charitable trust in order to establish its own legitimacy and to be able to secure resources independently of the Council to continue its CD work in GI.

In 2003, I was invited to join the KMTW governance board by virtue of my relationships with both the KMTW manager at the time and a recent KMTW board member who was also the facilitator of the Burmese community group, one of the six Asian action projects. They were both keen for me to bring my CD experience to support KMTW's work in the community. In my role as KMTW board member, I shared the CAR study aims and objectives with my colleagues. The empowerment and people-centred principles were considered to be well in keeping with what they wanted for the people of GI. When the incumbent project manager resigned in 2004, I applied for the position and was successfully appointed to the role in July.

Because the SCAF contractual obligations resonated well with my own research intentions, I decided to use my role as the new KMTW manager to usher the wider whole-of-community CD agenda into reality. In consultation with John Raeburn, my doctoral supervisor, the Asian action projects in the Entry phase were curtailed in June 2004, but most of the Asian groups or their members transitioned into the new whole of GI Project; for all intents and purposes, the KMTW Project was now also the GI Project. In this manner, the enlarged overall PEOPLE System's first step of Objectives and Values statement was met because the objectives and values of the CD research (including all the entry phase Asian action projects and other activities) and that of the KMTW CD Project were overlapping and congruent.

The next section describes the approach I took to the research aspect of my role with KMTW, to provide the basis for what is contained in the rest of this thesis.

Establishing the concept of an overall Project based on the PEOPLE System

The aim of this section is to describe a number of strategies used to make the overall Project a reality.

Getting the support of the KMTW board

The first strategy was to convince the KMTW board of the validity and usefulness of the concept of an overall empowering CD Project that was people-centred, people-led and people-controlled. As described in the earlier section, the resonance between what was proposed and what KMTW was set up to do made the overall Project immediately acceptable. They were convinced, as was I, that the first PEOPLE step was successfully completed because of the match achieved regarding the values and objectives of both enterprises (the proposed research and KMTW's). The PEOPLE System was in keeping with KMTW philosophy and objectives. There was, however, some conflict around the best way to complete the second step of a needs and wishes assessment.

Initially, the board agreed that KMTW needed to organise an analysis of what the community's priorities were so that KMTW could be guided by these in its CD work. However, they were not initially keen on the idea of a random household survey method of conducting the needs and wishes assessment because they thought that GI people were "sick to death of talking about their needs all the time". They also considered that it would be focussing on deficits and negative perceptions. Instead, they chose to go with a visioning process that would focus on inviting community people to share their positive stories of hope and optimism (Hancock & Chilcott, 2005). As KMTW manager, I was

given the responsibility of supporting the two contracted project facilitators to conduct the GI Visioning Project in 2004 - 2005. I did this role with diligence and found it to be very rewarding, especially in terms of consolidating my new community stakeholder role and my relationships with the wider GI community. All five of the existing Asian action projects participated in this exercise.

The GI Visioning Project identified the community's key values as being respect, community spirit, optimism, working together, and integrity of purpose. It also named the key priorities as being enhancing community leadership, harnessing GI pride, strengthening community well-being, and working together. Some success factors that community participants highlighted were that community projects would be community-owned and driven; build on what had gone before; be inclusive; be action-focussed; be strategic; and be Treaty-based (Hancock & Chilcott, 2005).

In late 2004, when the GI Visioning Project was completing its last stage of data analysis, the idea of a random household survey project was again mooted by the KMTW board. They acknowledged that there were many people living in GI who were not included in the visioning process and that KMTW was responsible for ensuring every GI resident had an equal opportunity to be heard. By this stage, many of the board members had come to know and trust me, and some earlier perceptions of me as an outsider (not Maori, not Pacific Islander, not GI resident, not New Zealand citizen, university researcher) had been amended in a more positive light.

The board agreed that a random household survey would give every GI adult resident an equal opportunity to be selected to be interviewed and to have a say about what community priorities are. There were some board members who were concerned that supporting a random household survey would seem to contradict the GI Visioning Project that was just being successfully completed. Others reckoned that results from the survey would, in fact, complement and add to the GI Visioning Project findings. Further, the board strongly endorsed the stated intention to recruit a group of local volunteers to be trained in how to conduct the survey and analyse the results. In an effort to create more support for the project, I also asked for permission to undertake the survey in my own unpaid time. After four months of on-going deliberation, aided by the particular desire to build capacities in local people, the KMTW board agreed to the idea of supporting a random household survey, and even provided some funding for the project to begin.

Getting the support of the wider GI community

To get the support of the wider community was relatively easy, compared with that of eliciting support from the KMTW board. Part of that lay in the fact that the members of the KMTW board were all representatives of key GI sectors. They represented Maori, Pacific Island, European and Asian community groups. They also represented key local agencies and interest groups. In this way, acceptance by these KMTW board members was extended to facilitate acceptance by the different groups they represented and were members of.

My continued attendance at various community network and other meetings familiarised people with what I was intending to do in the community, and I received a great deal of support for it. I took every opportunity to volunteer to do presentations about the participatory action research and always agreed to requests for the same. I also undertook to always inform the meetings of what KMTW was planning to do and to get their feedback and support. By this stage, both the Asian and Pacific Island groups were becoming visibly a part of the GI community, and many people credited that increased connectedness with the CD projects that KMTW had been undertaking with these groups.

So, by the time the KMTW board decided to support the GI random household survey (GIRHS) project, it had many active supporters and encouragers. These included staff from the Council as well as the local community boards, which thought that such a community-led and community-controlled project was exactly the kind of democratic citizen participation they were working to achieve. There was also a lot of encouragement from the university staff and students as well, and I took every opportunity to share what was happening in GI with them at departmental meetings and related forums.

Finally, the ordinary GI people who participated in the many projects KMTW was involved in coordinating, supporting or promoting were looking forward to the GIRHS, and I had a list of willing volunteers who wanted to do the training and the research project. Media articles about the impending community research project were also important ways to spread the story and build up community awareness of the proposed study by KMTW.

The Needs/Wishes Assessment Survey

The PEOPLE System's requirement of a more systematic approach to this area of needs and wishes assessment was ideally met with a random-sample household survey, aimed at asking people what they want for themselves in the broad area of "community wellbeing"; therefore, as part of this research and fully supported by the KMTW board, a

random household survey was undertaken over a period of five months, between April and August of 2005. I will now describe the procedures used to get the GIRHS project started.

GIRHS project design and advisory team

To begin the process, a survey project design and advisory team was set up in late 2004 to get community input, ownership and control embedded from the very start. The team was made up of some members of the KMTW board of governance and interested community members from a range of ethnic groups (Maori, Pacific, Asian, New Zealand European) and backgrounds (e.g. local-born, migrants, refugees, youth). They were recruited in response to open invitations extended at all the various community and network meetings that I attended during that time. Invitations were also extended by members of the KMTW board to their own networks and contacts. All those interested were included; the only criterion was their interest in participating in the GIRHS project. Although the majority were GI residents, a few were not from GI but had interests in the area such as work, relatives or friends living in GI, wanting experience in doing community research, living in a neighbouring community or just interested in helping the GI community. Nobody who offered to help was turned away because this was in keeping with our PMHP conviction that every person has resources to contribute and that every offer of help would be welcomed as part of the community's expression of interest, support and participation.

When the first meeting was called, this project design and advisory team had 12 members. The role of this team was to help design the questionnaire and give advice regarding the processes to be used to ensure that the aims and objectives of a fully community-led and controlled project would be realised. They met once a month at the beginning and then once a fortnight as the project picked up momentum. They provided initial advice regarding the kinds of questions they thought the GIRHS should contain and later were instrumental in shaping the final questionnaire that went out. Over the course of the year that the GIRHS project was being implemented, some members of this project design and advisory team left and were replaced with new members, including GI people who had been interviewed as well.

GIRHS project team

The presentations and announcements made at various meetings, media articles and word-of-mouth recruitment helped to assemble a group of 40 community volunteers who underwent training in how to conduct the face-to-face household interviews. The training

included team-building, presentation skills, cultural competence, communication skills, how to approach householders, how to code the interview responses and how to do reflective practice. Two volunteers who had prior experience in doing social and marketing research offered to take on the administration tasks for the project. They used the KMTW office as the base of the GIRHS operations.

This whole participatory process of involving community people themselves (many of whom were unemployed) learning the skills of surveying, and undertaking this work, was seen as an intrinsic part of the community's active participation in this research. It was also in keeping with the overall empowering and capacity building intent of this project. An article in the local paper was published with a photo of some of the volunteers in training, and the write up included testimonials from volunteers regarding the reasons they offered to take part in the project, the intended outcomes of the community empowering themselves to mobilise actions, the expected time frames for project completion and contact details for people wanting more information. That article was a way of keeping the GI community informed about the project's progress as well as building public relations. The interviewers featured felt they were promoting a worthwhile project and highlighted the way it was building community connectedness and capacities.

GIRHS questionnaire development

To get the development of the survey questionnaire started, the GIRHS design and advisory team directed that this researcher draft an initial one based on feedback from scoping meetings and examples of similar surveys from previous community projects using the PEOPLE System. The first draft was produced in early 2005 and feedback on it from the design and advisory team was collected to produce a second draft. This reiterative process was repeated three times before the fourth draft was taken to be trialled by the trainee GIRHS interviewers on the project team.

The interviewers used role-playing with each other to test out the adequacy of the questionnaire, and they were given opportunities to comment and suggest changes to it as well. All suggestions for proposed changes were discussed within the group, and the final amendments, agreed to by the group, were submitted for the next draft. The resultant fifth draft of the document was circulated to the GIRHS design and advisory team for comments. This active consultative process was repeated one more time before the sixth draft was finally pre-tested in the community. This was done by the GIRHS interviewers conducting test interviews with at least two friends or relatives each. The seventh draft was finalised after minor changes were made based on feedback from the pre-testing and

was taken into the field in late April of 2005. It was estimated that each householder interview would take about 35 - 45 minutes to complete.

The topic areas in the survey covered several sections including personal demographic data and household composition; participation and use of recreational and other community facilities; comments regarding how families with children and the elderly may be supported better; comments regarding participation in personal education and learning events and how these may be improved to meet their needs; personal sense of belonging or connectedness; attitudes towards community development and criteria for success in GI; perceptions regarding the positive and negative points about living in GI. In each topic area, the aim was to make the person being interviewed comfortable with, and knowledgeable about, the kind of information being sought (for example, what is meant by "recreational facilities" or "community spirit") and then to find out what the person being interviewed would like for himself or herself with regard to that. The information was then aggregated to provide a list of prioritised needs and wishes, from which planning and goal-setting could ensue. In the GIRHS, the term "wishes" means "expressed needs" or "what people want for themselves and their families". (A copy of the full survey questionnaire is presented in Appendix C)

GIRHS interviews with 202 householders

The survey was conducted between April and August 2005. A total of 202 GI householders were interviewed. This means that the sample size of the GIRHS was about 5% of the total 4,000 households in GI at the time (ACC 2006).

The GIRHS team listed all the 84 streets in GI alphabetically, and divided the streets up between themselves to check the house numbers in each street. These were noted, and every twentieth house on the list was selected to be surveyed by the team. The actual addresses were recorded by the GIRHS project administrators, but an identifier was used on the questionnaires so that confidentiality was maintained throughout.

The GIRHS project administrators worked out a roster for scheduling the interviews. The aim was to ensure the work was shared out evenly and that interviews were spread over different times of the day and different days of the week. Interviewers differed on the length of times they were able to work (some could only work in the evenings, some only during the weekends, some only during school hours), and the administrators had to make sure the work was distributed fairly. They also had to ensure interview times enabled

workers to be included in the evenings or weekends. The GIRHS adhered to the safety principle of always making sure the surveyors worked in pairs; so two people had to be available at the same time for an interview to be scheduled.

The number of interviews completed on any one day or week was dependent on a host of factors that were beyond the control of the GIRHS team. These include the availability of interviewers to work in pairs, the weather (surveyors do not turn up when it rains; householders do not answer the door), day of the week (Tuesdays are pay days; so many householders are out shopping), time of the day (workers not at home during the day) and other personal reasons (ill health, caring for sick children). That meant that the initial expectation that the 202 interviews would be completed within a month was not met.

The guideline was that each pair of interviewers would complete an interview process (including arriving at address, preliminaries and checking over to sign off each completed questionnaire) in an hour and a half to two hours; the maximum number of interviews for a day would be four. Householders were not approached before 10 o'clock in the morning or after 8 o'clock at night. In the weekends, all interviews must cease after 6 o'clock in the evening.

Each householder was approached by interviewers to check their willingness to participate. Only adults over 18 were eligible to be interviewed. They were given a participant information sheet and asked to sign a consent form (Appendix D). If the householders were not available, interviewers left a card to explain the project and asked them to telephone the project office to suggest a suitable time for the interviewers to return. Each selected address was visited three times; if nobody was at home at any of those times, the address was replaced by the house to the left. Interviewers left all interviewed householders with a card signed by both of the surveyors, expressing thanks for their participation and containing contact details of the researcher at the KMTW office.

Each pair of interviewers was matched in order to balance levels of skill and confidence, languages spoken, preferences for the interview time and so on. Each pair took turns to be interviewer and recorder. After each interview, the pair briefly read over the survey to make sure that all relevant questions were covered, that the answers recorded were accurate and that any issues that might arise were clarified. In particular, they would check the accuracy of recording native language words used by the interviewees and then translate them into English so that data entries could be done more easily. When they

were both satisfied that everything was in order, they would both sign off the survey and return it to the KMTW office.

Two community volunteers undertook data entry training at the university and helped to enter the data into a SPSS computer software programme. The preliminary findings were shared and discussed during the GIRHS project design and advisory team meetings as well as the interviewers' meetings. They were analysed in preparation for the next part in Phase 2, the goal-setting step. (The findings of the GIRHS are discussed in detail in Chapter 5).

Goal-setting from GIRHS results

The aim of this part of the research process was to take the results of the GIRHS to the wider GI community so that they could engage in a participatory process of deciding on priorities among the needs/wishes identified in the survey, and then to set clear goals about what would need to be achieved in order to meet these needs/wishes. This process involved taking the GIRHS report of the results to the community for sharing, discussions and feedback.

In the latter part of 2005, key stakeholders (residents, community groups, agencies, service providers, local and central government staff and so on) were identified and invited to a series of 15 community-wide consultation events so that the research findings could be reviewed and the best ways of addressing them deliberated upon. In order that the participation was as wide and as representative as possible, the KMTW database was used to include community people and groups, all invitees were encouraged to suggest more names and groups, posters advertising the meeting were put up in strategic places in the community, and the meetings were held in public spaces (the marae, community hall, community library) to enable residents to drop in if they wished. These meetings were attended by a total of 215 people. Their specific tasks were to look over the GIRHS results with their identified priorities and suggested goals and to discuss whether these goals were relevant, valid, and realistic or needed amending in some ways. The aim was to have a final list of goals that KMTW could incorporate into their strategic plans; so they then could begin working with community people to participate in action projects to achieve the goals together.

Several actions during the meeting proceedings were taken to ensure participants were well-informed and included. Summaries of research findings were produced as electronic and hard copy hand-outs so that participants could refer to them before, during and after

their conversations. Large paper sheets or whiteboards were used to remind participants of the agenda of the meeting, as well as to record comments and ideas for all to see and check as needed. All meetings began with a welcome and a song or a meditation and closed with an appreciation of attendance, reminder about the next steps, and a closing song or blessing. For the GI community, the last set of meeting rituals are important acknowledgements of the population's cultural and faiths-based practices and evidence of the intent of meeting organisers to be inclusive and to accommodate preferred ways of working. All notes and minutes were typed up and hard and soft copies distributed to all attendees of the meetings.

These purposeful discussions and workshops were co-facilitated by community and agency people to ensure the best use of the time spent together. ("Community people" in this instance specifically included some members of the GIRHS project team members.) Typically, each meeting ran for a minimum of two and a maximum of three hours, including time for refreshment. These meetings were varied in terms of the venue used, days and times of the week and format in order to maximise opportunities for different groups to attend.

Other venues and ways of sharing the survey results included the GI monthly markets where KMTW ran information stalls with hard copy reports for people to peruse and take away; interactive games to guess the ranking of priorities or concerns as compared to actual GIRHS results; opportunities to ask any questions; and a "Have a Say" box where anonymous comments could be deposited. KMTW also tabled the reports at different community forums so they could be discussed e.g. at the GI community network, Eastside Youth Network, GI Visioning Stakeholders, Family Fun Day and other relevant community spaces and places. KMTW presentations were also made to staff at the Auckland City Council, Housing New Zealand Corporation and the University of Auckland.

One of the most important KMTW organizational goals identified through this process was better coordination and sharing of information amongst GI stakeholders. This goal was considered a high priority by so many community people that KMTW undertook to meet it immediately through the formation of several sector networks. These networks worked to enable more efficient intra-sector communications; dissemination of accurate information about issues, identifying trends and initiatives that pertain to particular interests and priorities; and developing innovative solutions accordingly. Examples of some of these new networks include the GI Health and Wellbeing Cluster group, GI Early Childhood Education network, GI Community Facilities group and the Pacific Providers' Network.

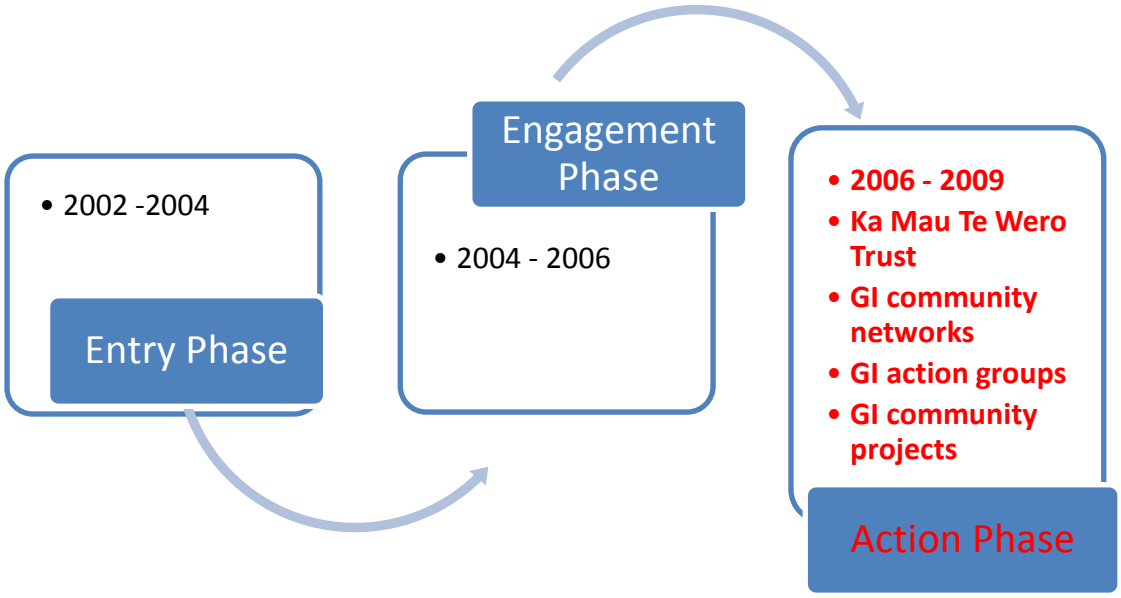
The end product of this process was the listing of fifteen community goals that were grouped into five main priorities. These priorities and goals will be given a more detailed treatment in Chapter 6, but the priorities will be summarised briefly now as relating to youth, community wellbeing, education, enterprise and environment.

Phase 3: Action 2006-2009

This phase, the last one of the research period covered for this thesis, involved two main components. One related to the fourth step of the PEOPLE System, namely ensuring that the organizational and resource systems were properly in place to manage and implement the action projects that resulted from the goals. The second relates to the initiation of the action projects themselves and what was required to support and maintain them.

The following is a process diagram that will highlight the activities that were conducted during this phase of the GI CAR project in the period covering 2006 and 2009.

Figure 3.7: Process diagram highlighting Action Phase



Organization and resource requirements

The aim of this step was to ensure that governance, constitutional, employment, coordination, evaluation, administrative and other systems were in place to keep the overall Project running well and that resources relating to finances, property, facilities, staff, political and environmental nature were sufficient to carry out the actions required. Many of those structures were already in place when I arrived in the role of KMTW

manager; however, there were a number of additional requirements that arose from the PEOPLE-driven Project and the various actions and resources that were associated with this. What was done to deal with these is now briefly described.

Setting up and supporting action projects

The aim of this step was to mobilize "action projects" to meet the goals that had been determined through the GIRHS and goal-setting consultation process and use the PEOPLE System in much the same way as the original Asian groups had done, to organize and direct the organization dimension of what they did. Some of the community groups involved at this stage already existed and readily integrated the goals into their activities to attain the goals that most interested them. Others had to be started especially for the purpose, and these will be described in greater detail in Chapter 6 of this thesis.

Starting with the networks

The process of setting up action projects and groups for me began by attending all of the early network meetings. To recapitulate, these networks were set up in response to the strong call by community participants at the goal-setting consultation meetings for KMTW to coordinate more effective ways for sharing information with and between community people and groups. These networks were the logical spaces to develop action projects from, since all network members would already be sharing common interests that would motivate them to participate in relevant action projects.

In my role as KMTW manager, I was able to share and model the KMTW's approach to community development which, as earlier described, matched the philosophy, values and objectives of the PEOPLE System. By this time, 2006, I had been in the KMTW role for over two years, and the empowerment approach and practices were very familiar and acceptable to the networks. For all of them, the participatory action research approach and the PEOPLE System's steps and procedures have become part of their standard operations and did not need to be reiterated. My attendance at these network meetings was more by way of nurturing and encouraging the participants more than anything else.

Most of the time, my role involved making sure that the venue and times were agreed to, facilitators for the events were identified, notices and reminders about the meetings were sent out, appropriate resources (summary of findings, other hand-outs, stationery and refreshments) were ready, attendance and meeting notes were recorded, typed up and distributed along with relevant notes and any back-up documents as required by the participants. After a few of these meetings, and if this did not happen naturally, a

network's members were encouraged to volunteer or nominate others to share in the tasks. Over time, each network had their own members take on these important maintenance roles.

As each network identified the community goals and priorities that they were keen to address, they began to develop their organisational and resource arrangements to carry out particular tasks and activities to attain those goals. Smaller project working groups were created to carry out sub-goals to focus on specific action and increase efficiency. Some examples of this developmental process follow next.

PEOPLE action projects

To get the action projects mobilized, my strategy followed a standard template. I have found that creating these templates saves a lot of time and effort in the long run and is in keeping with the PEOPLE System's planning and evaluation framework. The following is a typical template and, to keep everything clear and to differentiate between the KMTW overarching goals and the derivative sub-goals, the former will be denoted by the use of capital letters.

1. Identify appropriate network or group for working on each Priority or Goal;
2. Facilitate access to organizational and other resources needed by network or group;
3. Participate in review and evaluation activities;
4. Provide ongoing reports to KMTW board and community as appropriate.

1. Identifying appropriate network or group

This was easily done as the choices were quite obvious. The Eastside Youth Network was the natural base for the Youth Goals, the GI Health and Wellbeing Cluster for the Community Wellbeing Goals, for example. For many of the networks, their preferences were clearly articulated from the beginning because interest in working on specific Goals and Priorities was what brought them together to start with. Consequently, getting members to confirm their values, objectives, priorities and goals (PEOPLE System steps 1, 2 and 3) were quickly accomplished.

Often, however, Goals were too complex and needed to be broken down into smaller goals to be attained efficiently. For example, although most of the members of the Eastside Youth Network acknowledged that alcohol abuse was a big community concern, they thought the problem needs to be addressed in many different ways. The GI Drug and Alcohol working group was formed by interested members from both the Eastside Youth

and the Health and Wellbeing networks who wanted to work very specifically to address this issue by creating opportunities for raising the community's awareness regarding the harms caused by those dangerous substances, as well as on mobilizing community action to complete submissions regarding liquor law reforms. This smaller action group would also undergo a similar cycle of confirming the values and objectives of their members, agreeing on goals and priorities just as they had in the networks. I also attended most of the meetings of these action groups to fulfil the same kind of roles that I did with the networks.

2. Facilitating access to organization and other resources

After deciding on their goals, all the action groups would immediately identify the requisite resources needed for their work to be successful (PEOPLE steps 4 and 5). These included people to do the work, administrative support and funding for activities. Very often, the membership would include agency or people who had access to these resources. For example, council staff could help with the production of promotional material and health service agency workers are paid to meet similar goals as the action groups. Many service providers and government staff participate in these action groups because the goals match the ones set by their employers or funders. KMTW also sought funding and resources for these action groups where possible or, if it was able, to provide these directly. The KMTW budget also included some funds to help action groups meet the costs of venues, hospitality, promotional materials and volunteer expenses.

3. Participating in review and evaluation activities

To do this, I attend as many of these activities as possible and keep track of how the groups are progressing. All action groups maintain a process of taking meeting minutes and notes and these help members to review decisions made in previous meetings to ascertain the extent to which tasks have been completed or not (PEOPLE step 6). Some action groups perform this verbally but all of them do this in one way or another. All community events are followed by evaluation and debrief meetings to help identify success and scope for more future work. I also receive minutes and communications if I miss meetings. KMTW is on the email lists of all action networks and project groups. I make it a point to read all the documents sent to me from community networks and action groups and always give feedback on them. These will range from a simple "Thanks for this!" to suggested amendments and feedback on drafts. I see my role as maintaining very reciprocal and responsive relationships with all the groups because their work contributes ultimately to the success of community development in Glen Innes.

4. Providing on-going reports to KMTW board and community

I use the notes taken when I attend meetings plus minutes or other notes to compile my monthly, biannual and annual reports to the KMTW board. These are in effect on-going evaluation of the action projects (PEOPLE step 7) and provide high quality "big picture" information about the progress of the Goals and action project goals. Once a year, KMTW hosts an "accountability and appreciation" meeting where the extent of achieving community Goals is reported back to the wider community. Members of the community also get a chance to question and give feedback on what has been presented. These annual meetings also provide an opportunity for the action groups to present a report to the gathering themselves, to field direct questions and to receive community comments. Most importantly, it is a regular opportunity to take stock of what the different action groups in the wider community have done in pursuit of common Goals, celebrate successes and strengthen our collective sense of purpose, connectedness, support and control of what happens in Glen Innes.

Chapter summary

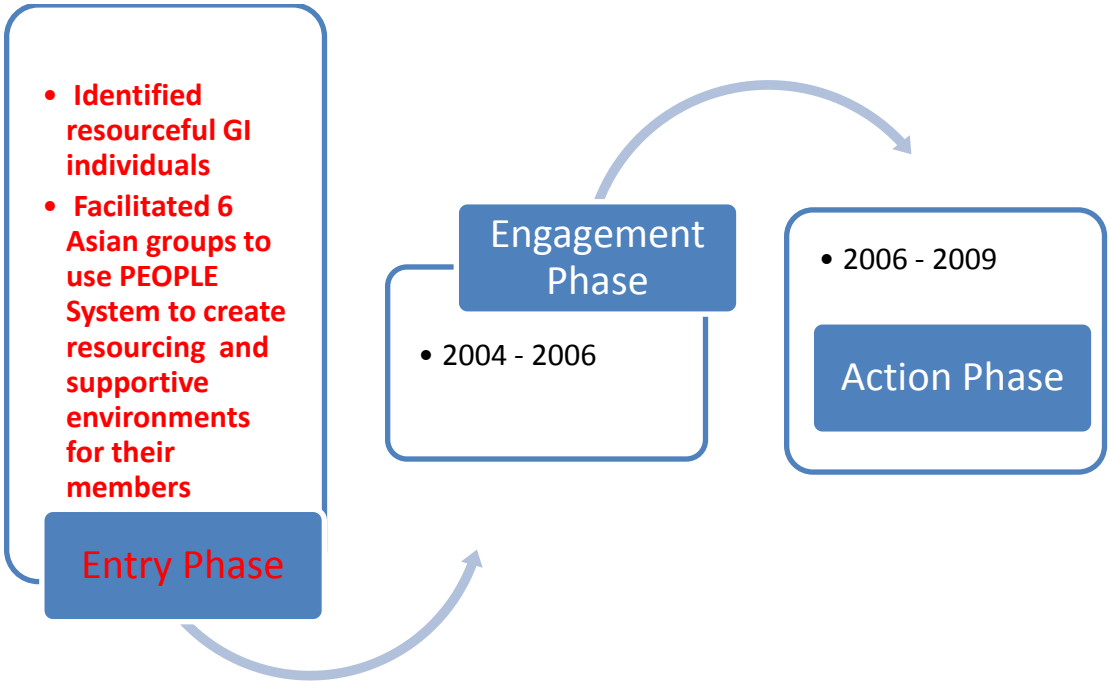
In this chapter, the methods and procedures used to frame and research the various phases and components of this multi-faceted project were described. As can be seen, a wide variety of approaches were used, with a variety of both quantitative and qualitative sources of information. What binds them together is the combination of the CAR (Community Action Research) philosophy and values and the PEOPLE System, which generates evaluative and other data as the project proceeds and which also allows for summative statements to be made about the progress and impact of the project. In the next three chapters, the processes and results associated with the Asian projects from Phase 1, the random household survey from Phase 2, and the action projects from Phase 3 will be presented.

