Exploration of international case studies on community participation and health

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Bachelor of Occupational Therapy, Master of Health Science

This thesis is submitted in total fulfilment of the requirements for the

Doctor of Philosophy

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May 2016

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List of Abbreviations

ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
CINAHL	Cumulative Index to Nursing and Allied Health Literature
GP	General Practitioner
KI	Key Informant
LGA	Local Government Area
NHS	National Health Service
PDF	Portable Document Format
RMT	Resource Mobilisation Theory
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research type
UK	United Kingdom
USA	United States of America
WFOT	World Federation of Occupational Therapists
WHO	World Health Organization

Abstract

In many Western countries, community participation in healthcare design and decision-making is central to health policy. Within the discipline of occupational therapy, calls to strengthen practices that improve inclusion and participation with communities and populations are in alignment with this policy position. There is, however, a dearth of occupational therapy literature to support those interested in working collaboratively with communities.

My doctoral studies commenced with team-based research, focused on scoping and critically analysing research and policy. This enabled me to identify a gap in knowledge of *how* and *why* people participate within communities, which I believed was important to strengthen community-level practice in the discipline of occupational therapy.

Using a qualitative case study methodology, two exemplary cases of community participation were completed. The first case study was of a Canadian food security network, and the second case study was of an Australian rural community banking initiative. Data were key informant interviews, fieldwork, historical documents, and online social media that were thematically analysed to develop descriptive themes. The findings describe *how*, within communities, people have diverse participation preferences, and different interests and expectations. The reasons *why* people participate illustrate interrelationships between people, place and community, and how motivations for community participation link with community sustainability and well-being.

In drawing together these findings, sociological perspectives are used to form a conceptualisation of 'community' as client for occupational therapy. I argue that occupational therapists should champion 'community-centred' practices, which integrate an occupational lens. In recommending strategies for future research and advocacy, I believe that as a

profession, occupational therapy has enormous potential to innovate and lead community-level practice research and development.

Statement of Authorship

This thesis includes work by the author that has been published or accepted for publication as described in the text. Except where reference is made in the text of the thesis, this thesis contains no other material published elsewhere or extracted in whole or in part from a thesis accepted for the award of any other degree or diploma. No other person's work has been used without due acknowledgment in the main text of the thesis. This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

Signed 

Date: 12/05/2016

Acknowledgements

I would like to thank my supervisors Professor Amanda Kenny and Dr Virginia Dickson-Swift, who have provided a huge amount of time, energy, intellectual insights and creativity into my research supervision. Thank you for guiding me through my ‘research apprenticeship’.

I would like to acknowledge my friends and family, especially my partner Oliver, thank you for supporting me through the hard times and celebrating the good times, and for maintaining unwavering confidence in my abilities.

Thank you to Dr Carol McKinstry for her expert mentorship and career advice, and to the international, occupational therapy ‘community’, for inspiring and reinforcing my passion for our profession.

Publications and Author Contributions

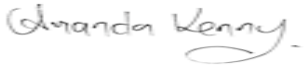
The following list includes reference citations and a table of author contributions for the five published articles included in this thesis. The author contributions are identified, and the amount is represented as a percentage. This is in accordance with La Trobe University guidelines, which state that where a thesis includes published work, it should include a statement of the author contributions, and specify, "The extent of collaboration with another person or persons" (La Trobe University, 2016, p. 6).

Table 1. ***Publications and Author Contributions***

Publication	Citation	Author contributions
1	Kenny, A., Hyett, N., Sawtell, J., Dickson-Swift, V., Farmer, J., & O'Meara, P. (2013). Community participation in rural health: A scoping review. *BMC Health Services Research, 13*(1), 64. doi:10.1186/1472-6963-13-64	Kenny (30%), **Hyett (20%)**, Sawtell (20%), Dickson-Swift (10%), Farmer (10%), O'Meara (10%). I assisted other authors with designing the search strategy and completing database searches. I completed narrative literature analysis, and prepared early manuscript drafts.
2	Kenny, A., Farmer, J., Dickson-Swift, V., & Hyett, N. (2015). Community participation for rural health: a review of challenges. *Health Expectations, 18*(6), 1906-1917. doi:10.1111/hex.12314	Kenny (70%), Farmer (10%), Dickson-Swift (10%), **Hyett (10%)**. I assisted with the critical literature analysis and prepared early manuscript drafts.

3	Hyett, N., Kenny, A., Dickson-Swift, V., Farmer, J., & Boxall, A-m. (2014). *How can rural health be improved through community participation?* Canberra. Retrieved from https://ahha.asn.au/system/files/docs/publications/deeble_issue_brief_no_2_improving_rural_health_through_community_particpation_.pdf	**Hyett (80%)**, Kenny (5%), Dickson-Swift (5%), Farmer (5%), Boxall (5%). I completed the policy analysis, liaised with key stakeholders, and prepared the report with inputs from other authors.
4	Hyett, N., Kenny, A., & Dickson-Swift, V. (2014). Methodology or method? A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-being, 9*. doi:10.3402/qhw.v9.23606	**Hyett (80%)**, Kenny (10%), Dickson-Swift (10%). I designed the search strategy and completed searches, developed the critical analysis framework and analysed the literature. I prepared the manuscript for publication with input from my supervisors.
5	Hyett, N., McKinstry, C., Kenny, A., & Dickson-Swift, V. (2016). Occupational therapists: improving the health and wellbeing of populations. *Australian Journal of Occupational Therapy*, *63*(1), 5-8. doi:10.1111/1440-1630.12222	**Hyett (70%)**, McKinstry (10%), Kenny (10%), Dickson-Swift (10%). I conceived the idea for the viewpoint and prepared the manuscript for publication, with input from other authors.

I confirm that the above author contributions are accurate:



Professor Amanda Kenny, Principal Research Supervisor

Chapter 1

Introduction

Participation used to be the rallying cry of radicals; its presence is now effectively obligatory in all policy documents and project proposals… Community participation may have won the war of words but, beyond the rhetoric, its success is less evident. Part of the problem is clearly political. True participation is a threat to powerful and vested interests. (Dudley, 1993, p. 7)

1.1 Introduction

This thesis is an exploration of community participation in Western, developed contexts. In many Western countries, community participation in healthcare design and decision-making is central to health policy. The purpose of the research was to address knowledge gaps relating to community participation, and build theoretical and conceptual understandings, which may be used to advance the discipline of occupational therapy in the field of community and population health. This doctoral study was approached from a population health viewpoint, which is "focused on understanding health and disease in community, and on improving health and well-being through priority health approaches. . . [that address] disparities in health status between social groups" (Australian Institute of Health and Welfare, 2015, para. 1). The research was underpinned by a conceptualisation of health promoted by the World Health Organization, which argues that health is more than the absence of disease and can be improved with prevention and early intervention, through community action and cross-sector partnerships (World Health Organization, 1986).

In the thesis, I outline my research journey, which was inspired by my own practice experiences and failings with community participation in a rural[1] community health service

[1] In this thesis and the published articles, the term 'rural' is defined as any non-metropolitan location.

context. This research was conceived within a larger, team-based research program on community participation and rural health. This program was designed to understand how community participation can improve health and well-being in rural contexts, and to develop health policy and practice recommendations. Building on this team research, I completed two qualitative case studies using a constructivist tradition of qualitative case study methodology (Stake, 1995), to gain a deeper understanding of how and why communities participate in two highly regarded initiatives; including a national food security network in Canada, and a rural community banking[2] initiative in Australia.

I conducted this research using an inductive reasoning process, which involved identifying knowledge gaps, and creating and revising research strategies, using an iterative process of research and critical analysis (Denzin & Lincoln, 2011a). In doing the research, I came to realise how a poor understanding of community participation would impact on the abilities of community leaders and health professionals to lead and facilitate health programs and initiatives.

In this thesis, I discuss research findings relating to how and why communities participate to build knowledge of community practices for my own discipline of occupational therapy. Completion of this research has provided a timely opportunity to reflect on, and further analyse the role of occupational therapy with community participation, within community and population health fields. This included research of extant disciplinary understandings of community-level practice (where client is a community), and the development of a proposed professional position statement.

[2] Community banks are retail banking businesses that are owned and operated by community members, with support from a financing corporation. The community banking initiative included in this doctoral study is further described at 3.5.2 *Case selection*

There are calls for the profession of occupational therapy to move beyond traditional biomedical illness/treatment paradigms and consider new or emerging roles in non-traditional fields (Gerlach, 2015; Kronenberg, Algado, Pollard, Werner, & Sinclair, 2005; Pereira & Whiteford, 2013; Polatajko, 2001; Thew, Edwards, Baptiste, & Molineux, 2011; Tucker, Vanderloo, Irwin, Mandich, & Bossers, 2014; Whiteford & Hocking, 2012). Drawing from my own community practice experiences, I was inspired to explore how occupational therapists could develop new roles with communities, which move beyond mainstream, individual or person-centred practices. Utilising the work of principal authors in occupational science, my objective was to develop sociologically informed understandings of community participation, which could be used to transform community-based practices by integrating critical or radical ideas (like entrepreneurship, activism and protest) (Gerlach, 2015; Pollard, Kronenberg, & Sakellariou, 2008; Townsend, 1997; Whiteford & Townsend, 2011).

The research recommendations presented in this thesis illuminate how an occupational perspective can be used to differentiate the profession from other community and population health professionals, and I hope that this will support occupational therapy to stake a claim in this contested space.

1.2 Overview of thesis structure

This doctoral thesis is a thesis with publications, which contains five published articles[3] that are linked by their focus on community participation, and the research aim of exploring community participation in different contexts (via case studies). The thesis was developed and submitted in accordance with the La Trobe University (2016) guidelines, which state:

[3] Published articles are numbered throughout, for example [Publication 1]

> Your thesis may contain one or more scholarly articles or book chapters, published, accepted or submitted for publication by reputable journals or publishers… When your thesis contains articles or book chapters, these will be thematically linked and describe a coherent research program. (p. 3)

In accordance with the La Trobe University (2016) guidelines, the published articles are submitted for examination as a component of the thesis, because they were produced as part of my doctoral research program. There are two published literature review articles [Publication 1 and 2] that are included in lieu of a traditional literature review chapter. Publication 3 was produced in the first year of my candidature, during a summer internship with the Australian Healthcare and Hospitals Association, and contains preliminary doctoral research findings that relate to Case Study 1, the case study of the Canadian food security network (see Chapter 5). Publication 4 highlights the research completed on my doctoral study methodology, and Publication 5 was produced when writing the *Discussion* and *Recommendations and Conclusions* chapters. Due to the length of time needed for journal submission, peer review and publication, my aim is to convert Chapter 5 and Chapter 6 into manuscripts for journal submission after submitting my thesis for examination.

1.3 Background on community participation

1.3.1 Definitions

Community participation is the key concept explored in this thesis. In the occupational therapy literature, community participation is commonly conceptualised as a treatment outcome. Used similarly to terms such as community mobility or community integration, community participation is used to describe an individual's capacity to participate in a community group or setting (Radomski & Trombly Latham, 2014). Alternatively, community participation can be interpreted as synonymous with community development, which has emerged as an area of interest within occupational therapy (Lauckner, Krupa, &

Paterson, 2011; Lauckner, Pentland, & Paterson, 2007; Lauckner & Stadnyk, 2014; Trentham, Cockburn, & Shin, 2007).

In this thesis, community participation is defined as the ways in which a community (meaning a social group defined by place and/or setting) participates in joint action that is mutually beneficial, and driven by shared interests and goals (MacQueen et al., 2001; Schell, Gillen, Scaffa, & Cohn, 2013).

The different definitions of community participation in the occupational therapy literature reflect broader, cross-disciplinary challenges with conceptualisation. It is widely recognised that there is not one standard definition of community participation, and that this is understood differently across disciplines and fields (Morgan, 2001; Rifkin, 2003; Taylor, Wilkinson, & Cheers, 2006; Zakus & Lysack, 1998). There has been robust debate about meanings and definitions of community participation, and discussion of how this influences health practice and research (Morgan, 2001; Rifkin, 2003; Taylor et al., 2006). However, occupational therapists have not yet engaged with this discussion, or made collective decisions about how community participation should be defined or conceptualised, or what approaches or methods should be used.

1.3.2 Approaches

At the time of writing this thesis, there is no published evidence of occupation-focussed approaches to community participation that could be translated across contexts and settings. In examining literature outside my discipline, community participation is defined as a *process* not an intervention (Rifkin, 2009), and approaches to community participation are commonly differentiated by form, process of initiation, purpose and expected outcomes (Baum, 2008b). Three primary approaches are identified by health researchers, which are not mutually exclusive, but instead should be viewed on a continuum, ranging from marginal

participation to higher levels of community control (Draper, Hewitt, & Rifkin, 2010; Rifkin, 1985; Rifkin & Kangere, 2002).

The medical approach, which offers marginal or no control to people, is underpinned by the argument that health is the absence of disease, and community participation is needed to ensure people comply with professional (medical) advice (Draper et al., 2010; Rifkin, 1985; Rifkin & Kangere, 2002). Community participation with State-funded vaccination programs is one example (Draper et al., 2010), participation is informed by medical evidence, and in some countries (including Australia) is mandatory to avoid penalties. Second is the community health services approach, which is usually defined by the community health service, and invites community members to contribute (volunteer) time, materials, capital and/or money, to provide a service or achieve a specific outcome (Draper et al., 2010; Rifkin, 1985; Rifkin & Kangere, 2002). An example of this is a volunteer-based first responder program that was developed in rural Scotland (Farmer & Nimegeer, 2014). The third is the community development approach, where community participation is driven by the community, and participation is a means of empowerment, meaning a process of gaining power and control over decisions (Draper et al., 2010; Rifkin, 1985; Rifkin & Kangere, 2002). This approach is observed in community-led health activities, including peer support programs, where communities utilise health professionals and other partners as resources to achieve identified goals (Draper et al., 2010).

By undertaking research that builds theoretical and conceptual understandings of community participation, I hope to understand what approaches to community participation can be utilised by occupational therapists, which align with disciplinary strengths, professional identity and values. Additionally, my objective is to critically analyse common approaches to community participation, and the ways in which health practitioners enact participation.

1.3.3 Assumptions

By including community participation processes or targets in health programs, practitioners make assumptions about what communities can offer or provide, and what participation might achieve. Historically, it has been assumed that community participation will be a panacea for community and population health, a key to creating programs that are cost-effective, sustainable, and locally-relevant (Morgan, 2001; Rifkin, 2009; Shediac-Rizkallah & Bone, 1998).

However, there is little evidence of direct causal relationships between community participation and health outcomes, and because of the nebulous and contextualised nature of participation, outcomes are difficult to quantify, measure and compare (Rifkin, 2009, 2014; Rifkin & Kangere, 2002). Critical examination is needed that questions assumptions that have been made about community participation by health practitioners (including occupational therapists).

1.3.4 Typologies

There is no mutually agreed framework or typology of community participation that is used by occupational therapists. Without a shared frame of reference, there is a risk that the term ‘community participation’ is used without critical consideration of extant multiple and diverse meanings (Rifkin, 2003; Taylor et al., 2006). In health research, it is common for community participation to be conceptualised as a typology, which describes different types of participation and distinguishing features (Draper et al., 2010).

Historically, Arnstein’s (1969) ladder of citizen participation has been used to describe and analyse forms of participation, for example, in healthcare (Attree et al., 2011; Freeman et al., 2016; Tritter & McCallum, 2006), planning (Brownill & Carpenter, 2007;

Brownill & Parker, 2010), and natural resource management (Clarke, 2008; Ross, Buchy, & Proctor, 2002). Developed in North America, in the context of federally-funded development programs in marginalised communities (urban renewal, anti-poverty, and Model Cities), the typology is "designed to be provocative" and to challenge current ideas about citizen control and "maximum feasible involvement" of poor, disadvantaged minority groups (Arnstein, 1969, p. 216). Arnstein (1969) conceptualises citizen participation as a ladder with eight hierarchical rungs, the lower rungs represent forms of 'non-participation', and higher rungs represent increasing levels of citizen control (and power over decision-making), see Figure 1 *Levels of Participation* [Publication 1] page 66.

Arnstein's (1969) typology (the 'ladder') has been valuable in highlighting issues of power in participation, and later authors agree that participation is essentially about power and control (Baum, 2008b; Cornwall, 2008; Robyn Eversole, 2012; Rifkin, 2003, 2014; Zakus, 1998). However, while this typology makes a strong intellectual contribution, authors argue it has little practical value (Tritter & McCallum, 2006). Being uni-dimensional, use of the typology can create an adversarial position between 'haves' and 'have nots' pitching them as two different, isolated (and competing) homogenous groups (Arnstein, 1969; Tritter & McCallum, 2006). The typology does not describe the inherent complexity in power relations, or how power flows, or moves between people, groups and institutions, and provides little guidance relating to how power inequities can be overcome (Ross et al., 2002; Tritter & McCallum, 2006). Although the typology is often used to inform community participation initiatives (Draper et al., 2010), it is underpinned by a socio-political conceptualisation of citizen, not community, and is not designed for practical implementation in the community contexts that occupational therapists work.

Following Arnstein's seminal typology, a range of participation frameworks and typologies were developed, which have been extensively reviewed (see for example:

Cornwall, 2008; Head, 2007; Popay, 2006; Rowe & Frewer, 2005). However, similar to Arnstein (1969), few specifically discuss the *community* context of participation.

In the community participation literature, for example, the most popular or highly cited frameworks include the International Association of Public Participation Spectrum, which describes a range of participatory methods used in *public* participation initiatives (Inform, Consult, Involve, Collaborate, Empower) (International Association for Public Participation, 2004). Similarly, Pretty (1995) proposes a typology of seven types of participation (1. Manipulative participation, 2. Passive participation, 3. Participation by consultation, 4. Participation for material incentive, 5. Functional participation, 6. Interactive participation, and 7. Self mobilisation), that are recommended to represent the range of different ways people or groups participate in development projects. Baum (2008b) describes four types of participation along a continuum of increasing community control (1. Consultation, 2. Participation as a means, 3. Substantive participation, and 4. Structural participation) (p. 483). These typologies distinguish types of participation by levels of power, and how this is shared between power holders and communities; however, other contextual factors are rarely considered.

In beginning this doctoral study, I found it difficult to decide on one typology to guide the research, because of the wide range available, and the lack of specificity to community contexts. Instead, I utilised assumptions about community participation that were common across the typologies to inform the research in several ways, including the development of research questions and key methodological decisions (including case selection). Assumptions, for example, that participation can be implemented with varying levels of power and control (with empowerment described as the pinnacle, or most highly regarded form). Forms of participation are thought to be distinguished by certain features (for instance, frequency or intensity of participation), and participation processes are often created and

defined by program or initiative leaders (known as, 'invited' spaces) (Baum, 2008b; Cornwall, 2008). This indicated that the perspectives of community-based facilitators and leaders would provide valuable information on the purpose, process and intended outcomes of community participation that occurs in invited spaces (which was the focus of this research) (Baum, 2008b). Finally, because community aspects of participation are not well-conceptualised in existing typologies, I decided I would address this key knowledge gap.

1.3.5 Policy imperatives

Occupational therapy, like other health professions, is informed by international health policy frameworks, which are released by institutional authorities and endorsed by governments (Wilcock & Hocking, 2015). International health policy imperatives for community participation emerged in the 1970s. In 1978, the Declaration of Alma Ata highlighted a critical shift in international health policy, away from a biomedical (disease/treatment) focussed approach to health, to a stronger focus on prevention and early intervention (World Health Organization and UNICEF, 1978). This was defined as a Primary Health Care (PHC) approach, which promoted the use of "grassroots" community participation, to develop programs and initiatives that addressed the social causes of ill-health (Baum, 2007b, p. 34).

Community participation was identified as integral to PHC. The Declaration was used to emphasise the importance of designing healthcare services that were acceptable and accessible to individuals and families, "in their community through their full participation", in the spirit of self-reliance and self-determination (World Health Organization and UNICEF, 1978, pp. 1-2). People's participation in healthcare was identified as a "right and duty", and health professionals enablement of community participation, a core process and outcome of PHC (Baum, 2007b, p. 35). It was argued that development of a comprehensive PHC system would require "maximum community and individual self-reliance and participation in the

planning, organization, operation and control of primary health care" (World Health Organization and UNICEF, 1978, p. 2).

During this historical period of healthcare reform, the centralisation of community participation in health policy was supported by the best available research evidence, which indicated that involving people in health planning and delivery would result in better outcomes for individuals, communities and services (Rifkin, 2003). Rifkin argued that "In re-defining health problems in a context wider than only disease problems, the PHC strategy recognized that health is rooted in the social, political and economic environments" (Rifkin, 2003, p. 168). This reform signalled a major shift in the focus and priorities of healthcare systems. At this time, the idea of community participation aimed to revolutionise health policy, because it challenged the total dominance of professional people (including occupational therapists) in the planning and delivering of healthcare services, and raised important questions about how communities could (and should) be involved (Baum, 2007b; Rifkin, 2003). Instead of professionals, communities were identified as experts, which contained valuable knowledge and resources that should be harnessed to improve healthcare for all people and populations (Baum, 2007b).

Over the past four decades, community participation has maintained a central position in international health policy, which is observed in the WHO Community Involvement in Health reports (Peter Oakley, 1989; World Health Organization, 1985), the Ottawa Charter for Health Promotion (World Health Organization, 1986), and the People's Charter for Health (Baum, 2007b; People's Health Movement, 2000). However, despite the strong policy emphasis, critics argue that there has been inadequate progress towards the vision of community participation in healthcare that was proposed (Baum, 2007b; Draper et al., 2010; Morgan, 2001). Progress could be hindered by the different conceptualisations of community participation that are adopted within Government policies. Instead of empowerment models,

there is a stronger focus on pragmatic approaches to community participation, which address issues of waning healthcare resources through participation initiatives targeting efficiency and sustainability (Morgan, 2001; Rifkin, 2003).

Morgan (2001) concludes that policymakers have used the different meanings of community participation to their own advantage, stating:

> The proliferation of meanings attached to the phrase 'community participation in health' (also called 'popular participation', 'social participation' and 'community involvement') has allowed it to be analyzed as a political symbol capable of being simultaneously employed by a variety of actors to advance conflicting goals, precisely because it means different things to different people. (p. 222)

Critics argue that policies are used to urge individuals and communities to participate, so that they will take responsibility for their own health and well-being (Brownlea, 1987; Morgan, 2001; Rifkin, 2003). However, this goes against the original PHC policy position, which was grounded in the idea that people's health was determined by social and environmental conditions that were imposed upon them (Baum & Fisher, 2014; People's Health Movement, 2000). One objective of my doctoral research was to review the challenges of enacting community participation at the practice-level, which meets expectations of PHC policy.

1.3.6 Positioning occupational therapy

Historically, occupational therapists have a long tradition of practising in community settings. Since the emergence of the profession in the 1920s post war era (Meyer, 1983), occupational therapists have established roles with a range of community settings and groups (Christiansen & Townsend, 2010; Scaffa & Reitz, 2013). The aim of occupational therapy is to increase people's participation in *occupation*, which includes life endeavours and experiences, and the things that people *do*, that give life structure, purpose, meaning and value (Christiansen & Townsend, 2010; Pereira & Whiteford, 2013).

Using this understanding of occupation, I propose that the concept of community participation can be used to improve understanding of people's participation in occupation with community groups, and within community spaces. I recommend that conceptualisations of community participation can support occupational therapists to enable participation with and within communities. For many people, occupation includes participation within communities (groups and/or spaces) that hold meaning because of social, economic, cultural or aesthetic reasons (Iwama, Thomson, & Macdonald, 2009; Wilcock & Hocking, 2015). Occupation can include participation in community groups, such as Men's Sheds in rural Australia (Ormsby, Stanley, & Jaworski, 2010; Wilson & Cordier, 2013), and use of community spaces, such as a park, playground or garden (Moll, Gewurtz, Krupa, & Law, 2013).

This proposition is supported by key assumptions of occupational science, where it is argued that occupation is a determinant of health, and that occupation, participation and health are inextricably linked (Wilcock & Hocking, 2015). Occupational therapy, guided by an occupational science paradigm, recognises that occupation is a means to "meet socio-cultural needs and to contribute to and feel comfort and acceptance within family and community" (Wilcock & Hocking, 2015, p. 86).

Principal authors in occupational science argue that occupational therapists must increase opportunities for and remove barriers to participation, and take greater responsibility for social and political change (Whiteford & Hocking, 2012; Wilcock & Hocking, 2015). Community participation is integral to this political process.

The majority of occupational therapists focus on enabling occupation with individuals, however, occupational scientists encourage the profession to expand their focus to include practices that enable occupation with communities and populations (Whiteford & Hocking, 2012; Wilcock & Hocking, 2015). This paradigm shift aims to increase

opportunities for occupational therapists to have a wider and more substantial impact on population health.

In this thesis, I present a timely discussion of how occupational therapists can use the concept of community participation to engage in community-level practice, which is needed to support occupational therapy to make this passive to radical, and individual, to community and population, practice shift.

1.4 Research aims

The research aim was to explore how and why communities participate in a range of different contexts, and to build new theoretical and conceptual understandings, which will be used to design and strengthen community-level practices in the discipline of occupational therapy.

1.5 Research problem/significance

In this thesis I address knowledge gaps in theoretical and conceptual understandings of community participation, which limit healthcare policy to practice translation, and the capacity of health practitioners to work collaboratively with communities. The research is driven by policy imperatives that require healthcare services and practitioners to empower communities and support community participation, and the issues identified with terminology and definition, approaches, assumptions and typologies. Building knowledge of community participation has potential to strengthen occupational therapy, which is a discipline and profession driven by interrelationships between occupation, participation and health. However, to date, advancements in community practice have been limited by a lack of critical investigation.

The work of principal authors in occupational science informed this research, which inspired me to explore how occupational therapists could develop new roles in community and population health. My aim was to develop sociologically informed understandings of community participation, which will shift traditional community-based practices into a more critical and radical space. Improved knowledge of community participation is needed to expand practice focus from individuals to communities, which is a critical step for the profession's global development. The discipline of occupational therapy is differentiated from other health professions by a unique focus on occupation. Research guided by an occupational science paradigm will support the development of innovative roles for occupational therapists in community and population health, and will enable exploration of the profession's potential contribution.

My intention was to examine community participation in invited spaces, which are created by health practitioners and community leaders. I propose that qualitative case study methodology is the most effective method of examining community participation that is bounded by context, and to examine contextual elements, with the highest level of detail, and with the least possible intrusion (Abma & Stake, 2014; Stake, 1995). The following chapter, *My Research Journey*, describes my process of research development and methodological decision-making that underpins this thesis.

1.6 Thesis outline

In this thesis, I explore community participation in Western, developed contexts. The research purpose was to address significant knowledge gaps, relating to *how* and *why* communities participate in different contexts, which aimed to build theoretical and conceptual understandings for the discipline of occupational therapy. This is important to

strengthen practice, and advance the standing of the profession in community and population health.

The first three chapters are designed to orientate the reader to the research, which are substantiated by the published literature reviews provided in Publications 1, 2, 3 and 4. Chapter 1 is the *Introduction*, here I have introduced key concepts, and outlined important background literature. Chapter 2 is titled *My Research Journey*, which describes my experiential process of research and methodological decision-making. This chapter is important for a qualitative research thesis, and is argued to enhance study rigour (Stake, 1995). In Chapter 3 I have provided an overview of the doctoral study methodology and methods, including ethical considerations, rigour, and methodological strengths and limitations.

The five published articles are contained in Chapter 4. Chapter 5 and Chapter 6 contain the doctoral study findings of the two case studies, which are presented in the form of manuscripts to be submitted for publication post-thesis submission. In Chapter 7, the *Discussion*, I have critically analysed key research findings and utilised sociological theories to develop new learnings about community participation, for my discipline of occupational therapy. In Chapter 8, the recommendations and conclusions are discussed, including a myriad of theoretical and methodological insights, which will support future research and professional advocacy. Final concluding remarks include a discussion of study limitations, and to finish the thesis, I propose a conceptualisation of community-centred practice for occupational therapy, which will support role development and expansion.

1.7 Chapter summary

In this chapter I have introduced my thesis, including thesis structure, key concepts, and important background literature. I have outlined the need for the research, which draws on international health policy imperatives, and knowledge gaps within the health literature, including my discipline of occupational therapy. I identified the research aims, the significance of the proposed research, and outlined how the research problem will be addressed, and how this is reported within this thesis. The following Chapter 2, *My Research Journey*, builds on the introduction by describing my experiential process of research, and describes key methodological decisions, so that the reader can understand the research from my point of view.

Chapter 2

My Research Journey

Ah ha! That was it. I need to "reproblematise" what I know about community participation as an 'occupational therapist'. I have to "dismantle" my existing knowledge, and consider "the possibility of a different experience". I must conduct my research knowing that "each particular work is an experiment the outcome of which cannot be known in advance, that it is an experience in which one risks oneself in the sense that one emerges from it transformed not only in what and how one thinks, but thereby in how one is or might possibly be." Extract from reflective journal, including quotes from Burchell (1996, p. 31)

2.1 Introduction

In this chapter, I describe the experiential process of completing the research in this thesis. By describing this experience, my aim is to invite the reader into the inner realm of the research, to enable an understanding of influential knowledge and experiences. I have included reflections on why I began my research journey, including influential practice experiences from my work in a rural community health centre. I describe how my occupational therapy disciplinary perspectives and values underpin these experiences. I outline the initial scoping phase of research, which involved multi-disciplinary team-based enquiry, and working in partnership with local health service executives. This explains why, in the beginning, my journey is rurally contextualised.

In the middle phase of doing this research, and being in the field, my journey moved further away from practice-based and policy-driven enquiry, to exploration of perspectives from health sociology, and theory building. In this pivotal phase, I spent time forming and re-forming research questions to address 'how' and 'why' questions that emerged. It is during this phase that key methodological decisions were made, and I engaged more deeply in the process of academic inquiry. Finally, I concluded the research process by examining the implications of the findings for my discipline of occupational therapy, and for the profession.

This was a cathartic experience that led to understanding the significance of the research, and provided a conclusion for this part of my research training.

By providing insight into my research journey, my aim is to engage the reader in the experience of constructing new knowledge, and to craft a vicarious experience, which is a key objective of qualitative case study methodology (Stake, 1995). In being transparent about the research process, and providing information on my researcher perspective and reflexivity, my objective is to improve the trustworthiness of the study findings and implications (Denzin & Lincoln, 2011a; Lincoln & Guba, 2013).

2.2 Beginning my research journey

2.2.1 Situating myself in the research

Community participation is much harder to enact than most people will admit. My first encounters with community participation were before I commenced my doctoral studies. As an occupational therapist working in a rural community health service, I had experienced challenges with community participation firsthand. Throughout my research journey, I reflected on a number of influential practice experiences. This included a school-based drug education session that was only attended by the 'worried well',[4] and a focus group designed to seek feedback for quality assurance, which no one attended, and wasn't rescheduled. I reflected on a series of community consultations, which raised important issues about ageing in a rural community. However, the community concerns seemed to go unheard, and no action was taken by the health service or by local council. Another time, I worked hard to

[4] 'Worried well' is a colloquial term commonly used by community health practitioners I worked with, which is used to describe the people who are generally healthy, but who would regularly attend health events or programs because of their varied health anxieties.

engage youth living in a disadvantaged neighbourhood with an after-school homework club, however, the program was cut short because of insufficient funds.

In beginning the research, I had many unanswered questions that stemmed from these unsuccessful practice experiences. Questions such as, why do people participate, who benefits from participation, and what are the risks for communities? I had concerns about the potential harm that I might be inflicting through my failed community participation attempts. In discussions with friends and colleagues, I realised the challenges I faced were common problems encountered by other health practitioners. This realisation led me to two pivotal questions. First, what is community participation? From a practitioner perspective, I was unclear who the community was, and it seemed like community participation was more important to the service and service reputation, or arbitrary funding regulations. Secondly, considering my own, and the health services staffs good intentions, how can community participation be enacted in such a way that it is of value to communities, and what forms or methods of participation are people likely to value (and actively participate in)? It seemed important to find out what was meaningful about community participation, and what participation methods and strategies were effective for including people from a wide range of backgrounds and experiences.

Growing up and living in a rural community, I believe that belonging to community is important. But, I have also seen the dark side of community, which can exclude people for being different, or for having different values or ideas. In commencing my research journey, I found that I needed to "reproblematise" community (Burchell, 1996, p. 31), meaning I had to open myself up to the idea that communities may be both beneficial and harmful, and that my perspective is socially constructed, and is experienced differently by different people (Jewkes & Murcott, 1996). In this initial stage, I found it was important to understand my own ideas about community participation, so that I could put my opinions to one side, or understand

when they might be influencing research decisions (Lincoln & Guba, 2013; Lincoln, Lynham, & Guba, 2011; Stake, 1995). In doing this, I hoped to situate myself to be open to new ideas and explore this complex social phenomenon from the perspectives of others (Stake, 1995).

2.2.2 Understanding my occupational therapy disciplinary perspective

I was personally compelled to engage in this research because of my interest in occupational therapy practice in community settings. I was keen to develop greater insight into my past practice experiences and failings. In addition, as an educator, I felt a personal responsibility to support other occupational therapists that are interested or currently working in this field.

As an occupational therapist, I am qualified to work with clients (defined as individuals, groups, communities, organisations and populations), and to deliver interventions targeting occupational issues and needs (Polatajko & Townsend, 2007; World Federation of Occupational Therapists, 2010). In approaching this research, I reflected on how I felt confident in my practice with clients who were individuals, groups and organisations, because of the available evidence, and professional and public awareness and support. However, from my observations of practice and the literature, it was apparent that there was less professional recognition and understanding of occupational therapists' capacity to practice with clients who were communities and populations (Lauckner & Stadnyk, 2014; Rushford & Thomas; 2016; Thibeault & Hébert, 1997; Wood, Fortune, & McKinstry, 2013). Communities are identified as a potential client of occupational therapy services (World Federation of Occupational Therapists, 2010) and this warranted further study.