4 RESULTS: The Asian Groups

We came looking for paradise,
and paradise we found
but it wasn't enough, so we wept
and talked of leaving
and never left.
(Kapka Kassabova)

This chapter discusses the results from the Asian groups outlined in Chapter 3, particularly with the aim of determining whether the PCHP Model approach enabled participants to increase control over their health and wellbeing. The chapter also examines and reflects on the challenges encountered, the strategies used to overcome these challenges, and the extent to which work with the Asian groups was successful in providing a foundation for the researcher to engage the wider GI community in undertaking a strengths-building Project in the next phase of the CD research study. The chapter ends with a description of results from a small evaluation survey undertaken with the Asian participants at the beginning of 2010.

Figure 4.1: Process diagram of Entry Phase and PMHP outcomes



The earlier process diagram is reproduced above with the relevant study phase highlighted as a reminder for contextualising the following report.

PEOPLE System step 1: Objectives and values statement of the Asian groups

The first PEOPLE step was to take the time needed to get the participants to share their views on the overall philosophy, values and objectives of the group. This included sorting out what the project was trying to do, how they were going to be involved and in what way they wanted to work together to attain the goals that they were going to set together.

Most of the Asian groups did not take long to identify their group's philosophy and core values. The notion that a group has to negotiate their philosophy and values assumes that there are individual differences that need to be mediated before an agreement may be reached for working together; however, for groups with shared faith and identities, as well as from collectivistic cultures, participants were quickly and easily able to articulate the principal philosophical tenets of their groups because these were based on their own shared cultural values and faith. For example, the Afghani group stated that their group's philosophy and values were their Muslim beliefs and values, such as being peaceful, taking good care of their families, and speaking of "we" and "us". They were quite bemused that the question had to be asked at all. Most Asian groups placed emphasis on collectivistic thinking and stated that it was important for them to work together, cooperate, and support one another. The only exception was the Indian elderly group who spent almost an equal amount of time talking about what they wanted collectively and what they wanted individually.

The participants also discussed and agreed upon the expected behaviours or conduct within the group. These included: listening to each other respectfully without interrupting; not laughing at people; taking time to make sure that everyone who wanted to speak had the time to do so; coming to meetings (although many said it was not so important that they stay the whole time); and letting someone else know if they could not make a meeting. All of the groups agreed to promote respect for group consensus, except the Indian elderly group which wanted to vote on the decision if consensus could not be reached.

In terms of group objectives, all participants valued having opportunities to learn together and to increase their knowledge, skills and experience in ways that were meaningful to them. For example, the primary objective of both the Burmese and Afghani refugee

support groups was to settle successfully into their new community and country, whereas the main priority of the two elderly groups was health and fitness. Financial independence was also considered important for the Burmese group. They came from a country with no public welfare system and they had to depend on themselves or their kin to provide for them. The Indian elderly group was keen to find ways to generate more personal income because they were unwilling to depend either on their grown up children or the state for financial support. Many of the Indian elderly also felt lonely and isolated, as their children and grandchildren were busy with work or studies and could not spend much time with them.

The Asian women's group reflected on the objectives of their group over three sessions. Initially, the participants stated that their objectives were to learn parenting skills and to make new friends. In the second session, some members began to reflect on their personal experience of domestic violence and how these experiences impacted on their children's behaviours. The sharing enabled the participants to identify some individual objectives, such as learning to be more tolerant of differences in recognition of the diverse social, cultural and linguistic backgrounds amongst members, and learning to be happy.

Two main challenges were encountered when I worked through the first PEOPLE step with the groups. One of them was a language barrier. Except for the Indian elderly group, discussions in five groups were conducted via interpreters. These interpreters also acted as facilitators for the groups. For the Asian women's group, although no interpreters were used and I facilitated the group, some members with adequate English acted as interpreters for those who did not understand English. For the Chinese elderly group, a mixture of English, Mandarin and Cantonese were used because some members were keen for me to speak Mandarin and Cantonese with them. Across the groups, working with the Chinese mental health support group was the most difficult because of the low energy level of the members. This group was the most challenging one for me.

Despite encountering a language barrier, I soon learnt that it was not too difficult to understand what was going on in the groups if I paid attention to the nonverbal communication among members. For example, I felt I could identify who were the active members and who needed more encouragement to speak out. As I learned to appreciate the amount of information that could be gathered from being an active observer, I felt more relaxed and began to enjoy the rhythm of the groups working and conversing in different languages.

Another challenge encountered in the two elderly groups was their constant requests to do things for them because of my younger age. They often asked me to perform tasks that they would have asked their own adult children to do, such as driving them to their appointments and acting as their interpreter, negotiating with government and other agency staff on their behalf, writing letters and funding applications, and making phone calls to their children. It was very difficult to refuse their requests because I could see their need for help, especially if their requests related to communicating with health professionals, agency staff and other service providers; however, this also shows the great barriers many older minority people face in accessing services in the community. I was able to utilise the advice, help and support of other community workers and agencies as well as whatever personal time and resources I had available to meet most of these requests. When I took up the role as a community development manager two years later, I paid attention to the issues raised by these elderly groups and developed a database of willing volunteers, workers and agencies to enable community people to access culturally appropriate help when needed.

PEOPLE System step 2: Needs/wishes Assessment

Participants moved on to PEOPLE Step 2 after they had worked out their group's philosophy, values and objectives. During this step, participants shared with other group members some of the needs that they considered as important in promoting health, wellbeing and quality of life. For groups which had fewer than 12 members, whole group discussions were held. After each participant had shared his/her view, the group discussed and decided on the top three needs they would like to work on as part of their project. For the Indian elderly group and the Burmese support group which had over 12 members, participants were broken down into smaller groups of five. The small group discussion results were later summarised and reported back to the whole group, where further discussions were held and the top three needs arrived at by group consensus.

Most of the groups did not have much difficulty reaching consensus on the top three needs for their project. The exception was the Burmese group, whose members had divided interests. Initially, the female participants in the group were keen to learn English, to learn to cook New Zealand food, to find out more about their entitlements such as social welfare, training supplements and support for their children in schools. The male participants, however, were more interested in learning how to find work, how to get a driver's license, and how to set up small businesses. As a result, participants had lengthy discussions regarding which were the three most important needs for their group. Participants tried to persuade others to choose their preferred needs and went to great

length to explain how working on their needs would benefit the group. After much deliberation, a final list of three needs was decided. All agreed by consensus that learning and improving their English language skills was very important, both for their everyday living and for passing the citizenship interviews.

The following table presents the top three needs of the six Asian groups.

Table 4.1: Needs and wishes of the six Asian community groups

Group	Needs and wishes
Burmese refugees	
	To learn and improve English language skills
	To obtain accurate information about state entitlements and services
	To learn how to drive and get car licences.
Asian women	
	To socialise and support one another
	To learn practical parenting skills
	To learn how to be happy
Indian elderly	
	To improve personal health status
	To find out about and celebrate other cultures and faiths
	To increase a sense of contribution to the wider community
Chinese mental health support	
	To increase personal physical fitness and activity
	To promote acceptance by local community
	To increase participation in local community
Chinese elderly	
	To improve English conversational language skills
	To make more friends in the local community
	To become more active
Afghani refugees	
	To settle well in the new country and community
	To understand local culture and systems
	To ensure children are well and settled

Another need, getting a driver's licence, was prioritised after the women in the group agreed that getting a driver's license would also be useful for them. With a driver's licence the women could become more independent and could do shopping or transport their children around when their husbands were not home. The men also reframed their thinking and agreed to support the female participants' desire to obtain accurate information about services. They agreed that such information would make things easier for their wives and children when they were not at home.

The Indian elderly group differed from the other Asian groups in that their members decided to work on personal health needs as part of the project, rather than producing a list of three needs agreed upon by members collectively. They considered that each member's individual needs were as important as everyone else; hence, they decided that each would work on their personal health needs, while using the group to provide mutual support. For example, some members who had diabetes identified the need to exercise and make dietary change as important, while some members wanted to learn how to deal with stress, and so on.

The Afghani refugee support group, like the Burmese group, wanted to focus on needs that would generally help them with their resettlement into a new country. The needs that this group considered as important included: to learn English, to understand local cultures, and to find out how to access support services. The needs of the Asian women's group focused on support and wellbeing, including personal support for themselves, learning how to be happy, and learning practical parenting skills to enable them to better support their children. Members of the Chinese mental health support group shared their experiences of being discriminated against by the public, and wished to be included and able to participate more actively in their local community. The Chinese elderly group wanted to improve their English, make more friends in the local community, and be more active so that they could remain as independent as they could for as long as possible.

During this needs and wishes assessment step, I paid close attention to how members felt when their own personal needs were not chosen as priorities for the group project. If members felt their needs were ignored, this might impact on their future participation in the group. Most groups made decisions by consensus. This meant that every participant had the opportunity to speak as well as to listen to other members' needs and wishes and to the reasons why these needs and wishes were important to them. This process was important as it helped to cultivate a sense of respect for other opinions in the group. Participants also reminded one another regularly about their group's philosophy and

values and their agreed ways of working together; therefore, in the end, even though some members' needs were not chosen by the group to work on, they felt that they had contributed to the decision making process and did not feel marginalised or ignored. This was borne out by the fact that they stayed engaged in the group processes.

The facilitators and I frequently reminded the groups that the needs that did not make it to the top three on the list were still important and might be addressed at a later stage; therefore, members agreed that they would just "park" these needs for the time being. As it happened, over time, some of needs that had not made it to the priority list managed to get addressed. For example, a few members of the Burmese group wished to visit a historical site outside of Auckland. When the group found out that there was some money left from the funding they received for organising driving lessons, they decided to use the money to pay for a bus trip for the whole group to visit this historical site. This turned out to be a very successful team building experience for the group, as this trip was desired by many members who would not otherwise have had the opportunity to go there themselves.

Overall, the second step was a positive experience for the groups. For some members it was the first time that they had participated in a group project. By sharing with one another their needs and wishes, members began to build up trust with each other and a sense of group control. They were prepared to move on to the next step of goal setting.

PEOPLE System step 3: Goal Setting

In the preceding step, the groups had already prioritised their needs; so the next step involved determining action areas, or project activities, that could be implemented in order to achieve their goals.

The proposed group activities could be divided into two broad types. First, there were activities which helped members to socialise and to know more about one another. For the Asian women's group, members belonged to different social classes, spoke different languages and came from different family backgrounds; therefore, they wanted to know more about one another by taking turns to share their cultures and faiths in group sessions. In most of the other groups, members were from the same ethnic community and knew one another before the group projects started. For these groups, members were more interested in taking action which would enable them to know people from other ethnic groups in the local community.

Second, there were activities which were organised around increasing knowledge, skills and capacities. For example, both the Chinese elderly group and the Indian elderly group proposed actions to increase physical fitness. The Burmese group and the Chinese elderly group decided to run driver's licence lessons and English language classes respectively. The Asian women's group invited me to run a parenting skills course for them. In addition, the Burmese group also planned to invite speakers from the community to talk to them about entitlements and social services.

In addition, all of the groups were interested in learning about other cultures, faiths and languages. Most were particularly interested in taking actions to learn more about the indigenous Maori culture and language. The two Chinese groups also decided to learn different Chinese dialects within their community.

The following table presents the proposed project activities identified during this PEOPLE System step for each of the six Asian community groups.

Table 4.2: Group goals and activities of the six Asian community groups

Group	Group goals and activities
Burmese refugees	
June 2002 – June 2004	To pass the New Zealand citizenship interviews by organising English language classes to prepare members To get accurate information on criteria for entitlements and services by organising a series of invited guest speakers from government and other agencies To prepare members for passing driver's licence tests by organising driving lessons
Asian women	
March 2003 – May 2003	To get to know one another better by talking with each other more To have more confidence by completing a parenting skills course To have more understanding about other cultures by sharing each other's cultural backgrounds and faiths

Group	Group goals and activities
Indian elderly	
June 2003 – June 2004	To get healthier by setting and achieving three personal health goals for each member To learn more about other cultures and faiths by organising a series of invited guest speakers To improve the group's health & wellbeing by preparing healthy group lunches and having light exercise sessions at each meeting
Chinese mental health support	
October 2003 – June 2004	To increase personal fitness by organising a tutor for group martial arts exercise To increase acceptance in local community by joining in local activities with them To increase sense of belonging by participating in more community events
Chinese elderly	
March 2004 - June 2004	To improve English conversation skills by organising conversational English classes To increase sense of belonging by making more friends in the local community To become more active by taking part in daily Tai Chi group exercise in the local park
Afghani refugees	
March 2004 - June 2004	To settle well by finding a suitable venue for communal prayers To increase understanding of local Maori culture and systems by organising a workshop for members To feel more a part of the community by taking part in the Glen Innes Visioning community project

The main challenge during this step was the lack of funding. It was apparent that most groups did not want to bear any personal costs for attending the group meetings and for organising any of the group activities. To keep the groups going, they had to look for low

or no costs options for their planned activities, for example, by using volunteers and community speakers. The Burmese group and the Chinese mental health support group agreed to make a small contribution for special events, and sometimes they brought food to share. Even so, some members were unable to contribute. In order not to exclude any member from participating in the groups due to personal financial hardship, facilitators made special arrangements to enable these members to be involved.

Some groups decided to apply for funding to cover the expenses of running their proposed project activities; however, this was difficult because they lacked information about how to make applications. Even after the information was gathered, some groups, such as the Asian women's group and the Chinese mental health support group, were reluctant to proceed because they did not want to disclose sensitive information about their situations. At times, when funding applications were unsuccessful, members had to return to seeking low or no costs options for their planned activities. For example, many members of the Indian elderly group expressed a desire for outings; however, because they were unable to obtain funding to support these activities, they did not manage one single trip or outing in the two-year duration of the group.

Goal attainment success by the Asian groups

All the Asian groups started at different times but, except for the Asian women's group, all ended in June 2004 when I started my new role at Ka Mau Te Wero as the new community development manager. All of the Asian groups managed to get all their activities going and attained most of their goals. The following reports the status of their achievements as of June 2004.

All of the Burmese learners who started the driving lessons, for example, managed to become licensed drivers, and everyone who was called to the citizenship interviews passed, though one of them had to repeat the interview. The Asian women's group was terminated at the end of a successful parenting skills course and members reported increased confidence about their ability to understand and support their children. Due to the unexpected departure of a couple of their members, the remaining women felt they did not need to meet as a group anymore. They still kept in touch with each other because they had become personal friends and their children attended the same early childhood education services. The Indian seniors reported that they achieved all their goals, and they kept up the group healthy lunches and exercises. Many members of the Chinese mental health support group became members of the Glen Innes Chinese Friendship group, and the group facilitators tell me that they were enjoying the twice-weekly

meetings. The Chinese elderly group held daily Tai Chi exercises in a Glen Innes park and have become an iconic part of local community life. The Afghani group did manage to find a temporary venue for communal prayers by using the garage of a member (who did not own a car), but they remained dedicated to the search for a more permanent space.

By the time I officially ended my direct involvement with them in 2004, all five remaining Asian groups were continuing planning and carrying out their activities to meet their own goals with the support of their group facilitators and leaders. They still kept me informed about their all activities and often invite me to their special occasions which included their various New Year celebrations, trips, special speakers, birthdays, citizenship ceremonies and children's prize-giving or graduations. Most of them got involved in the 2004 GI Visioning project by participating in the focus groups that were facilitated by me in my KMTW manager's role, and a few of them went on to join my random household survey project in 2005. I visit them regularly in my KMTW role to keep them informed about what was happening in their community and many attend the events and activities in Glen Innes.

Results from a 2010 evaluation survey of Asian project participants

At the beginning of 2010, I contacted participants from the Asian groups to invite them to give me some feedback about how they were doing since they took part in the entry phase projects between 2002 and 2004. Of the original 81 participants who took part in the Asian PEOPLE project, 51 completed the survey. The others could not be located during at the time. The survey comprised just four very simple questions, kept to a minimum because of a lack of access to interpreters. The members of the Indian group filled in their forms independently. The Chinese members filled theirs in as a group while I translated each question separately into Mandarin and Cantonese. A few of their members who could read and write English went around the group to offer help. Most of the ex-refugee participants had gained enough English skills in the six to eight years since the project started to be able to complete the survey themselves. They also helped each other.

The following questions were asked of respondents:

1. Would you say your overall health and wellbeing is much better now than before? (Yes/No)
2. If "yes", how much did the project we did together help? (A lot, not at all, some)
3. Did you do all the things you said you wanted to do? (All, none or some)
4. Do you have any other comments about the project?

The following table is a summary of the results to the first three questions.

Table 4.3: Summary of answers from Asian groups' participants to the 3 questions

Questions	Yes/A lot	Some	No/None/ Not at all
1. Health and wellbeing better now?	43 or 84%	7 or 14 %	1 or 2%
2. How much did the project help?	43 or 84 %	8 or 16 %	0 or 0 %
3. Did you do all the things you said you would do?	41 or 80%	10 or 20 %	0 or 0 %

The results show that virtually all of the Asian participants rated their health and wellbeing as definitely (84%) or somewhat (14%) improved. In a similar pattern, 84% thought the projects we did together in the years between 2002 and 2004 helped improve their health and wellbeing "a lot', while the rest thought the projects helped to some extent (16%). The third question asked the respondents if they did all the things they said they wanted to do and was intended to indicate if they had persevered beyond the duration of the projects to achieve the goals they had set when in the Asian project groups: 80% indicated that they had met their goals while 20% indicated that they had not.

As for the fourth question, the absence of interpreters meant that many of them did not volunteer any extra comments to this. Some of the other answers were very short such as "good", "happy", "nice" or "thank you", but the following is a sample of longer responses:

- "Project was good" (Afghani)
- "Must do same for the new people" (Burmese)
- "Many have some problems now. You must make new group for them" (Chinese mental health consumer)
- "I am trying to buy a house in GI!" (Burmese: she formerly was keen to get out of Glen Innes as soon as she could)
- "Now we help ourselves" (Chinese elderly)
- "My children miss their father sometimes. I feel bad. But maybe it will be better when they grow up. I also miss my old friends, you know" (Women's group)
- "Other people have the same problem in GI but they don't want to talk. Very shameful but not good. They must talk and get some help" (Indian elderly)

- "It is good because it was a happy project" (Indian elderly)
- "Some Panmure people feel left out of GI project" (Chinese elderly)
- "I have some Maori and Island friends in GI now" (Burmese)
- "Not so lonely now when my friends come to my house" (Chinese elderly)
- "We want more English and Maori classes" (Chinese elderly)

Whilst the overall results do look very positive, I would have to declare the several flaws and limits to them. These include the fact that they had to be administered and responded to in English and, although many of their language skills have improved over the years, it could be argued that the language might still be difficult for many of them (excepting the Indian seniors possibly), if not a real barrier to accuracy or comprehension. Further, since I had approached them personally, they could be answering the questions positively to please or humour me. Finally, the questions were very simple and did not allow for any depth of qualifications.

In spite of these limits to the survey, and although many of these Asian participants are now involved with the wider GI community projects in some way, they were visibly pleased to see me and be reminded about their earlier projects. They relayed that they were looking forward to the report of the results that I had promised to make for the next annual KMTW appreciation and accountability community meeting at the end of 2010.

Discussion

The original purpose for the Asian community projects was to trial the applicability of the PEOPLE System's first three steps as collaborative processes for building up trust, unity and connectedness with and within two or three Asian groups.

In terms of the PEOPLE System application that these Asian groups were testing, the results reported earlier in this chapter attested to the fact that all the groups successfully negotiated the first three steps with generally positive results for themselves. As the PEOPLE steps constituted empowering processes to ensure participants maintain control of the processes and decisions at each one, it may be reasonably concluded that evidence of successful completion would validate demonstration of people control. Although some of these Asian groups were supported by interpreters, my close consultation and project reviews with them gave me confidence that the steps were conducted as intended. If so, then it would seem that working through the first three PEOPLE steps did improve their overall mental health, wellbeing and quality of life for the

Asian project participants. The group members were more connected to each other, were in control of choosing their goals and activities, built their capacities (skills, knowledge, access to services, relationships) and experienced social support. These initial results are encouraging in terms of the PMHP Model being applied on a wider scale in the wider GI community.

Chapter summary

In summary, the whole experience of the Asian group members cooperatively working through the first three PEOPLE steps was a salutary community-building exercise. It also helped to increase their capacities by rehearsing and improving interpersonal and group skills, boost confidence and modelled successful completion of their projects. By the time the Asian projects were completed, most of the participants could claim new community contacts and relationships, increased information and experience, more interest in finding out more about their host community of Glen Innes. To that end, five of the projects went on to participate in the wider Glen Innes community research when my change in circumstances led to the curtailment of this Asian phase. Their sustained interest and participation is proof that the Asian projects did help participants to feel more empowered and in control of their health and wellbeing, and that on-going participation would serve to increase the measure of that. Although flawed, the results from the 2010 evaluation survey conducted with some of the Asian participants did suggest that these PEOPLE projects at least did no harm and could have done some good for the participants. The activities of these Asian community groups helped to progress the entry phase of the community development Project that was about completing the first PEOPLE Step for the wider community.

The next chapter will present the results from the random household survey that was conducted to assess the needs and wishes of the Glen Innes community in 2005.

5 RESULTS: The Random Household Survey

This creative process of responsible all-embracing and useful knowledge-making...may lead simultaneously to greater awareness, social research and political praxis...the grass-roots and their cadres should be able to participate in the research process from the very beginning....and they should remain involved at every step of the process until the publication of the results and the various forms of returning the knowledge to the people are completed.

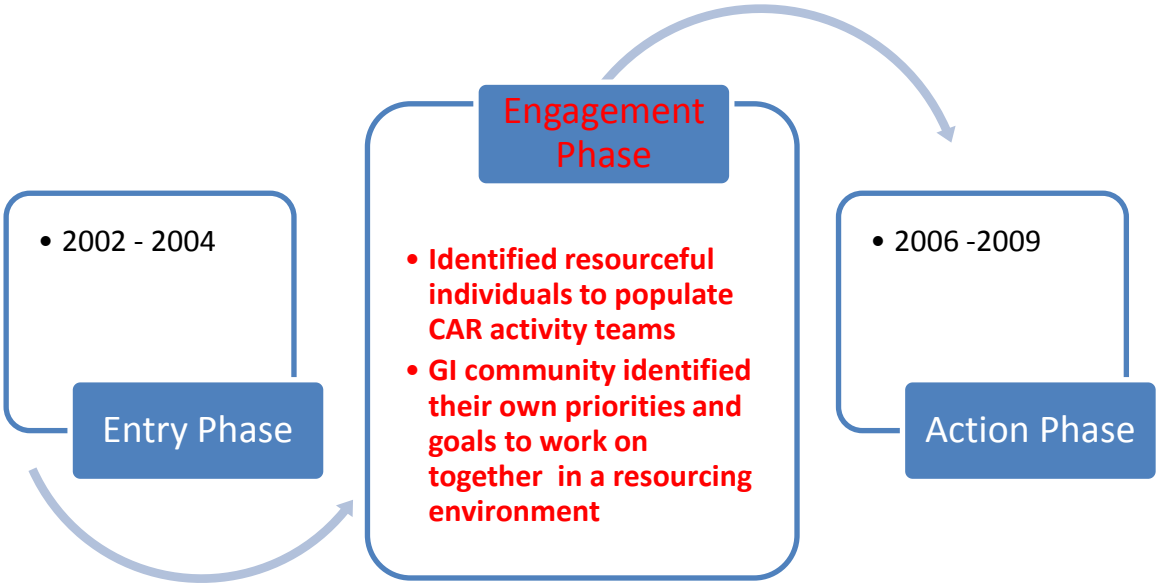
(Orlando Fals-Borda, 1987 p 337)

This chapter provides an analysis of the data collected by the questionnaire survey conducted between April and August 2005 to investigate the opinions and experiences of people living in the Glen Innes community. As explained in Chapter Three, the Glen Innes Random Household Survey (GIRHS) aimed to use community development principles and participatory action research methods to engage the wider GI community in identifying community priorities and needs and to recommend appropriate goals and projects to empower sustainable and positive community action. This chapter is divided into ten sections. The survey questionnaire is outlined first, followed by a discussion of the key characteristics of the survey participants and their housing situation. The next six sections present the main findings of the survey. They include an examination of community needs regarding the following: recreational activities and facilities; childcare, education and support services for parents with pre-schoolers, school-aged children and teenagers; activities and services for older people; participants' own needs for personal training and development; perceptions of community living and valued attributes of Glen Innes as a place to live; and views on community development.

The chapter concludes with the results of a community process that followed the analysis of the survey to identify community priorities and appropriate goals and projects. An original list of the recommended priorities and goals that were taken to the community, based on the raw GIRHS data, is provided. This list was later adjusted after wider community interpretation and debate, and the reformatted new list of priorities and goals was drawn up and included into the KMTW Strategic Plan for 2006 to 2009. This list will be presented as well. Finally, the chapter will be brought to a close with an overall summary.

A reproduction of the original process diagram is reproduced here to remind readers of the context to this phase of the community research project and the PMHP outcomes realised.

Figure 5.1: Process diagram of Engagement Phase and PMHP outcomes



In the first section of the survey form, participants were asked to provide information on their gender, age, ethnicity, occupation and household type. They were also asked how many children they had living at home and the ages of these children. The demographic data were compared against the 2001 census statistics to make sure that a reasonably representative sample of Glen Innes was obtained. Participants could also choose not to answer the question if they did not wish to.

The aim of section two was to gauge how people use their spare time. Participants were asked whether they took part in any regular sports, games and other activities in the past year. This included coaching, organising or being regular spectators. Participants were also asked what kinds of recreational facilities they used in Glen Innes, how they thought the facilities could be improved, and what facilities they would like to see in the area. This section was included in the survey because community conversations indicated that people felt there is not much to do in Glen Innes. Also, these questions were felt to be "non-controversial" and therefore a good way for interviewers to build good rapport with the householder in preparation for later sections where the householder was asked to give more personal responses.

For section three, the survey focus was on families with children - preschoolers, school-aged or teenagers. Just over half (52.6%) of the population of Glen Innes was under the age of 30 years, according to the last (2006) national census, and there was great motivation in the wider community to know how to support parents, extended families and

caregivers. The questions related to how easy it was for them to get childcare, what early childhood services were used, where school-aged children played when not at home, whether they considered there were enough safe activities and recreational spaces for their children, how facilities in Glen Innes could be improved for teenagers, what activities they did with their children, and what kinds of education, training or support events they would take part in if these were available.

Questions in the fourth section related to how things can be improved in Glen Innes for the elderly members of the population living there. This is in line with the Maori and Pacific Island cultures' valuing of their senior members, as well as concerns that many of older people were increasingly called upon to provide child-minding and other services for their adult family members who were at work and so on. Many of these elderly members had poor health and no transport and were stuck in the house with few opportunities to socialize and do things for their own pleasure. The survey wanted to find out how other family members and the elderly themselves thought their situations could be improved.

The questions in section five of the survey were intended to discover the extent of people's participation in educational, personal development or other learning events. Householders were asked about what types of these activities they were involved with, what other kinds they might like or be interested in if available, and what might be some factors that prevented them from taking part. There is generally community agreement that education is important for their personal circumstances to be improved; so this section of the survey sought to see how this translated into actual participation and what might be some ways to increase participation of everyone. Glen Innes people were also increasingly worried about high rates of truancy from school, and many believed that this could be addressed if the adults were interested in education and were able to use this interest to support their children in school and so on.