I developed an interest in working with communities from my experiences with community health promotion and development, and post-graduate study in public health.

However, similar to many occupational therapists, while I had worked in a community-based practice setting, the idea of working collaboratively with communities to design and deliver health programs was relatively new (Scaffa & Reitz, 2013). There is growing international interest in community-level interventions within occupational therapy, which aims to improve service accessibility, impact (reach), and health outcomes (Scaffa & Reitz, 2013; Wilcock & Hocking, 2015). This interest was reinforced during the course of research, with publication of our viewpoint in the Australian Occupational Therapy Journal [Publication 4] (Hyett, McKinstry, Kenny, & Dickson-Swift, 2016). Additionally, I had the opportunity to present my ideas about community-centred practice to occupational therapists in Japan at the World Federation of Occupational Therapists Congress, (Yokohama 2014), and Penang General Hospital in Malaysia (April 2015). Feedback from occupational therapists during these presentations helped me to develop a clearer understanding of practitioner's needs from research on community-level interventions and practice frameworks, and to identify current theory to practice knowledge translation gaps.

In examining the occupational therapy literature, I concluded that disciplinary understandings of community participation (for example, as an occupation, as a means to occupation, or as an outcome of occupation) could be improved by increased understanding of community, and why communities participate, and how participation occurs at the community-level. Definitions of community, and the complexities inherent in community-level practice, had not been examined, and there was little available evidence to guide transitions from individual or person-centred, to more community-focussed roles (Hyett et al., 2016).

Upon reviewing the literature, in the scoping phase of my research journey, I became aware that a critical, sociological understanding of community participation might be valuable for occupational therapists. In commencing research outside my discipline, I hoped

to critically examine community participation through a sociological lens, which would contribute new learnings for the profession.

2.3 Scoping phase: Team-based research and forming research questions

This doctoral study is grounded in a larger research program on community participation and rural health, which included a team of experienced researchers, health service executives, and six doctoral students. I first became involved as a research assistant, in the scoping phase of research program development, which then progressed into my doctoral candidature. Initially, I was attracted to this research program because it provided a pathway to uncovering answers on my unresolved questions about community participation, and because of the close links with the local health services, and the ability to use research findings to make an immediate impact on organisational policy.

In researching and writing our first research team publication, which was a scoping review of the community participation literature [Publication 1] (Kenny et al., 2013), I began to see how a multidisciplinary research team approach would more effectively produce research findings that would be transferrable across health programs and initiatives, compared with doing this research on my own.

Initially, research questions were identified in collaboration with the researchers, students and health service executives involved with the research program, which were:

In developed, high-income, Western nations:

- What models of "exemplary" community participation exist?
- How are exemplary models of community participation initiated, developed and sustained, and what challenges are encountered?

- How do exemplary models of community participation influence health indicators, policy and systems?
- What elements of international exemplary models are transferable to rural settings in Australia and overseas?

The initial research questions were designed to improve health services staff knowledge of community participation, by drawing learnings from international examples of good practice. Sitting alongside five other doctoral students, these research questions were integral to developing an in-depth understanding of community participation from multiple lines of enquiry. Research questions addressed by other candidates related to newcomers, community participation and social exclusion (Patten, O'Meara, & Dickson-Swift, 2015), community engagement and therapeutic landscapes, and assessment of community-level health literacy (Guzys, Kenny, Dickson-Swift, & Threlkeld, 2015).

The research questions were addressed in collaboration with the research team. At the commencement of our program of research we completed a scoping review on community participation in rural health settings [Publication 1] (Kenny et al., 2013). Following this, we conducted a critical review of papers retrieved in the initial scoping search, to identify and discuss the challenges of enacting community participation in the rural context [Publication 2] (Kenny, Farmer, Dickson-Swift, & Hyett, 2015).

This primary scoping phase of research was driven by the needs of health service partners and the policy context, which required that all accredited Australian health services devised ways of working with consumers for healthcare planning, design, delivery and evaluation (Australian Commission on Safety and Quality in Healthcare, 2011). Similarly, in other Western countries, there is increasing impetus for health services to partner with community organisations and groups, and increase their participation in service design and

delivery (Mockford, Staniszewska, Griffiths, & Herron-Marx, 2012; National Health Service, 2013; O'Mara-Eves et al., 2013).

This phase was critical to explore what was known about community participation in different contexts, and to identify knowledge gaps for the research program. For my doctoral research, this scoping phase was valuable for understanding rurally-contextualised community participation, but left a contrasting, non-rural context, unexplored.

I completed extensive searches of peer reviewed and grey literature to gather background information on the research topic. The search results lead me to discover several exemplary examples of community participation in metropolitan settings, for example the Detroit Community-Academic Urban Research Centre (see http://www.detroiturc.org/), and the Canadian food security initiatives (which are described in Publication 5). I hypothesised that learnings from a variety of contexts would provide valuable findings about community participation, which was needed to develop knowledge that was relevant to both rural and urban practitioners.

After publishing the scoping review [Publication 1] I had the opportunity to disseminate the research findings in a conference presentation at the Victorian Healthcare Association conference (Creswick, Victoria, 2013), and through a policy brief written during my summer internship within the Deeble Institute of Health Policy (Australia Healthcare and Hospitals Association) (Canberra, January-February 2014) [Publication 3] (Hyett, Kenny, Dickson-Swift, Farmer, & Boxall, 2014). The internship was especially influential because it provided me with a unique opportunity, very early in the course of my doctoral studies, to consult with a range of Australian government and non-government stakeholders on their understanding of community participation, and the challenges of enacting participation with rural health services. This evidence brief is included in my doctoral thesis because it

demonstrates the practical skills I learned relating to writing for differences audiences and knowledge translation, which I now understand to be important academic skills.

Knowledge gained from the scoping phase increased my interest in further investigating *how* and *why* research questions, about the nature and value of community participation. The focus of research that followed was on developing insights to these critical, theoretical questions.

2.4 Methodological decision-making

The next phase of my research journey was layered with research question revision, data collection and analysis, and methodological decision-making. As a qualitative researcher, this research involved an inductive, iterative process, and learnings from each phase informed the next (Denzin & Lincoln, 2011a; Merriam & Tisdell, 2016). Building on findings from the scoping phase of research, the revised research questions were:

In developed, high-income, Western nations:

- How do communities participate in initiatives that aim to improve community-level health and well-being?
- Why do communities participate in initiatives that aim to improve community-level health and well-being?

In this research phase, I made several key methodological decisions. How and why questions are integral to qualitative inquiry, which informed my decision to adopt a qualitative research approach. I decided to study existing models of community participation, and extrapolate learnings about community participation from peoples' experiences and contextual knowledge. This study design was underpinned by case study methodology, because this is most suitable for developing an in-depth understanding of community

context/s (Creswell, 2013b; Stake, 1995). This approach to research aligns with the philosophy of pragmatism as defined by John Dewey, which supports designing research studies that are driven by the research question, and selecting research methods that are best suited to increasing knowledge and understanding of the selected topic (Shank, 2013).

My interest was on the purpose and processes of community participation, which was highlighted as a key knowledge gap in our critical review [Publication 2] (Kenny et al., 2015). High-level conceptual work is needed to advance practice in this field. I hoped that the doctoral study findings would be used to strengthen theoretical foundations of future studies on community participation and health, which could include quantitative outcome measurement or randomised trials (Rifkin, 2014).

In the scoping review [Publication 1], only six studies of exemplary community participation were found, and no studies were of recent, or ongoing projects (all completed between 2003-2009) (Kenny et al., 2013). Following this, I decided to widen my search for case selection to include exemplary models of community participation that had been excluded because of location or setting. This resulted in a large number of potential cases from outside of mainstream healthcare settings, in rural and urban locations. The decision was informed by principal public health researchers, who argue that peoples' health is determined by social and environmental determinants at community and population levels, and recommend that healthcare services are only one component of the broader picture of community health and well-being (Baum, 2007a, 2008a; Baum & Simpson, 2006; World Health Organization, 2008). This is how I came to select the case studies of food security and rural community banking. In addition, by removing location and settings criteria, I decided to select cases that would inform theoretical and conceptual development of community participation, over the selection of cases that were representative of a particular setting, or would produce findings that could be generalised. This is a defining characteristic of Stake's

(1995) qualitative case study tradition, which differs to that of Yin (2009, 2012) [as discussed in Publication 4] (Hyett, Kenny, & Dickson-Swift, 2014).

The decision to research *exemplary* models was twofold. Firstly, because of the challenges experienced by practitioners, I assumed that people who had developed models of community participation that reported positive outcomes must have encountered and overcome challenges, and that important learnings could be drawn from these practice experiences. Secondly, the decision was methodological, being guided by Stake (Stake, 1995). For cases to warrant investigation they must be unique in some sense, for example particular (Abma & Stake, 2014), or deviant (Thomas, 2011). I used the exemplar characteristic to define how cases selected would be unique (compared to the broader population of potential cases) (Ayres, Kavanaugh, & Knafl, 2003; Thomas, 2010, 2011; Thorne, 2012).

During this phase, I developed an interest in the methodological process of case selection, and the defining characteristics of case study methodology, which was channelled into Publication 4 (Hyett, Kenny, & Dickson-Swift, 2014). Additional discussions of exemplary community participation frameworks were provided in the *Introduction* chapter, and are contained in the published works, including Arnstein's (1969) model of citizen participation (see Publication 1, Kenny et al., 2013) and coproduction models of participation (see Publication 2, Kenny et al., 2015).

2.5 Doing research and being in the field

The primary purpose of this research phase was to use qualitative case study methodology to explore how and why communities participate in two highly regarded initiatives.

In the first case study (see Chapter 5) we explored *how* community participation is facilitated, and how difficulties with sustaining community participation processes were overcome with particular approaches and methods. The Canadian food movement was selected because it exemplifies community participation that has attracted a large number of participants (over 5000 people participated in the Kitchen Table Talk initiative, and food security initiatives are delivered in the majority of provinces), and participation has been sustained for a substantial period (over 30 years). Sustainability was identified as a key issue for discussion, which was identified as a knowledge gap in our critical review [Publication 2] (Kenny et al., 2015), and within the broader health and social science literature (Morgan, 2001; Rifkin, 2009, 2014; Shediac-Rizkallah & Bone, 1998).

In Chapter 5, the case study findings are used to advance theoretical knowledge of *how* community participation is enacted. Additionally, four innovative approaches to community participation are described.

Building on findings from the first case study, I felt that the second case study (see Chapter 6) needed to explore community participation in a different and contrasting context, and provide new (and perhaps contradicting) perspectives (Stake, 2006). The aim of the second case study was to answer the research question relating to *why* communities participate.

The Bendigo Bank,[5] community banking initiative was selected for case study because it exemplifies community participation in a rural context that has successfully increased in size and scale of operations, and in scope of sponsorships and grants (reported in Chapter 6). Encouraged by my supervisors, I used this second case study to delve deeper into the sociological aspects of community participation that were revealed by the case, primarily,

[5] Permission obtained to use real name because of difficulties related to concealing identity of a large, well known Australian corporation.

why communities participate, and the connections between people, communities and place. Additionally, reflecting upon the literature reviews [reported in Publication 1 and 2], I theorised that reasons 'why' communities participate could be drawn from analysis of contextual drivers and motivations (Abelson, 2001; de Freitas, 2015; Fienieg, Nierkens, Tonkens, Plochg, & Stronks, 2012), which could be extrapolated from qualitative case study findings (Stake, 1995).

I completed the analyses from the paradigmatic perspective of constructivism, however, I found it important to critique the case studies, or 'de-construct' my constructions using 'what if' style thinking, to delve deeper into my study findings (Reich, 2009). One unexpected finding that I critiqued through this process was the participants' perceptions of people who do not participate with the community bank. The participants' used the "ten per center" analogy to describe the people who are highly committed and engaged with community initiatives, and identified the larger proportion of the community who do not participate (up to 90 per cent), as bystanders. This included people who might follow events from a distance and choose not to become directly involved, or people who are not interested in community initiatives. Findings from this study inspired further theoretical investigation of why non-participation might occur, which is addressed in the *Discussion* chapter.

The final phase of research, which occurred after the fieldwork and case studies were completed, involved sociological exploration and theorising. The focus of the next phase was on determining the importance of the doctoral research findings for policy and practice, consolidating my research training, and understanding my research niche.

2.6 Final phase: Returning to my occupational therapy roots

As a result of this research, I have developed knowledge of how a sociological understanding of community participation can inform occupational therapy practice at the community-level. In this final research phase, I realised my research journey had been circular, with each phase of research taking me incrementally, further and further away from my beginning, disciplinary viewpoint. Now I felt I was circling back to my occupational therapy roots, like an enlightened world explorer, on a journey home to share my new discoveries with my peers.

I have been happy to discover that my peers are interested in the research findings. I had positive feedback while presenting at conferences, including the Occupational Therapy Australia National Conference in Melbourne, Australia (June/July 2015), and the global OT4OT 24 hour Virtual Exchange (November 2015). I have had correspondence with occupational therapists from different countries via social media, who are interested in the position taken in the viewpoint article [Publication 5], in which we proposition community-centred practices for occupational therapy, and consider some of the opportunities and barriers for community-level intervention (Hyett et al., 2016).

It has been through discussions with my peers that I have been able to identify and understand my research niche and intellectual contribution within my discipline. I began to build this understanding while writing the viewpoint [Publication 5] (Hyett et al., 2016), and my *Discussion*, and *Recommendations and Conclusions* chapters. In completing my research journey, I have realised my intellectual contribution is research that informs the development of community-centred practice within occupational therapy, which integrates knowledge of community participation from the broader interdisciplinary literature, and champions an occupational lens. By completing a full circle, and returning to my 'occupational therapy roots', I am confident that this thesis will contribute new knowledge to my discipline and

profession, which is a cathartic endpoint to my doctoral research journey, while also being an exciting starting point to an academic career.

2.7 Chapter summary

In this chapter, I have described my experiential process of research, to provide the reader with an in-depth and vicarious experience, so that they can understand my point of view. Overall, the study aim was to explore community participation in Western, developed contexts. My primary research purpose was to build theoretical and conceptual understandings of community practices, which could be used to advance my own discipline of occupational therapy in community and population health. In this chapter, I described why I was compelled to do the research, which relates to my practice experiences, and limitations and gaps I identified in extant disciplinary knowledge. I described key methodological decisions, including reasons for engaging in a team-based, multi-disciplinary process of research enquiry, and for using qualitative case study methodology.

I discussed the importance of sociological exploration and theory building within this thesis. I described how, by completing this journey, I hoped to build new knowledge of community participation, and of how occupational therapists can work collaboratively with communities, which would be shared and valued by my peers.

In the following chapter, *Research Methodology and Methods*, I describe the research methodology that informed the study, including the constructivist research paradigm and qualitative research methodology. I provide an outline of the research methods that were used to complete the two case studies, and discuss ethical considerations, strategies used to enhance study rigour, and methodological strengths and limitations.

Chapter 3

Research Methodology and Methods

"No aspects of knowledge are purely of the external world, devoid of human construction" (Stake, 1995, p. 100)

3.1 Introduction

In this chapter, I outline the research methodology and methods that were used for this doctoral research. This description of research methodology is necessary to justify how the research questions align with paradigm, methodology and methods, and to enable evaluation of rigour.

The chapter includes an outline of study background and research questions. I provide a description of the study methodology, including the research paradigm and qualitative case study methodology. This is followed by an overview of the research methods that were utilised to complete the two case studies. Case study one is of a Canadian community food security network (see Chapter 5), and case study two is of a rural Australian community bank (see Chapter 6). I conclude the chapter with discussion of ethical considerations, study rigour, and methodological strengths and limitations.

3.2 Study background

The purpose of this research was to explore community participation in Western, developed contexts, to address knowledge gaps, and build theoretical and conceptual understandings for occupational therapy. Research is needed to inform occupational

therapists' practice development and expansion in community and population health, which will enable them to meet health policy objectives.

The study of community participation and collaborative community practice approaches, is relatively new within occupational therapy (Gerlach, 2015; Kronenberg et al., 2005; Kronenberg, Pollard, & Sakellariou, 2011; Scaffa & Reitz, 2013). Few researchers have examined ways of working collaboratively with communities that integrate an occupational lens (Lauckner & Stadnyk, 2014). In this doctoral study, because of the paucity of research within occupational therapy, the research was not confined to occupational therapy programs. Rather, research methods were used to gather in-depth data of community participation in two purposively selected, community contexts, to draw new learnings from outside the discipline. The study was designed to enable theoretical and conceptual development, through the exploration and discovery of concepts and ideas.

3.3 Research questions

The aim of the research was to build theoretical and conceptual knowledge of community participation, and to address knowledge gaps, and to strengthen community practices in the discipline of occupational therapy. I approached this research from the philosophical perspective of pragmatism, which involved first developing research questions, and then using these questions to guide the selection of research methods (Shank, 2013). This approach is consistent with Stake's tradition of case study methodology (Stake, 1995). The research questions were developed from the team-based research program, which involved scoping the literature for international exemplars of community participation, examining what is known about community participation in a health context, and identifying knowledge gaps. The research questions that guided this doctoral study were:

In developed, high-income, Western nations:

- How do communities participate in initiatives that aim to improve community-level health and well-being?
- Why do communities participate in initiatives that aim to improve community-level health and well-being?

'How' and 'why' questions are well suited to qualitative research methodologies (Yin, 2012). Qualitative research was selected because it is valuable for exploring areas of interest where little is known, and can be used to build theoretical understandings of complex social phenomena (Merriam & Tisdell, 2016; Stake, 1995). In the following section, I detail the qualitative research methodology that informed the study design.

3.4 Research methodology

Methodology is the research theory that informs study design, which includes research paradigm, strategies and methods (Carter & Little, 2007; Denzin & Lincoln, 2005, 2011b). In this section, I describe how the research methodology "shapes and is shaped by research objectives, questions and study design" (Carter & Little, 2007, p. 1316). My aim is to provide the reader with insight into theoretical perspectives that influenced the research, including views on the nature of reality, of truth and knowledge, and ways of meaning-making.

3.4.1 Research paradigm

The research paradigm is the set of beliefs and values that were adopted during the conduct of research, about truth, knowledge, and the world (Denzin & Lincoln, 2011a). The nature of the research questions, being 'how' and 'why' questions, influenced selection of a constructivist research paradigm. Constructivism is aligned with hermeneutical and

dialectical methodologies (Lincoln & Guba, 2013; Lincoln et al., 2011), which involve cyclical processes of exploration, interpretation, and sense-making, which inspires further action (Lincoln et al., 2011). The study design, guided by this paradigm, involved data collection and analysis that formulates consensus, by investigating similarities and inconsistencies in human experiences (Lincoln et al., 2011).

The purpose of research guided by a constructivist paradigm is to build knowledge by collecting and analysing multiple perspectives, through a process of data collection and reconstruction (Lincoln et al., 2011). The research, conducted from this paradigmatic perspective, was focussed on building social constructions of the phenomenon of interest, through dialogue and interaction between researcher, and research participants and subject/s (Denzin & Lincoln, 2011a, p. 11).

Authors argue that a constructivist paradigmatic position influences research practices through three mechanisms, the views on the form and nature of reality (ontology), theories about knowledge (epistemology), and perspectives on how knowledge is best obtained (methodology) (Appleton & King, 1997; Denzin & Lincoln, 2011a). In this doctoral study, by adopting a constructivist stance, ontology and epistemology were viewed as interconnected, and it is argued that knowledge is revealed and accumulated through individual and collective social reconstructions (Appleton & King, 1997). The doctoral study was influenced by the ontology of *relativism*, which suggests that knowledge is gained through exploring multiple subjective experiences (or realities), held by people and subjects in different contexts (Appleton & King, 1997; Guba & Lincoln, 2005). Guided by relativism, the research was planned and implemented on the premise that there are no absolute truths, and that knowledge gained from the research would be relative to person/s, researcher and context (Guba & Lincoln, 2005; Lincoln & Guba, 2013; Merriam & Tisdell, 2016).

The constructivist viewpoint of epistemology is similar, which is that knowledge is gained through social immersion and vicarious, subjective experiences, and that processes used to build knowledge require interaction, interpretation and reconstruction (Lincoln & Guba, 2013; Lincoln et al., 2011). This epistemological viewpoint is described as *transactional subjectivity*, which recommends that knowledge accumulation involves researcher-participant knowledge *co-creation* (Appleton & King, 1997; Guba & Lincoln, 2005; Lincoln & Guba, 2013). This epistemology influenced many of the research actions and decisions, including the perspectives, actions and constraints I applied during research planning, implementation and evaluation (Carter & Little, 2007). This theory of transactional subjectivity, for example, informed the development of procedures for recruitment and data collection, which involved partnering with key informants who were experts in the case (Stake, 1995). Additionally, this perspective influenced my process of data analysis, which involved a period of immersion in construction and interpretation of the case studies, and thick description (Abma & Stake, 2014; Geertz, 1973).

Research informed by a constructivist paradigm should reflect a process of developing and building "more informed and sophisticated reconstructions" of the phenomenon of interest (Guba & Lincoln, 2005, p. 196). In adopting a constructivist paradigm, it was important to engage in in-depth interpretation and theorising, to ensure the research findings extended beyond superficial descriptions, to reach an "understanding of the essential meaning of the constructions" (Appleton & King, 1997, p. 15). This perspective influenced my decision to adopt a critical lens for data analysis, to increase research depth and practice relevance (Reich, 2013; Shank, 2013). This approach was influenced by Dewey's Theory of Pragmatism, which is used to explain how research can be driven by research questions, in comparison with rigid methodological rules (Shank, 2013). Shank (2013) argues that in using this approach "the nature of the problematic situation drives

inquiry: research questions and modes of inquiry (methods) must be coordinated together in a way that reflects and addresses real-world complexity" (p. 187).

It is argued that constructivist-oriented research can be viewed as illusory, or limited by its subjectivity (Stake, 1995). Alternatively, this subjectivity can be viewed as a research strength, which is "not seen as a failing needing to be eliminated but as an essential element of understanding" (Stake, 1995, p. 45). In adopting a constructivist viewpoint, it was important to select research methods that provide opportunities for the researcher and research participants to interact, which informed the selection of qualitative case study methodology, and social and naturalistic research methods (Abma & Stake, 2014; Creswell, 2013b; Denzin & Lincoln, 2011a; Stake, 1995).

3.4.2 Qualitative case study methodology

The study design is grounded in qualitative case study methodology, which is a naturalistic, heuristic and descriptive approach to research (Abma & Stake, 2014; Creswell, 2013b; Merriam & Tisdell, 2016; Stake, 1995). Qualitative case study methodology is effective for addressing how and why questions, where little is known about the topic (Stake, 1995; Yin, 2012), and is well suited to a constructivist paradigm (Stake, 1995). In this doctoral study, case study methodology was defined as "the study of particularity and complexity of a single case" that is undertaken to generate and interpret understandings of a phenomena within a specific (bounded) context (Stake, 1995, p. xi).

The study design was influenced by several elements of qualitative case study methodology. The research was conducted in *natural settings*, with the aim being, "to make sense of or interpret phenomena in terms of meanings people bring to them" (Denzin & Lincoln, 2011a, p. 3). I utilised *progressive focusing*, which is an inductive, iterative research practice that involves analysing data and querying assertions (Stake, 1995). Using

progressive focusing, the study design was developed around key research issues relating to community participation, and the aim was to use the case studies to increase understanding of the issues, and to expand knowledge (Stake, 1995).

Stake (1995) defines this type of case study as an *instrumental* case study, in which the case study is used to increase understanding of a phenomenon of interest, which is broader than the case itself. Primarily, an instrumental case study design is informed by etic issues, which are issues identified by the researcher. In this study, these were research questions and ideas that I had developed from my various clinical practice and research experiences, and from discussions with the research team (Stake, 1995). In doing an instrumental case study, emic issues emerged during the research process, which are issues of the "people who belong to the case" that became the focus of data analysis and reporting (Stake, 1995, p. 20). In the doctoral study, this process involved identifying and progressively focusing on issues that emerged (emic issues), and seeking explanations for their occurrence (Stake, 1995).

In comparison with alternate approaches to case study underpinned by postpositivist views (Flyvbjerg, 2011; Yin, 2009, 2012), the aim of the constructivist tradition is not to produce findings that are generalisable across contexts, instead, "the real business of case study is particularization", which is focused on case *uniqueness* (Stake, 1995, p. 8). One objective of this tradition of case study, is to stimulate *naturalistic generalisations*, which is achieved by facilitating reader engagement and interaction with the case (Stake, 1995, 1998). This theory informed the development of case descriptions, and the use of verbatim quotes and images, which aims to support the reader to make sense of the case, by relating research findings to their own personal context and experiences (Stake, 1995, 1998).

In utilising this approach to case study, researcher subjectivity is encouraged (Stake, 1995). It was important that I adopted a "non-interventionist" research role, to "see what would have happened had they [the researchers] not have been there" (Stake, 1995, p. 44). In the current study, this is why I decided to use a non-intrusive approach to fieldwork, which encourages the use of careful positioning to "observe the ordinary" (Stake, 1995, p. 44), and to construct understandings of "how the subjects perceive and interact within a social context" (Lincoln et al., 2011, p. 110) with researcher reflections and detailed field notes.

In designing this doctoral study, I became aware of the inconsistencies in the literature in the ways in which case study is defined, and queried whether case study is a methodology or method [Publication 4] (Hyett, Kenny, & Dickson-Swift, 2014). In this doctoral research, case study was the qualitative research methodology followed, not one method used. I adopted the view that case study methodology, similar to other qualitative traditions, "bears the traces of its own disciplinary history" (Denzin & Lincoln, 2005, p. 7). I stand by the perspective described in the critical review [Publication 4], where we argued that case study is an established qualitative research methodology, which is historically and philosophically situated (Hyett, Kenny, & Dickson-Swift, 2014). In the following section, I describe the research methods used to conduct the research, which align with the paradigm and methodology.

3.5 Research methods

The focus of this section is on the qualitative research methods that were used to complete the two case studies. The first case study [Case Study 1] is of a Canadian community food security network, and the second case study [Case Study 2] is of a rural Australian community bank. Further descriptions of the case studies are included in Chapter 5

and Chapter 6 of this thesis. In this section, I provide an overview of the doctoral study design, and describe methods used for case selection, data collection and analysis. I conclude the chapter with discussion of ethical considerations, study rigour, and methodological strengths and limitations.

3.5.1 Study design

A qualitative case study design was used that incorporated Stake's (1995) instrumental case study approach. An instrumental case study design is used to investigate a phenomenon of interest via case studies, as compared to an intrinsic case study that is focussed on building knowledge and understandings of the case itself (Stake, 1995).

Using this instrumental case study design, the phenomenon of interest, 'community participation', was explored via case study of a Canadian food security network [Case Study 1] that operates as part of a social movement, and a rural Australian community bank [Case Study 2], which is part of a national, private industry initiative.

The study design included research methods that are naturalistic, meaning data sources were utilised that were naturally occurring in the case study context (and accessible during/shortly after fieldwork) (Abma & Stake, 2014; Stake, 1995). Methods were selected that would support the development of in-depth descriptions of the case, including its multiple contexts, from different perspectives (Geertz, 1973; Stake, 1995). Data collection for this research involved observing, exploring, and interpreting community participation, in two different, purposively selected contexts. Collection of data from a range of sources aimed to enhance study rigor, complexity, richness and depth (Denzin & Lincoln, 2005). Data were collected via interviews and field observations, and secondary sources, including documents, webpages and social media (where applicable). The study design, underpinned by a constructivist research paradigm and qualitative case study methodology, was guided by the

assumption that “objective reality can never be captured” (Denzin & Lincoln, 2005, p. 5), and research methods should be employed that investigate multiple perspectives and truths (Guba & Lincoln, 2005; Lincoln & Guba, 2013; Merriam & Tisdell, 2016).

Using Stake’s (1995) approach to qualitative case study, it is common practice to select and utilise research methods that are best suited to the specific (unique) case study context. This is different to Yin (2009), who recommends developing study protocols and implementing the same research methods across different cases (to promote comparison and generalization). Therefore, in this section, I have described the research strategy or methods used, followed by a short description of how they were applied in the two case studies.

3.5.2 Case selection

Case selection is a critical first step of qualitative case study research (Stake, 1995). In earlier chapters, I discussed the criteria used to select ‘exemplars’ of community participation (see *Introduction* and *My Research Journey*). I have compiled the key factors in Table X below. This criteria was used to define how the cases selected for study would be particular and unique (Patton, 2015; Stake, 1995). Cases were selected that would best address the research questions. Therefore, it was important that cases were from Western, high-income, developed contexts, and were of highly regarded community participation programs or initiatives. Programs needed to be current/ongoing to allow for interviews and field observations (for case immersion (Stake, 1995)). The Canadian food security network was the first case study selected [Case Study 1], and the rural Australian community bank was the second [Case Study 2].

Table 2. ***Key Factors for Case Selection***

Inclusion	**Exclusion**
• Located in a Western, high income, developed country • English language proficiency • Community participation is particular and unique in this field i.e. will offer new theoretical and conceptual insights, has overcome a range of challenges identified in literature/reports (e.g. sustainability), reports highly positive health and social outcomes (i.e. via research publications, evaluation reports, and/or new items • High level of community participation is reported, as defined by key authors (see for example, Arnstein, 1969; Cornwall, 2008; Morgan, 2001) • Accessible using resources available to doctoral students at La Trobe University.	• Developing, low-middle income country • Non-English language • Community participation is customary, with evidence of tokenism or placation (low level participation), and with no/minimal evidence of outcomes • Community participation is not current or observable (i.e. program has ceased/finished) • Located in place/setting that is not accessible with resources available to doctoral students at La Trobe University

Case Study 1

I became aware of the Canadian food security network during the scoping phase of research, through Internet searches of community participation programs and initiatives in Western, high-income, developed countries. This national food security network was selected as an exemplar case of community participation because it met several criteria, community participation has been sustained for a substantial period of time (over 30 years), participation has been up-scaled and expanded within and across provinces, and positive outcomes were reported, relating to community-level health and well-being (Baker, 2004; Levkoe & Wakefield, 2011; MacRae & Donahue, 2013; Saul & Curtis, 2013). One particular initiative conducted by the food security network, called Kitchen Conversations[6] was reported to illustrate power sharing and increased community control over decision making and policy development, which had drawn attention from the United Nations.

Case study 2

Where I live, community banking is known as a popular form of community participation. However, it was not until after I completed Case Study 1 that I considered the potential benefits of selecting this case. After completing the case study of the community food security network, it was decided that a different, potentially contrasting case study was needed, to investigate elements of the research questions that had not been fully addressed by the first case. This is typical practice, when using an instrumental, collective (more than one) case study design (Stake, 1995, 2006)

The case of the rural Australian community bank was selected as an exemplar of community participation because of several reasons. The community banking initiative is a

[6] Pseudonym.

national program, and over 300 banks have been established, with approximately 100 operating in rural locations (Bendigo Bank, 2014a, 2014b). The initiative was conceived in the context of rural hardship and drought, when banking businesses were closing in rural towns, and community members were unhappy with the loss of local business and employment. The community banking initiative was established in response to community protest, and promoted as a method of rural community empowerment (Knights, 2002; Mayne, 2005; Tarrant, 2007).

Community banks are established, owned and operated by community volunteers, and rely on community participation for business oversight and viability. Another reason I selected a local case study was so that I could use my own insight of the case study context (rural Victoria, Australia), including lived experience of the natural disasters and major economic challenges that have impacted the region. Authors contend that this subjective perspective can add depth to qualitative research (Merriam & Tisdell, 2016; Stake, 1995). In addition, as researchers, being identified as local, rural persons with shared interests, was valuable for building rapport with participants and gaining access to the case study. Establishing rapport prior to interviewing is thought to increase the quality of information provided (Merriam & Tisdell, 2016).

I consulted with the Bendigo Bank national office that oversees the initiative to develop a list of potential community banks located within two hours driving distance of where I live. The Eylestown[7] community bank was appropriate because it is located in a rural town of Victoria, Australia, with a population of approximately 1,000 people (which is in contrast with the urban based programs I had visited in Canada). This particular community bank was identified as an exemplary initiative, which has been sustained for ten years, has

[7] Pseudonym.

increased its scale of operations and scope of community grants and sponsorships. This case was selected because it had potential to address unanswered aspects of the research questions, specifically why people participate in community initiatives, and factors that influence community participation within a rural context.

3.5.3 Recruitment and sampling

In completing a qualitative research project, "thick and rich data refer to the entire data set" (Morse, 2015, p. 1214). The data set of a qualitative case study refers to the case selected, and typically, a sample of interview participants (key informants), field observations, research reflections or stories, and documents and/or artifacts (Stake, 1995).

In this doctoral study, once the potential case was identified, I contacted key people via email who were identified as leaders within their respective program, to invite them to participate in the research. Program/initiative leaders, known as key informants, were purposively selected, because they were identified as people who were experts on the case (Stake, 1995), and who were able to provide information on how and why community participation was enacted in their specific context (Merriam & Tisdell, 2016; Patton, 2015). When they expressed interest in participating, I arranged a telephone or video call to discuss the study details, and to arrange a time for an interview and/or field observations. Secondary sources were sampled that could provide additional information on the case study context, and descriptions of methods and strategies used to support community participation.

Case study 1

Internet searches were conducted to locate people responsible for community participation in Canadian food security programs that were linked with a national network. Email invitations were sent to relevant community program leaders at different organisations.