The overall aim of section six was to get an indication of the sense of belonging or connectedness that participants might have toward their community of place and how ready they might be for a whole-of-community development endeavour. Interviewees were asked what they considered their community to be, what "community spirit" meant to them, and what the positive points and negative points about living in Glen Innes were. These last two questions were to start eliciting community priorities, needs and wishes to inform our community development project's setting of collective goals. The interviewees were asked whether they had access to social support. There were also questions about what the term "community development" meant to them and what they thought were

success factors for a Glen Innes effort. The survey asked what they thought would be some priorities for spending resources the Glen Innes community might receive for undertaking community development. Finally, participants were asked whether they would personally participate in a community-controlled community development project in Glen Innes.

Characteristics of survey participants and housing situation

On the whole, the survey sample was representative of the Glen Innes population as shown in the 2001 Census. Table 5.1 outlines the demographic characteristics of the survey participants.

Over half of the respondents were women (58.4%) and 41.6 percent were men. In terms of age, the majority of participants (70.3%) fell between the ages of 26 and 65 years; another 15.3 percent were aged between 18 and 25; 13.9 percent were aged over 65 years. In terms of ethnicity, over a third of participants were Pacific Peoples (37.1%), close to a quarter were New Zealand European/Pakeha (27.7%), and nearly 20 percent were New Zealand Maori. A further 5 percent were Asian, 3 percent European and 7.4 percent of other ethnicities.

In regard to household structure, two-thirds (66.3%) of participants lived in family households, either as single parents, or with a partner and children, or resided in a house with extended whanau. Only 11.9 percent lived alone and just 2.5 percent lived with friends or flatmates. Another 18.8 percent lived as a couple without children. Given the youthful age structure of GI, it is not surprising that 63.9 percent, or 129 households, had children living at home.

Of those that had children, just over a quarter (27.1%) were under the age of 6 years, 17.8 percent were primary-schooled aged and 13.2 percent were in college or tertiary aged. Another 7.8 percent of households with children had children living with them that had left school. Just over a third (34.1%) had more than one child living at home.

Table 5.1: Selected characteristics of survey participants

Characteristic	Survey Participants	
	Number	Percentage
Gender		
Male	84	41.6
Female	118	58.4
Total	202	
Age group		
18-25	31	15.3
26-35	37	18.3
36-45	48	23.8
46-55	38	18.8
56-65	19	9.4
66+	29	14.4
Total	202	
Ethnicity		
NZ Maori	39	19.3
NZ European / Pakeha	56	27.7
Pacific Islander	75	37.1
European	6	3.0
Asian	10	5.0
Other	16	7.9
Total	202	
Household type		
Living alone	24	11.9
Solo parent with children	34	16.8
Couple no children	38	18.8
Couple with children	59	29.2
Extended Whanau	41	20.3
Living with friends / flatmates	5	2.5
Other	1	0.5
Total	202	

Characteristic	Survey Participants	
	Number	Percentage
Children		
No children / NA	73	36.1
Household with children	129	63.9
Total	202	
Household with children		
Preschoolers	35	27.1
Primary-aged children	23	17.8
College students	14	10.9
Tertiary students	3	2.3
Left school	10	7.8
More than one child	44	34.1
Total, household with children	129	

Table 5.2 gives the occupation and employment status of survey participants. Of those participants who responded to the question on job satisfaction, nearly half (49.7%) said that they were satisfied with their current employment, while 18.9 percent said that they were not satisfied. A large number of participants did not answer this question (Table 5.2).

Their occupations were varied, but a majority were homemakers (22.8%), retired (16.3%) or employed in low or semi-skilled jobs such as service workers, tradesmen, factory workers, drivers or labourers (24.9%). Another 8.9 percent were professionals, technicians, managers or business persons, 9.9 percent were students and 7.0 percent were unemployed, job seeking or receiving a sickness benefit.

Table 5.2: Occupation and employment status of survey participants

Characteristic	Survey Participants	
	Number	Percentage
Employment satisfaction*		
Yes	71	49.7
No	27	18.9
Maybe	1	0.7
NA	44	30.8
Total	143	

Characteristic	Survey Participants	
	Number	Percentage
Occupation		
Retired	33	16.3
Homemaker	46	22.8
Professional/ Technical	15	7.4
Business/ Managerial	3	1.5
Clerical	5	2.5
Service (drycleaners, cleaners, kitchen hands)	28	13.9
Tradesman/ apprentices	10	5.0
Retired	33	16.3
Homemaker	46	22.8
Professional/ Technical	15	7.4
Factory	5	2.5
Driver	2	1.0
Labourer Unskilled	5	2.5
Unemployed/ Job Seeking	9	4.5
Student	20	9.9
Community Worker/ volunteer	3	1.5
Self Employed	2	1.0
Beneficiary (sickness)	5	2.5
Other	9	4.5
NA	2	1.0
Total	202	

*Excludes 59 participants who did not answer the question on employment satisfaction.

Table 5.3 presents the living situation of survey participants and their satisfaction with housing. Only 145 people answered questions on home ownership and housing conditions. Of these, 17.9 percent stated that they owned their own home, while over two-thirds (68.3%) said they were renting. The survey wanted to find out whether people were satisfied with their housing situation. The majority of people (69.0%) were satisfied with their homes, while 17.2 percent were not. Even though interviewers were keen to reassure respondents that they were not from Housing New Zealand, participants were reluctant to offer responses about housing conditions because HNZ owns many of the rented

properties in Glen Innes. Some 18.6 percent of householders said that no improvements were needed, while over a quarter (28.3 %) stated they did not know.

The interviewers had the distinct impression that interviewed householders were wary about disclosing too much personal details in case their doing so might prejudice their relationship with HNZ and possibly jeopardize their negotiations with the state agency to be allotted different housing options e.g. bigger, warmer, different neighbourhoods and so on. People were more willing to talk about housing in general, than about their own situation.

When asked what could improve housing situations in Glen Innes, the largest category of responses still was “don’t know” (26.9%). As earlier mentioned, this outcome is congruent with the general reluctance for participants, mostly rental tenants, to disclose opinions on personal housing circumstances for fear of implications for their own contexts.

The community narratives around rental housing had to do with concerns about overcrowding and the impacts of that on the health and wellbeing of families, especially that of young children. The fact of overcrowding is implicated in poor health and social outcomes and remains an important current housing issue for many communities, including Glen Innes. Many garden sheds and garages in local houses, for example, have been long been converted to living spaces for members of extended families and friends needing support, accommodation and shelter. Although we did not delve into this topic in our survey, many on the survey team observed it might need to be more specifically addressed in some way for improving the situation.

The next largest group of responses wanted improvement to the quality of housing and the number of houses made available to people in Glen Innes (24.1%). At the same time, a significant number of people (20.7%) said that there was a need to reduce the number of houses in Glen Innes. This may have been in response to the fact that zoning changes meant that more in-fill housing was expected. Expectations among some participants were that HNZ would put in “ugly flats” and there would be “thousands more people”. Some people were concerned that HNZ will build more houses and flats for students using the nearby University of Auckland Tamaki Campus. They thought this would mean fewer houses available for themselves, non-students and Glen Innes families.

Table 5.3: Home ownership and satisfaction with housing situation

Characteristic	Survey Participants	
	Number	Percentage
Home Ownership*		
Rent	99	68.3
Own	26	17.9
Don't know	20	13.8
Total	145	
Satisfaction with housing situation*		
Yes	100	69.0
No	25	17.2
Don't know	20	13.8
Total	145	
How to improve personal housing situation*		
None needed	27	18.6
Better quality	23	15.9
Personal factors	21	14.5
Social factors	10	6.9
Lower costs	7	4.8
Home ownership	5	3.4
Environmental factors	5	3.4
Other	6	4.1
Don't know	41	28.3
Total	145	
How to improve general housing situation in GI*		
More/better quality	35	24.1
Reduce quantity	30	20.7
Social justice/cost	12	8.3
None needed	9	6.2
Other	20	13.7
Don't know	39	26.9
Total	145	

*Excludes 57 participants who did not answer the question on home ownership.

Community needs regarding recreational activities and facilities

The GIRHS asked participants about how they used their spare time over the past year. Table 5.4 details how many people spent their spare time participating in games and hobbies, with whom and where.

Table 5.4: Participation in games / hobbies

	Survey Participants					
	Male		Female		Total	
Characteristic	Number	Percent	Number	Percent	Number	Percent
Participation in games / hobbies						
Yes	53	63.1	60	50.8	113	55.9
No	27	32.1	46	39.0	73	36.1
Other/NA	4	4.8	12	10.2	16	7.9
Total	84	100	118	100	202	100
If yes, what game/hobby						
Arts/crafts	7	13.2	18	30.0	25	22.1
Gardening	4	7.6	10	16.7	14	12.4
Cards	7	13.2	6	10.0	13	11.5
Board games	6	11.3	3	5.0	9	8.0
Reading	4	7.6	3	5.0	7	6.2
Computer	6	11.3	1	1.7	7	6.2
Performance arts	2	3.8	4	6.7	6	5.3
Other	17	32.0	15	25.0	32	28.3
Total	53	100	60	100	113	100
If yes, in what context						
Solitary/alone	28	52.8	32	53.3	60	53.1
Social/with others	15	28.3	15	25.0	30	26.5
Club member	6	11.3	7	11.7	13	11.5
Other/NA	4	7.5	6	10.0	10	8.8
Total	53	100	60	100	113	100
If yes, what location						
Glen Innes	31	58.5	39	65.0	70	62.0
Outside GI	9	17.0	4	6.7	13	11.5
Both	10	18.9	13	21.7	23	20.4
NA	3	5.7	4	6.7	7	6.2
Total	53	100	60	100	113	100

Over half (55.9%) of the people surveyed said that they participated in some kind of game or hobby in their spare time. Many chose not to disclose what these were. Over half of participants enjoyed these games and hobbies on their own. Men were more likely to be involved in games and hobbies than women, with 63.1 percent of men in the survey stating they participated in games or hobbies compared to 50.8 percent of women. Women were more likely to be involved in arts/crafts and gardening, while men were more likely to be involved in board games and computers.

Just under half (46.0%) of the 202 people surveyed took part in some kind of sports activity in the last year (Table 5.5). The most common sports activity was rugby, followed by working out in gyms.

Table 5.5: Participation in sports

	Survey Participants					
	Male		Female		Total	
Characteristic	Number	Percent	Number	Percent	Number	Percent
Participation in sports						
Yes	45	53.6	48	40.7	93	46.0
No	39	46.4	63	53.4	102	50.5
Did not answer	0	0.0	7	5.9	7	3.5
Total	84	100	118	100	202	100
If yes, which sport						
Rugby	14	31.1	9	18.8	23	24.7
Gym	4	8.9	6	12.5	10	10.8
Netball	0	0.0	8	16.7	8	8.6
Rugby league	6	13.3	1	2.1	7	7.5
Walking / running	2	4.4	3	6.3	5	5.4
Water sports	2	4.4	1	2.1	3	3.2
Soccer	2	4.4	2	4.2	4	4.3
Basketball	2	4.4	1	2.1	3	3.2
Other / NA	13	28.9	17	35.4	30	32.3
Total	45	100	48	100	93	100

	Survey Participants					
	Male	Female	Total			
Characteristic	Number	Percent	Number	Percent	Number	Percent
If yes, in what context						
Active player	28	62.2	30	62.5	58	62.4
Admin / coaching	2	4.4	5	10.4	7	7.5
Spectator	12	26.7	13	27.1	25	26.9
Did not answer	3	6.7	0	0.0	3	3.2
Total	45	100	48	100	93	100
If yes, what location						
Glen Innes	18	40.0	15	31.3	33	35.5
Outside GIen Innes	17	37.8	27	56.3	44	47.3
Both	9	20.0	6	12.5	15	16.1
Other/NA	1	2.2	0	0.0	1	1.1
Total	45	100	48	100	93	100

Not surprisingly, more men were involved in rugby and rugby league, while women were more likely to take part in netball. The list of sports that some participants took part in included expensive ones such as scuba diving, surfing, windsurfing and skiing. This was surprising given the cost involved in these types of activities; however, this may reflect the more affluent areas on the edges of Glen Innes, such as Glendowie, which fall into the survey area. Of those who played sports, more than half were actively involved as players and about a third were spectators.

Participants also spent their spare time involved in other activities aside from games, hobbies and sports. This included attending church, being involved in school committees, community/welfare, or cultural groups. Nearly half of the participants (45%) said that they were involved in these types of activities (Table 5.6). It is not surprising that attending church was the most popular activity, with 51.6 percent of those participating in other activities stating that they do so because Glen Innes has a large number of churches and a high proportion of Pacific Peoples. Variations of religious or faith activities (going to a temple or mosque for example) are included under “other”. Women were more likely than men to be involved in activities through schools and community/welfare groups.

Table 5.6: Participation in other activities

	Survey Participants					
	Male		Female		Total	
Characteristic	Number	Percent	Number	Percent	Number	Percent
Participation in other activities						
Yes	33	39.3	58	49.2	91	45.0
No/Don't know	51	60.7	60	50.8	111	55.0
Total	84	100	118	100	202	100
If yes, what activity						
Church	20	60.6	27	46.6	47	51.6
School	2	6.1	15	25.9	17	18.7
Community/welfare	4	12.1	6	10.3	10	11.0
Cultural	4	12.1	5	8.6	9	9.9
Other	3	9.1	5	8.6	8	8.8
Total	33	100	58	100	91	100
If yes, what location						
Glen Innes	14	42.4	27	46.6	41	45.1
Outside Glen Innes	12	36.4	23	39.7	35	38.5
Both	3	9.1	4	6.9	7	7.7
Other/Did not answer	4	12.1	4	6.9	8	8.8
Total	33	100	58	100	91	100

The survey also asked people about the kinds of activities they were doing or facilities they were using in Glen Innes at the time of the survey and ways they thought these facilities could be improved for them and their families.

Nearly half of the survey participants were using facilities in Glen Innes at the time of the survey. For those people, a majority of them were using gyms and/or pools in the community (73.7%), and some were using local sports fields, parks and reserves (35.4%). In regard to how these facilities could be improved, over one-third stated that the quality and range needed to be improved (36.4%).

The figures are presented in the following table.

Table 5.7: Activities or facilities that participants use in GI & ways to improve them

	Survey Participants					
	Male		Female		Total	
Characteristic	Number	Percent	Number	Percent	Number	Percent
Use of facilities in GI at the time of survey						
Yes	38	45.2	61	51.7	99	49.0
No	46	54.8	57	48.3	103	51.0
Total	84	100	118	100	202	100
If yes, what facilities (multiple answer)						
Gym / pools	29	76.3	44	72.1	73	73.7
Sports fields/parks/reserves	16	42.1	19	31.1	35	35.4
Library	5	13.2	6	9.8	11	11.1
Schools	1	2.6	1	1.6	2	2.0
Community Hall	1	2.6	1	1.6	2	2.0
Other	4	10.5	8	13.1	12	12.1
Total	38		61		99	
If yes, how to improve facilities						
Did not answer	11	29.0	14	23.0	25	25.3
No improvements needed	14	36.8	19	31.1	33	33.3
Quality/range improved	10	26.3	26	42.6	36	36.4
Costs/hours open	3	7.9	2	3.3	5	5.1
Total	38		61		99	

In the survey, householders were asked to list three activities they would like to do but were currently unable to as well as the factors that prevented them from doing each (details in Table 5.8).

A total of 80 participants did not answer this group of questions. The interviewers thought this could be because people did not want to feel judged if they did not participate in these activities; some might feel that it was too personal. Among those who answered, many people would like to participate more in sports or health related activities (74.6%). Others would like to be involved in games/hobbies (17.2%) or personal development (32.8%). Time was given as the number one reason why people were unable to participate in these

activities (68.0%). Other reasons included costs (23.8%), lack of facilities (18.0%) and information (17.2%).

Table 5.8: Activities participants would like but are unable and limiting factors

	Survey Participants					
	Male		Female		Total	
Characteristic	Number	Percent	Number	Percent	Number	Percent
Activities (multiple answer)*						
Games/hobbies	4	9.3	17	21.5	21	17.2
Sport and health	43	100.0	45	57.0	88	72.1
Community and welfare	4	9.3	7	8.9	11	9.0
Personal development	8	18.6	32	40.5	40	32.8
Theatre (performing arts)	5	11.6	8	10.1	13	10.7
Other	10	23.3	25	31.6	35	28.7
Total	43		79		122	
Limiting factors (multiple answer)*						
Facilities	6	14.0	16	20.3	22	18.0
Vacancies	1	2.3	3	3.8	4	3.3
Information	5	11.6	16	20.3	21	17.2
Time	38	88.4	45	57.0	83	68.0
Money	9	20.9	20	25.3	29	23.8
Motivation	2	4.7	3	3.8	5	4.1
Childcare	3	7.0	8	10.1	11	9.0
Security	0	0.0	4	5.1	4	3.3
Personal	11	25.6	13	16.5	24	19.7
Total	43		79		122	

*Excludes 80 participants who did not state any new activity that they would like to do.

Finally in this section, the interviewers asked people what new activities or facilities they would like to have available to them. This question was included to be able to plan for potential goals or projects in the community to improve health and well-being. The results are presented in Table 5.9. Out of the 202 survey participants, 88 (43.6%) shared ideas for activities and facilities they would like for themselves personally, and 94 (46.5%) answered what they thought would benefit the whole community. A number of people who

provided answers said they would like to have more or improved sports fields, parks and reserves (43.5%). Although these facilities are currently already available in Glen Innes, many participants felt that the currently available spaces are not very appropriate or satisfactory due to their unsightliness, petty crime and poor lighting and/or seating. Some felt that they were not very safe or nice play areas for children and that litter, graffiti and the loitering of teens or drunks was a problem.

The suggestion for a youth centre, or some similar facility, was included among ideas participants saw as important for themselves (23.9%). Many respondents who have lived in Glen Innes for some time remarked that they have been lobbying for such a facility for many decades since the first documented community survey in 1995. Since that time, the community had repeatedly expressed their desire for a local affordable facility that would provide safe and structured programmes and activities for local young people in order that their many and diverse young people may be gainfully and safely occupied, as an alternative to “aimless roaming in the streets” and possible juvenile mischief. The people of Glen Innes were promised one such facility when the local Tamaki College Community Recreation Centre project was proposed. Provision of a youth centre was a requirement imposed on that joint community-council facilities partnership project funding application. For reasons that many of the survey respondents were only able to speculate about with interviewers, the desired youth-centred facility never eventuated although the project provided an affordable sport and recreation option for those youths and their families who could afford it. Much to their disappointment, the call for a dedicated youth centre remained unanswered. The same desire for a youth centre was reiterated when participants were asked about what community facility they think would be good to have in Glen Innes (21.3%).

Some participants (17.0%) also indicated the need to have a “community place” so that more community people can come together and participate in activities. The general feeling was that a more neutral place (that is, not church or marae) would be good, especially if it can be flexible enough to accommodate all the diverse groups who may want to use it. Some people remember a time when the current community hall in Line Road was run by a local group. Although they think there were some problems then, most thought this idea should be re-visited.

Table 5.9: New facilities or activities participants would like for themselves and the community

	Survey Participants					
	Male		Female		Total	
Characteristic	Number	Percent	Number	Percent	Number	Percent
Suggestions for new facilities in GI for themselves						
Yes	31	36.9	57	48.3	88	43.6
No	53	63.1	61	61.7	114	56.4
Total	84	100	118	100	202	100
If yes, what facilities or activities (multiple answer)						
Sports fields, parks, reserves	14	45.2	26	45.6	40	45.5
Youth Centre	5	16.1	16	28.1	21	23.9
Gym/pools	5	16.1	6	10.5	11	12.5
Shops	2	6.5	8	14.0	10	11.4
Movie theatres	2	6.5	7	12.3	9	10.2
Other	15	48.4	29	50.9	44	50.0
Total	31		57		88	
Suggestions for new facilities in GI for the community						
Yes	37	44.0	57	48.3	94	46.5
No	47	56.0	61	51.7	108	53.5
Total	84	100	118	100	202	100
If yes, what facilities or activities for the community (multiple answer)						
Sports facilities	12	32.4	17	29.8	29	30.9
Youth Centre	10	27.0	10	17.5	20	21.3
Community place	5	13.5	11	19.3	16	17.0
Entertainment	7	18.9	7	12.3	14	14.9
Other	15	40.5	27	47.4	42	44.9
Total	37		57		94	

Services and facilities for families with children

The survey was interested in the experiences of households with families in relation to the state and availability of community activities and facilities. Families with children have additional needs in regard to community support, especially in terms of accessibility and affordability of appropriate services and facilities. A total of 129 households in the survey (63.9%) had children living at home (see Table 5.1).

Although the questionnaire contained separate questions for families with pre-schoolers, with school-aged children and with teenagers living at home, respondents with children were usually asked these questions together instead of separating them out into different age groups. This was because many of the householders had children in more than one age group, and separating the questions caused repetition of the same questions for the different age groups; therefore, the number of respondents for questions regarding services or facilities for pre-schoolers, school-aged children and teenagers does not necessarily match the number of households with these children. For example, Table 5.1 shows that there were 35 households with pre-schoolers, but 61 participants responded to the questions for families with pre-schoolers (Table 5.1). Also, a number of participants who no longer had any under-sixes at home, they were still keen to comment on community needs regarding services and facilities for pre-schoolers because they had recent experiences of having had pre-schoolers.

Nearly half of those who responded to survey questions on preschoolers found it easy to find child-care (44.3%), many utilising extended whanau and family (see Table 5.10 below). About a third of respondents (31.1%) were able to get a break away from the demands of looking after very young children more than once a week. About the same proportion (32.8%) could only manage this less than once a week, and one in five never had time out. It seemed that while it was relatively easy to get childcare, having “time out” was another matter. It is likely that childcare was used when parents needed to do things, such as work, run errands or shopping, rather than for time to themselves. Our local interviewers shared their view that having “time out” was a predominantly Pakeha or European concept and it was seen as an indulgence or luxury item rather than an important part of self-care and provides relief from the everyday stresses and strains of child care and parenting.

A significant number of pre-schoolers (49.2%) did not attend an early childhood education or care facility, despite the efforts by the Ministry of Education to increase uptake in such centres. Of those whose children did not attend any facilities, many gave no particular

reason for why this was the case (30.0%) or did not answer (30.0%). Respondents were also not able to give many ideas on how to improve facilities for young children, with 39.3 percent stating that did not know how they could be improved. Our local interviewers opined that although many young children were not in formal early childhood education or care facilities or services, they were not deprived of good care and cultural learning. Many of these youngsters were cared for by either their own parents or members of their extended families – aunties, uncles, nannies, cousins, grandparents – and friends. These caregivers were important resources and models for keeping the diverse cultural values, beliefs, knowledges, languages and practices alive. Also, many local churches and community groups ran informal play groups that were not funded from the public purse, run by volunteers and, hence, not included in the databases for early childhood education and care services.

Table 5.10: Views on facilities and support for parents with preschool children

	Survey Participants	
Characteristic	Number	Percentage
Child-minding*		
Easy to find	27	44.3
Hard to find	12	19.7
Don't want to use	10	16.4
Other/Don't know	12	19.7
Total	61	
Time out for parents/caregivers*		
Less than once weekly	20	32.8
More than once weekly	19	31.1
Never	12	19.7
Did not answer	10	16.4
Total	61	
Pre-school/care facilities*		
Attend	22	36.1
Not attend	30	49.2
Don't know	9	14.8
Total	61	

Characteristic	Survey Participants	
	Number	Percentage
If attend, type of facility		
Kindergarten	6	27.3
Playcentre	3	13.6
Kohanga/Language nest	8	36.4
Other	5	22.7
Total	22	
If attend, does it meet needs?		
Yes	10	45.5
No	6	27.3
Not sure	3	13.6
Don’t know	3	13.6
Total	22	
If not attend, reasons for non-attendance		
No special reason	9	30.0
Cost	5	16.7
Don’t like facilities	2	6.7
Other	5	16.7
Did not answer	9	30.0
Total	30	
How to improve facilities for young children*		
Costs cheaper	7	11.5
Better facilities	6	9.8
No improvements needed	6	9.8
Don’t know	24	39.3
Other	16	26.2
Did not answer	2	3.3
Total	61	

*Excludes 141 participants who did not comment on services and facilities for pre-schoolers.

Table 5.11: Views on activities and support for primary-aged children

Characteristic	Survey Participants	
	Number	Percentage
Where do primary-aged children play?*(multiple answer)		
Organised activities	18	25.4
Parks/reserves	27	38.0
Friend's houses	30	42.3
At home	9	12.7
In the street	13	18.3
Other	15	21.1
Total	71	
Enough safe areas to play?*		
Yes	11	15.5
No	43	60.6
Not sure	11	15.5
Don't know	6	8.5
Total	71	
Ways to improve things*		
Better and more facilities	42	59.2
Past better	3	4.2
None needed	2	2.8
Other	4	5.6
Don't know	20	28.2
Total	71	
After-school or weekend activities*		
After-school programs	19	26.8
Sports facilities	10	14.1
Entertainment facilities	4	5.6
Cultural facilities	3	4.2
Enough activities	1	1.4
Other	14	19.7
Don't know/Did not answer	20	28.2
Total	71	

*Excludes 131 respondents who did not comment on services and facilities for school-aged children.

In terms of activities for primary-aged children (5-12 years), a total of 71 participants provided feedback. Only about a quarter (25.4%) of primary school-aged children

participated in organised activities at the time of survey, and the majority of respondents (60.6%) stated that there were not enough safe areas for children to play (Table 5.11). Over half suggested that better and more facilities were needed to cater for primary-aged children in Glen Innes. When asked what after-school or weekend activities or facilities they would like for their children, many mentioned after-school programs (26.8%) and sports/entertainment/cultural facilities (25.3%).

Table 5.12: Views on activities and facilities for teenaged children

	Survey Participants	
Characteristic	Number	Percentage
Where spare time spent?*		
Organised activities (e.g. school sports/clubs, cultural/church groups, sports & other clubs)	19	30.6
Friends' houses	18	29.0
Working	5	8.1
Other	1	1.6
Don't know	19	30.6
Total	62	
Enough facilities/activities?*		
Yes	9	14.5
No	22	35.5
Not sure	9	14.5
Don't know	22	35.5
Total	62	
Ways to improve things*		
Future will be better	25	40.3
Other	4	6.5
Don't know	31	50.0
None needed	2	3.2
Total	62	

*Excludes 140 participants who did not comment on services and facilities for teenaged children.

With more than half the population in Glen Innes classified as "youth" (under 24 years), it was important to find out the experiences of parents with teenaged children. A total of 62

participants commented on the state and availability of facilities for teenaged children (shown in Table 5.12 above). While nearly a third stated that their teenaged children took part in organised activities (30.6%), the same number of parents did not know where their teenagers spent their spare time. A significant number of participants did not think there was enough activities for teenagers in Glen Innes, were not sure or did not know. Once again, better facilities was the number one suggestion for improving the lives of teenagers (40.3%), although half were not sure how things could be improved.

Table 5.13: Family activities

	Survey Participants	
Characteristic	Number	Percentage
Family activities (multiple answer)*		
Visiting friends/relatives	99	68.8
Picnics/parks/beaches	73	50.7
Walks/tramps/camps	48	33.3
Playing sport	50	34.7
Church	37	25.7
Movies/theatre	34	23.6
None	3	2.1
Other	23	16.0
Total	144	
New activities		
Movies/theatres	26	18.1
Playing sports/water sports	8	5.6
Picnics/parks/beaches	7	4.9
Walks/tramps/camps	4	2.8
Other	24	16.7
None	12	8.3
Don’t know	63	43.7
Total	144	

Characteristic	Survey Participants	
	Number	Percentage
Enough education, training and support for parents/caregivers?*		
Yes	75	52.1
No	6	4.2
Not sure	51	35.4
Don't know	12	8.3
Total	144	
Involvement if above education offered*		
Yes	59	41.0
No	14	9.7
Not sure	11	7.6
Don't know	60	41.7
Total	144	

* Excludes 58 participants who did not have responsibilities for providing care for young children.

All parents and caregivers were asked questions in regard to family activities; this included householders who did not have children living with them but who had some responsibilities for providing care for young members of their extended whanau. The most common activity done together as a family was visiting friends and/or relatives (68.8%). The number of those going to church together was low given the earlier observation that churches and related activities were important for the community. On reflection, this may be due to the fact that many families would consider going to church as being a normal part of life and thus not interpreted as an "activity" done by the family.