Two interviewees responded to this initial email invitation, which then recommended other key people from their network. Further emails were sent to the community program leaders identified, and an additional three agreed to participate. This sampling process resulted in a total of five research participants; three in Toronto, Ontario (pop 2,615,060), one in Montreal, Quebec (pop 1,649,519), and one in Halifax, Nova Scotia (pop 390,096) (Statistics Canada, 2012). Participants were all employed in paid positions, two in national level organisations, and three at a municipal level. I emailed the Participant Information and Consent Forms (see Appendix B), and obtained voluntary written consent prior to beginning each of the interviews.

Initially, the plan was to also recruit community members who participated in the food and gardening programs, to gather their perspectives in addition to the program leader's views. However, the first two key informants agreed to an interview only and declined the request for support to send invitations to community members and support recruitment of community research participants. This was because of the short time period we were available for fieldwork in Canada, and the anticipated difficulties/burden of advertising and recruitment via international communications. Instead, it was decided that interviews with program leaders, and guided tours of program sites, would provide sufficient data to address the research questions.

Secondary sources of data were collected from Internet sources and during fieldwork. During case selection and research fieldwork, I became aware of online community participation with the food security network, which utilises social media platforms. For each program site I visited, for interviews and/or guided tours, I collected online, public data from respective organisational social media pages, including Twitter, Facebook, websites, and blogs.

The number of interviews and program sites visited was limited to what could be undertaken within two weeks of fieldwork, however, some respondents provided their details and offered to participate in email or video calls when I returned to Australia. However, no further interviews were arranged because repetition of interview responses indicated data saturation (Merriam & Tisdell, 2016).

Case study 2

I gained written permission from the Bendigo Bank to send email invitations to community bank chairpersons to invite them to participate in the research. Two local community banks were identified that met case selection criteria. The first community bank I approached for recruitment was Eylestown. The chairperson agreed to participate in an interview and to forward the research participation email to past and current community bank volunteers. An additional five people replied via email with their contact details, and expressed interest in participating. I replied email with copies of the Participant Information and Consent Forms, and when requested, arranged to speak with them via telephone to clarify study details. All six participants provided written consent prior to beginning the interview. No further participants were recruited because repetition of interview responses indicated data saturation, and because there was sufficient data from across both case studies to provide answers to the research questions (Merriam & Tisdell, 2016).

Secondary sources of data were sampled from Internet webpages, and were provided by participants, including ten years of media articles and relevant public documents.

3.5.4 Data collection

In both the case studies, data were collected through semi-structured interviews with key informants. A list of open questions and probes was used to conduct the interviews (refer

to Appendix C for example interview questions). Interviews ranged from 30 to 90 minutes, were digitally recorded, and transcribed verbatim. Researcher reflections and field observations were recorded immediately after conducting each interview, which included photographs of program sites (not people) (refer to Appendix D for example of field observations and researcher reflections).

All data collected were collated using NVivo 10, a computer-assisted qualitative data analysis application (QSR International, 2014). NVivo 10 was used to import data from online documents, webpages and social media pages, for example, micro-blog posts (Twitter), wall posts (Facebook) and videos (YouTube and Vimeo). This involved using the NVivo 10, NCapture application, which converts data into a file type that can be more easily coded, for example Portable Document Format (PDFs) and charts (Ampofo, Tennent, Brundell, & Knight, 2015; Edhlund & McDougall, 2012). Documents sourced as hard copies were scanned and saved in NVivo for coding.

Case study 1

Data collected for the Canadian food security case study were interviews, field observations and researcher reflections, public documents, and social media posts and pages.

Interviews. Five interviews were conducted in October 2013. The interviews were conducted in-person at the interviewees' place of employment. All interview participants provided informed written consent to have the interview audio-recorded and transcribed verbatim. Interviews were conducted by two researchers (Amanda Kenny and I) using a semi-structured question guide, and were approximately 60 minutes duration.

Field observations. Field observations were collected over two weeks in October 2013, during visits to program sites, guided tours, and informal conversations with people

who work and volunteer in the programs. Observations were taken of eleven sites, including seven field site visits in Toronto, two in Montreal and two in Halifax. The sites were community program centres, gardens and markets, and we had three guided tours of community food hubs led by program leaders (not interviewed). Field notes included written observations, researcher reflections, photographs, and collection of artifacts (program pamphlets, information brochures). In addition to in-person fieldwork, data were recorded from observations of online communities, which involved 'hanging out' in virtual spaces, and participating in public webinars and twitter chats.

Public documents. Public documents of seven organisations were collected during fieldwork in October 2013 and via online sources until December 2013. The thirty-four documents collected were annual reports, evaluation reports, policy submissions/briefs, research papers written by interviewees, program manuals, and information handouts.

Social media. Social media data were collected because the community programs visited utilised social media platforms to support community participation. The social media data of seven organisations were collected, which was publically available online. Online social media data sources (N=94) included Twitter (n=9), Facebook (n=9), YouTube and Vimeo (n=6), blog pages (n=22), and webpages (n=48). Data were collected between July and December 2013, which involved extracting and storing social media data using the NVivo 10 application and NCapture plugin (QSR International, 2014).

Case study 2

Data collected for the rural Australian community banking case study included semi-structured interviews, field observations and researcher reflections, public documents, media reports and webpages.

Interviews. Six interviews were conducted in July 2014. The interviews were conducted in-person at the study participant's home or at the community bank. All interview participants provided written consent to have the interview audio-recorded and transcribed verbatim. I conducted the interviews using a semi-structured interview guide, which ranged from 45-90 minutes duration.

Field observations. Written records of field observations and researcher reflections were completed immediately after each interview, to support researcher immersion in the case and understanding of case context (Abma & Stake, 2014).

Public documents, media reports, and webpages. Consistent with case study approaches, data in the form of documents and webpages (N=30) were obtained in addition to interviews to gain an in-depth understanding of the case study context (Merriam & Tisdell, 2016). Media releases and newspaper articles were provided of the community bank launch (n=6) and the first public meeting (n=2). The webpages of the community bank and the local Shire were reviewed and pages that contained information on community participation and that described the community context (social, political, physical aspects) (n=10) were included using the NVivo 10 NCapture application (QSR International, 2014). The community bank steering committee plan and business establishment plan (n=2), and annual chairpersons reports (n=10) were included, which provided additional information on why the community established the bank, and how people came to be involved with the initiative.

3.5.5 Data analysis

The processes used for analysing the data and exploring meaning and sense-making, occurred simultaneously with data collection. This involved narrative description, thematic coding, and categorisation and interpretation of themes (Stake, 1995). Data analysis involved searching for emic issues, which were the issues that emerged through case study

reconstructions (Stake, 1995), for example, challenges of sustainability [Case Study 1], and motivations and drivers of rural community participation [Case Study 2]. Analysis was undertaken of each case in its entirety, before comparisons were made. Cross-case comparisons involved comparing similarities and differences in thematic findings, to identify and define emergent concepts (Patton, 2015; Stake, 1995, 2006).

Thematic coding strategies were used that align with case study methodology (Saldaña, 2013). The coding process was assisted by use of NVivo 10 coding functions (QSR International, 2014). Data analysis involved reading and re-reading transcripts, general line by line coding of all written data (or coding images), and identifying, listing, grouping, and mapping codes. Following this, specific coding methods were used that were suited to the data being analysed and the research questions (for example, process or emotion coding). NVivo functions were used to group codes and categories, to support analysis, and the development of themes. A snapshot of this coding strategy is provided in Table 3, which relates to Case Study 2. Findings from data analysis were case descriptions and themes. During data analysis, strategies were used to enhance credibility of study findings and trustworthiness of the research, which are outlined in the sections on *Study rigour* and *Methodological strengths and limitations*.

Table 3. ***Snapshot of Coding Analysis for Case Study 2***

Theme	**Sources**	**Coding references**	**Example codes**
The ten per centers	16	46	*Hark work* *Responsibility* *Commitment* *Labour of love* *Enjoyment* *Interesting and rewarding*

			Resilience
Benefit to community	15	67	*Benefit to community* *Belief* *Hope* *Shared success* *Different to large banks* *Rural towns are the real success stories* *Giving money back*
Taking control	13	55	*Town decline* *Loss* *Frustration* *Confusion* *Choice* *We built a bank*

Note. 'Sources' are the number of individual items stored in NVivo that were coded in relation to the theme, for example, an interview transcript would be one source. 'Coding references' are the total number of codes per theme.

Case study 1

In addition to the general coding techniques described above, the coding strategies used to complete the case study of the Canadian food security network were descriptive, in vivo, and process coding methods (Saldaña, 2013). Descriptive coding methods were used to develop codes that described the data (Saldaña, 2013). In-vivo coding was used to identify verbatim text as codes, and the process coding method was used to code text that described processes used for community participation (for example, how people participated) (Saldaña, 2013). Codes were grouped into categories, which were analysed to develop themes (Saldaña, 2013). The themes developed in this case study related to how community participation is enacted and sustained, which were: *use of multiple methods*, *good leaders are fundamental*,

online participation via social media, and *leveraging outcomes: "Is there a way we can seed it or spark it"*.

Case study 2

In addition to the general coding techniques described, the coding strategies used to complete the case study of the rural Australian community bank included descriptive, in vivo, emotion and value coding methods (Saldaña, 2013). Descriptive and in-vivo coding was completed similarly to Case Study 1. Emotion and value coding strategies were used to develop codes that reflected the participants' feelings and values about community banking, and reasons for participating. Codes were grouped into categories, which were analysed to develop themes (Saldaña, 2013). The themes that describe the participants' reasons for participating with the community bank include: *the ten per centers*, *benefit to community*, and *taking control*.

3.6 Ethical considerations

Ethics approval was obtained through the La Trobe University, College of Health, Science and Engineering, Human Research Ethics Committee (approval number FHEC13/170). Approval to conduct the study was secured and maintained by ensuring compliance with the Australian Governments, National Health and Medical Research Council (NHMRC), *National Statement on Ethical Conduct in Human Research* (2015) and the *Australian Code for the Responsible Conduct of Research* (2007). A number of ethical factors were considered prior to, and during the conduct of the research. Ethical considerations, for example, informed the development of the Participant Information and Consent Forms, and other study details, such as the purpose of the inquiry, the methods used, the potential

benefits and consequences of participating, information on confidentiality, and data access, ownership, storage and use (Merriam & Tisdell, 2016).

In completing both case studies, all participants provided active, informed, written consent. The participants provided consent to have their interview audio-recorded, and were aware that they could stop the interview and/or the recording at any time. No participants requested to have their data withdrawn from the study. They were made aware that their participation was voluntary, and that were no expected benefits of participating, or consequences if they chose not to participate.

For Case Study 1, participants were recruited from a national network that operated as part of a social movement. They consented to participate by reading the Participant Information and Consent Forms developed for individual staff and volunteers, and then providing written consent (refer to Appendix B). For Case Study 2, I first sought written consent from the Bendigo Bank, and then from the community bank chairperson, which was forwarded to the university ethics committee prior to commencing data collection. Following this, an email invitation was distributed by the community bank chairperson to community bank volunteers inviting them to participate in the study.

To minimise risk of coercion during recruitment, the Bendigo Bank spokesperson and community bank chairperson read and agreed to follow an approved recruitment procedure (refer to Participant Information and Consent Forms for organisations and key spokepersons in Appendix B). The Bendigo Bank provided written consent to be involved and named in the research, and the community bank chairperson was ensured the community bank would not be named in the research, and who to contact in case of complaints. This was different to the Canadian case study [Case Study 1], where key informants consented on behalf of themselves, and were not involved with recruitment of staff and/or volunteers within their

respective programs. During Case Study 1, while we did disclose that we were touring community food and gardening program sites as researchers and provided tour guides with information on the study, the tours are available to the public, therefore written consent was not required.

I provided my contact details to all potential interview participants, so that they could seek more information about the study before making a decision about whether or not to participate. The majority of the participants used this opportunity to speak with me and clarify details about research participation (either via telephone or video call). Although I used these strategies to make sure participants could provide active, informed consent, because of the social nature of communities, I cannot be sure that participants did not feel inclined to participate because of the participation of others in their social networks.

Potential risks of research participation were reduced by using data sources that were publically available in the case study context (Merriam & Tisdell, 2016), including people employed in community leadership positions (as compared to vulnerable/marginalised community members/groups), public (not private) documents, and public social media pages.

3.7 Study rigour

Traditional methods of evaluating the quality of constructivist-oriented, qualitative research were used, including credibility, transferability, confirmability, and trustworthiness (Guba & Lincoln, 2005; Lincoln & Guba, 2013; Lincoln et al., 2011). Study credibility was enhanced by the use of research methods that improve the validity of study findings, for instance, data were collected from multiple sources, using different methods (triangulation of sources and methods) and by recording in-depth descriptions of field observations (Geertz,

1973; Merriam & Tisdell, 2016). I used a reflexive journal to document and query research decisions, and recorded an audit trail (a detailed account of methods used and coding decisions) (Merriam & Tisdell, 2016). I engaged in regular peer review (peer group supervision and research supervision), to discuss data analysis processes and query emergent findings (Lincoln & Guba, 2013; Merriam & Tisdell, 2016).

Transferability in qualitative case study research, refers to the quality of, and potential for naturalistic generalisation, which in this study was used to ensure that readers could relate the research findings to their own personal experiences and contexts (Lincoln & Guba, 2013; Merriam & Tisdell, 2016; Stake, 1978, 1995). To ensure readers can make decisions about how the research findings could be transferred, information was collected and provided on case background and important contextual factors. In addition, thematic descriptions are supported by verbatim narrative so that readers can compare the participants' experiences of participation with their own.

The research methodology and practices are described to enhance study trustworthiness, and to enable the reader to evaluate study rigour (Lincoln & Guba, 2013). It is important that readers can understand how I planned and implemented the research, and how I arrived at the results of the study, which is a measure of study confirmability (Lincoln & Guba, 2013). This was addressed by keeping records (including a written reflexive journal and audit trail) on research interpretations and decisions, records of my discussions with research supervisors, and critical reflections of research practices.

In addition to these general strategies, there were several strategies used that are commonly used to enhance rigour of qualitative case study research (Creswell, 2013b; Crowe et al., 2011; Stake, 1995). These criteria are outlined in Table 9 (see Publication 4) *Checklist*

for Assessing the Quality of a Case Study Report. Examples of strategies used in this doctoral study are listed in Table 4 below.

Table 4. ***Strategies Used to Enhance Case Study Rigour, Adapted from Stake (1995, p. 131)***

Checklist Criterion	**Strategy/Example**
Is the case adequately defined?	Case selection processes were defined and described. Descriptions of case background were provided in case study findings.
Is there a sense of story to the presentation?	Descriptions of case background provide a narrative for readers to understand the historical, socio-cultural, and physical context of the case study.
Is the reader provided some vicarious experience?	Verbatim quotes are provided to describe the participants' experiences. Themes are described in-depth to present the participants experiences.
Has adequate attention been paid to various contexts?	Various data sources were used to collect information on case study contextual factors.
Were data sources well chosen and in sufficient number?	The key informants were purposively selected. Sufficient data were collected to indicate data saturation. Data sources were selected that were available and relevant to the specific case study.
Do observations and interpretations appear to have been triangulated?	Multiple sources of data were selected for triangulation, including interviews, researcher reflections, field observations, webpages and social media, media articles and documents.
Is the role and point of view of the researcher nicely apparent? Is empathy shown for all sides? Are personal intentions examined?	In Chapter 2 *My Research Journey*, my role and point of view are described, and how this changed through the course of completing the research, this includes my personal intentions in completing this doctoral research.

3.8 Methodological strengths and limitations

By adopting a constructivist research paradigm, I approached the research from a view of transactional-subjectivity, which means the research findings are relative to my own experience (with the selected people and contexts), which might be considered a study limitation. The research involved researcher and participant/subject interaction for case selection, recruitment and sampling, and data collection, and my subjective experiences of these processes and interactions were seen as an important part of case study development (not as a bias or variable that needed to be bracketed out or controlled).

To account for researcher subjectivities, documentations of researcher reflexivity was an important strategy, which involved keeping a reflexive journal and audit trail. This was a strategy that was used to increase research transparency and trustworthiness (Morse, 2003, 2015; Sandelowski & Barroso, 2002).

In using qualitative case study methodology, it is recommended that researchers become immersed in the case, and gather information from multiple perspectives, during a period of fieldwork (Stake, 1995). Fieldwork could have been extended if additional resources were available, however, this project was not externally funded and I only had access to what was typically available to postgraduate students within my university. With the postgraduate student travel grant I had received, I was able to visit Canada for two weeks, and visit three cities. My fieldwork with the rural Australian community bank was limited to one bank site, one reason for this is the long travel distances in rural Victoria. I had limited resources for car travel, and non for accommodation. Although fieldwork may have been limited by available resources, as mentioned previously, data collected were sufficient for addressing the research questions.