Many families would like to go to the movies more together (18.1%); price was identified as a factor that prevents this from happening. Although about half of those interviewed believed they had enough education and support, a large proportion (41.0%) indicated that they would like to take part in more education, training or support for parents if it was offered to them.

Activities and facilities for older people

Survey participants were asked for their opinions regarding the activities and facilities for older people in Glen Innes. Many thought there needed to be more clubs or activities for older people and spoke about their own relatives and friends they knew who were isolated and suffered from loneliness (Table 5.14).

Table 5.14: Views on activities and support for older people

Characteristic	Survey Participant	
	Number	Percentage
How to improve things for older people in GI (multiple answer)*		
More clubs/activities	59	38.1
Involvement in the community	71	45.8
More interest by neighbours	56	36.1
Better council/government services	48	31.0
Other	39	25.2
None needed	21	13.5
Total	155	
Issues/concerns regarding situation for older people		
Security	28	13.9
Community involvement	22	10.9
Facilities/amenities	14	6.9
Information	3	1.5
Other	35	17.3
Don't know	100	49.5
Total	202	
Issues/concerns faced by older people**		
Personal	8	17.0
Facilities/amenities	5	10.6
Community involvement	4	8.5
Security	3	6.4
Other	9	19.1
No improvements needed	3	6.4
Don't know	15	31.9
Total	47	

***** Excludes 47 participants who did not comment on how to improve services for older people in GI.

**This question was only asked to participants aged over 55 years.

Many wanted to see older people being involved in the community (45.8%) and shown more interest by neighbours so that such isolation would not occur (36.1%). Security was given as a top concern for older people and examples of bad experiences were often

offered, such as purse snatches, assaults and property damage. When participants aged over 55 years were asked about their issues or concern, security was not seen to be as important as some other issues such as personal health and income.

Personal learning and development

The survey asked participants about their attitudes to and ideas about personal learning and development. A total of 81 participants (40.1%) had attended some sort of classes or lessons in the past year (Table 5.15); some of these people attended more than one class.

The majority of people who had attended classes had done so at a school, polytechnic or university (48.1%), and many people indicated that they wanted more of these types of classes (32.1%). The most popular type of classes were in the category of “practical and living skills” (60.2%). These included cooking, typing, driving, computing, first aid and so on.

The most common barrier given that prevented people from participating in classes was time (43.6%). Other barriers included access to transport (18.6%) and lack of childcare (28.9%). More than half (61.9%) of survey participants said they thought more community classes should be available, and 45.5 percent said that they were interested in community discussion groups. Topics of interest for these discussion groups included health (22.8%), youth or elderly concerns (14.1%), and general education and self-improvement (13.0%).

Table 5.15: Personal learning and development

	Survey Participants	
Characteristic	Number	Percentage
Attended classes		
Yes	81	40.0
No	109	54.1
Did not answer	12	5.9
Total	202	

Characteristic	Survey Participants	
	Number	Percentage
If attended, type of classes (multiple response)		
School/polytechnic/university	39	48.1
Crafts/hobbies	7	8.6
Practical skills	23	28.4
Living skills	9	11.1
General interest	7	8.6
Other	22	27.2
Total	81	
Desired classes		
Yes	156	77.2
Did not answer	46	22.8
Total	202	
Types of classes desired (multiple response)		
School/polytechnic/university	50	32.1
Crafts/hobbies	29	18.6
Practical skills	66	42.3
Living skills	28	17.9
General interest	26	16.7
Other	14	9.0
Total	156	
Limiting factors (multiple response)		
Time	68	43.6
Distance/Transport	29	18.6
Childcare/Family	45	28.9
Availability	23	14.7
Costs	31	19.9
Personal reasons	6	3.8
Information	5	3.2
Other	17	10.9
Total	156	

Characteristic	Survey Participants	
	Number	Percentage
Desire for more community classes		
Yes	125	61.9
No	13	6.4
Maybe	20	9.9
Don't know	44	21.8
Total	202	
Desire for more community discussion groups		
Yes	92	45.5
No	40	19.8
Maybe	21	10.4
Don't know	49	24.3
Total	202	
If yes, topics of interest		
Public health-related	21	22.8
Youth/elderly	13	14.1
Education/self improvement	12	13.0
Security	4	4.3
Other	25	27.2
Did not answer	17	18.5
Total	92	

Satisfaction with community living

The Glen Innes Household Survey also wanted to gauge what householders thought about living in Glen Innes – their sense of "community spirit", place and belonging. The more people experience a sense of "community spirit", place and belonging, the more likely they will be to engage in community-wide action and participate in the democratic processes of affecting community change for themselves and their fellows.

Survey participants were asked whether they liked living in their house, street, neighbourhood and Glen Innes. The results indicated that the majority of people liked living where they did (Table 5.16). Almost nine out of ten people liked living in their home, 88.1 percent in their street, 84.2 percent in their neighbourhood and 83.2 percent in Glen Innes. When participants were asked "who or what do you consider to be your

community", over half of respondents considered Glen Innes to be their community, which was a promising result for a community project dedicated to promoting and practising community-led development. Another 15.8 percent of participants considered their immediate neighbourhood as their community, and 7.4 percent saw this role occupied by their street.

Table 5.16: Satisfaction with community living and meaning of "community"

Characteristic	Survey Participants	
	Number	Percentage
Like living in house		
Yes	180	89.1
No	16	7.9
Not sure	4	2.0
Don't know	2	1.0
Total	202	
Like living in street		
Yes	178	88.1
No	9	4.5
Not sure	13	6.4
Don't know	2	1.0
Total	202	
Like living in neighbourhood		
Yes	170	84.2
No	6	3.0
Not sure	19	9.4
Don't know	7	3.5
Total	202	
Like living in Glen Innes		
Yes	168	83.2
No	10	5.0
Not sure	20	9.9
Don't know	4	2.0
Total	202	

Characteristic	Survey Participants	
	Number	Percentage
What/who is considered to be community?		
Whole of GI	104	51.5
Neighbourhood	32	15.8
Street	15	7.4
Ethnic group	9	4.5
Other	21	10.4
Don’t know	21	10.4
Total	202	

A significant number of participants were fairly recent arrivals to Glen Innes. Nearly 40 percent of people had lived in Glen Innes for less than five years, with nearly half these people arriving less than a year ago (Table 5.17). There were also a large proportion of participants who had lived in Glen Innes for over 20 years (29.2%). A high proportion (69.8%) of participants had no plans to move out of Glen Innes; of those that did intend to move, most planned on doing so in the next five years.

Table 5.17: Length of time in Glen Innes and plans to move

Characteristic	Survey Participants	
	Number	Percentage
Length of stay in Glen Innes		
Less than 1 year	39	19.3
1 to 2 years	15	7.4
3 to 5 years	25	12.4
6 to 10 years	31	15.3
11 to 20 years	31	15.3
More than 20 years	32	15.8
All of life	27	13.4
NA	2	1.0
Total	202	
Plans to move		
Yes	50	24.8
No	141	69.8
NA	11	5.4
Total	202	

Characteristic	Survey Participants	
	Number	Percentage
If yes, time frame for moving		
Within 1 year	29	58.0
Within 5 years	19	38.0
Over 5 years	2	4.0
Total	50	
If yes, reasons for moving		
Personal	0	0.0
Environment	8	16.0
Other	12	24.0
Don’t know	30	60.0
Total	50	

It was important to find out whether there was a strong sense of community spirit in Glen Innes. Participants were asked what community spirit meant to them. Three-quarters or 153 of the participants said they knew about the term “community spirit”; of these over half (51.0%) responded by saying it meant people helping and supporting each other, in both practical and emotional ways (Table 5.18). Another 19.0 percent thought that it meant having a sense of familiarity with others in the community.

Table 5.18: Meaning and importance of “community spirit”

Characteristic	Survey Participants	
	Number	Percentage
What is “community spirit”?		
Responses	153	75.7
Don’t know the term	49	24.3
Total	202	
If responded, what does “community spirit” mean to you?		
Mutual support/help (emotional/practical)	78	51.0
Familiarity	29	19.0
Sense of belonging	16	10.5
People	8	5.2
Pride in Glen Innes	6	3.9
All of the above	3	2.0
Other	13	8.5
Total	153	

Characteristic	Survey Participants	
	Number	Percentage
Importance of community spirit		
Yes, definitely	96	47.5
Yes	61	30.2
Yes, but not personally	9	4.5
Maybe	5	2.5
No	4	2.0
Definitely not	2	1.0
Don’t know	25	12.4
Total	202	
Do you feel there is community spirit in your street?		
Yes	111	55.0
No	38	18.8
Maybe	31	15.3
Don’t know	22	10.9
Total	202	
Do you feel there is community spirit in your neighbourhood?		
Yes	118	58.4
No	29	14.4
Maybe	28	13.9
Don’t know	27	13.4
Total	202	
Do you feel there is community spirit in Glen Innes?		
Yes	96	47.5
No	24	11.9
Maybe	41	20.3
Don’t know	41	20.3
Total	202	

The majority of people (82.2%) thought that community spirit was important for the community, although to differing degrees. Only 3.0% of respondents did not think it was important at all. More than half of respondents thought that community spirit existed on their street (55.0%) and in their neighbourhood (58.4%); just under half thought it existed in Glen Innes (47.5%).

Participants were asked to identify valued attributes of Glen Innes as a place to live. The most positive features or good things about living in Glen Innes were its location (35.1%) and friendly atmosphere and people (32.2%) (Table 5.19).

Table 5.19: Strong and weak points of Glen Innes as identified by survey participants

	Survey Participants	
Characteristic	Number	Percentage
Strong/positive aspects of Glen Innes		
Location	71	35.1
Friendly atmosphere/people	65	32.2
Familiarity	12	5.9
Shops	11	5.4
Environment	9	4.5
Other	13	6.4
Don't know	21	10.4
Total	202	
Weak/negative aspects of Glen Innes		
Security	32	15.8
Environment	24	11.9
Youth behaviour/attitudes	24	11.9
Negative social/ethnic interaction	23	11.4
No weak points	18	8.9
Housing	14	6.9
Shops	11	5.4
Income/employment	11	5.4
Health/drugs/alcohol	10	5.0
Other	11	5.4
Don't know	24	11.9
Total	202	

Many people thought Glen Innes was handy to everything – transport links, shops, beaches, schools and family - and was easy to get around. People also spoke about the friendliness of Glen Innes residents and remarked on the multi-cultural aspects of the community.

The negative points about Glen Innes drew a wider range of responses. The main disadvantage was identified as security (15.8%). People were concerned about their personal safety as well as general talk of crime rates in the community such as burglaries, break-ins, assaults and vandalism.

Another weak point was dissatisfaction with the environment (11.9%), such as litter, graffiti, broken glass, abandoned cars and the state of parks and gardens. People also cited youth behaviour and attitudes as a negative aspect of living in Glen Innes (11.9%), saying that many youth loiter and get into trouble. Negative attitudes were not confined to youth: some respondents said that they experienced negative social interaction with other community members (11.4%). Almost nine percent of people did not believe there were any weak points to living in Glen Innes (Table 5.19).

Table 5.20: Friends and neighbours in Glen Innes

	Survey Participants	
Characteristic	Number	Percentage
Friends in Glen Innes		
Yes	168	83.2
No	32	15.8
NA	2	1.0
Total	202	
If yes, how did you befriend them?		
Through friends/neighbours	36	21.4
On street/over the fence	36	21.4
Organisations/clubs/churches	21	12.5
Other	30	17.9
All/some of the above	40	23.8
Don’t know	5	19.0
Total	168	
Desire for more friends		
Yes	97	48.0
No	55	27.2
Maybe	30	14.9
Don’t know	20	9.9
Total	202	

Characteristic	Survey Participants	
	Number	Percentage
If yes, how do you think this could happen?		
Community activities/events	46	47.4
Communicating with them	21	21.6
Church/cultural groups	6	6.2
Other	15	15.5
Don't know	9	9.3
Total	97	
How well do you know your neighbours?		
Well	72	35.6
Quite well	53	26.2
To say "hello"	47	23.3
Not well	18	8.9
Not at all well	8	4.0
Don't know	4	2.0
Total	202	
How well do you get on with your neighbours?		
Well	141	69.8
Mixed	20	9.9
Not at all	7	3.5
Don't know well	23	11.4
Don't know	11	5.4
Total	202	
Family in Glen Innes		
Yes	116	57.4
No	82	40.6
NA	4	2.0
Total	202	
Non-family help		
Yes	160	79.2
No	29	14.4
Don't know	13	6.4
Total	202	

The majority of participants (83.2%) claimed to have friends in Glen Innes (Table 5.20). Most people said they met friends through other friends or neighbours (21.4%), by talking

to them on the street or over the fence (21.4%) or through organisations, churches and clubs (10.4%). Just under half of participants said they wanted to make new friends and thought the best way to do this was through community events and activities.

Most participants know their neighbours (85.1%) and get on well with them (69.8%); only very small numbers did not know their neighbours at all (3.5%). Many people interviewed had family in Glen Innes (57.4%); of those that did not, most said they were able to visit them regularly as they lived in Auckland. The majority of survey participants also said that there were non-family people in Glen Innes who they could turn to for help (79.2%).

Community development

Householders identified the main problems for the people in Glen Innes as drugs and alcohol (35.7%), low income/unemployment (28.0%) and negative attitudes of both youth and people in general (27.4%) (Table 5.21).

Table 5.21: Main problems for people living in Glen Innes

	Survey Participants	
Characteristic	Number	Percentage
Main problems for 68 people living in GI (multiple response)*		
Drugs/alcohol/gambling	60	35.7
Low income/unemployment	47	28.0
Youth attitudes/behaviour	46	27.4
Negative attitudes/behaviour	46	27.4
Security	26	15.5
Environment	16	9.5
Housing	13	7.7
Other	39	23.2
Best ways to deal with these problems*		
Community interaction/support	37	22.0
Education	19	11.3
Law enforcement	19	11.3
Create more jobs	11	6.5
Other	48	28.6
Don’t know	34	20.2

* Excludes 34 participants who gave no comments on these questions.

It was interesting to note that security only ranked fifth, yet it was the main negative point identified by participants earlier in the survey (Table 5.19); however, all of the top four problems are actually related to security. For example, the use and abuse of alcohol and drugs can result in negative, destructive and criminal behaviours which contribute to the community's feeling of lack of security.

When asked what the best ways of dealing with these problems were, participants gave strong responses to community support, communication and interaction (22.8%). Others suggested initiatives around education and fostering more positive attitudes (11.3%). Law enforcement was also mentioned (11.3%), along with creating more job opportunities for people (6.5%) (Table 5.21). There was every indication that most people were willing to take some collective responsibility for the problems in the community and expressed some keenness to participate in appropriate community action in order to resolve them.

Just over half (51.5%) of participants had heard of the term "community development" (see Table 5.22). This is not surprising as there had been a lot of activity in the community at that time which had been labelled as such; however, when participants were asked to provide some comment on what they thought community development meant, few were able to offer any comments. It was decided that at this point the interviewer would offer a GIRHS definition of community development so that everyone would be talking about the same thing or something similar to it. The definition was a collaborative effort and was given was as follows:

Community Development is a way of getting all the people who live and work in the community the choice to be involved in making decisions; taking responsibility to make GI a better place to live in; GI people working together to build a sense of belonging; GI community having control of resources and decisions affecting the community; and ensuring GI becomes a sustainable place to live and work in. It is GI people who will be the ones saying what their own wishes and priorities are, GI people setting their own goals, and GI people taking responsibility to make sure they achieve those goals together.

The majority of survey participants thought that that was a useful way of understanding community development. Most people were clear that the community itself was responsible for community development. This was an open-ended question so that participants were able to offer any answer they wanted. Community or "everyone", in one form or another emerged as the most common response (66.7%). Local council or local government was another popular response (22.4%) (Table 5.22).

Table 5.22: Views on community development

Characteristic	Survey Participants	
	Number	Percentage
Have you heard of the term “community development”?		
Yes	104	51.5
No	85	42.1
Maybe	1	0.5
NA	12	5.9
Total	202	
Usefulness of term as defined by GIRHS		
Yes	160	79.2
No	11	5.4
Maybe	6	3.0
NA	25	12.4
Total	202	
Seen or heard of community development in GI?		
Yes	102	50.5
No	72	35.5
Maybe	1	1
NA	27	13.4
Total	202	
Who is responsible for community development?*		
Community	70	42.4
Local council and government	37	22.4
Individual and everyone	26	15.8
Community and council	14	8.5
Other	4	2.4
Don’t know	14	8.5
Total	165	

Characteristic	Survey Participants	
	Number	Percentage
Top priorities for community development (multiple response)*		
Youth/children's education/development	96	58.2
Community and other facilities	72	43.6
Upgrade/beautify environment, town centre/amenities	69	41.8
Housing	23	13.9
Other	52	31.5
Total	165	
Support of idea of community group managing community development in GI		
Yes	152	75.2
Probably Yes	14	6.9
No	11	5.4
Not sure/Don't know/No response	20	9.9
ESOL	5	2.5
Total	202	
What are some of the things needed for a community group to work		
Good leadership/management	54	26.7
Community interaction/support	42	20.8
Communication/information	36	17.9
Other	13	6.5
Don't know	57	28.1
Total	202	
Willing to take part in community group		
Yes	89	44.1
No	63	31.2
Maybe	24	11.9
NA	26	12.9
Total	202	

* Excludes 37 participants who did not comment on who is responsible for community development.

Survey participants indicated that the top priority for Glen Innes was investing in youth or child-related education or development programmes (58.2%). This was gratifying because

it was clear people were not looking for “quick fix” solutions such as actions to deal with security-related issues: people considered youth as both the community’s problem and its solution. The next set of priorities suggested by participants was the need for more or improved community facilities (43.6%). Many also wanted money invested in beautifying or upgrading the natural and built environment in Glen Innes (41.8%).

The vast majority of survey participants supported the idea of a community group managing community development in Glen Innes (82.1%; Table 5.22); only 5.4 percent were definitely against this idea. Conditions identified as being success factors for community group included good leadership and management (26.7%) and inclusive practices that ensured the wider community would interact, participate and offer or receive support (20.8%%). Other factors included good communication with the community, plus good information-sharing methods (17.9%). Many people remarked, in several places, that it is “hard for people to know what’s going on”.

Some 89 people (44.1%) indicated that they would be willing to take part in a community development group. When this number is added to the group of “maybes”, the number increases to 113 people or over half of all participants (56.0%).

Identifying community priorities and formulating goals: results of Reference Group process

The results from the GIRHS were taken to the research project design and advisory team as well as the interviewers’ meetings. At this stage, both these groups indicated that they would meet as one group - “GIRHS Reference Group” – to work on the results together. At the same time, some of the original members of the project design team considered that their work was completed and wanted to withdraw, leaving the remaining design team members and interested interviewers to carry the project on to the next step: identifying community priorities, goals and projects.

The findings were first divided into three major categories of “positive”, “challenging” and “interesting” by the GIRHS Reference Group. Many of the members found the GIRHS experience to have been a very positive and empowering one and were keen to keep “looking at the glass being half full” and find all the information that they could to celebrate with the community about. This was also in line with responding to an unexpected and strong criticism at one of the very first presentations of preliminary findings at the marae - some locals were upset about the “problems” and “weak points” being highlighted

because they were shown first and asked that the focus go back to drawing attention to possible “solutions” and “strong points”.

The original intention of the presenters was to “first get the negative stuff out of the way” so as to continue and end with the “positive stuff”. On reflection, the group agreed that the presentation would be improved for community audiences by ensuring that the language used would be strengths-based and that it would begin and end with “positive stuff”; so, the “weak points” and “problems” would be termed “challenging” instead.

“Positive” results to celebrate

Overall, the Reference Group found that the most gratifying aspects of the results were that the majority of participants felt they experienced a strong “community spirit” in GI and that their outlook was mainly optimistic. The participants liked the GIRHS definition of community development, thought it was a good way to work, supported a community group conducting CD, and opined that the community itself was responsible for CD in Glen Innes. A large percentage of them (44%) had also indicated that they would join CD community action groups. These findings were construed as clear support for community-controlled community development in GI and a strong indication of community readiness for a CD project.

As well as the good support for CD generally, the results also indicated that participants had good social connectedness and that they liked living in their community of place. They valued learning and education, both for themselves and for their children, and were interested in more of these opportunities being offered. These indicators seemed to show that future CD action projects and activities could be reasonably expected to find strong support and participation from other people in the community. These community projects would build upon the general goodwill and desire for GI people to connect with others, their optimism and sense of collective responsibility to work and learn together to create an even better Glen Innes for them and their families.

“Challenging” results

An analysis of the results in this category helped to identify main concerns or needs for the participants surveyed. These included the negative points about living in GI which highlighted the desire for participants to be able to feel more secure and safe in their homes and the neighbourhood, to see improved and positive behaviour and attitudes amongst youth and the general population, and to create actions to generally beautify and upgrade the local environment.

Feedback regarding “main problems” more specifically pointed to the social harms and impacts of misuse of drugs and alcohol, low employment and related low household incomes, and the earlier observation of negative and anti-social attitudes and behaviours displayed by youths and adult members of the population as well. One outstanding result concerning the young people was observed in the finding that parents and family members professed not to know where their teenagers spent their time when not at hom, or what they were doing during those times. This finding was in concordance with community expressions of concerns regarding “aimless youths roaming the streets” that were offered at many social network discussions and meetings.

It was not surprising, then, that one of the top priorities for community development action identified by GIRHS participants was to put any available community resources towards providing educational, training or developmental programmes and activities for local youth. What was a bit surprising for many of the Reference Group members was that most of the participants interviewed did not allocate overall blame to parents or schools for young people “falling in between the cracks” (although some of them most certainly did).

In the main, they saw positive educational, learning and training opportunities as appropriate solutions to make the outlook better for GI youths. The other priorities for community development action included the building of new community facilities and amenities and upgrading or ensuring better maintenance of existing ones. These community facilities and amenities include the local town centre and shops, public meeting spaces and housing, as well as public parks and reserves. The challenge was for any future community development initiatives to address these specific priorities in ways that would be empowering, that is, increasing community participation and control.

“Interesting” results

This category included information that the Reference Group thought would help guide and inform their interpretation of both the “positive” and “challenging” category results.

They found consideration of two sizable and distinct sub-populations of participants instructive for understanding parts of the results. The first group of residents had lived in GI for more than 20 years (39%) and the second group for less than a year (19%). They agreed that the different experiences of these groups would go some way to explaining why there was simultaneously strong show of social connectivity and support as well as strong expressions of concern at the lack of perceived security and safety. Members believed that GI “newbies” could be expected to feel unsafe and focus on the negative

aspects of community life because they were still to build those necessary social relationships and support systems that would mediate these for them. The members thought these new residents would also be more likely to respond with “don’t know” or “no answer” types of responses to survey question because they felt that they did not know enough to comment.

They agreed that most of the main issues or priorities identified by participants were to do with the extent and quality of social connectedness experienced by them in the community. Reference Group members thought that the “challenges” (such as insecurity, alcohol and drugs, negative behaviours, environmental degradation, lack of supervision of youth) were symptomatic of disconnectedness in the lives of some community people. Similarly, “positive” priorities related to how to reconnect or to increase connectedness (such as youth development initiatives, more community learning opportunities, improved social facilities and amenities). This was also evidenced by the fact that many participants alluded to the lack of “things to do in GI” when most Reference Group members were aware of many such activities in the community. This strongly added to the reflection that one very important community development early task would be to improve the channels of communications within the community so that accurate and timely information about community happenings could be shared with all GI people. This effectively led to the formation of several community networks and action groups to fulfil this important task of connecting the community people and groups.

Original GIRHS Priorities and Goals as presented to community

The following table (Table 5.23) is a summary of the first set of Priorities and Goals recommended by the GIRHS Reference Group, that were included in the 2006 report to the community (Liew, 2006). It was taken out to the wider GI community for consultation, discussion and feedback so that the community participants would be empowered to actively discuss and debate the most appropriate goals and projects for the whole community to work on together. The list was made in response to particular advice that community people would appreciate having something to refer to and to debate rather than “starting from scratch” to develop priorities and goals themselves from the GIRHS raw data.

The GIRHS Reference Group members worked together with the researcher to prepare the original draft. This group also created a model GIRHS community presentation that would communicate the draft in a consistent and engaging manner. Over a period of six months, these presentations and draft goals were taken to more than 20 community

presentations for community people and groups to work on. The end result of those community discussion processes was a final list of agreed community goals and priorities.

Table 5.23: Original recommended GIRHS Priorities and Goals taken to community

Priorities	Goals
1. Youth To provide GI Youth with a range of safe and practical programmes that will include them and help them to make more positive choices in controlling and improving their health and well-being	Youth Centre To have a Youth Centre in GI that will provide a safe, useful and fun environment for the use of all GI youth
2. Community Facilities To advocate for and promote community facilities and activities that are appropriate for the use and enjoyment of all the people living and working in GI	Community Centre To have a Community Centre/House appropriate for serving all GI people and groups who wish to meet, socialise and work together
3. Environment To ensure that the physical environment in GI is safe and clean so that people can enjoy and take pride in their surroundings	Environment & Facilities To partner fully with Auckland City with regard to the GI Community Hall area and Maybury Reserve developments
4. Community Safety To create and support initiatives that will help make GI a place where the people feel safe to live, work and visit	Community Safety To set up at least one Neighbourhood Watch or similar group in Glen Innes

Priorities	Goals
5. Community Education Development To support initiatives that will give GI people positive choices for appropriate educational development	Community Education Development To plan and coordinate classes, courses, discussion groups etc in the community around topics identified by community members
6. Economic Development To create and support initiatives that will offer GI people opportunities for economic development e.g. training, enterprise, small businesses	Economic Development To have an Economic Development Working Group to identify practical and sustainable ways to develop opportunities for GI people to have improved economic futures
7. Early Childhood (0-6) To support development and accessibility of appropriate early childhood educational and care facilities for pre-schoolers in order to increase their participation rates	Early Childhood To support increase the numbers of young children participating in early childhood education facilities
8. School-aged Children (6-12) To support development and availability of appropriate programmes, activities and facilities for school-aged children	School-aged Children To organise, advocate for and support safe, fun and affordable initiatives and programmes for after-school and weekend activities for school-aged children
9. Teenagers (13-18) To support development and availability of appropriate programmes, activities and facilities for teenagers and their whanau or families	Teenagers To develop and support good mentoring programmes for teenagers to encourage them to stay in school for as long as possible and achieve qualifications

There was general community consensus that all Goals would be framed in terms of positive actions and outcomes, as in the words of an attendee at a 2006 GIRHS presentation: “what we can start doing instead of what we must stop doing” (Liew, 2002 - 2010). For example, the alcohol and drug issues were considered to be better solved by working collectively towards promoting community wellbeing, education and youth Goals because these would affect the social determinants protecting social connectedness and wellbeing.

Community people agreed that communities that experience good social support would make more informed and better health-promoting decisions for themselves and their families. Goals were also very broadly defined, on purpose, so that they can be interpreted by different groups in ways that were appropriate for them and their own contexts.

The community feedback on this first list was that the number of priorities could be shortened because some of them related closely to each other and could be subsumed. For example, an overriding “Youth” priority would include the first one, Youth, and all of the last three, Early Childhood, School-aged Children, and Teenagers. Also, “Community Wellbeing” was a preferred way for grouping “Community Safety” and “Community Education Development” priorities into one.

In the main, community informants felt that grouping some of the priorities and goals together would take into account their inherent overlaps and lead to more efficient use of the limited human, time and other community resources. The list of community priorities and goals that was finally adopted by KMTW for the 2007 – 2010 Strategic Plans is presented in the following table. It is this that can be regarded as the definitive final set of project goals that arose from the survey process.

These recommendations were widely circulated as presentations, hand-outs and electronic copies, distributed to all interested community groups as well as to external stakeholders. All attendees at these presentations as well as recipients of the final list of goals were invited to indicate which goals they would like work on with others. These names formed the core of community groups that will develop actions for achieving the goals.