Purposive sampling involved recruiting and interviewing people who were identified as experts on the case, and I did not have a socio-demographic criteria. I did find it interesting that Case study 1, the Canadian food security case study had an all-female sample, and Case study 2, the rural Australian community banking initiative, had an all-male sample. I do not have any data that describes the socio-demographics of participants in the Canadian food security network, so I am not able to make any judgments about this sample. However, research on Australian rural community banking participants has described this population as mostly male, middle-aged, small business owners (Cutcher, 2010), which is a good depiction of my study sample. It was not my intention to achieve a representative sample, or to draw study conclusions based on representation and generalization. However, the homogenous nature of the interview participant samples in each case study could influence evaluation of study rigour (made by naturalistic generalisations and assessment of study transferability), and impact how the results might be interpreted and transferred across contexts. This limitation was addressed by maximising diversity across the case studies, to provide a wider range of experiences from which to conduct cross case analyses and to draw study findings and conclusions.

3.9 Chapter summary

In this chapter, the research methodology and methods are outlined, including the paradigmatic position, qualitative case study methodology, and research methods used. I describe how a constructivist paradigm informed the study design and implementation, and possible implications this has for evaluation of study rigour. The qualitative case study methodological approach was described, and elements of this methodology that informed the

study design. I provided an outline of the methods used to conduct the two case studies, and discussed ethical considerations, study rigour, and methodological strengths and limitations.

The following chapter contains the series of publications I authored and co-authored, which forms part of the research that underpins this thesis.

Chapter 4

Published articles

"Co-authorship helped students move through the struggles and anxieties of publishing. It taught them how to be robust in the face of rejection and ongoing revision" (Kamler, 2008, p. 292)

4.1 Introduction

This chapter contains five publications that I authored and co-authored with my research supervisors and research team. The first two publications [Publication 1 and 2] are review articles that were completed with the research team in the scoping phase of my doctoral study. This involved reviewing the extant literature on community participation and health, to identify research gaps, and understand current research and practice issues. Publication 3 is an evidence brief that was completed during my summer internship with the Deeble Institute of Health Policy (Australian Healthcare and Hospitals Association). In this publication, I summarised my preliminary research findings for health executives and policy makers, which aimed to support research to policy translation.

A critical review of qualitative case study methodology is provided in Publication 4, which was completed to aid methodological decision-making and doctoral study design. The final publication is a viewpoint article [Publication 5], which argues the importance of community-centred practice for occupational therapy, and highlights opportunities and challenges for practice expansion.

4.2 Publications

Publication 1:

Kenny, A., Hyett, N., Sawtell, J., Dickson-Swift, V., Farmer, J., & O'Meara, P. (2013). Community participation in rural health: A scoping review. *BMC Health Services Research, 13*(1), 64. doi:10.1186/1472-6963-13-64

Journal impact factor: 1.712 (retrieved 27/03/2016)

Kenny et al. BMC Health Services Research 2013, 13:64
http://www.biomedcentral.com/1472-6963/13/64

BMC
Health Services Research

RESEARCH ARTICLE Open Access

Community participation in rural health: a scoping review

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Abstract

Background: Major health inequities between urban and rural populations have resulted in rural health as a reform priority across a number of countries. However, while there is some commonality between rural areas, there is increasing recognition that a one size fits all approach to rural health is ineffective as it fails to align healthcare with local population need. Community participation is proposed as a strategy to engage communities in developing locally responsive healthcare. Current policy in several countries reflects a desire for meaningful, high level community participation, similar to Arnstein's definition of citizen power. There is a significant gap in understanding how higher level community participation is best enacted in the rural context. The aim of our study was to identify examples, in the international literature, of higher level community participation in rural healthcare.

Methods: A scoping review was designed to map the existing evidence base on higher level community participation in rural healthcare planning, design, management and evaluation. Key search terms were developed and mapped. Selected databases and internet search engines were used that identified 99 relevant studies.

Results: We identified six articles that most closely demonstrated higher level community participation; Arnstein's notion of citizen power. While the identified studies reflected key elements for effective higher level participation, little detail was provided about how groups were established and how the community was represented. The need for strong partnerships was reiterated, with some studies identifying the impact of relational interactions and social ties. In all studies, outcomes from community participation were not rigorously measured.

Conclusions: In an environment characterised by increasing interest in community participation in healthcare, greater understanding of the purpose, process and outcomes is a priority for research, policy and practice.

Keywords: Community participation, Community engagement, Rural health, Health policy, Health reform, Health services

Background

Rural health is identified as a key priority for health reform across the United States [1-3], Canada [4], the United Kingdom [5,6], Europe [7], Asia [8] and Australia [9-13] due to complex access and equity issues associated with geographic distance, socially determined disadvantage, mal-distribution of health professionals, scant resources and poorer health outcomes across key indicators [1-15]. However, internationally, there is increasing recognition that while rural areas share some commonality, health inequalities vary considerably, requiring locally targeted responses that align with local population health need [4,5,11,13,14]. Accordingly, international policy is increasingly identifying the role of communities in healthcare planning, design, delivery and evaluation to avoid an ineffective 'one size fits all' approach [2,4,6,12,16].

In 1978, the World Health Organisation [17] identified the centrality of communities in health planning and decision making, yet three decades later, conceptualisations of rural communities as disempowered and distanced from urban centres of power continue [16,18,19]. Calls for meaningful multi-sectoral partnerships with communities recognise that collaboration is central to ensure acceptable, appropriate and effective responses to begin to tackle entrenched rural inequities [18]. Internationally, social, political and economic changes in rural

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environments, particularly associated with 'mechanisation, modernisation and downsizing' in agricultural industries [4] has impacted on rural social cohesiveness and contributed to the 'circle of decline' [7] being experienced in many rural locations.

Rebuilding or harnessing community capacity is integral to developing locally responsive health services [4] and is in the interest of communities and government as it draws together rural social capital, maximises the innate, adaptive, inventive and innovative nature of rural people [12,20] and leads to empowered communities capable of developing local solutions [21,22]. There are shared advantages for communities and government in terms of rural town survival, resilience, sustainability, and fiscal responsibility [23], but consistently, a lack of knowledge on how to build effective community/policy maker partnerships that empower communities and encourage citizen control and responsibility in local decision making is identified [4].

The community participation agenda

Despite the desire to meaningfully engage communities in health care planning, and the adoption of community participation as central in the health agendas of many countries [4,6,7,11-13,24], researchers continue to debate models, approaches, motivations, definitions and operational challenges [22,25,26]. Most commonly, researchers define communities as groups bounded by geographic location [27], and participation as collective actions that harness socio-cultural affiliations, customs, values and beliefs through social interactions to influence and localise outcomes [28]. In theoretical terms, participation is understood to be multi-level, depicted as a ladder by Arnstein [29] (see Figure 1), or as a spectrum (see for example International Association for Public Participation [30]).

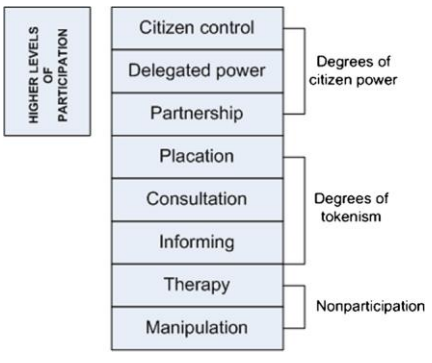

Figure 1 Levels of participation. Adapted from Arnstein [29].

The seminal work of Arnstein [29] has been extensively cited and is influential in theories of participation and the interaction of power structures in society. Arnstein [29] argued that whilst participation is theoretically the cornerstone of democracy, in reality, large sections of the community are powerless and excluded from political and economic decision making. Participation is described in categorical terms as citizen power, and a typology proposed, illustrated by a ladder of participation, to highlight the divergence of views between those who have power and those who do not. She describes the ladder as an illustration of the different grades of participation, and by understanding these differences there can be greater understanding of citizens demands for meaningful, power redistribution and the tokenistic way in which participation is often considered by those in power [29].

At lower levels, participation is consultation or information provision, and at highest levels is full citizen control that involves the redistribution of power from 'government to the governed' [29]. While there is robust debate in the literature about Government agendas for community engagement [16,22], particularly from a neoliberal perspective [21] current policy in several countries [4,6,13,31] reflects a desire to engage communities at the higher level of Arnstein's [29] ladder; partnership, delegated power and citizen control.

The Australian rural context

As Australian rural researchers, our interest in Arnstein's [29] higher levels of community participation is driven by the emphasis on community participation in the Australian healthcare reform agenda [11-13,31,32], international recognition of the lack of knowledge on how higher level community engagement is achieved [4], interest in the sustainability and empowerment of rural communities [4,12], and interest in policy agendas that promote local responsiveness [13]. Like many countries, Australian health care reform is driven by increased demand for health services, inequities in health care access and outcomes, issues of quality and safety, workforce mal-distribution and inefficiency and system fragmentation [13]. While Australia has a universal health care system, Medicare, there is recognition that a universal system does not result in universal access, with significant access and equity issues evident in rural areas [12,13]. The increasing emphasis on community participation, consumers, patients and citizens, to develop services that are locally tailored is evident in Australian policy [11,31] and the imperative for community participation to be central to decision making is mandated in National Safety and Quality Health Service Standards [33]. Key Australian reform documents state that policy, system and service reform must result in local responsiveness, flexibility and agility [11], and that 'public

voice and community engagement' [13] is one of the most important levers to achieve a continuously improving health care system:

> *Consumers should not only be the focus of the health system, they should be at the centre of decision-making in health. Both at a policy level and an individual level, consumer experiences and preferences should help lead health system reforms, alongside the evidence base. The reality of shared responsibility requires not just declaring it but building consumer health literacy and access to quality information and advice* [13].

While definitions of rural are debated [34], for the purposes of this article we refer to rural as areas outside capital cities and metropolitan centres. In Australia, community participation in rural areas is described as an important strategy to build self reliant and self determined communities, and in health policy terms, is viewed as central in developing locally, responsive healthcare that is based on rigorous population health needs assessment [10,31]. Researchers note the long tradition of rural community participation in Australian health services [35], that many communities demand involvement [22], and that the sustainability of rural health services is viewed as central to the sustainability of towns [36]. Kilpatrick [22] suggests, however, that there is a wealth of community participation in rural health service planning that is never reported and that given policy imperatives for higher level community engagement, there is an urgent need to capture examples and commit to 'analysing the processes of community engagement in order to improve them' [32]. There is a commitment to community participation but 'reluctance by policy makers to analyse and measure' [32] and at the practice level, little guidance on how policy is best enacted [4].

Given international imperatives to develop locally responsive services and build sustainable empowered communities, research that investigates process and outcomes of community participation is of central importance for policy and practice. The aim of our study was to identify examples, in the international literature, of higher level community participation in rural healthcare.

Methods

Study design

We designed a scoping review to map the existing evidence base on higher level community participation in rural health. In progressing an agenda of exploration and analysis of the process of higher level community participation, our definition of higher level utilised Arnstein's [29] categories of partnership, delegated power and citizen control, most commonly clustered as 'citizen power'. Arksey and O'Malley's [37] work on scoping reviews was useful in our conceptual thinking. Consistent with their work, we acknowledged that the first step was to 'identify gaps in the evidence base' and draw 'conclusions from existing literature regarding the overall state of research activity'. Researchers have identified scoping reviews, as an effective means of capturing a range of literature on a topic [38] and for our purpose it was a useful approach to mapping and collating existing literature in a summary format that would be useful for policy makers and practitioners. Scoping reviews differ from systematic reviews, in that the focus is not on the assessment of quality as defined within a biomedical research paradigm [39], rather, the approach enables a broader range of literature to be captured, including all types of study designs [37]. Arksey and O'Malley [37] propose a methodological framework for scoping reviews to enable replication and strengthen methodological rigour. The five stages of their framework; identifying the research question, identifying relevant studies, study selection, charting the data, and collating, summarising and reporting results were utilised in this study.

Identifying the research question

To guide the search strategy, and ensure that a broad range of literature was captured, the research question: 'What examples of higher level community participation in rural healthcare exist in the international literature?' was developed. In defining parameters it is recommended that wide definitions of key terms are initially adopted to 'generate breadth of coverage' [37] and we considered the broad terms appropriate for this stage.

Identifying relevant studies

To balance the need for comprehensiveness with pragmatic cost and time limitations, we developed inclusion and exclusion criteria based on our review purpose (outlined in Table 1). A methodological limitation is that choices may have excluded relevant papers.

Key search terms were developed and a search of the Cochrane Library (see www.thecochranelibrary.com) identified one study on consumer consultation [40] and confirmed the absence of registered Cochrane reviews. The existing Cochrane review did not meet the inclusion criteria. A broad scan of Medline located a scoping review by Mitton et al. [41] who had scoped a similar topic, but not with a rural focus. Recognising that qualitative and mixed method studies can be difficult to locate, terms were mapped using SPIDER [42]. The phenomenon of interest was community participation. Linked descriptive terms were used to represent the types and levels of participation, to increase the range and depth of search

Table 1 Inclusion and exclusion criteria

Criterion	Inclusion	Exclusion
Time period	January 1990 and February 2012	Any study outside these dates
Language	English	Non-English
Type of article	Original research article published in a peer reviewed journal	Any article that was not original research and/or unpublished
Study focus	Community participation	No reference to community participation, i.e. individual consultation between health professional and client
Health service	Rural	No reference to rural health care services
Geographical place of study	International, developed countries	Developing countries
Population and sample	Mixed population sociodemographic	Reference to only a single sociodemographic factor i.e. gender, cultural group

results. Table 2 illustrates the search terms used noting that the term rural was used in all searches.

The developed terms were used to search Medline, CINAHL, Proquest, Expanded Academic, Informit and Cochrane databases, with additional searches using Google Scholar.

Study selection

Using the developed search terms 2467 articles were identified. An initial scan of title and abstracts identified large numbers of irrelevant studies, particularly those related to patient consultation and one off engagement activities that did not fit with Arnstein's definition of higher level participation. Through a process of elimination, driven by inclusion/ exclusion criteria, 99 studies were identified as potentially relevant. Full text versions of the articles were obtained and, as a key parameter for our review was high level participation, each paper was reviewed by more than one team member for evidence of partnership, delegated power and citizen control. Discussion occurred between the researchers to ensure there was consensus on the level of participation identified.

Over one-third of publications found were from Australian rural health journals including the Australian Journal of Primary Health and the Australian Journal of Rural Health. Australian researchers published 40 of the 99 articles retrieved; the United States of America (USA) 16, Canada nine, United Kingdom (UK) five and New Zealand one. After review, 24 studies demonstrated Arnstein's lower levels of participation [29], with publication dates between 1994 – 2011; 15 were Australian, seven from the USA, one from both the UK and New Zealand. Key topics covered by these 24 articles included consumer representation on health boards and governance, community consultation in strategic planning, strategies to involve community feedback in health care planning and design [43-45], and funding submission [46].

Overall, of the 99 articles located, innovative research methods for rural community participation were an emerging area, with eight articles published from 2006–2011; four were Canadian, with the remainder from USA, UK and Australia. Other topics covered were participatory action research design, development of theoretical frameworks or production of toolkits for consumer feedback and consultation [16], and development of conceptual frameworks for guiding or measuring processes [27]. The exploration of interagency partnerships [47-49] and workforce development [44,50,51] were considered by six articles. Conceptual discussion of community participation, defining key terms and highlighting issues for research and ethics were the focus of eight articles [52].

Table 2 Search terms

SPIDER Tool[1]	Search terms
S	("rural" OR "regional") AND ("population" OR "healthcare" OR "community")
P of I	("communit*" OR "consumer" OR "citizen") AND ("participation" OR "engage*" OR
	"involve*" OR "partner*" OR "collaborat*" OR "develop*")
	OR "cooperative behavio*" OR "stakeholder governance" OR "community network*" OR "community develop*" OR "social capital health services" OR "community-institutional relations" OR "community health planning" OR "health service*" OR "health planning"
D/E/R	"qualitative" OR "quantitative" OR "mixed method*" OR "community participation action" OR "case study" OR "cohort study" OR "quality assurance"

[1] [S AND P of I] AND [(DER)].

While the identified articles provided important background to our research question, the process of review for evidence of partnership, delegated power and citizen control only yielded six articles; published in the period 2003–2009. Three studies were conducted in rural USA [53-55], one in rural Canada [56] and two in rural Australia [57]. They included community capacity building [55,57], partnership development [35,55], and community involvement in health care design and development [35,53-57]. Figure 2 illustrates the process of study selection.

Consistent with the purpose of the review, to identify examples of high level participation that could be useful for policy and practice, we refined our final article selection to the six articles on rural health that most closely demonstrated higher level participation or Arnstein's notion of 'citizen power'.

Data charting and collation

The fourth stage aligned with Arksey and O'Malley's description of a charting approach. We developed summaries of each article and documented data related to author, year, location, study design, methods and sample (see Table 3).

Summarising and reporting findings

Arksey and O'Malley describe the final stage of scoping reviews as an overview of the located studies. As the purpose of our study, was to identify examples of higher level community participation in rural healthcare, our reporting focuses on the six articles that best demonstrate this.