Table 5.24: KMTW Strategic Plan 2007 -2010 in response to community feedback

Priorities	Goals
Youth	1. Develop connections and communication with GI youth to ensure relevant issues and trends are identified and addressed through the Eastside Youth Network 2. Collaborate with agencies to provide and promote opportunities for youth in GI
Community Wellbeing	3. Strengthen community connectedness 4. Enhance community pride and cohesion 5. Encourage sustainable collaborations to build community capacity and leaderships 6. Promote healthy living
Education	7. Facilitate and promote quality education opportunities 8. Encourage lifelong education in GI 9. Sustain effective educational networks
Enterprise	10. Promote and develop economic opportunities in GI
Environment (incorporating Community Facilities as well)	11. Work effectively with community groups and individuals to enhance the environmental state of GI (inclusive of parks and reserves, community facilities and housing) 12. Maintain strong relationships with local and/or other government or agencies on issues that meet the environmental goals as listed 13. Maintain strong relationships with local and/or other government and environmental agencies on issues and initiatives that meet the common environmental goals and strategies as listed above

The next phase of the community research fieldwork involved working with interested community people and groups to determine the organisational and resource arrangements to translate goals into actions. The outcomes of these community interactions with GIRHS results will be presented in the following chapter.

Chapter summary

In this chapter, the results from the Glen Innes random household survey that involved a total of 202 householders being interviewed by a group of community action researchers were presented. That CAR survey constituted the PEOPLE System's second step of needs and wishes assessment. The GIRHS results comprised the responses from 202 GI householders to questions from six main sections of the survey, which related to their demographic characteristics; experiences and opinions about recreational activities; services and support needed for families with young children as well as for the elderly; personal learning and development; living in GI and the positive and negative aspects of that; what community development meant for them including success factors for community-led development in GI.

These responses were used to help reveal the needs, wishes, concerns and priorities for the householders interviewed. The results were presented to the community first as a list of recommended priorities and goals developed from the data by the GIRHS Reference Group. Over a period of six months and via a series of participatory community consultations that were co-facilitated by members of the GIRHS Reference Group, feedback and comments from these community discussions were used to arrive at a final list of community Goals.

These community Goals provided a launching pad to begin the work on the next phase of this community participatory action research project, which involved making decisions regarding organization and resource arrangements to implement the actions that will contribute to the successful attainment of the Goals.

6 FINAL RESEARCH STEPS: Organising, Resourcing, Taking Action

Never doubt that a small group of thoughtful,
committed citizens can change the world.
Indeed, it is the only thing that ever has.
(Margaret Mead)

In this final chapter reporting on the research process, Steps 4 and 5 of the PEOPLE System are described. The Organization and Resource Arrangements step is rather arbitrarily positioned where it is because the matters associated with that step are on-going issues in a CAR project such as this. The setting of formal goals for the enterprise means that organizational matters such as governance, staffing, and management come into prominence, as do resourcing issues, especially with regard to financial and other such support for the action phase to follow. The Action step brings us to the end of the formal research period described in this thesis (August 2009), with this step being an on-going "work in progress" that is continuing after the research period ended. In the GI setting, both these steps are still seen as part of the research process, since the particular ways these steps are handled here are unique to this setting and the requirements of the PMHP model and are integral to the overall assessment of the applicability of this model within this kind of context.

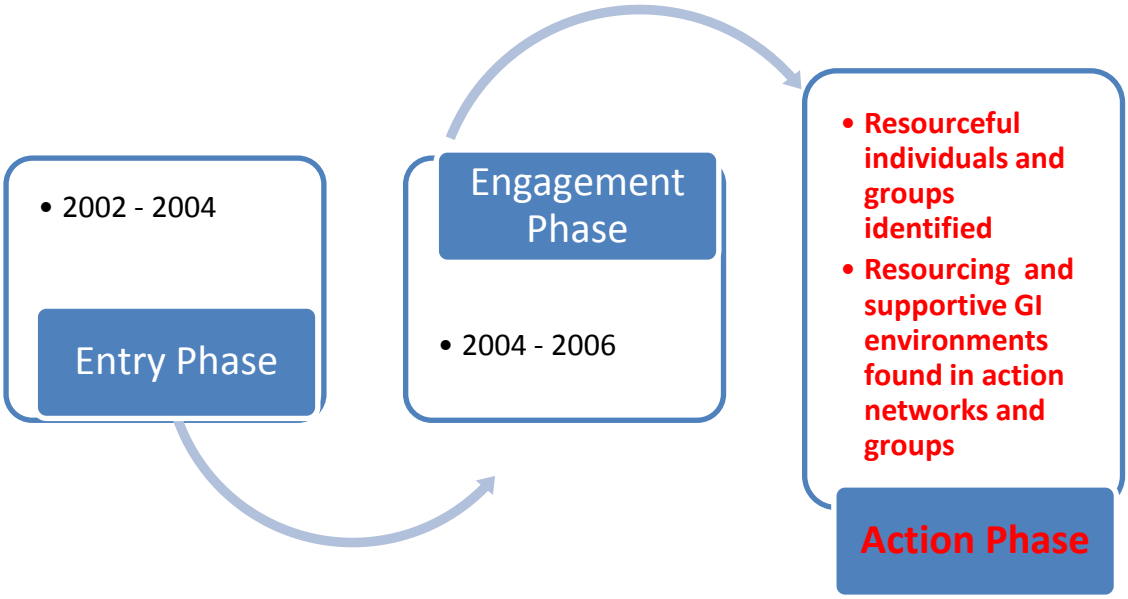
I will begin this discussion by describing how we went about completing the fourth PEOPLE System step of considering and securing the organisational and resource arrangements to enable the fifth step of taking action on the goals to be implemented. I will then relate the degree to which the goals presented at the end of the previous chapter were considered to have been achieved at the end of the Ka Mau Te Wero (KMTW) 2007-2010 Strategic Plan time frame, as judged by the board members. This includes a general overview of how the different ratings, based on the criteria of CD processes used to attain them, were allocated to the goals.

I will include some examples to illustrate the processes involved, and evidence for how empowerment, community control and social support were activated and realised for their participants. I will also give a brief explanation of the significance of the KMTW 'brand' in connecting the people of GI with the project. After that, I will present some evaluation data to put the case that the PMHP model worked well in GI. This penultimate chapter will be

brought to a close with some a discussion that reflects on this action phase of the research, and then a summary of the chapter.

Once again, the original process diagram will be reproduced below as a reminder where the activities relate to the overall phases of the research project and related PMHP outcomes.

Figure 6.1: Process diagram of Action Phase and PMHP outcomes



Organisational and resource arrangements: PEOPLE System step 4

This step of the PEOPLE System requires the members of the 'people-led endeavour' to set up some governance structure and resource arrangements that will help the group to do the work of achieving their goals. For the purposes of this research, the 'people-led endeavour' is represented by the members of the Ka Mau Te Wero project for the reasons outlined in Chapter Three regarding its genesis as an expression of the will of the Glen Innes community.

To quickly recapitulate, KMTW was set up in 2001 as a public funded pilot project to conduct a community-led and driven project using a devolved decision-making model. It was co-managed by the Auckland City Council and the KMTW board, made up mainly of GI people and representatives of local GI community groups. When the funding from the government was terminated in 2006, the KMTW project was running on unspent funds that the group has set aside to deliver on community goals. They spent some of those

funds on the GI Visioning and the GIRHS. However, these funds were beings used up and the group had to secure some new resources to keep going. This resourcing need was noted in the wider community and stakeholders rallied around to address the situation.

The required resources included

- An appropriate governance and decision-making organised structure
- Suitable facilities and equipment
- Adequate human resources (paid staff and volunteers)
- Funding to pay for staff, overheads and project costs

Governance structure and organisation

The KMTW board members underwent an intense period of debate and discussions leading up the end of its funding in mid-2006 in order to agree on how to organise themselves to attain the community goals under the specific circumstances. The processes undertaken were akin to PEOPLE System steps in form and function during this period, as will be shown now.

Setting up the organisational structure

To begin the process, the Board had to clarify its objectives and values (step 1) again to make sure these will be embedded in whatever organisational structure it would adopt. They had to work out the advantages and disadvantages of their options and how these might affect their effectiveness and purpose.

This exercise finally led them to decide to become an incorporated charitable trust to achieve its independence from the council and be eligible to apply for resources on its own merits. This independence would also ensure that KMTW's work will remain under community control as expressed through its participatory processes and community representation on its governance board. The KMTW official mission statement declared that "Ka Mau Te Wero will build, support and strengthen relationships with communities to improve the wellbeing of all Glen Innes people" (KMTW 2007).

By July 2006, KMTW also had completed a community needs and wishes assessment (step 2) the year before, and had a final list of five priorities and thirteen goals that was confirmed for them via a series of community participatory meetings and workshops, conducted over a period of about six months (step 3). These forums saw community people discussing, debating and decided upon what they wanted KMTW to focus on to attain their priorities and goals. In effect, KMTW was to be an operational arm of the GI

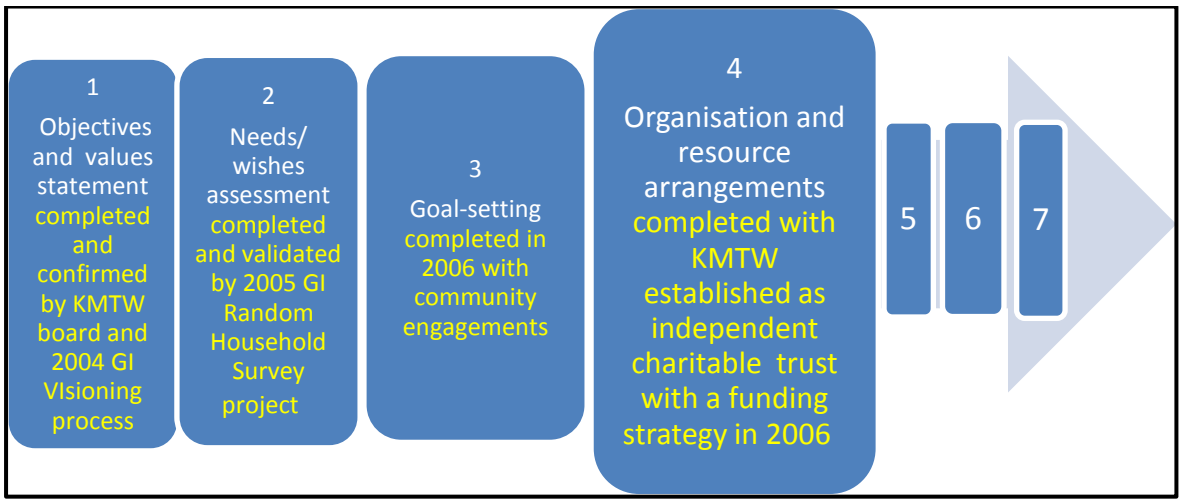
community's will. It was to perform a coordinating and facilitation function to help community people and groups to realise its vision of "GI working together for community prosperity" (KMTW, 2007).

The legal requirement to submit a trust deed resulted in KMTW committing itself to be constitutionally guided by its stated values that encompass honouring the Treaty with Maori to advocate, promote and protect their interest; inclusiveness; partnership; respect; participation; integrity; accountability; optimism; courage and leadership (KMTW, 2007). Here, it may be evidenced that the PMHP principles and values of empowerment, building connectedness, social support and community control are implicitly addressed in intents.

Having clarified its philosophical stance, KMTW also needed appropriate facilities, equipment and, most importantly, people to do the work in order to do its job as directed by the community. Based on the strong community mandate and support for its continued role in GI, KMTW submitted a funding application to the Department of Internal Affairs to pay the wages of a full time community worker.

The submitted funding proposal contained the sanctioned five community priorities and 15 goals, and it was successfully received and secured the required resources until August 2009 (step 4). (This was later extended to August 2010). KMTW now had the organisational structure and the funding to progress the community goals. It also managed to renew its lease of the small office it was in at a "peppercorn" (small or tokenistic) rate from the Auckland City Council, to be reviewed annually.

Figure 6.2: Progress of KMTW in relation to PEOPLE System steps



Relationship between board and staff

In this example of KMTW, the researcher was the incumbent sole paid staff of the project, and the funding from Internal Affairs was used to retain her in the role for the duration of the contract. However, KMTW needed more than one fulltime person to discharge its duties to the community.

Specifically, it needed people to help coordinate and support the community action groups that would be required to be mobilised around particular goals, continue to seek ongoing resourcing to enable projects to be completed well, attend to administrative and other tasks needed to run a project office, build and maintain relationships within and outside of the community, and monitor the progress of the different community goals.

In essence, a project that is based on the PMHP Model must definitely model its principles and values in its own practices. An important part of that is also that the governance and the staff are clear about their responsibilities and roles. A more detailed account can be found in Raeburn and Rootman's 1998 book (Raeburn & Rootman, 1998), and different groups will adapt the guidelines to their specific needs.

The following is a summary of the KMTW governance board responsibilities and roles:

- Provide stewardship of KMTW's stated philosophy, values and objectives as agreed to in its trust deed, governance policies and strategic plans – need clear statements in official documents with regularly scheduled cycles of review and updating them
- Ensure the interests and priorities of the wider GI community are articulated, advocated for and protected – need accurate information about community trends and developments; maintain good relations with community stakeholders and networks
- Maintain oversight of ethical and responsible use of resources including funds (good financial systems and accountability), facilities (safe and appropriate for project use), equipment (provision and maintenance) and staff (empowering and fair policies for paid and unpaid personnel) – clear policies and job descriptions developed and updated, annual financial audit processes and receiving reports
- Provide support (including dealing with conflicts and grievances) and advice for staff (administrative, logistic and cultural guidance) when carrying out their duties – build and maintain good relationships, undertake personal and professional development

- Ensure that adequate resources are found to run the project and its activities – create and execute resource plans and strategy for accessing resources
- Model empowering ways of working and promote the project and community goals – develop skills and familiarity with what these are and explore opportunities to practise them

The following are a summary of the KMTW staff responsibilities and roles:

- Model people-centred philosophy, principles, values and objectives - undertake personal and professional development, undergo regular self and peer review of personal practices
- Build, strengthen and support relationships with communities within GI community to ensure their voices and aspirations are included – update community database of contacts and maintain relationships, identify vulnerable groups and seek to offer and find equitable support and help
- Organise community needs and wishes assessment, goal setting, implementation of actions, reviews and periodic outcomes assessments (PEOPLE System steps 1 - 7) – secure resources to undertake process every five years to keep abreast of emergent community aspirations and concerns
- Encourage, invite, train, model, support and nurture community people to participate in action groups to organise and implement activities required for achieving goals – provide training and development workshops, organise mentoring and coaching networks, maintain strong relationships, create project templates, acknowledge and appreciate support and participation
- Coordinate and take overall responsibility for day to day running of project activities and tasks – keep to tasks and manage time well, monitor progress of goals and activities, maintain good oversight of the 'health' of the projects and their members
- Prepare regular reports to board and funding agencies to account for use of resources and progress towards goal attainment – collect appropriate data and information to complete reports on time, prepare different reports to match the audience, maintain document trails, keep track of reporting cycles, distribute to appropriate stakeholders and as requested
- Advocate and promote community priorities and goals - prepared resources to share with stakeholders (as in GIRHS report, strategic plans, project briefs, council plans), maintain "Have A Say" suggestion boxes at strategic community locations, offer and respond to invitations to do presentations

I retained the role of the manager and so many of the basic organisational issues have been worked out in the preceding two years that I was in the manager's role.

However, it is very important that the guidelines are documented clearly and updated regularly to ensure that the project is keeping to its principles and that the group can refer to them when there are disagreements or new members (board and staff) who need to be kept informed. Clear descriptions of roles and responsibilities empower members by clarifying scope and limits and minimise conflicts to a great extent. The ability to affect and negotiate these also offers a sense of control of them.

For the wider community, the monthly board meetings are open to them, and hard copies of all related documents are held in the GI office to refer to. Large laminated sheets of the KMTW Strategic Plan, its Vision and Mission statements as well as current goals are posted on the office walls.

Annual accounts are audited and community accountability meetings held at the end of each year. KMTW also contributes updates through community newsletters, articles in the media and verbal reports at key community network meetings. In these ways, the KMTW board maintains its links and mandate with the community it serves.

The resources needed for the community action groups will be discussed next.

Resource planning and arrangements for community action groups

Having decided on an organisation structure for KMTW and successfully secured some resources to deliver to its strategic plan for the next three years, the next tasks were to find, recruit, resource, support and nurtures some community people to mobilise around chosen goals. At the end of the methodological Chapter Three, I described how these action groups have been recruited in some detail, so I will only briefly touch on the main aspects here to take progress the discussion to the next Action step.

To reiterate my working template, I set out to contact likely community networks or groups that I thought would have some interest in particular goals and supported them to nominate the goals they would work on together. I also explained how some new networks and groups were created to meet the gaps if these were identified. I went on to relate that each of these action groups went through their own variations of the PEOPLE System steps to go on to plan their actions to achieve their chosen goals, while maintaining

regular reviews and process evaluations. I also shared how KMTW had set some funding aside to support these groups and their project activities.
In actuality, extra resources needed to be found because the KMTW funding was very limited and inadequate for meeting all the needs of the action groups.

The following were some of the resources identified as being needed for the action groups.

- People – paid full time or part time employees or contractors, volunteers, consultants, advisors, caterers, tutors, accountants, lawyers
- Facilities – meeting venues, rooms for working in, office spaces, suitable spaces for community events or workshops
- Equipment – telephones, computers, mobile phones, photocopiers (or access to them), transport, desks, filing cabinets, cameras
- Incidentals – stationery and resources for running meetings (paper, pens, pins), hospitality items for providing refreshments, personal reimbursements for out-of-pocket expenses related to projects
- Personal or professional development – training courses, registration and related fees or costs for attending conferences, socialisation and networking, subscriptions to magazines or membership fees for strategic organisations

KMTW put together a funding strategy that included ongoing investigation of sources of funding and other resources. Some of these funding sources explored include:

- Local or central government funding schemes (state departments, local community boards, city council, regional bodies)
- Philanthropic organisations (Lions, Rotary Club, charitable trusts)
- Corporate funders

A good place for locating these was the internet and the telephone directory. An issue that KMTW kept, and keeps, grappling with was the tensions around needing to secure funding against the source of funding.

For example, one recent debate was whether it was ethical to seek funding from sources that gather their revenues from dangerous consumptions such as the alcohol or gambling industries. The action groups have similar debates when they are doing their own resources applications and these groups engage in their own ways for resolving these issues.

Apart from funding, there are other avenues for finding resources for action groups that include:

- Fundraising activities in community (sausages sizzles, raffles, car washes, karaoke or film evenings)
- Sponsorships (can get scholarships, paid or subsidised registrations at conferences or courses, freebies for prizes)
- Donations (phones, computers, paper, stationery, food, furniture, used equipment, free meeting venues)
- Services (use of photocopiers, fax machines, phones, office space, vehicles, websites)
- Volunteers (people offering their time, skills, experience, loyalty, goodwill, faith, encouragement)

Lessons learnt regarding organizational and resources arrangements

When I first started working in GI, my observation was that many of the groups there were informal networks that were not keen to get organised in any formal manner because it seemed 'too much hard work', 'takes too long' or 'too much paper work'.

Via the KMTW experience of deciding what kind of organisation was suitable for its work, a series of workshops in governance and management was run and well-attended. Over the years, more and more groups have become aware of the benefits of becoming legal entities and many have subsequently been incorporated as charitable trusts or incorporated societies.

As KMTW manager, I fielded requests by small community groups to write letters of support for their resources applications and often pointed out that the access to resources would be increased if they chose to be legally incorporated. For example, an informal group may not be eligible for many grants or funds and, if they were, they would be affected by a limit on the amount able to be allocated. The legal requirements for becoming incorporated ensures a group is clear about its objectives, can be accountable and has adequate infrastructures for self-management. Increasingly, many GI groups have found the process very empowering and beneficial.

One of the practical ways KMTW resources community groups is by supporting them to be legally incorporated and organising training in how to maintain those organisational structures and financial accountability systems. I have found that the more accurate

information that was shared with groups and practical support offered, the more receptive they became about the option of becoming legally incorporated.

In my experience, many agencies and corporations are willing and able to donate ‘in kind’ during these times of reduced finances where money is hard to find for projects. It is important to maintain good relationships to be kept informed about what is available to groups in terms of money or other resources. Nowadays, the social networks are also good places for posting and receiving requests for support. For the GI action groups, all of these potential sources for assets are mined and explored to different extents.

Some groups choose not to access any funds or support from the gambling or alcohol-related industries, for example, while others consider that the revenue could be put to more good use if used for the public good in their communities. The thing I believe to be vital in trying to deal with these kinds of issues is to ensure any decision made is collaborative and all dissenting voices are given fair hearing. Some groups have made decisions one way, only to change their minds and re-decide another way for the next time. Such are examples of good reflective practice in groups who subscribe to the policy of ‘learning as we go’. It may seem that regardless of the nature of the decisions, if the process itself was empowering, inclusive and educative, then there were important lessons learnt.

For the individual action groups and KMTW, the resourcing issues are ongoing ones and we deal with it the best we can. One useful lesson is always to be prepared to take advantage of any arising opportunities by

- Identifying the resources needed for particular projects or activities (update regularly)
- Creating project proposals for each that include budgets and resource requirements (such budgets should always include the contributions the group is making in terms of voluntary hours, use of vehicles and so on)
- Identifying likely sources for financial and other resources
- Creating a schedule of these sources including attendant criteria for funding, application processes and submission dates
- Submitting proposals or applications as appropriate (including sometimes writing to likely sources to get permission to submit unsolicited proposals)
- Keeping good financial records and document trails
- Submitting accountability reports well and on time
- Acknowledging sources of funding and other support diligently

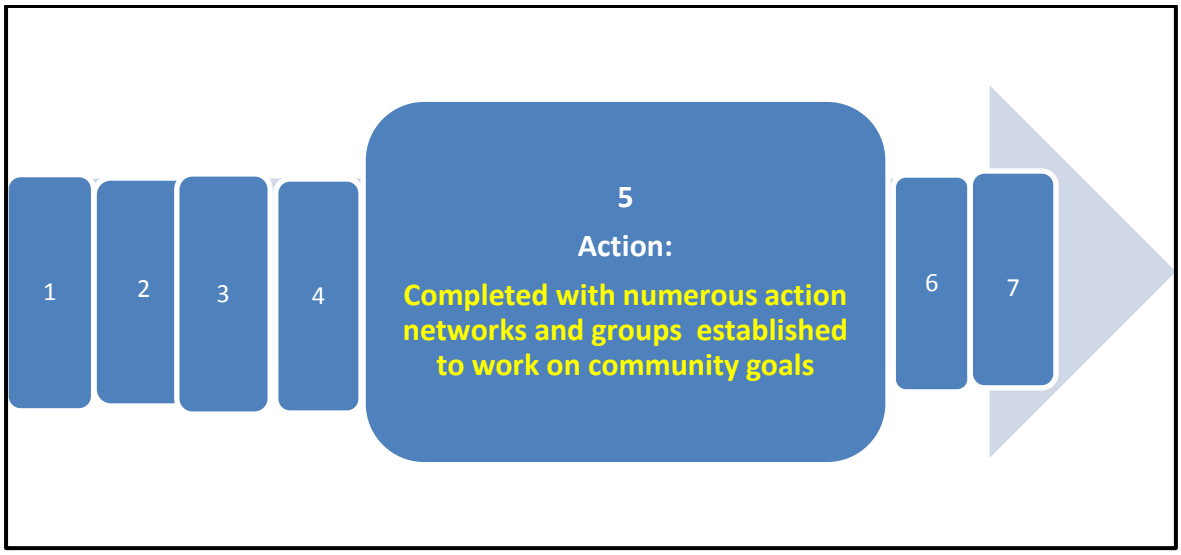
- Cultivating and collecting appropriate letters of support, attestation and references (and updating these regularly)
- Reciprocating the generosity of other groups by writing letters of support or being referees for them
- Remembering that money is not everything and exploring low cost and no cost options always
- Encouraging collaborative projects and joint applications

There are many more ways that are not mentioned, but KMTW and the action groups have tried all of these and we have managed to get most of what we need for our projects. In the cases where appropriate resources were not found, those projects or activities were reviewed, reshaped or retired until more resources can be found.

PEOPLE System step 5: Action

Following is a diagrammatic representation of KMTW's progress as a CD group in GI working on the fifth PEOPLE System step.

Figure 6.3: Progress of KMTW in relation to PEOPLE System step 5



Following the PEOPLE System steps, what we have so far is a process that has ended with a set of 13 goals, as shown in Table 5.24, and an organization and resource structure that allows action to proceed. How the PEOPLE System interprets "Action" is by smallish groups of people working together as a sub-project – that is, they coalesce around a particular goal, and use the PEOPLE System as a guide to setting up actions that will meet that goal.

This is a good time to reiterate an extremely important principle that, in the PEOPLE System and PMHP context, this kind of collective group action around a goal that has emerged from the community has two co-equal aspects – one is the straightforward one of meeting that goal in an effective way (a task aspect), and the other is building relationships between the people taking part (a community-building aspect). Both have always been of crucial and equal importance to the community development work in GI, with maybe the second being even more important than the first. What we are after is building a strong and cohesive community, and this is the best way to do it.

At the end of Chapter 3, I described my process of seeking out or helping to create appropriate and likely networks and groups to mobilise around the community goals. The following are the results of what happened after that process.

The following Table 6.1 shows a list of community networks and groups in action in GI by August 2009. Some of them were existent groups that have picked up on specific priorities and goals identified through the random household survey to work on. Others were new networks and groups that were set up and established after the CAR project findings. Although they were not all responses to the CAR findings, they certainly worked with other community groups to progress community goals as these are interpreted by them. New community GI networks and groups will be indicated by *italic script* in the following table.

Table 6.1: Community goals and networks and groups in action by August 2009

Community goals	Action networks or groups working on goals
1. Develop connections and communication with GI youth to ensure relevant issues and trends are identified and addressed through the Eastside Youth Network	• Eastside Youth Network • *Digivoice youth project* • Urban Unity squad • *Changesz youth movement* • Youth Development trust • Soul Unit
2. Collaborate with agencies to provide and promote opportunities for youth in GI	• Erick-Holmes Foundation Trust • *Youthworks* • *Artstation/ACC/KMTW creative arts project group* • Playtheatre program • *Logo Design project team* • Te Huruhi Trust

Community goals	Action networks or groups working on goals
3. Strengthen community connectedness	• *GI Chinese Friendship group* • GI Community Directory project • *Neighbours' Day project* • PACIFICA • *Diversity Forum* • *Just 4 Dads* • GI Family Centre • Sanctuary@mayfair
4. Enhance community pride and cohesion	• *Telling our stories project group* • *GI Champions project* • *Community Pou (totem poles) in the Park project* • *Aitutaki Mamas and Papas* • Tongan community group • *Burmese community group* • Shakti Seniors • *Ruapotaka Kapa Haka group* • *Tamaki Parenting Network*
5. Encourage sustainable collaborations to build community capacity and leaderships	• *Joint governance project* • *Tamaki Inclusive Engagement Strategy group* • *Kokiri Ngatahi economic development project* • GI Community network • Te Waipuna Puawai • Tamaki Transformation Programme • Support for Parents And Children's Education (SPACE) project
6. Promote healthy living	• *Community Healthy Initiatives Planting Scheme (CHIPS)* • Healthy Kai project • *Fizzicool and Fitness group* • *KMTW community gardens* • Morning Tai Chi group exercises with GI Chinese Friendship group • *GI Drug and Alcohol working group* • Safety Net • Diabetes support group • *Butterfly gardens project*

Community goals	Action networks or groups working on goals
7. Facilitate and promote quality education opportunities	• *Pasific Parents Support Group* • Tamaki Achievements Pathways • Akozone project • Pua Rangatahi programme for Pacific youth • *Community workshops and discussion groups* • Ruapotaka Marae komiti
8. Encourage lifelong education in GI	• East Auckland Adult Community Education network • Selwyn College community education programme • *GI Friendship Events group* • *Resilient Aging in Place project* • Inspiring Communities Leadership Forums • Adult Literacy project
9. Sustain effective educational networks	• *Early Childhood Education network* • *Schools' Broadband network* • School Principals cluster • *GI Centre of Excellence project* • *Tamaki Summer Scholarships project* • Refugee Education for Adults and their Families • Home Instruction Programme for Parents and Youngsters
10. Promote and develop economic opportunities in GI	• *GI community markets* • *Made Simple* • Project 273 • Sharat Trust • Elevator project for people with disabilities • *Charity Love Bits* • GI Business Association • The Business Lounge
11. Work effectively with community groups and individuals to enhance the environmental state of GI (inclusive of parks and reserves, community facilities and housing)	• *GI Parks working group* • GI Housing Trust • *GI community facilities working group* • *Music and Arts Glen Innes Centre (MAGIC) project group* • Island Child Trust

Community goals	Action networks or groups working on goals
12. Maintain strong relationships with local and/or other government or agencies on issues that meet the environmental goals as listed	• *GI Parks working group* • GI Health Project • Tamaki Estuary Protection • GI Lobby action group • *Housing New Zealand Corporations' community gardens project*
13. Maintain strong relationships with local and/or other government and environmental agencies on issues and initiatives that meet the common environmental goals and strategies as listed above	• *Tamaki Inclusive Engagement Strategy group* • Panmure and Glen Innes Liaison Group on Safety and Policing • GI community network • *Community Engagement Team* • *GI Community Development workers' breakfast club*

As was natural, some groups are involved in working on more than one goal and many goals overlap with each other. For example, the MAGIC project group was ostensibly set up to work on getting a purpose-built community facility that will enable the hosting of music and arts programmes, as well as having the capacity to stage live performances in GI. Such a project addresses the Youth, Community Wellbeing, Education, Environment as well as Enterprise goals. Placing this action group against an Environment goal simply situates it in the space it began; it could easily have been placed against any one of the other 12 goals and would not be considered out of place. The same can be said of most of the other groups as well.