Results and discussion

The assessment of higher level community participation

The six studies had strong citizen investment, with power balanced in a mutually beneficial partnership [35,53-57]. Decision-making was democratic [35,53-57], with community members equipped and skilled in prioritisation, strategic business and financial planning. In the planning stages, stakeholders had a shared and agreed vision, control and responsibilities and leadership was shared and distributed [35,53-57]. In two studies, the idea for a partnership was initiated and driven by community leaders [35,54]. In all other studies, participation was initiated by government and driven by state initiatives [55] or funding through local council and research partnerships [53,56,57]. Coady [56] described that 'the decentralisation of health decision making was

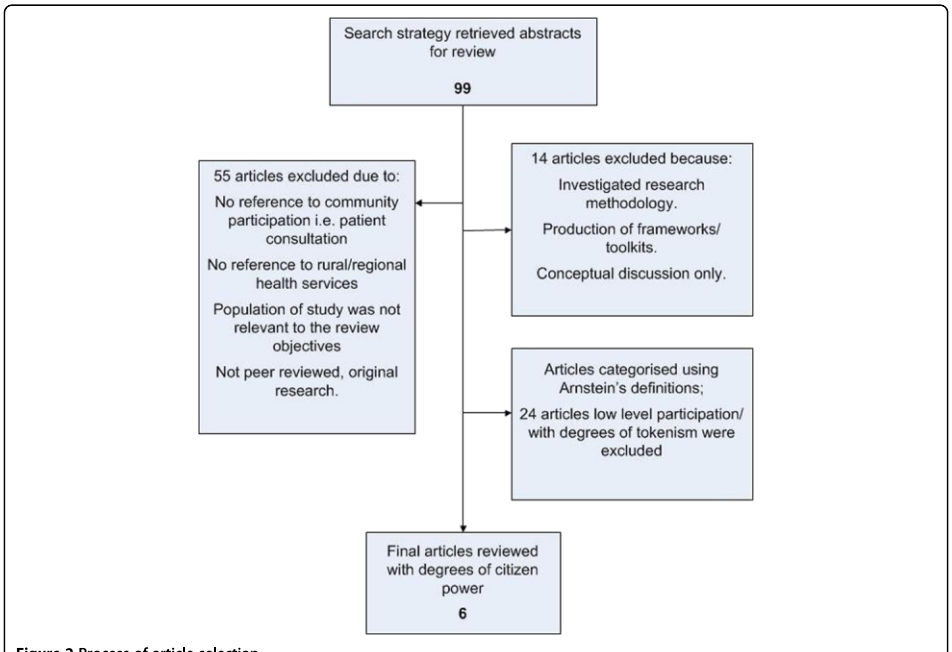

Figure 2 Process of article selection.

Table 3 Articles with high-level community participation located in rural and regional health settings

No.	Author	Year	Location	Intervention	Study design/methods/sample
1	Broussard [53]	2003	USA	Development of community health networks	Case study with mixed methods survey; Two rural communities located in Louisiana, St Marys parish population 53 500, Vermillion parish population 50 755
2	Coady [56]	2009	Canada	Volunteers on community health boards	Qualitative study with focus groups; sample 45 volunteers, working on community health boards, population rural shire of 50 000
3	Johns [35]	2007	Australia	Health service redevelopment	Case study with individual and group interviews[1]; Two Tasmanian rural communities, greater Oatlands population 6101, Deloraine population 5524
4	Kegler [55]	2008	USA	Citizen involvement in paid/ unpaid rural health leadership positions	Case study with mixed methods including postal survey, telephone interviews, and focus groups. California, sample N=243, 58% of respondents were from rural sites (n=140). Rural region/municipality combined area population 43 298
5	O'Meara [57]	2007	Australia	Council-led community capacity building	Qualitative design with content analysis of project documents and focus groups with community members; Gippsland, Victoria N= 9829; Korumburra 4465, Trafalgar 2685, postcode 3925 n= 2679 including Newhaven 428, San Remo 1017, Cape Woolamai 1234[2]
6	Huttlinger [54]	2004	USA	Primary healthcare community events	Case study with mixed methods survey; Rural Appalachia, Virginia area population N=1754[3]. Population N=3310 total health event participants, sample n=752 completed surveys, population including Wise, Virginia (3286) and Mountain City, Tennessee (2531) [3]

[1]Number of interview participants not reported. [2]Population numbers not reported in article, sourced from 2006 Australian census data. [3]Population not reported in article, sourced from 2010 U.S census data.

welcomed as a meaningful opportunity to bring the voice of the community fully into the process of setting local health agenda' [56]. Community representatives had bargaining influence over planning and outcomes and authority to veto or disagree with proposed plans and actions [35,53-57]. Researchers reported that shared power and leadership, transparency and accountability, enduring relationships, and mutual trust and respect, contributed to service outcomes [35,53,54,57]. In two studies, community members had the majority of decision making seats [35,57], however, in all studies power was retained by health professionals, paid coordinators, academics or health service managers as they held financial resources and ultimately decision-making powers [35,53-57].

Partnerships were needed to assess community strengths and resources, create management structures, facilitate comprehensive planning and negotiation, and to work through resistance [35,53,54,57]. However, gaining trust and acceptance was important and partners must be committed to long term outcomes for population health, and supportive of community ownership of health issues and solutions [35,57]. Utilising the knowledge, skills, resources and capacity building initiatives of universities and health services supported the achievement of outcomes [35,53,54,57].

Three of the studies reviewed [35,54,57] identified that higher level community participation is influenced by the nature of close knit rural communities and social interactions that support the development of new community sub-groups committed to local health care initiatives. Kegler [55] identified the importance of drawing on existing local leadership, and extending development opportunities to new leaders. In the rural context it was suggested that fewer resources provide a higher incentive for working together [35].

Outcomes of higher level community participation

In the studies reviewed, outcomes from community participation were indicated, though not rigorously measured. Reported outcomes included awareness of the health services provided [35] and improved self efficacy, social capital and accountability [35,55,56]. Benefits to community members included learning new skills [35,53-57], particularly in strategic planning [53,56], meeting facilitation [35], grant submission [53] and leadership [55,56]. It was reported that paid and unpaid leadership positions were created [35,53-57], with benefits for the people employed and the broader community.

It was reported that community participants enjoyed the learning process, the positive impact of contributing to healthcare in the community [56], new and strengthened relationships, reduced isolation, improved social support, and achieved a "strong sense of empowerment" [55]. Outcomes for the broader community included implementation of new public policy [56], new infrastructure and health services [35,54,57], and increased local employment positions [35,55]. Access to grant funding was described in some of the studies for community service development [53], and capacity building activities [35,57], with suggestions of small financial investment to reap large returns [55].

Challenges in community partnerships

Some of the studies demonstrated that delegation of power to the community is challenging for some individuals or groups [56] and power may be shared conditionally and withdrawn in times of conflict [57]. In their study, O'Meara, Pendergast and Robinson described a situation of conflict where "council attempted to become more directive through the facilitators, rather than involving the community in defining their own solutions and strategies" [57]. Despite intentions of authorities to share power and ownership with the broader community, in all studies reviewed, the final decision-making powers were still held by a person or group in a professional, leadership position [35,53,54], such as local government [55-57]. Sustainability was supported by continuity of leadership [35,53,57], with one report of a study being temporarily suspended when a paid community facilitator was lost [57].

Limitations of the studies

While all of the reviewed studies reflected elements of higher level participation, the study by Johns was closest to full citizen control [35], where power was only delegated to the partner health care organisation when managerial responsibilities exceeded the group's capacity. In all of the studies, only scant details were provided about processes of nomination, election and representation with groups developed through self-selection or from existing leaders within the community [35,39,53-56]. In one study, participants included unemployed or low income volunteer community members [56] but in all studies little description was given about who was included or excluded and the rationale for these decisions. While one study described the community population as vulnerable and underserved [53], consideration of issues associated with working with marginalised populations was absent.

None of the reviewed studies reported the use of web based interfaces or social media to mobilise and engage communities but instead relied on local media to disperse information, raise public perception and acceptance of community action and progress [53,54]. Early release of needs analysis research data in local newspapers and television news was identified as a cost effective method of gaining community interest but none considered the use of the internet to transfer or gather information.

The six studies had a similar study design, using qualitative research methods such as interviews and focus groups for collecting and analysing data on the participants' experiences of participation [35,39,53-56]. This descriptive information provided an overview of possible outcomes for participants and the broader community, however no quantitative methods were used to measure or validate the outcomes reported.

Conclusion

The limitations of this review related to size, breadth, inclusion and exclusion criteria, article selection and review are acknowledged. The very small number of articles identified is perhaps not surprising given contentions that a great deal of rural community participation is not reported. However, in an environment characterised by increasing interest in community participation in rural communities the need for rigorous research that explores and analyses higher level community participation is needed. Policy promotes community participation as highly desirable, but for many policy makers, practitioners and community members there are major gaps in understanding the purpose, process and outcomes.

Abbreviations

WHO: World Health Organization; USA: United States of America; UK: United Kingdom.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

VDS, AK, JF and PO conceived and designed the scoping review, and completed the first draft. JS developed the search strategy, completed the database searches and preliminary synthesis of findings; and provided input on early drafts. VDS and AK provided intellectual content to shape the findings and discussion. NH and JS made final decisions about article verification with consensus from all authors. NH collated all materials, completed the analysis of key findings and prepared the manuscript. AK edited the final manuscript, and all authors read and approved the final version prior to submission.

Acknowledgement

The authors would like to acknowledge the academic staff within the La Trobe Rural Health School and the contributions made to discussion forums and feedback on preliminary article plans.

Received: 24 October 2012 Accepted: 11 February 2013
Published: 18 February 2013

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doi:10.1186/1472-6963-13-64
Cite this article as: Kenny *et al.*: Community participation in rural health: a scoping review. *BMC Health Services Research* 2013 **13**:64.

Publication 2:

Kenny, A., Farmer, J., Dickson-Swift, V., & Hyett, N. (2015). Community participation for rural health: a review of challenges. *Health Expectations, 18*(6), 1906-1917. doi:10.1111/hex.12314

Journal impact factor: 2.852 (retrieved 27/03/2016)

doi: 10.1111/hex.12314

Community participation for rural health: a review of challenges

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Accepted for publication
31 October 2014

Keywords: challenges, community participation, rural health

Abstract

Context Internationally, community participation is highlighted in health policy reform as good for rural communities. Implicit in this policy is the message that the complexities of the rural environment are too difficult for easy solutions and that community participation will somehow build resilient, self-determining communities capable of dealing with complex rural access and equity issues and poorer health outcomes. The underpinning proposition is that by giving decision-making powers to community members, health care will be locally responsive, costs will be contained, and health outcomes will improve. What happens in the practice of enacting community participation in health-care decision making is less clear.

Objective Despite the growing body of work that documents different levels and models of community participation, significant gaps that outline the practical challenges inherent in rural community participation remain. In this article, we draw on a body of literature to outline the practical considerations in implementing community participation policy in health settings in rural areas. Through a critical review, we aim to stimulate debate, progress ideas and provide a conceptual representation of the somewhat 'messy' nature of rural community participation at a grass-roots organizational level.

Discussion and conclusion Based on our analysis of the current literature, we provide a summary of challenges and practical strategies that might mitigate some of these challenges. Our review highlights that despite policymakers suggesting that community participation is good for rural communities, policy enactment must move beyond mandated tokenism for there to be a recognition that meaningful participation is neither easy nor linear.

Introduction

Community participation in health-care design and coproduction is increasingly highlighted in health policy reform in the United States,[1] Canada,[2] Asia,[3] Europe[4] and Australia[5] as good for rural communities. Implicit in this policy is a view that rural settings require

customized solutions[2,4,6–8] and that rural communities are appropriate places of participation. There is an assumption that involving citizens will build the resilient, self-determining communities needed to deal with complex rural issues of access, ageing, and poor health and social outcomes.[9]

Coproduction is a term increasingly evident in key policy documents when referring to participation and is defined as a collaborative approach to bringing together professionals, people using services and citizens to develop and deliver public services.[10] The underpinning proposition is that by giving decision-making powers to community members, health care will be locally responsive, costs will be contained, health outcomes will improve, and health professionals and health systems will be more accountable.[1,2,8,11]

Whilst governments across many developed countries are promoting community participation as central to health reform,[8,12–15] a major policy flaw in the current community participation agenda is acknowledgement by governments, sometimes quite overtly, that they are unclear about how meaningful community participation will actually be achieved.[11,14,16] Increasingly, there is a move from governments in several countries to mandate community participation by linking it to quality and safety reporting.[17–19]

As researchers, we work closely with rural health service partners who struggle to enact mandated standards that require communities to participate at all stages of health-care design, delivery and evaluation. Whilst we are located in Australia, it is evident that there is a lack of international knowledge on the enactment of community participation at a grassroots level. This impedes the ability of rural health services to identify what meaningful community participation might mean for their organization, their staff and the communities that they work with.

In a previous review (add reference to our 2013 article following peer review of this manuscript), we sought to identify examples of community participation in rural health care that could support participation processes at a community level. We found few examples, and those that did exist lacked critical analysis of the rationale for rural community participation in health care and the challenges that communities face in enacting participation policy at a local level. There was little discussion of processes, inclusion or health/social outcomes. Our findings were consistent with other researchers who argue that there is limited evidence of outcomes from community participation across all health-care settings, not only rural.[20,21] Our review revealed a gap in knowledge of the practical challenges inherent in rural community participation, and it is this gap that we seek to address here.

Method

Our research question for this study 'what is known about the practical challenges in enacting rural community participation' informed our choice of review method. Grant and Booth[22] provide a useful typology of reviews, and from their work, a critical review aligned best with our question and purpose. Critical reviews are used to source, analyse, synthesize and 'take stock' of a diverse range of literature.[23] The focus is on the conceptual contribution of a broad range of literature, rather than an assessment of the quality of the work.[22]

Whilst typically critical reviews do not include formal presentation of search strategies,[22] we believed that a documented search was useful to meet our aim of identifying and providing commentary on the challenges of rural community participation. We identified key search terms reflecting our research question, and the following Boolean search string was used: (rural or regional) AND (population or health care or community) AND (commun* or consumer or citizen) AND (participation or engage* or collaborat* or partner*). The use of truncated words and wild cards (*) enabled a broadening of the search to capture terms with the same root. The search was conducted in Medline, CINAHL, Proquest, Expanded Academic and Informit.

Our initial search yielded 2467 articles. Following a scan of titles and abstracts, large numbers were excluded, as most were focused on patient consultation. We focused our study on developed countries, and after excluding literature from developing countries, 99 full-text articles were retrieved. We then hand searched reference lists to capture key additional literature on community participation. Through a process of in-depth reading, we extracted information about challenges in community participation and aggregated these challenges under three main clustered headings: shared understanding, governance and practical application, and sustainability. Consistent with limitations of critical reviews, our 'interpretative elements are necessarily subjective',[22] but we did achieve agreement through a team approach of discussing sourced literature, clustering and cowriting.

In presenting our review, we aim to illuminate challenges in the practical enactment of health policy. Our purpose in doing this is to stimulate critical debate, progress ideas and provide a conceptual representation of rural community participation at a grass-roots organizational level.

Shared understanding

Definitional challenges

'Community' and 'participation' are debated terms,[24–28] which create challenges for those seeking to start local initiatives. Participation has been variously defined in terms of individual, personalized relationships, through broad collective citizen involvement,[17] 'meaningful' engagement,[5] active involvement in policy implementation,[18] shared or delegated power,[29] and coproduction.[30]

Common definitions of 'community' include people in a relatively bounded geographical area,[31] a social space with interactions and transactions,[32,33] people with social and cultural affiliations and common norms and customs,[28] and people who drive locally beneficial solutions.[34] There is a premise of a somewhat cohesive group of individuals with a common purpose and shared focus.

However, whilst rural communities are sometimes characterized as bound by relationship ties and unofficially governed by local hegemonies,[35] classically portrayed in the notion of *gemeinschaft,*[36] the need to be cognizant of the complexity and changing nature of rural communities is an important consideration prior to embarking on community participation initiatives. Assuming that communities will welcome participation opportunities and engage as 'well-behaved' citizens is at best naïve. Oakley's[37 (p. 4)] comments about rural people, whilst almost two decades old, are a timely reminder of rural complexities:

> Participation...cannot merely be proclaimed or wished upon rural people... It must begin by recognising the powerful, multi-dimensional and, in many instances, anti-participatory forces which dominate the lives of rural people. Centuries of domination and subservience will not disappear overnight just because we have 'discovered' the concept of participation.