In fact, many of the groups have members who belong to other action groups. To illustrate the last point, the facilitator of the GI Drug and Alcohol working group actively supports the Changesz youth movement as a leadership mentor, is a member of Eastside Youth Network, the Parenting Cluster, the MAGIC project, and the Panmure and GI Liaison group on Safety and Policing.

These groups all have their own protocols and ways of working together that are often independent of KMTW. What connects us is the commitment to similar values of community-control and participation, and the realisation that we all work towards the same

goals in our different ways. The intercourse between the different action groups and their members serve to cross-pollinate each other's activities and all benefit from the cooperative learning and enquiry. Groups share templates for meetings, project proposals, information and social support. All have the interests of the GI community at the fore of their work. This was one huge contribution that the GIRHS has been credited with making for increasing greater connectedness for GI groups.

Of course, the groups do not always agree with each other, as is par for the course for any democratic civil society. The GI community is also full of many highly vocal people who feel strongly about community issues, and some community meetings in GI can get quite heated and uncomfortable. What happened mostly is that people either agree to disagree, or they disengage and find another group more suited to their interests. This seems to work out well. Some groups have members who do not agree with the decisions and will work actively to influence them. They sometimes succeed; but other times, they choose to exit and form their own groups. This democratic process allows for people exercising choice and control over how and with whom they work with.

For example, KMTW developed a "GI Ways of Working" document in 2006 that was based on the findings of the 2005 GI Visioning project. It was promoted as a way of conducting intergroup relationships between community groups that was underscored by community values identified from the GI Visioning project. The GI action groups used this as a guide to maintaining good connectedness and support for their membership, and with other groups. Later, when faced with trying to mobilise a collective response to a inter-governmental agency urban renewal project (Tamaki Transformation Programme) proposed for the wider Tamaki area (that GI was part of), this document was use to create an expanded "Tamaki Ways of Working" (Tamaki WOW). The latter version incorporated input from people from the other communities affected by the proposed project, and was created to reflect the common values of the Tamaki community of communities.

A sample of some agreed ways of working that KMTW promoted actively to support the community groups working to attain their goals follows. Of course, these practices serve to remind all groups of the agreed values and serve to remind everyone of the reasons we choose to work together. KMTW continue to work with as many of the groups as possible to support and nurture their pursuit of their goals because their success adds to the community's success.

Below is a table outlining the GI values and some examples of protocols promoted by the "GI Ways of Working" that KMTW models and promotes to community groups.

Table 6.2: Examples from the "GI Ways of Working" model based on agreed community values and preferred practices

GI Values	Respect	Community Spirit	Optimism	Working & Learning Together	Integrity of Purpose
How we prefer and like to work together as a community	Identify and respect different points of view	Ensure that everyone has an opportunity to be involved	Value everyone's contribution, especially what's working well	Take time to understand the interests of all parties	Keep the community in the 'driver's seat'
	Talk and give information in language and ways that everyone can understand	Work in ways that build community	Be positive, enthusiastic and have fun!	Seek actively to build organisational and community capacity	Foster participation that enables community to help shape decisions affecting their future

Assessment of community goals attainment at August 2009

I presented the 13 community Goals that the 2007 – 2010 KMTW Strategic Plan was based on at the end of Chapter Five. I have also explained how these community goals were taken round to community people and groups as possible to enlist support and interest in working toward. Many GI groups incorporated these goals into their own strategic or annual plans and proceeded to work towards attaining them in their preferred ways. I kept in touch with them as KMTW manager by way of attending and participating in their meetings and events, as well as receiving any correspondence and informational materials. They were also encouraged to refer to and use the GI Ways of Working as a guide to help their groups and members to stay focussed, connected and supported through their work in this Action phase.

Their planning or review meetings are of special significance because it was at these forums that they reviewed their progress on their own goals, and gave a good indication of where the whole community is at with the progress of the goals.

Members of the KMTW board and staff conducted an annual review of its strategic plan, annual goals and budget in August 2009, and these group outcomes were contained in an annual report to the community and the funding agency. The report was shared and presented at the KMTW annual community accountability and appreciation meeting in December 2009 where community members were invited to attend and give feedback and comments on it. Community networks and action groups also reported at this annual meeting and allowed the wider community to be kept informed about progress of Goals.

The following Table 6.3 is a summary of the 13 community Goals and my subjective rating on each one, based on its achievement status: A for those rated as fully achieved (more than 75 % of annual sub-goals met), B for those rated as mostly achieved (more than 50 % of annual sub-goals met), C for those rated as half achieved (up to 50 % of annual sub-goals met), D for those that were deemed as somewhat achieved (up to 25 % of annual goals met), and E for those considered not achieved at all (0 % annual sub-goals met).

These ratings were based on a similar one used in another PEOPLE project in Auckland (Raeburn & Rootman, 1998) in 1975. I have also added a “+” or a “-” to indicate the degree of achievement on the Goals.

Table 6.3: Outcomes of community action on GI community goals at 2009

Goals to be attained by August 2009	Status
1. **Youth:** To have developed and continued to maintain connections and communications with GI youth to ensure relevant issues and trends are identified and addressed through the Eastside Youth Network and other appropriate forums	A +
2. **Youth:** To have collaborated and continue to collaborate with agencies to provide and promote opportunities for youth in GI	A -
3. **Community Wellbeing:** To have strengthened community connectedness by finding ways to reconnect different sectors with each other e.g. youth, the elderly, cultural and ethnic minorities, disabled, people with experience of mental illness, as guided by GIRHS findings	A -
4. **Community Wellbeing:** To have and continue to enhance community pride and cohesion by exploring opportunities for cross-cultural learning and positive community interactions, as indicated by the GI Visioning and GIRHS projects	A +
5. **Community Wellbeing:** To have done, and continue to encourage sustainable collaborations to build community capacity and leaderships and worked to link up like-minded people and groups to explore joint efforts	B +
Goals to be attained by August 2009	Status
6. **Community Wellbeing:** To have done, and continue to promote healthy living by facilitating and supporting appropriate initiatives and programs, and KMTW providing best practice modeling	B -
7. **Education:** To have facilitated and promoted quality education opportunities, and continue to support all relevant initiatives	B -
8. **Education:** To have done, and continue to encourage lifelong education in GI by celebrating positive role models, and facilitating workshops and other learning events to help build capacity of GI people to lead and manage their own projects	B+
9. **Education:** To have done, and continue to sustain effective educational networks by creating or promoting opportunities for community and sector networking and cooperative learning	C +

10. **Enterprise:** To have done, and continue to promote and develop economic opportunities in GI by building strong cross sector partnerships with enterprise, employment and training providers	C +
11. **Environment:** To have done, and continue to work effectively with community groups and individuals to enhance the environmental state of GI (inclusive of parks and reserves, community facilities and housing),and connect like-minded people and groups to meet, talk and work together	B -
12. **Environment:** To have done, and continue to maintain strong relationships with local and/or other government or agencies on issues that meet the identified community environmental goals	B +
13. **Environment:** Maintain strong relationships with local and/or other government and environmental agencies on issues and initiatives that meet the common environmental goals and strategies including community learning forums and networks, developing and promoting recycling and like initiatives to address expressed concerns as per GIRHS findings	B -

Comments on ratings allocation

I have described how I went about trying to get community people and groups mobilised to choose Goals to work on by themselves. My role varied from group to group and also changed over time, depending on the circumstances then. Some of these main ways of engaging with community groups were explained in Chapter Three regarding Methodology, and they have remained largely similar.

As I have also outlined in the Introduction in Chapter One, these community groups generally follow a typical action research cycle that is formally enshrined in the PEOPLE System. Although they do not all claim to be following the PEOPLE System steps, they all kept to a participatory process of generally agreeing on how to work together (as in GI Ways of Working) on their priorities, set common goals and actions, identify what resources were needed and how to organise these for completing their actions, implement their action plans, review and report to the rest of the group, and then an overall general outcome evaluation of the group's achievement. The processes were all PEOPLE System steps in function if not in name.

Even though different groups may have been working on similar goals (such as Education), each would have made their own decisions about the specific focus that suited their interests (such as early childhood or tertiary), as well the activities they might

elect to do (such as organising a pre-school service to be attached to a primary school for young children who will be enrolling with it later on, or matching mentors to help college students with their homework assignments). All these related actions by groups helped towards overall successful attainment of the community goal. Groups working on related goals, in the way I have just described, would also tend to be invited to participate in a wider community network as well, such as the Early Childhood Education or Eastside Youth Network (EYN), although not all accepted the invitations to do so. Also, there will always be groups who wish to work independently (like some faiths-based or ethnic-specific entities) or whose activities are unknown to network members and so do not get invited. This means that the rating earned by each goal was limited to the action groups that were known to me or whose work was known to others who commented on them in relation to the goals.

Generally though, I would be aware of most of the relevant groups (KMTW has the responsibility of compiling a biennial GI community directory with listing of all known community groups and agencies), and so the rating would be inclusive of the majority of them.

The rating was based on my assessment of the goal on several indicators. These included: Were the sub-goals attained successfully as intended? Were the actions and processes used to attain them empowering and under community control? Did the processes build greater connectedness amongst the participants? Did participants have increased capacity through the process of carrying out the actions? Were the processes and outcomes culturally appropriate? Did the experience build group solidarity? And, one last important one: Did the participants enjoy the experience? The answers to those questions were based on my personal observations, participant reports by way of minutes and correspondence, verbal feedback from participants and community members, and visible or measurable outcomes such as submissions completed, photos of happy and engaged people, new participants or leaders, and so on.

One important point to make about these ratings is that they were based on judgments made at the end of August in 2009 on overall goal attainment. These ratings would contain more B's and C's, and perhaps even an E if they had been made earlier.

The last comment relates specifically to the example in 2008 when the EYN and KMTW partnership arrangement on the Digivoice youth project was stretched to almost breaking point as tensions between balancing bureaucratic compliances and people-centred processes surfaced. The successful resolution of that conflict, over an intense period of a

few months, was credited to the quality of personal relationships and the passion for the intentions of the project itself. For that salutary lesson learnt by both parties, the goal rated an A by August 2009.

So, while some annual sub-goals were unmet or only partly met, the overall aggregation with the rest of the annual sub-goals contributed to the final score. I am not reporting that there were no mistakes or mishaps because there were, even some very large ones. I am reporting that there were more successes than not, and that the overall verdict was very positive for all of the goals.

Comments on contributing factors for successful goal attainment

A large part of the data that informed the rating I finally allocated to each of the community goals came from my assessment regarding the extent to which the processes used to attain the goals were empowering, people-centred and health promoting. These last three, after all, make up the basic premise of the PEOPLE System's theoretical framework.

What I will do next is to look at some examples of how PEOPLE principles have been translated into practices in this GI research.

To do that, I will choose the examples that illustrate contributing factors based on some of the most essential and key components of the PEOPLE System. These are alluded to in the PEOPLE acronym and are People-centredness, Empowerment, Organisational and community development, Participation, Life quality and Evaluation (Raeburn & Rootman, 1998). What I would also say that although the examples I will be using are mostly salutogenic or strengths-based ones, the implicit argument is that the more that these PEOPLE empowering components exist in the community groups in terms of approach and practice, the more successful the experience for the participants. The rest of the argument follows, of course, that the reverse is also as true by implication. It will also become obvious that the Goals are not discrete and all reciprocally impact each other. Using examples to make a point in relation to a specific PEOPLE principle or goal does not detract from their impacts on each other.

People-centredness

The idea of people-centredness has to do with acknowledging and respecting the perspectives of the community people that we work with. This involves trusting that community participants know what is best for them and that the role of community workers is to support them with finding out how they can be helped with resources, knowledge, skills or whatever they need. The great thing about the action groups is that, for the most part, they include members who are passionate about working with people in this way. For example, one of the action groups contributing to the success of the Youth Goal 1 and 2 was the Digivoice youth project. Some of the KMTW annual sub-goals for these Youth Goals include "creation of a new resource that reflects GI youth voices and their needs", "increase GI youths' awareness of opportunities available for youth" and "publicise at least one opportunity a month" (KMTW, 2007).

The 2008 Digivoice project was undertaken to create better connectedness between GI youth and the wider community in response to the GIRHS finding that this was a priority for the community. It involved diverse youth, adults and sectors of community and the project coordinators were absolutely committed to working with where the young people were at in terms of their strengths, motivations and interests. The project coordinators managed to enlist the participation of 26 local youth groups, which was a huge achievement. To begin with, many local youth groups operate independently of each other and it was quite hard to know their numbers and types with any accuracy. This was one of the reasons that led to the formation of the EYN. The number of youth groups involved with the Digivoice project is a mark of the successful reach of the EYN that helped the project coordinators' recruitment process.

For instance, the 26 groups were divided into four categories in terms of how involved they wanted to be towards the middle of the project's duration. These ranged from "very active", "active", and "desire to be active" to "inactive" groups that, after initial expression of interest, found their availability greatly reduced due to other commitments school, family and so on.

The coordinators worked flexibly with all the groups and offered support and resources as desired. The less active groups were not pressured to do any more than they were able or wanted to (due to school, family or other factors), and the active ones were given every encouragement, support and resources as needed to complete their self-directed projects. Some of these active participants volunteered to support the project and help the coordinators by offering to run workshops, help with administrative tasks and organising

project events. Project participants report increased confidence and connectedness to each other, their families and the wider community (Dickinson, 2009).

Both EYN and KMTW consider this project to be a huge contributor to the successful attainment for the Youth community goal, and a good example of how people-centred ways of working are translated in practice in GI.

Empowerment

Empowerment is about building on people's strengths and capacities so they can have greater control over the determinants of their life quality. This is also the basic PMHP premise for advocating trust in people's basic resourcefulness in terms of their experiences, skills, attitudes and so on. This bounty of resources exists within every individual, group or community, and accessing this is the intent of empowerment in the PMHP Model. Empowerment is closely related to the concept of control in that the more empowering an experience is for an individual, group or community, the more the corresponding perceived sense of control should be.

In the earlier Chapter Two's Literature Review, I presented some of the arguments regarding this relationship, and especially how this increased sense of control in individuals, group or community is positively linked to their mental health, wellbeing and quality of life experience. An example of this is with the Aitutaki Mamas and Papas group, whose work contributed to the Community Wellbeing goals 3, 4, 5 and 6. Some of their sub-goals contributing to the overall Goals include "collaborate on opportunities that strengthen community connections", promote "projects that help build community cohesion", "enhance cross-cultural learning" and support "events that build GI pride, cohesion and leadership".

This group of elderly members would meet informally in the GI community library to socialise, share news, and to enjoy the library's air conditioning that kept them warm in the winter, cool in the summer, and dry when it rains. As the library was used very often by KMTW to conduct community meetings and presentations because of its central and neutral positioning, the Aitutaki Mamas and Papas (AMAP) came to be regular participants of these forums. It was this familiarity and the relationship built with them that contributed to the very active participation of this group in the majority of our projects.

One of their favourite activities was making "lei", a woven headband worn by Pacific Island men and women that was constructed either from real or artificial flowers and leaves. They made these lei to wear themselves or to give to lucky people like the researcher who

happened to be around at the time. I asked them to teach me how to make this, and they did. I asked them if they would teach other people who might like to learn to make these for themselves, and they did. The people who attended these lei-making sessions in the library suggested the AMAP run more of these workshops in the library, and they did. Today, the AMAP run lei-making, quilt-making, Pacific Cook Island drumming and dancing workshops in the community library as community 'tutors' in the East Auckland Adult Community Education Programme.

In 2009, they won an award during the National Adult Learners' Week celebrations for recognising inspirational groups of adult learners. (One of their members won an award for outstanding tutors in 2010.)

This example was to show how the AMAP used their personal, group and cultural skills, strengths and expertise to find a way of using these resources to empower themselves. They met their own goals of making new friends, becoming more connected with the wider community, contributing to community wellbeing, raising funds to support their social activities, teaching others about their culture and controlling the ways they would do all that. They remain great role models for other older community members and groups for promoting lifelong education and cultural empowerment. All these contribute equally to the overall Education and Enterprise Goals as well.

Organisational and community development

This feature of PEOPLE has to do with making sure the way groups are organised and structured - policies, rules, procedures and accountability systems - are also empowering as well. This may be done by groups becoming incorporated societies or public trusts which processes require public declarations of the principles, values and objectives that the group agree to work to. Administratively, it means committing in writing to participatory, inclusive and ethical processes and outcomes. These documents are publicly available for reference and scrutiny, as well as providing transparency and accountability for the way groups behave.

The decision by KMTW to become a legally incorporated trust was, in part, motivated by the desire to enshrine its people-centred approach and attendant values so as to keep the community in control of all its undertakings and associated activities. The KMTW governance policies, likewise, detail how decisions will be made, expectations of staff, board and volunteers regarding behaviour and conduct, as well as grievance and complaints procedures if there are occasions to do make these.

For large groups like the EYN, the decision not to become legally incorporated does not exclude the need to keep faith with its intentions to work in empowering ways. Logistically, this amounts to keeping good track of group proceedings in minutes, maintain close contacts and communications to keep everyone informed about what was happening, as well as making opportunities available for debate and discussion. All EYN meetings are set at the beginning of the year for the rest of the year so that everyone knows when they will occur, as well as time lines for suggesting items for meeting agenda and receiving minutes.

A standard meeting template sets up clear expectations and increases the possibility that no important steps are missed inadvertently. Some of these include opening reminders of group expectations, introduction round to acknowledge the regulars and welcome new members, reviewing minutes and attending to general as well as new business. People who volunteered for or allocated tasks are also reminded to report on these. Keeping to these predictable schedules maintains group cohesion, morale and intentionality. Experienced members model empowering relationships and this helps to embed these values as well as developing group culture.

Both KMTW and EYN examples show how groups and entire communities can grow and develop their organisational skills and expertise. When people-centred principles and values are applied in these formal and informal ways, the projects and enterprises are more likely to deliver positive outcomes for their members. The earlier discussion under PEOPLE step 4 attests to the successful translation of the Organisational and community development principle.

Participation

No community or population based programmes can be successful if they lacked adequate and appropriate participation. This means both in terms of numbers of them, as in the more the better, and also in terms of how well they represent the actual diversity of the community they are in. For GI, the population of about 12,000 people is made up of a large number of diverse cultural, ethnic, lingual and faith groups as evidenced in the demographic data presented in this thesis' introductory Chapter One. For good participation in GI events, the people would attend in large numbers, and their numbers would be inclusive of as many of the diverse communities as possible. The inherent 'problem" with this issue of participation is that, the larger the group, the more diverse by definition and, consequently, the harder it is to get good representative participation.

Representativeness in participation requires community workers to be able to engage with the diverse groups in culturally sensitive and appropriate ways. The multiplicity of cultures, ethnicities and languages in GI make this a herculean undertaking indeed. One example of a group that achieves good participation is the GI Friendship Events group.

The example I wanted to highlight with this group is their way of working that extends the participation of the minority groups. The events group hold their meetings in English and each member acts as a conduit of information that connects the group to the other smaller community groups who do not feel confident to participate in these meetings due to their limited English skills. By maintaining this "second tier" information system, the core members manage to contact the other groups to relay information and receive feedback, instructions or advice. This way of working takes a lot of time and patience but it is seen to be more equitable and empowers many more non-English speaking members to contribute. They do this by organising cultural performances, ethnic crafts workshops, catering and their colourful attendance to add to the festivities. This inclusive practice ensured that planning meetings were efficiently run and kept to time while as many of the other groups as possible are still connected in and included.

For the last International Day of the Older Person planning meetings, a Chinese community group member attended with me to "give support and face" to the project. At the last two meetings that I did not attend, one group member reported that the Chinese woman attended to "sit with my new friends" and participated in the meeting by asking two questions in English and asking one of the other members to write down a contact number for her.

The original project group was a collection of about 12 core members and the first community event attracted about 60 community people. Last year, 2 busloads of GI people were taken on a trip around scenic spots in Auckland for a day of the International Day of the Older Person community celebrations; this year there were 5 busloads of them. Also, we had 12 ethnic groups represented last year compared to the 22 ethnic groups this year. Events organised by the GI Friendship Events group typically include educational workshops, discussion groups, informational stalls, complimentary services, cultural performances and community meals. They are hugely popular and feedback from participants has been consistently positive. Each of the main event days, with cultural performances and a community meal attract between 150 to 250 community people. The maximum capacity of the community hall is listed at 120 people.

The group's goals contribute specifically to the Community Wellbeing and Education goals. They also contribute to the Youth goals because young people are recruited as volunteers to help organise the events as well as accompany participate as family members. The events are examples of participation of numbers as well as of representativeness. Not only are the diverse cultures celebrated by the group's activities, they also contribute to a distinct "GI Culture" of inclusiveness, solidarity, unity through diversity and, intrinsically related to all those attributes, joyfulness.

Life quality

The overall aim of both PMHP and the PEOPLE System is health, well-being and life quality. In terms of our project in GI, this was about facilitating people in the community to have more say and control over the resources needed for them to enjoy better lives. The quality of life is a concept easier to understand than to explain. Having said that, most people would agree that life quality would be greatly improved with good health, social support, peaceful environment and all the necessaries for sustaining life such as food, shelter and clothing. Life quality is about a holistic view that also includes the 'spiritual' aspects of our human existence – our relationship with the planet and its finite resources, the nature of our human spirit, happiness, faith, hope, and love. Striving for a better life quality keeps people optimistic, resilient and motivated. The PMHP paradigm postulates that resilience in people can be cultivated within supportive environments and communities because these contexts empower the people to use their inborn striving to increase control over their life quality. Therefore, the more successful our efforts to connect people, to empower them and to help them achieve self-identified goals, the better their quality of life.

The GI Chinese Friendship group meets twice a week to socialise, make friends, conduct communal activities to keep fit (badminton, table tennis, cultural dancing, tai chi exercises), learn new things (English and Cantonese language classes, ballroom dancing, brush painting) for and maintaining a community garden by the KMTW office site) and to "be happy" (mah-jong games, playing traditional Chinese music instruments, singing). They have 166 members today and are a very visible group in the GI community. They attend most of the community events and are very willing participants although the language barrier is still a barrier to some events such as discussion workshops, presentations and community meetings. They raise some funds by distributing leaflets and newsletters around the community, preparing food for events, receiving donations from their cultural performances and holding stalls to sell services (giving massages, Chinese calligraphy keepsakes), bric-a-brac, crafts or food.

Initially expressing anxiety about their safety, nowadays their members conduct group Tai Chi exercises, every morning at seven o'clock, in a local GI park. Their increased connections with the wider community via various positive engagements have empowered them to feel more at home in GI. Some of their members maintained a community vegetable garden that contributed produce to the local food bank and families, as well as a supply of medicinal herbs for traditional use in their homes. Local volunteers help them complete funding applications and accountability reports. Young people challenge the elderly Chinese members to games of table tennis (the elderly Chinese usually won these) and many GI people join in their morning Tai Chi exercises in Talbot Park. Their activities contribute to the Goals of Community Wellbeing, Education, Enterprise and Environment. Some of these annual sub-goals included "facilitate and support initiatives that promote healthy living", "work effectively on common environmental goals" and "at least two appropriate workshops or events every year". The last included workshops on composting, worm-farming and raised gardens.

Evaluation

Some of the community project groups, including KMTW, receive public funds for which they need to account for by evaluating their outcomes and meeting of project objectives. Also, many of them undergo ongoing reviews of their activities against agreed tasks and goals. A good number of these groups also hold annual meetings where they go over all their annual goals and reset new ones for the next year. These include verbal and written reports, self and peer reviews, group feedback sessions, online surveys, interviews, anonymous feedback sheets and so on.

For my role as KMTW manager, I submit monthly as well as annual reports against the Strategic Plan; biannual and annual reports to the Community Development Scheme contract that funded my role from 2006 to 2010, as well as other reports to funding agencies to account for the funding and resources we received. I have described KMTW's own processes of an annual accountability and appreciation meeting where the manager and the board chairperson make presentations to the wider community to account how we used the funds, sponsorships, volunteer hours, goodwill, trust, faith, promotion, feedback, support and collaborations that the community has gifted to us.

The GI Drug and Alcohol working group (GIDAG) evolved from conversations around the main findings from the GIRHS that highlighted community concerns around alcohol and drug use and abuse. These included access and use among young people, and the impact of this for personal health, impacts on family life and wellbeing in community. This

group organised community meetings to work on writing individual and group submissions to influence relevant regulations, law and policy reviews. Youth leadership and facilitation workshops were held to increase and strengthen these capacities in young people as well so that they can work more effectively in their families, their settings and with their peers. Drugs and alcohol-free family events were organised to raise critical community awareness as well as to provide accurate information about the protective and risk factors relating to the use of alcohol by young people in GI.

The strategy of empowering young people by creating opportunities for political engagement and modelling democratic processes was an important one employed by the GI Drug and Alcohol working group. This energetic and well-led group won the Auckland City Council's Innovation in Community Safety in 2009. Their successes contributed to the Youth, Community Wellbeing, Education and Environmental Goals. Evaluating GIDAG would include taking into account their outputs like the number of submissions, events, meetings and petitions completed; empowering and participatory processes for involving community; media articles (radio, television, print) about the impact of their work; the amount of new information and resources created for and used by the community; and undeniable GI support and pride in their achievements. The GIRHS produced clear and mandated goals for them to work with, and they gave the GIRHS project a huge validation regarding the power of data to inform and mobilise community. The GIRHS goals were also useful for evaluating their work against.

This discussion on Evaluation will be followed on with a brief discussion regarding the Ka Mau Te Wero "brand" and how the GI community connects with it.

Connecting KMTW and the GI community

The successful engagement of KMTW with the different community action groups in attaining community goals relied heavily on the personal and professional relationships that have been built and maintained over the previous four years of the researcher working in the community. By the end of this last Action phase of the research, members of the wider GI community no longer referred to me as "that Chinese researcher from the uni". I became more familiar to them as the "Ka Mau Te Wero manager" or, for better or worse, just "Ka Mau Te Wero". (Those who knew me personally, naturally, refer to me by name.) For many GI people and groups, Ka Mau Te Wero is a unique "brand' and the relationship the GI community has with the group is a special one.

The words and phrase “Ka Mau Te Wero” means “rise to the challenge” in the indigenous Maori language. In GI, most community people, especially those who are from Maori and Pacific Island communities, would refer to “Ka Mau Te Wero” in full, instead of by its initials, because the name had “mana”. “Mana” is an indigenous Maori word meaning authority, power, control, influence or pride (H. W. Williams, 2000). The name was given by Maori elders from the community and was retained by the KMTW governance board to remind its members of the original challenge issued by the elders to the local government authority to “do something to help the people”.

As manager, one of my most important personal goals when I started my job was to learn to pronounce the name correctly so that it would not lose its “mana” in the translation by a person whose first language is not Maori. I did this with help from the four Maori members of my board, as well as cultivating a good relationship with some Maori elders at the Ruapotaka Marae. All were very supportive towards my desire to learn, and I was able to advance my Maori language skills. Nowadays, I would always begin my introductions with a simple Maori greeting and endeavour also to introduce my job and myself simply in Maori. This is a small yet meaningful way of personally acknowledging the cultural back story to the creation of the name and the agenda for the project. The use of “KMTW” is employed in written texts, such as this one, or when talking with people who do not feel confident to say it in Maori.

When I was working with the community action groups, I tried to cultivate an ease with the full name because I thought it was a way of acknowledging our history, as well as a symbol of our CD efforts to build community solidarity in GI. As an acknowledgement of this legacy, I have also alluded to the meaning of “Ka Mau Te Wero” in the title of this thesis.

Since KMTW began in 2001, the community has learnt to have trust and confidence in the group’s intentions to build “stronger and more resilient communities” and the previous manager was an exceptionally talented Maori woman who built up considerable “mana” and credibility in her role. When I came on as the new manager, I inherited many strong relationships and contacts that aligned themselves to the Ka Mau Te Wero philosophy and practice. Fortunately for me, despite some initial wariness, the majority of GI groups that work with KMTW have accepted me in the role as KMTW manager. This is an important point for the longevity and sustainability of the KMTW endeavour in GI because it means that, regardless of the person occupying the role, it is the philosophy and values of the

KMTW “brand” that continue to earn the community’s trust, goodwill, confidence and participation.

I will now present one set of evaluative data from a recent community survey undertaken at the September 2010 GI community’s Heritage Day event to support my attestation that the PMHP Model employed in GI proved to be a successful experience.

Feedback from GI community regarding results from application of PMHP Model

A community short survey was conducted with community participants over a two week period in late September, corresponding with Heritage Day celebrations, to get some preliminary evaluation and feedback regarding aspects of community development outcomes in GI.

Community members and groups were informed about KMTW plans to repeat the 2005 random household survey in 2011, and that the group would appreciate some feedback as to how successful, or not, the last survey was in delivering community development goals over the last five years since it was carried out. These CD goals were imputed in the 2005 GI random household project as components making up the definition of community development. The data from a total of 277 completed surveys were entered into the PASW computer software to generate numerical data as indication of community perceptions.

The survey form may be found in Appendix E; a summary of the results is presented below. The seven self-explanatory goals were lifted in their entirety from the original GI random household survey and are listed on the left of the table below.

Overall, the results were gratifying feedback and validation for all the GI community project participants as they indicated that the majority of respondents thought that the GIRHS goals for community development have been achieved in GI compared to five years ago, when the community action projects first began.

In terms of empowerment, perceptions that people have more information (61.7%), value diversity (77.9%), have more choices to be involved (61%), take more responsibility (67.9%), work together to build a sense of belonging (68.9%), feel more able to control and influence decisions (55.6%), and like living and working in GI (74.3%) compared to five years ago strongly suggested that GI people do indeed feel more empowered. The above information tells us that the GI respondents seemed to be experiencing greater

personal confidence (more information, choices and cultural acceptance), effectiveness (working together and taking responsibility), and control (able to influence decisions). People and communities who have these attributes are conceived as being more empowered and, consequently, more likely to be healthy and resilient to stress (Raeburn & Rootman, 1998; Sarafino, 2006; Steptoe & Appels, 1989).

Table 6.4: Status of community development goals in GI compared to five years ago

	Number	Percent
CD goal 1: People know what's happening in Glen Innes		
A lot less than 5 years ago	17	6.1
Less than 5 years ago	26	9.4
No change	53	19.1
More than 5 years ago	120	43.3
A lot more than 5 years ago	51	18.4
Missing or no answer	10	3.6
Total	277	100
CD goal 2: People value the diversity in Glen Innes		
A lot less than 5 years ago	3	1.1
Less than 5 years ago	10	3.6
No change	39	14.1
More than 5 years ago	127	45.8
A lot more than 5 years ago	89	32.1
Missing or no answer	9	3.2
Total	277	100
CD goal 3: People have choices to be involved in making decisions about what happens		
A lot less than 5 years ago	12	4.3
Less than 5 years ago	23	8.3
No change	61	22.0
More than 5 years ago	130	46.9
A lot more than 5 years ago	39	14.1
Missing or no answer	12	4.3
Total	100	100

CD goal 4: People take responsibility for making GI a better place to live and work in		
A lot less than 5 years ago	9	3.2
Less than 5 years ago	22	7.9
No change	46	16.6
More than 5 years ago	146	52.7
A lot more than 5 years ago	42	15.2
Missing or no answer	12	4.3
Total	277	100
CD goal 5: People work together to build a sense of belonging in the community		
A lot less than 5 years ago	6	2.2
Less than 5 years ago	10	3.6
No change	57	20.6
More than 5 years ago	133	48.0
A lot more than 5 years ago	58	20.9
Missing or no answer	13	4.7
Total	277	100
CD goal 6: GI community is able to control and influence decisions made about Glen Innes		
A lot less than 5 years ago	10	3.6
Less than 5 years ago	25	9.0
No change	70	25.3
More than 5 years ago	114	41.2
A lot more than 5 years ago	40	14.4
Missing or no answer	18	6.5
Total	100	100
CD goal 7: People like living and working in GI		
A lot less than 5 years ago	7	2.5
Less than 5 years ago	14	5.1
No change	64	23.1
More than 5 years ago	118	42.6
A lot more than 5 years ago	60	21.7
Missing or no answer	14	5.0
Total	277	100

Chapter summary

Overall, the results from this final action phase of the research indicated that the PMHP model worked well in the GI context. The GIRHS successfully enabled an analysis of the needs and wishes of the GI community. The inclusive and participatory processes used with GI people and groups helped to confirm a final list of community goals to take forward into the next PEOPLE steps of Organisation and resource arrangements and Action.

The community action groups generally succeeded in completing the tasks and actions that they have decided on to achieve their goals, and this shows the PEOPLE System's planning and evaluation steps were effective and useful in helping community people to get what they want. More importantly, however, all the community processes undertaken in the execution of these PEOPLE steps contributed to building greater cohesiveness and connectedness among the action group participants.

As stated earlier in this chapter, this kind of community building and solidarity is exactly what the PMHP Model is going for. In many ways, the coalescing around community goals is only the means for bringing people together. The ultimate end for PMHP and PEOPLE context is fostering a stronger and more resilient community by building and strengthening relationships among all the participants in the groups. When people are engaged in "just doing stuff together", a sense of community is being built, regardless of the successful attainment of goals or not. For the intentions of both the PEOPLE System and PMHP, the connected and strengthened community will provide the supportive environment for its members to be able to empower themselves and improve their own wellness.

As a researcher who has worked in the GI community now for over 10 years, I can conclude that this community is certainly more connected and strengthened now than it was when I first entered it. The number of groups and networks has increased and, more importantly, these groups are working together more intentionally and more often. KMTW's coordination of both the GI Visioning and the GIRHS served to provide meaningful data to reflect back to the GI community regarding what were considered to be their important values, priorities and goals. These were used to guide how GI people would relate and work together in groups. That they do this well is the main prize for the PMHP Model; that they achieved their goals is the bonus.

I have used some examples of GI community groups to illustrate how they have worked together to build capacity, confidence, connectedness and control. I have also indicated that their successes were not based on everyone agreeing with everyone else. There

have been disagreements, conflicts, mistakes and disappointments as well, but these are inevitable, and invariably did contribute to learning and development. What most of these groups have that rendered these episodes resoluble is their adherence to empowering values and ways of working. They trusted the process.

On reflection, it is true that not everything worked as planned. It is also true that not all groups in GI collaborated or worked with KMTW, or each other. I would own that not everyone or every group will even have knowledge of KMTW or the work it did and does in the community. The reality is that the context of the GI community is larger than the reach of the KMTW project. As a researcher, I can only work with the parts of the community that were available to me and that were willing to engage. With these parts of the GI community where the PMHP Model was used, I can say that the success is real.

I began this chapter by giving the background of how KMTW used the GIRHS goals to develop a three year 2007 – 2010 Strategic Plan, and then on how these goals were rated against the Plan in August 2009. A, B, C, D and E scores were allocated according to how successfully each of the Goals was met by the collective efforts and actions of the GI community action groups and projects. I followed that on by showing how some of the groups translated the PEOPLE components of People-centredness, Empowerment, Organisational and community development, Participation, Life quality and Evaluation into healthy experiences for their participants.

Finally, I shared the results of an evaluation and feedback survey conducted in September 2010 in an attempt to gauge how GI community people perceived the community as changed since the PEOPLE System's step 2 (GIRHS in 2005) was implemented. I ended the chapter by describing the evidence of the community-building and increased connectedness in GI that was seen as the more important indication of the PMHP Model's successful application, although successful goal attainment is the more obvious success factor.

The next chapter will discuss the implications of this research in GI for applicability of the PMHP Model to promote population mental health in other communities.

7 CONCLUSION

Go to the people.
Live among them.
Start with what they have.
Build with them.
And when the deed is done,
The mission accomplished,
The people will say 'We have done it ourselves.'
(Lao Tse, 600 BC)

To recapitulate the overall aim of this thesis, I set out in 2002 to test the new Population Mental Health Promotion (PMHP) paradigm that aspires to a vision of empowered and self-determining communities that enable their peoples to experience improved mental health, wellbeing and quality of life. The overall approach that was deemed most appropriate for that endeavour is community development (CD) with its focus on empowerment, social justice and sustainability. To implement the CD approach in the community of choice for this research, Glen Innes (GI) in Auckland City, New Zealand, I chose to use a New Zealand-originated procedural approach called the PEOPLE System, which was very much in accord with the values and principle of the type of CD desired here. This combination of the PMHP paradigm with the PEOPLE System way of working I called the PMHP Model. Essentially, this thesis was a trial of that model in one of the most disadvantaged urban communities in New Zealand.

Summarised, the specific objectives for this research were:

1. To determine if the PMHP Model could be applied in Glen Innes, with the long term aim of enhancing the mental health, wellbeing and quality of life that whole community
2. To critically assess the merits of this model in the Glen Innes setting
3. To determine whether this project aided the development of a positive relationship and partnership between the Glen Innes local community and the university campus; and
4. To draw conclusions about the more general applicability of the PMHP Model to the theory and practice of PMHP in a New Zealand context, and its potential applicability throughout New Zealand.

What conclusions, then, can be drawn about these objectives?

Applicability of the PMHP Model to Glen Innes

Clearly, the PMHP Model was applicable in this context, both in the initial studies involving the Asian groups, and in the wider KMTW context. With regard to the latter, the preliminary discussions in the community; the implementation of the random household survey and the widespread participation in it; the participatory goal-setting process which gave rise to goals that obviously had strong resonance in the community; the healthy governance and operational systems; and then the many action groups that arose out of the process and continue to flourish after the formal period of the research finished; are all testimony to the applicability of the Model.

Furthermore, at every point in this process, the degree of participation and the obvious sense of control; the satisfaction expressed at all stages at what was being done; and the wellbeing expressed continuously by the community participants in a wide variety of ways, show that the mental health, wellbeing and quality of life dimensions were positively affected from the start, and continue to improve. The 2010 survey mentioned in the previous chapter was testimony to the positive changes sensed in GI since the project got under way and which have persisted and continue to grow steadily. Furthermore, the current health and expansion of the project suggest that there is every likelihood that these processes are sustainable and will continue and grow in the future. The fact that other community projects in New Zealand using the PEOPLE System approach have lasted for 30 years or more also indicate the sustainability of such an approach.

A critical appraisal of PMHP Model in the Glen Innes setting

While there is no doubt that the overall impact of this project in Glen Innes is positive and that the model “works”, there are a number of points to warrant critical consideration in relation to the merits of this model in GI. I will choose to highlight a few of these to highlight, in no particular order.

Community participation numbers and representativeness

The first main point has to do with the fact that there are still a large number of people and groups in the GI community who have not been engaged with the project. Although the participation rates at the community events organised by KMTW and the action groups have been growing visibly, most of these numbers are derived from word-of-mouth promotion that bring in people who are already in the social networks of current participants. For example, the people from the Burmese community who participate in our activities are mostly Buddhists and members of the Asian action group from phase 1 of the research. Though some Muslim Burmese have recently made contact with KMTW

requesting some help with a housing issue, the project has no contact at all with Christian Burmese in GI. I would like to include more of these groups that are currently not connected, including people from other refugee groups such as Somalis, Eritreans and Sudanese. The numbers of participants have certainly grown, but participation can still be greatly improved if the representativeness grows as well.

The learning from this is that representative participation is an on-going priority and needs to be addressed. One practice recommendation is to create a stakeholder gap analysis grid to identify the gaps in the community groups or people we wish to be engaging with. The following sample shows how this might look for identifying gaps in engagement work with local Burmese groups in GI.

Table 7.1: Stakeholder gap analysis grid example

Community stakeholder gap analysis for Glen Innes				
Current Group/s	Current contact/s	Current gaps	Possible contact/s	Person responsible
Burmese Community	VS and JK @ Buddhist temple	Burmese Christians	Khaw @ English classes?	John
		Burmese Muslims	RR who works at GAS garage?	Mandy
		Burmese youth	Local schools?	Jimmy
			Colleges?	
			Facebook?	
		NZ born Burmese	Ma Naing?	John
			Facebook?	
		Burmese expatriates	Mrs. Lane?	Sally
			Facebook?	
Etc	Etc	Etc	Etc	Etc

Once the relevant gaps have been identified by key community people, suggestions of possible contacts for addressing those gaps may be made. Specific individuals could volunteer or be nominated by others to follow up on the suggested contacts and facilitate introduction to members of the non-engaging groups to see if they might wish to be involved in some way. This kind of template can be modified to serve other purposes involving a systematic sweep of what is present or absent in the community e.g. funding for projects or activities.

Another practice recommendation is creating posters or flyers in Burmese (or whatever language the target group uses) to promote community events. These may be delivered to temples, churches, mosques, schools and so on where Burmese (or whatever group) people congregate to increase their chances of participating. Burmese community members, for instance, are usually very family-oriented; any events involving their children are more likely to kindle their interest. Having bilingual interpreters in attendance will always increase the ability for these members to engage meaningfully at events. The Burmese (or whatever group) members who are currently engaged and participating may also be invited to encourage their friends to join or, at the very least, be asked about the best ways to increase participation.

It is also important to be mindful of the other priorities in their lives that often demand attention and time as well. Most importantly, we need to ask ourselves whether these community members will reap any benefits from their participation in our projects. All community projects and activities must contain opportunities to increase their capacities, connectedness or sense of control. And they must all be culturally sensitive.

Dependence on government funding

Another point of concern is the project's continued dependence on government funding, the main source for such projects. This usually means that, no matter how empowering the language of the funding contracts may be, the reality is that these contracts have criteria, priorities and outcomes that are driven by government rather than the local community. In my experience in Glen Innes, a change in local or central government can change funding and resourcing policies with no warning and leave projects stranded. Although the two state funding streams for KMTW were less prescriptive than most others, there is as yet no other comparable type of funding streams currently available that are purely for community development endeavours with "no strings attached".

Also, these funding applications are complex and complicated to complete and quite beyond most of the disadvantaged groups that might be eligible for them. Further, the funding is usually for shorter terms (six months or one year is the standard time frame); the five- and four-year funding contracts that KMTW received were the rare exceptions to that rule.

Currently, at the point of writing this, KMTW is in the position of actually having exhausted the main funding streams for generic community development, and it has to resort to applying for small fragmented sums that are tagged to funder-driven outputs. These funds

are not very useful for the sorts of people-led and controlled projects that we have been doing. Applying to multiple sources to make ends meet financially is time-consuming and takes energy away from the work. KMTW remains vulnerable to the possibility of having to cease operations at some stage for these reasons.

A related issue to dependence on government funding is that the lack of resources generally increases the competition for them, and this can cause considerable tensions in a small community like GI. In the past, this has resulted in quite a bit of “gate-keeping” or reluctance to share information about possible funding sources.

To overcome the above tensions somewhat, KMTW and many other local groups now disseminate information related to available funding to all the other groups and networks in GI. This information-sharing is also being reciprocated by more groups. Many community groups are also increasingly interested in putting in joint applications to work together on projects, which is yet another way of addressing this problem. The local council and community boards have become very active in promoting funding opportunities among community groups and they often send information to key community groups so the information may be shared in the usual manner for those groups. The government also provides free access to a funding database that gathers and provides information about funding agencies, philanthropies and other sources that solicit applications for resources.

This dependence of funding from the crown has been recognised by some philanthropic and private sector groups and these have been promoting other ways of resourcing community groups and their activities. These include offering training and development opportunities for staff and volunteers; scholarships and internships; donating equipment; seconding paid staff to work for organisations, supporting fund-raising events through sponsorship of prizes, providing venues and so on. Community groups are innovating ways to stretch their funding or to replace the need for funding e.g. time banks, green barter and swaps. Other initiatives include ethical lending and small economic enterprises that may lead to financial sustainability. For instance, KMTW publishes resources that are sold to generate income including data from our community research activities. We are also investigating charging fees to agencies and groups that request for workshops and presentations.

Community development in vogue

One interesting tension currently applicable to GI is that some philanthropic and private sector groups are beginning to express interest in wanting to resource community development-type projects. This trend is contributing to an increase in the number of groups in GI now labelling their activities as “community development”. Until about a year ago, KMTW was the sole agency claiming and recognised for that role. The issue has created some questions about the legitimacy of these claims because many of these groups are service providers who are based in the community, and who may well be using approaches that are more empowering than other providers, but which could not be said to completely adhere to the community-controlled philosophy that we were intent on following. The tension that arises is one of accountability. Who would hold all these groups against their stated intents against their actual practices?

However, this can be a good development if the normalisation of the CD term means the empowerment principles get discussed, strengthened and practised. KMTW will certainly work with these groups whenever possible: to inform each other’s knowledge and practices, and to help better the lives of GI people together.

One important strategy KMTW has developed to deal with this issue is to network intentionally with all these local and wider CD groups by creating training and workshop opportunities so we can converse together, debate and strengthen the CD profile and provide each other collegial support. KMTW almost always accepts any invitation by any such group or networks to present or offer workshops relating to the work we do in GI.

Since 2010, there also exists a network called the Auckland Community Development Alliance that was wrought out of widespread concern for the potential negative impacts on disadvantaged communities when the proposal for amalgamating the seven separate local authorities making up Auckland city into one “super” Auckland Council. KMTW is a member of this network and continues to work closely with the other members to grow the CD cohort in Auckland, and beyond.

Empowerment issues

While the GI action groups have definitely been engaging in empowering processes and outcomes, how long will it last? Related to the issues discussed above, many of those who talk about “people-power” do not, in fact, share real power with people in community. Many of the projects that claim to be working to empower people come to the people with well-laid plans that will be put into place regardless of what the local people want or say.

Even with the GI project, the logistics of working closely with the community in truly empowering ways takes a huge amount of time and energy. It is not only agencies and government bodies that default to a tokenistic interpretation of people-centredness; GI community groups do this too.

I have found myself in situations where there were urgent deadlines to meet (usually for funders or government agencies) which meant there was no time or opportunity to consult with the people who needed to be involved. I had to choose between not making any recommendations at all, because I have not consulted with people in the community properly, or giving my personal suggestion and hoping it approximated the community's voice. There have been times when I have chosen the latter and had to face the wrath of the community. I did get censured once but, on the other occasions, was given the generous benefit of the doubt in the context of the urgency of the matter.

One way to ensure our practices are as empowering as possible is to conduct good on-going reviews and debriefs. Good plans and processes will always include checks and balances to ensure we do not default to "we know best" mentality. In GI, we refer to the GI Ways of Working template as well as developing "integrity check lists" that allow us to perform quick self-reviews.

For example, giving people enough time to consider their willingness to participate in any event is one way of empowering them. In GI, the guideline is that any local consultation event allows for a time frame of at least two weeks for advertising and promoting it to community people and groups. Specific people or groups take responsibility for contacting their networks and communities to publicise the same. Further, collated responses must be circulated for at least one week so feedback and comments can be taken into account before the final document is drafted. Any consultation event that does not meet these time frames will be sure to receive strong messages of disappointment, and the protagonists would make sure they can answer to the expected questions about the reasons why that happened. More and more, key local groups request more time for consultation when they get presented with short (mostly three to four days) time frames for submitting responses or feedback and, more and more, agencies are complying with these requests.

Representational issues

Another related problem is that many agencies wanted to consult with community representatives instead of a whole room full of exercised locals. In GI, no such people actually exist in the sense that no one person or group can adequately represent such a

diverse community. Insisting on only dealing with representatives has made many community groups feel that it is a “divide and rule” tactic adopted by agencies to split community into potentially competing interest groups. Also, sometimes these so-called representatives are offered compensation for their time which adds a further tension as payment for such services sometimes sets up one group against another in competition for the scarce resources or the opportunity to influence decisions. KMTW and some of the key community groups have been invited to occupy these positions because of our connections into community networks. These situations were very awkward to resolve and the following is one example of how we addressed one such situation.

In response to a recent request to nominate some representatives to form part of an inter-sectoral committee, the community chose to nominate a few people so as not to risk the community missing out entirely on having any input at all into the strategic roles, on the grounds that the agency would just choose other more cooperative people. In that particular case, the community requested that there be at least two ‘community commentators’ (a more preferable term for us), that they be compensated for their time, that they work in rotated pairs and that they be able to share what they learned with the rest of the community. These requests were partially accepted: two ‘commentators’ were given reasonable compensation but could not rotate and had to sign confidentiality contracts that allowed only some sharing of information. I think that was good progress, and the compromise is currently being tested in GI.

Our main approach to addressing this issue is to continue endeavouring to cultivate as many relationships with as many community groups as possible and to invite them to join our networks and databases so they can be contacted and information shared efficiently. The Tamaki Inclusive Engagement Strategy group, for example, worked tirelessly to educate stakeholders about the community’s preferred ways of working, as published as the Tamaki Inclusive Engagement Strategy book (containing community engagement tools and resources), so that these groups can begin and continue to amend their practices and be more inclusive when drafting policies and guidelines.

Personal issues

I have saved this one for last because it is a difficult one to be objective about. It is also one that has been articulated by key community stakeholders when the future of KMTW is discussed. The fact remains that there is a real and critical concern that much of the success of the GI project may be reasonably attributed to the quality of personal

relationships that the researcher has cultivated and maintained. Although all is apparently flourishing at present, will this continue so well when the researcher departs?

It is probably fair to say that not enough has yet been done to make the project sustainable and to make it remain true to its PMHP values and goals in the future. What is now needed is a more concerted capacity building and resource planning effort, as well as the design of a training-oriented governance and operational structure to ensure that the project will continue and grow into the future.

I am happy to say that this is currently being pursued by KMTW in its plans for creating a Centre of Excellence for Community Development to be based at KMTW. In 2010, KMTW hosted 10 students, at different times, from local universities and technical institutes, as interns to get practical community development or health promotion experience. KMTW also has a pool of volunteers who contribute to the work and it is from this pool of more experienced CD practitioners that we draw our candidates for any project contracts or short term paid roles we have to offer. Of course, these opportunities are always widely advertised to model equity. However, candidates who have demonstrated fidelity to the CD purposes and processes would naturally and justifiably be preferred.

The chances of sustaining our CD role and capacity has also been improved as invitations to help neighbouring communities to start similar CAR projects there are being received. KMTW is also exploring ways to package the data collected via our CAR activities for agencies to pay to use. The modest funds from the sale of our reports and books have given us much hope in this venue for economic development.

Relationship between the university and the community

As stated in Chapter One, the community of GI was very wary about the university when this research began. This was based on some bad experiences with research and also with a general unease about the large and somewhat forbidding establishment just up the road. This unease gradually disappeared over time. A combination of the goodwill generated by the project; efforts of academic colleagues to support the community (one is currently a member of the KMTW board); other university research projects begun and planned with and for community; university scholarships for students to work for community groups; and visits of community members to the university (for example, in the analysis of the survey and to use health clinics on campus) all help to foster an increasingly positive relationship between the two potential partners. At the time the

formal research period ended, it was fair to say that the university was regarded as being more benign, and even somewhat of a resource.

For example, community groups have been offered campus meeting venues pro bono during the teaching term breaks, invitations issued for campus seminars and exhibitions; campus staff runs an annual event to collect items for the community food bank in GI. Most recently, the Pro Vice Chancellor of the Tamaki Campus agreed to an invitation from the MAGIC (Music and Arts Glen Innes Centre) working group to become a member of the project's governance body after he also agreed to support an application from the group for planning approval for the proposed arts and music centre from the Auckland City Council.

Unfortunately, although some individual staff members and departments have become more aware of and willing to engage with the Glen Innes community, in the main the institution still remains relatively an "ivory tower". The community has high expectations of university staff who engage with them and are understandably disappointed when these people have shown to have very little influence over how the university behaves generally. For example, a university research project was keen to organise a GI community group to cater for an event but were unable to use the service because the community group was not on the university's list of "preferred providers". This situation was rectified when the university was persuaded to include some local community groups and services on their list. Community people understand the complex considerations that the university have to account for to make such decisions to include them, and they express their appreciations accordingly. That happened also because a couple of university staff were willing to explain the situation for community in ways that the latter understood and acknowledged.

After having been in the GI community for more than ten years, I can say that there is a feeling in the community that "some of the university staff were willing but their muscles are weak". While there are significant changes in some attitudes on the part of the university, the majority of the university staff still does not consider the people of GI as a community of interest to them except as being interesting for research purposes or as a needy population that the university might charitably help.

Some lecturing staff have begun inviting community people and groups to give lectures and presentations to their classes such as Social and Community Development, Population Health and Health Promotion. Students seemed to enjoy listening to practitioners, and the community people enjoyed the experience equally. This recognition

of community expertise is an empowering way of re-viewing the potential of a community-campus partnership where the community does not always occupy the role of the lesser partner. It is only a gradual development, but it is a great start.

The University of Auckland's strategic plan does include aspects relating to promoting relationships that support community health and wellbeing, and the Tamaki Campus especially has its strategic plan identifying campus-community relationship-building as important components. The Pro Vice Chancellor continues to accept invitations from the community to engage with it. The new Auckland Council's vision to model good CD approaches also lends weight to the university's intent of promoting ethical and mutually beneficial partnerships with communities. The current mayor of Auckland City has been voted in by a huge mobilisation of community people who do not usually exercise their voting privileges and rights (mainly from the "poorer" communities like GI) and the zeitgeist seems sufficiently promising for expecting a more collaborative and people-centred council, led by a visionary and passionate liberal mayor. This high profile local government leadership will undoubtedly provide additional motivation for the campus to be more community-friendly.

As usual though, the price exacted for people living in a democracy remains that of our on-going vigilance and holding our public servants to account for delivering on promises made in their strategic plans and vision statements. KMTW maintains a healthy interest in university matters and is on their database for receiving campus newsletters to keep us up to date with campus developments.

Applicability of the Model to Theory and Practice, to Wider Dissemination in NZ

Although none of the various components of the PMHP Model as applied in GI were in themselves new, both the combination of elements and the nature of the community to which the model was applied were quite so.

From a theoretical perspective, what I feel has been accomplished here was that a variety of ideals – the principles of empowerment, equity, self-determination, community control, respect, inclusion, social justice, collaboration, capacity-building and agency have all been blended into a coherent whole around a population-based mental health promotion agenda and have been shown to be effective.

The proof of any theory in the applied mental health field is both in its face validity and whether it works (that is, is successful in its outcomes and processes) when applied to the

kind of situation for which it is designed, and in the way its proponents intend it to be used. The premises that underlie the PMHP Model do make a coherent, holistic or ecological theory, based on the idea that mental health is enhanced when people feel in control of their own destinies and can bring about positive social and personal change of their own choosing when done in a collective, supportive and "community" way. This is very much in accord with a number of mental health promotion theories and approaches specifically, as well as with health and social change theories generally (Joubert and Raeburn 1998; MOH 2002; Herrman, Shekar et al 2005; Lahtinen et al 2005; Liamputtong and Gardner 2003).

As for practice, the relatively straightforward steps of the PEOPLE System are designed to facilitate effective practice, and its community-controlled aspect means that it fits the theory very well. Furthermore, it is readily understood by community people, so that it can be used sustainably to continue to run a successful project, long after its professional instigators have disappeared. In short, although there is still work to be done in this respect, the researcher has every confidence that this project will continue to work well and expand independently of her input in the years to come.

The issue of the applicability of this approach to other settings has already come up. On the strength of this study, the researcher has been offered the opportunity to coordinate and develop a new project called The WROC Project, where WROC stands for Wellbeing Resourcing of Communities. This offer has been made by a successful mental health non-governmental organisation in Auckland which has put up money for its development over the next few years. The aim is to create community centres throughout Auckland, and ultimately New Zealand, for community-controlled projects in the wellbeing area, based around resources available in these centres for whole communities to work in the same way as created in the Ka Mau Te Wero Project in Glen Innes. This will no doubt have to happen slowly over the next few years, but certainly the opportunity is there to show that what has been trialled in this thesis is applicable on a much wider scale.

Where to now?

One has the sense that research based on the PMHP Model could be the start of a new era of research in this area of applied mental health promotion on a community level. Given the effectiveness of the PMHP Model in a challenging and culturally mixed community such as GI, it is well worth trying elsewhere. That is not to say it is applicable

to all communities, and it may have to be modified to some extent in entirely different kinds of settings, but it certainly looks promising.

At a more immediate level, the GI project itself needs continuing development, as the researcher had to finish her PhD study without fully working through all the steps of the PEOPLE System. The Action step has been reached but still requires some refinement, especially with regard to the review process, which is the next step. Ideally, the convenors of all groups and activities would come together on a regular basis (weekly, fortnightly or monthly) and go through a process of systematically sharing with each other how they are progressing on their goals, which means they get support when struggling, get affirmed when succeeding, and are kept up to the mark and accountable with regard to the tasks they have agreed to undertake. When the PEOPLE system approach is fully operational, this review process becomes the heart of the whole endeavour.

Then there is, finally, the Outcome Evaluation step. Again ideally, the main project goals would be set in terms of a time frame where they can be monitored on an annual basis, as a kind of periodic audit of goal attainment and overall project direction. This annual stock-take would also provide an opportunity for new goals to be set, on the basis of "needs/wishes" information gathered during the year. Although another major GI random household survey is planned for 2011, a formal process has yet to be set up. Once established, the whole Project becomes increasingly driven by what are called Annual Goals, that is, goals that need to be achieved by the next annual review.

Looking further into the future, there is the previously mentioned WROC project which will be a major development, and, to the extent that this becomes widespread in New Zealand communities, there may also be a need for a national coordinating office for this and other PMHP kinds of projects, with opportunities for more student and funded research. It is also intended to promulgate this approach at conferences and in journals, including to international audiences, and the author firmly believes that this approach is one with enough promise and potential to have international application and to be the basis of widespread use in many different countries.

Conclusion

An argument could be made that the time in world history is right for an approach that strengthens community wellbeing in the face of fragmenting and threatening forces, given the realities of global warming; increasing environmental crises; global financial recession; continuing population growth; rampant consumerism; rapidly advancing communication

technologies; energy and food shortages; growing inequalities and inequities; and many other stresses, demands, and threats to human societies and wellbeing.

Without wanting to overstate the case based on this one study, it does seem that there is the possibility of building the strength and wellbeing of communities, based on their taking the determinants of their wellbeing into their own hands, and using the resultant empowerment and sense of control to manage their lives and create a more harmonious world.

Hope is like a road in the country;
There was never a road,
But when many people walk on it,
The road comes into existence.

(Lin Yutang)

APPENDIX A: Participant Information Sheet

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

The University of Auckland
Private Bag 92019
Auckland
New Zealand,

Level 1, Ecom, 3 Ferncroft St., Grafton
www.health.auckland.ac.nz

Telephone: 64 9 373 7599
Facsimile: 64 9 373 7493

Applied Behavioural Science

Title: A Community Development Health Promotion Project in Glen Innes, Auckland to improve the health, well-being and quality of life of Asian Immigrants.

To: Subjects

My name is Theresa Liew. I am a student at The University of Auckland enrolled for a Doctor of Philosophy (Ph. D) Degree in the Department of Applied Behavioural Science. I am doing this research for my thesis on a Community Development Health Promotion project for Asian Immigrants living in Glen Innes.

I have chosen this field because I am an Asian immigrant myself and I am very interested in how the health, well-being and quality of life of Asian immigrants can be improved. I also want to see how the Asian Immigrant groups living in Glen Innes can feel that they belong in the community and how to get support and help in the community.

I would like to ask you to help me in my research. I am happy to speak with you on your own or with your group to explain my research project, and to let you ask me any questions about it.

You and your group can choose to take part in any meeting or discussion with me or not. These meetings or discussions will usually take a few minutes to about half an hour or so. We can arrange to have them at a time that is easy for you.

Sometimes, I might want to audio-tape the discussion, but this would only be with your permission. If that happens, you can also ask for the tape to be turned off at any time, or you can ask for the information to be destroyed at any time up to the end of 2005.

If you are happy to help me in this way, please let me know by filling in a Consent Form and sending it to me. If you want more information, you can phone me on 5704255, after hours.

All information you give in the meetings is confidential and your name will not be used unless you give your permission for this to happen.

Also, I would like to continue to talk with you if you and your group decide to take part in the project.

Thank you very much for your time and help with my study. If you have any questions or wish to know more please phone me at the number above or write to me at:

Department of Applied Behavioural Science,
The University of Auckland
Private Bag 92019
Auckland.
Tel: 373-7599 Ext. 83036

My supervisors are:

Assoc. Prof. John Raeburn,
Department of Applied Behavioural Science,
The University of Auckland
Private Bag 92019, Auckland.
Tel. 373-7599 ext. 86545

Dr. Samson Tse,
Department of Applied Behavioural Science,
The University of Auckland,
Private Bag 92019, Auckland
Tel. 373-7599 ext. 86097

The Head of Department is:

Dr. Peter Adams
Department of Applied Behavioural Science,
The University of Auckland
Private Bag 92019, Auckland.
Tel. 373-7599 ext. 86538

For any questions regarding ethical concerns please contact:

The Chair,
The University of Auckland Human Subjects Ethics Committee,
The University of Auckland,
Research Office - Office of the Vice Chancellor,
Private Bag 92019, Auckland.
Tel. 373-7999 ext 87830

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE on 21 August 2002 for a period of three years, from 21/08/2002 Reference 2002/244

APPENDIX B: Consent Form for Asian Projects

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

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Private Bag 92019
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Level 1, Ecom, 3 Ferncroft St., Grafton
www.health.auckland.ac.nz

Telephone: 64 9 373 7599
Facsimile: 64 9 373 7493

Applied Behavioural Science

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Title: A Community Development Health Promotion Project in Glen Innes, Auckland.

Researcher: Theresa Liew

I have been given an explanation of this research project. I have had an opportunity to ask questions and have them answered. I know what it is about.

I understand that I can stop taking part in the project at any time without giving a reason, up to the end of 2005.

I understand that I can also ask that any information that can be traced back to me, be removed at any time up to the end of 2005 without giving any reason.

- I agree to take part in this research.
- I agree/do not agree that the interview/discussion can be audio taped

Signed:

Name:
(Please print clearly)

Date:

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS COMMITTEE
on 21 August 2002 for a period of three years, from 21/08/2002 Reference 2002/244

APPENDIX C: Random Household Survey Form

INTERVIEWER & HOUSEHOLD COPY

The Glen Innes Community Random Household Questionnaire 2005

Thank you for agreeing to answer our questionnaire, I would like to remind you that all the information to this questionnaire will be strictly confidential.

A Details of person interviewed:

A.2 Looking at this list please tell me which of the following best represents your household situation?

Person living alone	01	SKIP TO RED SECTIO
One parent with child/ren at home	02	
Couple living without child/ren	03	SKIP TO RED SECTION
Couple living with child/ren at home	04	
Extended whaanau/ family	05	
Group of friends/ flatmates	06	
Other (Write In Answer)	97	

A2.1 Could you please tell me ***how many*** children you have? HOW MANY?

Pre-schoolers (00YRS – 04YRS)		02
Primary school age (5YRS – 12YRS)		03
Intermediate school age (10YRS – 12YRS)		04
Secondary school age (13YRS –18YRS)		05
Left school		06
Tertiary/Course (please specify)_____		97

A3. Please tell me which number best represents your age?

A	18-25	D	46-55
B	26-35	E	56-65
C	36-45	F	66 +

A4. Could you please tell me which ethnic group(s) you most identify with?

NZ Maori	01
NZ European/Pakeha	02
Pacific Island (please specify)	03
European (please specify	04
Asian (please specify)	05
Other (please specify)	06

A5. What is your current occupation?

B The following questions are to find out how people utilise their spare time – for everyone
RECREATION

B.1 Did you take part in any regular sports, games or other similar activities in the past year? This includes helping in any way e.g. Coaching, organising or as a regular spectator.

NO	SKIP TO NEXT QUESTION "GAMES"
YES	CONTINUE

B2. SPORTS e.g. activity for pleasure, competition or exercise, rugby, netball swimming

2.1. Are you involved in any sporting events? If so, how were /are you involved?

2.2 From the *SPORTS* you have mentioned – were they held in GI?

Q1				Q2		
Type of Participation				Location in GI		
SPORT	Active	Admin	Spectator	In	Out	Both
	1	2	3	1	2	3
	1	2	3	1	2	3

	1	2	3	1	2	3
	1	2	3	1	2	3
	1	2	3	1	2	3

B3. GAMES OR HOBBIES E.g. Chess, cards, mah-jong, bridge, knitting, sewing, painting etc.
Do you play any sort of games? What sort of games do you play? **RECORD UNDER "GAME"**

NO	SKIP TO NEXT QUESTION OTHER GROUP INVOLVEMENT
YES	CONTINUE

3.1 Are you a member of a ***club*** or do you play socially with your ***friends***? **RECORD**
3.2 Where do you play?

	Q1			Q2		
Type of participation				Location in GI		
GAME/HOBBIES	DONE ALONE	CLUB MEMBER	FRIENDS ONLY	IN	OUT	BOTH
1.	1	2	3	1	2	3
2.	1	2	3	1	2	3
3.	1	2	3	1	2	3
4.	1	2	3	1	2	3
5.	1	2	3	1	2	3
6.	1	2	3	1	2	3

B4. OTHER GROUP INVOLVEMENT
Are you part of any of the following groups as either a volunteer or paid employment?
Eg. (including school, services, cultural/ethnic, welfare, early childhood)

What Other Groups You Involved In?	LOCATION		
1.	In	Out	Both
2.	1	2	3
3.	1	2	3
4.	1	2	3

B5. NEW ACTIVITIES

5.1 What 3 activities would you like to do but are currently unable to?

For each of the activities you have mentioned, what stops you from doing each of them?

*Can circle more than one choice for each Activity mentioned.	Activity 1 (5.11)	Activity 2 (5.12)	Activity 3 (5.13)
1. No facilities	1	2	3
2. No vacancies	1	2	3
3. Lack of information	1	2	3
4. Time	1	2	3
5. Money	1	2	3
6. Transport	1	2	3
7. Motivation	1	2	3
8. No childcare	1	2	3
9. Security/safety reasons	1	2	3
10. Other	1	2	3

B6. What sports or similar recreational facilities in GI do you use? (3 max)

B7. Can you think of *how* each of these recreational facilities can be improved? (Name facilities)

B8. Do you use any sports or similar recreational facilities *outside* GI that you would *like to see* or have here in GI? (3 max.)

B9. Can you think of any other *new* activities or facilities that you would *personally* like to see in GI? (3 max.)

B10. Can you suggest any other new activities or facilities in GI that *the community as a whole would find useful?* (3 max.)

B11. How do you usually travel to your sports or similar recreational activities?

Using own car	01
Getting a ride with friends/family	02
Using public transport	03
Walk	04
Not applicable	05
Other (please specify) _____	97

C THIS SECTION IS FOR PRESCHOOL CHILDREN (00YRS – 04YRS):

The following list of questions helps us get an idea of your needs regarding child-minding and other preschool facilities around GI.

C1. PARENTS OF PRESCHOOLERS

C1.1 Is it usually easy or hard for you to get child-minding?

Always or usually easy	01
Difficult or hard to find	02
Difficult or cannot afford	03
Don't use child-minders	04
Other: _____	05

C1.2 Are you ever able to leave your children with someone else to have time out?

Less than once a week	01
More than once a week	02
Never	03

C1.3. Do any of your children attend or use any child-minding and childcare facility?

NO	SKIP TO QUESTION 4
YES	CONTINUE

C1.3.1 What childhood educational facility do your children attend or use?
PLEASE READ

Playcentre	01
Kohanga Reo/ Language Nest	02
Kindergarten	03
HIPPY/PAFT	04
More than one	05
Other: _____	06

C1.4. On the whole, do you find that the local childminding or childcare facilities meet your needs?

Comments: _____

C1.5 Is there any reason why they cannot attend any early childhood educational facility?

No special reason	01
No facilities available	02
On waiting list	03
Lack of transport	04
Costs/Fees	05
Don't like the facilities available	06
Other: _____	97

C1.6 In general, what ways can local facilities/services in GI be improved for you and your young children?

C2 To the parents of school-aged children (5 to 12 years):
C2.1. What ages are your school-aged children? _____

C2.2. Looking at this list - Where do your children usually play when away from your home?

Organised Activities	01
Street	02
Nearby parks or reserves	03
School grounds	04
Friends' houses	00
Other: _____	99

C2.3. Do you think there are enough safe areas nearby for your children to play in?

C2.4. In general, are there ways to improve things for your children in GI?
Comments _____

C2.5. What things do you think would be good to have for after school or weekends activities for your school-aged children?
Comments:

C3. TEENAGERS LIVING AT HOME AGED 13YRS – 19YRS OLD
C3.1 What ages are your teenagers? _____

C3.2 Where do your teenagers spend their spare time away from home?

At organised activities (see next question)	01
At friends' houses (including cars)	02
On the street	03
Parks and reserves	04
Don't know	00
Other: _____	99

C3.3 What organized activities do your teenagers take part in?

School sports or clubs etc.	01
Discos, dances etc.	02
Sports clubs, scouts, guides etc.	03
Cultural groups/church groups etc.	04
Other: _____	99
None	97

C3.4 Do you think there are enough facilities and activities for your pre-schoolers/ primary aged children and teenagers in GI?

Comments: _____ _____

C3.5 In general, how can things in GI be improved for you and your teenagers?
Comments: _____

C4 PARENTS AND GUARDIANS SECTION
C4.1 Are there any facilities or spare time activities you and your family do **together** outside your home?

Visiting friends, relatives etc.	09
Picnics, trips to parks, beaches etc.	02
Walks, tramping, camping etc.	03
Play sports	04
Water sports	05
Movies, theatres etc.	06
Museums etc.	07
Church etc.	08
No	01
Other: _____	99

Comments: _____

C4.2 Are there any from the above list of activities or other suggested family activities that you would like to see becoming available in GI?
Comments:

C4.3 Do you think there is a need for education, training and support for parents on how to bring up their pre-schoolers/ primary aged and teenagers?

Comments: _____

C4.4 If such education, training and support opportunities were available in GI, would you take part in them?

Comments: _____

D. OLDER PEOPLE

We would like to find out *your* views and opinions regarding the older people in GI

D1. Do you think that there are ways to improve things for the older people living in GI? If so, what? (3 max.)

No improvements needed	01
More clubs for senior citizens etc.	02
More attempts to include the older people in community activities	03
More interest taken by neighbours	04
More or better council or government activities or services	05
Others: _____	97
Comments: _____	

(QUESTION JUST FOR OLDER PEOPLE 60+)
D1.1 Are there ways that things can be improved to make life easier for you in GI?
Comments:

The following questions help us to find out if there is a need for personal learning and development.

E. PERSONAL LEARNING AND DEVELOPMENT

E1. Have you attended classes or lessons of any kind in the past year?

No	SKIP TO NEXT QUESTION 2
Yes	CONTINUE

E1.1 What type of classes or lessons did you attend?

School, polytechnics, university etc.	01
Crafts, hobbies etc.	02
Practical skills (cooking, driving, computer courses etc.)	03
Living skills (communication skills, parenting etc.)	04
Creative skills (painting, music etc.)	05
General interest (languages, law etc.)	06
Cultural skills	07
Other: _____	97

E2. If you could do any classes you wanted (if time, money, transport etc. did not count), what classes would they be?
Comments: 3 max._____

E2.1 What would stop you from doing these? (3 max.)

Too far away	01
Not available	02
No time	03
No transport	04
Cannot afford	05

Child-minding	06
Commitments to children or family	07
Motivation	08
Don't know	00
Comments: _____	

E3. Do you think more classes or groups should be available at the local community level in GI?
Comments:

E4. Are any community discussion groups (like "How to deal with drug use in young people") of interest to you?
Comments:

E5. Any particular topics interest you more? (Probe)
Comments:

E6 EDUCATION

E6.1 Do you think there is enough information about education for people in Glen Innes? (**Probe fully for Yes or No**)

Yes 01	No 02

Comments:

E6.2 How do you feel about tertiary study?
Comments:

E6.3 Who do you think is responsible for telling the public about the choices we can make for education?
Comments:

E6.4 Is study further than college important to you personally?
PROBE – Why?

Yes (why)	No (why)

Comments:

E6.5 Who do you think should make the decisions concerning education for children?

Parents	01
Themselves	02
Council/Government	03
Teachers	04
Other	

Comments:_____

E6.6 How involved are you in the local educational facilities e.g. early childhood, schools, colleges?

Very Involved	1.
Involved	2.
Not Involved	3.
Not interested	4.
	5.

Comments (PROBE - Why)

E7 JOB

E7.1 Are you satisfied with your current employment situation?

YES (continue)	NO (go on to question 3)

Comments:_____

E7.2 What do you like about your current employment situation?
Comments:_____

E7.3 How would you like to change your current situation? **(Probe for specific answers)**
Comments:_____

E7.3.1 What is stopping you from being able to do any of the above changes?

*Instruction: Can circle more than one choice for each Activity mentioned.	Answer
1. No facilities/ courses	01
2. No job vacancies	02
3. Lack of information about what's available	03
4. Lack of time to look for job	04
5. Money for training	05
6. Transport (for new job)	06
7. Motivation	07
8. No childcare	08
9. Security/safety reasons	09
10. Other _____	99

Comments:

E7.4 Generally, what do you think can be done about improving the economic situation in Glen Innes?

F. COMMUNITY LIVING

F1. Do you like living here in …?

House (1.1)	Y	N	NS
Street **(1.2)**	Y	N	NS
Neighbourhood **(1.3)**	Y	N	NS
Glen Innes **(1.4)**	Y	N	NS

Y= Yes
N= No
NS= Not sure
Comments:

F2. Within GI, what do you consider to be your "community"? For example, your street, the neighbourhood, the whole of GI? (Specify streets, areas etc.)
Comments:

F3. How long have you lived in GI?

1. Less than 1 year
2. 1 to 2 years
3. 3 to 5 years
4. 6 to 10 years
5. 11 to 20 years
6. Over 20 years
7. All life

F4. Have you got any definite plans to move?

No	SKIP TO QUESTION 5
Within one year	01
Within one to 5 years	02
Over 5 years	03

Comments

F4.1 If you have plans to move, do you plan to *remain or move out of GI*?

1. Does not apply
2. Remain in GI
3. Outside GI
4. Don't know or not sure

F4.2 If you have plans to move, *why*?
Comments:

F5 HOUSING

F5.1 Do you rent or own your home now?

rent 01	own 02

F5.2 Are you satisfied with this situation?

Yes 01	No 02

F5.3 How do you think your living situation could be improved? **(Probe for specific answers)**

Comments:

F5.4 Generally, what do you think about the housing situation in Glen Innes? How can the situation be improved?

PROBE

Comments:

F5.5. What does "community spirit" mean to you?

Comments:

F5.6. Do you feel that "community spirit" is important?

1. Yes, most definitely	06
2. Yes	02
3. Yes, but not for me personally	04
4. Maybe	00
5. No	01
6. Definitely not	-1
7. Don't know	00

F5.7 Do you feel that there is "community spirit" around here?

1. In your street?	Y	N	MAYB	DK
2. In your neighbourhood?	Y	N	MAYB	DK
3. Glen Innes?	Y	N	MAYB	DK

F5.8 On the whole, what do you see as the *strong points about living in GI*?

Comments:

F5.9 What do you see as the weak points about living in GI that need improving?

Comments:

F5.10 Do you have friends in this neighbourhood?

Yes	CONTINUE
No	SKIP TO QUESTION 11

Comments:

F5.10.1 If yes, can you remember how you got to know those friends?

1. Through other neighbours-
2. On the street/ Over the fence
3. At community events
4. Through an organisation/club/church
5. Other: _____

F5.11 Would you like to know more people around here?

1. Yes
2. No (Go to Question **)
3. Maybe

If YES or MAYBE how do you think this can happen?

Comments:

F5.12 How well do you know your neighbours?

1. Well
2. Not well
3. Quite well
4. To say "Hello" to or greet
5. Not at all

Comments:

F5.13. Do you get on well with your neighbours?
1. Well
2. Mixed
3. Not at all
4. Don't know them enough to comment

F5.14 Do you have anything against getting to know your neighbours well or better?
Comments:

F5.15. Do you have family living in GI?

F5.16. Are there people living close to you that you can, if necessary, turn to times of trouble?

F5.17. What do you think are the main problems of the people living around here in GI?)
1) _____
2) _____
3) _____

F5.18. What do you think are the best ways to deal with these problems?
Comments:

G. COMMUNITY DEVELOPMENT

G1. Have you heard the term "community development"?

YES	02	NO	01

Comments:

"For this survey, we take **community development** to mean a way of getting all the people who live and work in the community the:

- Choice to be involved in making decisions
- taking responsibility to make GI a better place to live in
- GI people working together to build a sense of belonging
- GI community having control of resources and decisions affecting the community
- Ensuring GI becomes a sustainable place to live and work in

It is GI people who will be the ones saying what their own wishes and priorities are, GI people setting their own goals, and GI people taking responsibility to make sure they achieve those goals together."

G2. Do you think *"Community Development*" is a useful way to improve the GI community?
Comments:

G3. Have you seen or heard anything about 'community development' in GI?
Comments:

G4. Who do you think *is responsible or should be responsible* for community development in GI and why?
Reply:

G5. If there was a large amount of money to invest on community development in GI, what would you see are the top priorities for GI?
5.1
5.2
5.3

G5.1 For each one of the priorities you mentioned above, please say *why* you think each is a priority for GI.
5.1.1
5.1.2
5.1.3

G6. If there was only a small amount of money was available to invest in community development in GI, what would be the priorities be then?
6.1
6.2
6.3

G6.1 For each of the priorities you mentioned before, please explain your reasons.

6.1.1
6.1.2
6.1.3

G7. Do you think you would support the idea of a GI Community Group managing the way community development is done in GI?
Comments:

G8. What do you think would be some of the things this GI group need to do to make sure it will work well?
Comments:

G9. Would you personally be interested to be part of this managing group?
Comments:

G10 Attitudes to current and future changes in Glen Innes

The following are some of the current changes or developments happening in Glen Innes. For each one indicate if you have heard of it and if you consider it to be a 'threat' or 'opportunity'?

Developments Circle Yes/No and indicate either Threat or Opportunity	Answer Circle Yes/No and indicate either Threat or Opportunity
G10.1. Talbot Park Renewal Project (HNZ): YES/NO	Threat Opportunity Why?
G10.2. Quarry Development: YES/NO	Threat Opportunity Why?
G10.3. Glen Innes Town Centre/ Train Station: YES/NO	Threat Opportunity Why?
G10.4. University of Auckland Tamaki Campus Upgrade: YES/NO	Threat Opportunity Why?
G10.5 What other developments or changes do you know of? WRITE ANSWERS IN BLANK SPACES BELOW	
G10.5.1	Threat Opportunity Why_
G10.5.2	Threat Opportunity Why?
G10.5.3	Threat Opportunity Why?
G10.5.4	Threat Opportunity Why?

G11 So, in general, what kinds of changes or developments would you like to see in Glen Innes? **Probe for specific answers.**
Comments:

H: For everyone

H1. Would you take part in a community event organised by the Glen Innes Community Action Group to tell you about the results of this Random Household Questionnaire?
Comments:

H2. What other comments do you have to make regarding this Random Household Questionnaire?
Comments:

Once again, we thank you for your time and to show our appreciation here is our thank you card. If you have any questions regarding this questionnaire, please contact us.

APPENDIX D: Consent Form for Random Household Survey

THE UNIVERSITY OF AUCKLAND
FACULTY OF MEDICAL AND HEALTH SCIENCES

Theresa Liew,
Social and Community Health,
School of Population Health,
Faculty of Medical and Health Sciences,
The University of Auckland
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Auckland
New Zealand,

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Facsimile: 64 9 305 5932
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THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF SIX YEARS

Title: The Glen Innes Random Household Survey

- A Community Development Health Promotion Project in Glen Innes, Auckland.

Researcher: Theresa Liew

I have been given an explanation of this household survey and the research project.

I have also had the chance to ask any questions and have them answered.

I understand that I can stop taking part in the interview at any time without giving a reason.

I agree to take part in this research.

Signed:

Name:
(Please print clearly)

Date:

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN SUBJECTS ETHICS

COMMITTEE for a period of three years from 21/08/2002 to 21/08/2005

(21/08/2002: Reference 2002/244)

APPENDIX E: Evaluation Survey Form

Ka Mau Te Wero – *Rise to the Challenge*

Glen Innes Stronger Communities Action Group

Vision: Glen Innes working together for community prosperity

Mission: KMTW will build, support and strengthen relationships with communities to improve the wellbeing of Glen Innes people.

Kia ora, malo e Leilei, talofa lava, kia orana, m'bula vinaka, ni hau, namaste and hello!

KMTW is interested in finding out how the people living and working in the GI community think about the **ways our community has changed over the past five years.** This information will help KMTW to work more effectively with GI community people and groups in future so that GI continues to be a good place in which to live, work and play. This information will also help us plan for our next community survey in 2011. Please complete the forms and return to the KMTW office @ 102 Line Road or into the collection boxes in the GI library and other places **before 4pm Saturday 25th September 2010**.

*Put your name and contact number on the form if you wish to be in the draw for some shopping vouchers.

*Your name:_____*Contact number: _____

(*Optional, only fill in if you want your completed form to go into the draw for vouchers. ☺)

1. How long have you lived or worked in Glen Innes (GI)?
   - [ ] Less than 5 years
   - [ ] 5 to 9 years
   - [ ] 10 years or more

2. Do you think GI has changed in the last 5 years?
   - [ ] Yes – Please give ONE example what has changed in GI.
     _____
   - [ ] No – Please give ONE example what hasn't changed in GI.
     _____

3. Each statement below describes a goal that community development intends to achieve. Using the scale below, **tell us how you think community development has impacted on GI over the last 5 years.** Tick only one box for each statement.

Compared to 5 years ago:

a) People know what's happening in GI.

A lot less than 5 years ago	Less than 5 years ago	No change	More than 5 years ago	A lot more than 5 years ago

b) People value the diversity in GI (i.e. different cultures, ethnicities, faith, arts, food).

A lot less	Less	No change	More	A lot more

c) People have choices to be involved in making decisions about what happens in GI.

A lot less	Less	No change	More	A lot more

d) People take responsibility for making GI a better place to live and work in.

A lot less	Less	No change	More	A lot more

e) People work together to build a sense of belonging in the GI community.

A lot less	Less	No change	More	A lot more

f) GI community is able to control and influence decisions made about GI.

A lot less	Less	No change	More	A lot more

g) People like living and working in GI.

A lot less	Less	No change	More	A lot more

4. Overall, how satisfied or dissatisfied are you with living or working in GI?

☹ Most unsatisfied	Unsatisfied	Not satisfied or dissatisfied	Satisfied	☺ Very satisfied

5. Your gender is:
   [ ] Male [ ] Female

6. Your age group is:
   [ ] Under 18 years
   [ ] 18 to 24 years
   [ ] 25 to 44 years
   [ ] 45 to 64 years
   [ ] 65 years or over

7. Your ethnicity is: (You may tick more than one answer)
   [ ] NZ European
   [ ] Maori
   [ ] Pacific Peoples
   [ ] Asian
   [ ] Other (please specify) _____

Thank you very much for taking part in our survey. We hope to have the results published in the local media, and KMTW will share them at the end of year Appreciation and Accountability hui. If you have any questions, please contact KMTW on 521 8436 or call in at our office at 102 Line Road (Behind Plunket), Glen Innes. Good luck for the draw!

Tess Liew ☺

KMTW Manager

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