Community participation: purpose and rationale

When embarking on community participation at a local level, having a clear understanding of its purpose and rationale would seem a basic starting point. However, globally, there is debate on motivations for policy's emphasis on community participation.[27,38] Questions are asked as to why greater community participation is espoused in countries with the democratic right and power to influence political decision making, through free and open electoral voting processes.[27,39] Normative arguments centre on active citizenship, as key to quality democracy. The focus is on cohesive social capital and good governance, including scrutiny of governments, to increase transparency, honesty and accountability.[27,39] Instrumental arguments[27,38] centre on service users having valuable insights into service delivery and improvement, ensuring service efficiency and effectiveness.[40] In complex and controversial situations, it is argued that diverse groups of stakeholders may assist in reducing conflicts, by harnessing collective problem-solving to

address 'wicked' or complex problems that require collective input.[41]

Critical questions are posed as to whether community participation is simply governments' attempts for legitimization[39] or neoliberal underpinnings of passing responsibility for design and delivery of services to end-users.[39,42] It is argued[27,38,43] that democratic governments have been traditionally reticent to delegate any real power in decision making, beyond the political gain that might be engendered through being seen to listen to the 'voice' of the people. Whilst these debates centre largely on participation at a macro level, they do provide a cautionary note at the rural community level. Questions could be asked about the purpose, goals and focus of a community's participation and whether there are local organizational commitments to delegate decision-making power, or whether participation is designed simply to meet statutory requirements (i.e. bureaucratic box-ticking).

Embedding community participation in a meaningful way means to move from 'symbolic' or 'representative' engagement to direct, cogovernance, involving communities in the planning, design and delivery of health and well-being services and amenities.[42,44] When participation is embedded at operational levels, it is expected to define and uncover solutions to complex local problems, create momentum and draw on expertise from diverse sources of knowledge, including practical experiences of those working and living in the proximate field.[27]

Whilst the concept of participation emerged through international health policy,[45] a range of interpretations of community participation and foci of its application have developed, and we argue that confusion has resulted, to an extent impeding more widespread adoption in the rural context. The WHO[46] interchangeably refers to 'participation' 'involvement', 'engagement' and 'empowerment', and this creates widespread confusion.

In rural policy,[2–5] community participation is suggested to be good for rural communities without much explanation of what it means. As Morgan[24 (p. 222)] explains,

> The proliferation of meanings attached to the phrase 'community participation in health'... has allowed it to be analysed as a political symbol capable of being simultaneously employed by a variety of actors to advance conflicting goals, precisely because it means different things to different people.

Regarding rural places, variation in understanding might be expected due to heterogeneity of rural contexts, nationally and internationally, and the consequent mix of demographics and pertaining policy frameworks. Indeed, participation has been described as an umbrella term, suggesting an on-going, active relationship with shared power and ownership, understood in different ways by different people.[15]

Lack of shared agreement on theoretical frameworks

Theoretical models or frameworks to underpin community participation are debated. Since 1969, Arnstein's ladder of citizen participation (Fig. 1) has been promoted as the seminal community participation model. It represents the redistribution of power from 'government to the governed'.[29]

However, since the 1990s, critics of Arnstein[26,47–53] have identified issues with the ladder, including lack of consideration given to the quality of the participation and limitations associated with the categories chosen. Modifications, refinements and adaptations of Arnstein's ladder have occurred with those by Burns[47] and Wilcox[49] most commonly cited.

Despite these refinements, contemporary authors[50–53] critically reject the use of Arnstein as the 'touchstone for policymakers and practitioners'.[53] It is argued that refinements to the model have promulgated hierarchical thinking, with uncritical embracing of power as a single dimensional, finite commodity that can be seized by citizens and used to shape health decision making.[50–53] Bishop and Davis[50] argue that the simplistic, linear notion of participation

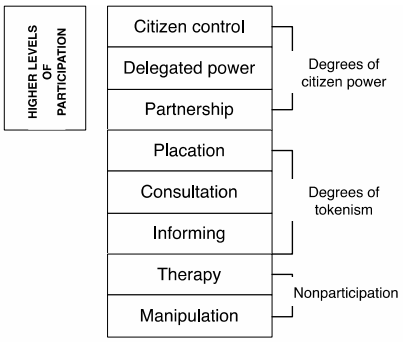

Figure 1 Levels of participation. Adapted from Arnstein S. A ladder of citizen participation. Journal of the American Institute of Planners 1969, 35:216–224.

creates a false view that policy problems are static and that different levels and types of participation are needed to address the same problem.

Critics contend that Arnstein's top rung, citizen control, creates a view that any participation below this level is not legitimate[51] and fails to acknowledge that for different people and different purposes, different levels may reflect successful participation.[52] Tritter and McCallum[53] refer to 'dangerous snakes' in Arnstein's ladder. Using the analogy of snakes, they describe a multitude of issues that limit participation and argue that the ladder is built on the 'assumption that power will trickle down from involvement'.

Focusing on groups that may be disadvantaged, Tritter and McCallum[53] and others,[50,51] argue that the emphasis on citizen control has a risk of capturing popular opinion without attention to involving disadvantaged citizens. Others[52–54] contend that hierarchical models assume that all people want to be involved in the same way, rather than capturing the desired level or type of involvement of different community members.

In arguing that the transfer of power to citizens has the potential risk of creating adversarial positions between policymakers, service providers and users (and indeed within these groupings), Tritter and McCallum[53] propose that community participation is more like a 'vague mosaic' than a ladder with defined rungs. Collins and Ison[52] argue that the fundamental flaw in Arnstein's and adapted models is the lack of consideration of how all stakeholders might work together collectively to pursue an issue that is contested or ill-defined. Their proposition is social learning, which they define as learning that occurs through situated and collective involvement with others. They argue that this is more appropriate to reflect interdependencies, complexity, uncertainty and controversy. Whilst they argue for a new policy paradigm of social learning for concerted action,[52] they also acknowledge that lack of a consistent theoretical underpinning for community participation is a challenge for those wanting to embrace different approaches.

The lack of evidence for embracing participation

Health-care providers' interest in community participation may be provoked by the argument that community participation is useful to manage health-care rationing and decentralization, and thus central to efficiency models that are localized to regions and community priorities.[55,56] However, researchers argue there is little evidence of widespread policy change to locally appropriate, diversified, health-care delivery models as a direct result of citizen inputs to design.[57]

In a number of case studies, participation has resulted in improved infrastructure, funding and beneficial changes to service provision, and there is some evidence to suggest that participatory processes increase social capital and cohesion.[58,59] However, there are still gaps in evidence linking participation and health-care service improvements, particularly in the rural context. Study findings are limited in capacity to replicate or generalize, and scalability of small rural projects to larger systems and policy is unknown. There is a paucity of longitudinal research to demonstrate whether short-term efforts are sustained, or whether they result in

cost-effective solutions for rural health improvement objectives, such as reducing the burden of chronic disease and health spending.

When discussing rural community participation, Kilpatrick[60] states that engaging communities in health care is expected to have desirable outcomes for citizens, however, implementation has superseded robust research evidence and more needs to be known about whether participatory methods achieve anticipated results. More broadly, several authors have identified a paucity of research that identifies whether the outcomes of participation meet purported objectives.[14,38,61–64] This gap in knowledge presents a significant challenge when convincing all to participate.

Governance and practical application

Improving how government and related organizations work with communities is an international policy interest.[54,65–67] Researchers argue that the major challenge in rural areas is unequal positions of power, stemming from differences in social class, knowledge and expertise, societal position, and other educational and occupational advantages.[9] Williamson and Fung[68] describe information gulfs that separate different groups in the community, and knowledge that separates 'outsiders' from locals. In the rural context, Kilpatrick[60] argues that strong governance to bridge gaps is a necessary preparatory step for meaningful community participation.

However, evidence of governance models to support community participation is limited, particularly in the rural context. Ethnographic fieldwork in rural Australian communities in three states suggests 'governance is not a single process in which communities are, or are not, adequately engaged ... governance is comprised of different processes, instigated by different actors for different reasons, both in and out of dialogue with public agencies'.[54 (p. 55)] An important consideration is a pervasive view in many rural communities that those from government are outsiders with little understanding of how local communities actually work.[54]

Inclusion and representation are challenges in establishing governance, and in rural communities, this may mean an inner circle of key community leaders to developing an effective governance environment. As Morgan[24] highlights, the challenge is to develop governance frameworks that enable participation to arise from inside and occur as spontaneous and self-generating, rather than from outside or above. There are a few examples of governance structures that have partnered community members, health care and other service stakeholders to bring together lay and expert knowledge and community resources,[69,70] but the paucity of evidence-based governance processes provides a major challenge for local implementation.

Additionally, even in situations where governance mechanisms are established, government regulations, for example, that require community organizations to acquire formal bureaucratic processes such as working with children checks, food handling and insurances, present challenges that conflict with ways rural communities have traditionally governed themselves. This can serve to de-legitimize the communities' own forms of self-organization.[54]

Considerations of who participates

Questions of who participates, who does not and whether it matters, are challenging for enacting rural community participation. In participatory activities, community members are generally assumed to share a vested interest in making their community a good place to live. In rural communities, this can mean appointing 'local champions' or the 'usual suspects' to attend structured meetings and provide opinions or feedback.[69,70] It is expected that community members, who either self-select or are appointed, are able to set aside their individual interests and develop a shared vision for beneficial community outcomes. Methods such as citizen juries, neighbourhood committees, community forums and community champions are built on this premise.[21,71]

However, who really represents 'the community' is debatable.[54,65] Community members

may have conflicting interests, and individual conflicts between community members may determine who volunteers to represent others. Representative participation is common in rural communities with consumer representatives on local boards, networks or action groups.[72] However, by only including those who are available, have the capacity to participate in a power-compromised social setting, or who self-elect, participation may exclude others with diverse perspectives. Mechanisms to engage the disadvantaged and marginalized remain elusive.[34] Whilst there are some examples of inclusion involving disadvantaged or marginalized people and subcultures,[73] there is limited evidence to suggest that participatory approaches alone, without specific strategies to target marginalized groups, result in an inclusive model of community participation.[34,60] Insider–outsider tensions are widely discussed in the literature.[65,74–76] Eversole[66] contends that it is impossible to adequately represent those who are not directly participating. However, she acknowledges the importance of what she terms 'translation agents' – those people who are comfortable in the circles of both the powerful and the powerless and who are able to facilitate transactions among groups.

Whose knowledge counts?

There is a need to consider that different forms of community knowledge exist and how to access forms of knowledge. Local community knowledge is grounded in context, which challenges those external to rural communities to accept local knowledge as a legitimate form of understanding as well as to find ways to gain access to this information base.[77] Eversole[77 (p. 34)] argues that dialogue is often complicated by 'the persisting assumption that experts are still holding the only real "knowledge"'.

In the context of the rural community, longstanding community members can dismiss the views of others who are not considered 'real locals' as they do not have familial roots within the community. Whilst residents may have lived in the community for extensive time periods, they are not viewed as having legitimate claims to knowledge about the community until they have lived there for decades.[15]

A criticism of rural community participation approaches, is that one group (often endogenous and usually the more powerful), tries to 'engage' the other group, using its own processes. This may include having workshops and/or meetings that are presented in a format and language that makes sense to one group but can alienate others.[61,78,79] Cornwall[67] criticizes these 'invited spaces', highlighting that no matter how participatory groups seek to be, they are 'still structured and owned by those who provide them' as compared to spaces that people create for themselves.

Sustainability

Researchers argue[53] that for some people, participation itself may be their goal, that is without the necessity for some punctuating endpoint or output. They suggest that the opportunity that participation offers to come together for social interaction can be highly valued. However, there can be on-going demands for people to participate in various activities in their communities, which can result in what has been termed 'participation fatigue'.[21,67,80] In rural areas with small populations, this can pose a barrier to participation. Community members who have been involved in participation processes have reported negative physical and psychological health consequences including exhaustion and stress.[81]

Issues of sustainability have recently been drawn into the community participation and rural health literature as a measure or indicator of progress,[82] but the issue is problematical. The increasing association of participation, sustainability and rural health services may derive from issues related to service closure and changing rural population demographics. There is a risk in using community participation processes as an outcome or performance measure reported to funding bodies. Desiring sustainable community participation, in this sense,

may be imposing an artificial, indeed unhelpful measure that is useful to outside bureaucrats and not to local citizens.[83] Reinvigoration for the sake of funding may occur, or superficial changes made to programmes to meet requirements, denouncing the idea of 'full citizen control' and acting as a reminder to communities of who essentially has the power. Using sustainability as an outcome measure of participation may impose an endpoint to an otherwise continuous process of engagement and cultural change.[24] By compartmentalizing participation as a 'project' or 'product', political ideals are imposed on what may occur as a spontaneous, naturally occurring process of change.

In tangible terms, researchers have argued that the scale of participation indicates sustainability. Morgan[24] states that 'in order for participation to be sustainable it must extend beyond the local (or project) level'. Enduring through disadvantage, or disasters, and continuing to function under strain are included in the rural health conceptualization of sustainability.[24] Sustainability as an outcome of community participation might be better viewed as improved community liveability and enrichment, strengthened social connections, and liveable physical space and natural and built resources.[84] Farmer, Prior and Taylor[85] suggest that these dimensions, or resources, can be measured as stocks of types of capital when indicating outcomes for communities, where improvement indicates growth and prosperity in addition to longevity.

Discussion, practical strategies and conclusions

In this paper, we have drawn together literature to highlight some key challenges for enacting rural community participation. We are not suggesting that the challenges we have identified represent an exhaustive set. Rather our purpose was to provide a thought-provoking overview. Some issues raised are widely applicable to non-rural settings, but we argue that the rural environment creates a complex context that community participation policy directives[1,2,15,86] fail to acknowledge. Rural communities have small populations that must continue to live in proximity with each other, before, during and after participation exercises, and they tend to have ageing populations, which mean dwindling human capital. Whilst government acknowledges confusion over directions for enacting community participation, we argue that there are many issues beyond simply 'how to do' community participation. These make involving communities in health-care design and provision very complex for rural community health service providers.

Whilst the policy environment assumes that community participation is good for rural communities and many authors present arguments for community participation related to active citizenship, democracy, transparency, government scrutiny, collective problem-solving, social capital, and improved efficiency and effectiveness,[27,39–41] questions about purpose, goal and focus are fundamental and need, if not resolution, at least acknowledgement and discussion in policy arenas.

The proliferation of meanings of community participation,[24] definitional challenges,[24–28] and debate surrounding appropriate theoretical frameworks[26,47–53] provides a chaotic picture for citizens and health-care providers seeking clarity. Rural health services may be told that participation is central to local ownership and efficiency, but the paucity of evidence to support these contentions presents a significant challenge to convincing local stakeholders.

The intention of governance processes is to produce strategy and order, so the lack of knowledge of governance processes to support effective community participation[60] is a gap. In establishing community participation initiatives, there are complex questions of inclusion, representation, and legitimate types of knowledge. However, even if these issues can be dealt with, there is often tension between innovation and documentation of evidence on what works in the community participation space.

The challenge of enacting community participation and strategic imperatives of organizations results in questions of sustainability. There are risks associated with community

participation processes being viewed as outcomes or outputs, in that community fatigue from being involved in a multitude of projects, impacts on the ability to really harness sustained, long-term participation for change.

In drawing together the findings of our review, we provide a summary of the major challenges and propose some practical ways these might be addressed.

Shared understanding

Before embarking on community participation, it is important that all stakeholders have a shared understanding of the purpose and rationale. Organizations must be clear whether they are delegating real power in decision making or whether participation is simply meeting mandated requirements. Moving from 'symbolic' engagement to coproduction requires a commitment if shared ownership is to be developed. Early conversations between all involved are paramount. Importantly, organizations must clearly understand that participatory processes might not lead to solutions that fit with directions of the organization, locally responsive health care or improved health outcomes.

Bucolic, idealized views of rural communities might serve to perpetuate a picture of cohesive groups. However, these same views might serve to ensure that those who do not fit the idealized rural mould are further marginalized. There is a need for communities to have open and honest discussion about changing demographics and develop a number of strategies to engage with populations that are hard to reach. This might involve the use of peers to guide participation, participatory activities in different settings, the use of different participatory processes, including social media, and engaging in different, creative ways. There is a need to spend some time ascertaining the desired level or types of involvement of individuals and different groups.

Governance and practical application

Unequal positions of power are inherent in community participation. Consideration should be given to ensure citizens have practical training in participatory processes and where appropriate citizen advocates are engaged. Whilst inclusion and representation are challenging issues for governance, community 'champions' or key community leaders are useful to engage in planning and implementing a solid governance environment. The focus should be on developing strategies that support participation by marginalized population groups.

Sustainability

Participation fatigue can be a real issue in rural communities. Developing different ways for people to participate might be one strategy, but there is also a need to clearly recognize that all participation does not have to be protracted for a long time period to be sustainable. Sustainability as an outcome might be represented by improved liveability and strengthened social connection. The fundamental message is that organizations should be clear about what they are participating about, and once the issue has been explored and considered, it may be appropriate to cease participation on that issue.

In concluding, we argue that whilst policymakers may present community participation as a desirable process, where people queue in a somewhat orderly fashion, to climb the rungs of a ladder towards citizen control, the reality shows we are not at all sure about solid structures, organization and processes. Rural communities are not homogenous, connected and uniform. The analogy of a ladder suggests safety, careful steps and an upward climb. Our experience of community participation fits with Tritter and McCallum's[87] 'messy' description. Policy might suggest that community participation is good for rural communities, but if policy enactment is to move beyond mandated tokenism, there must be recognition that meaningful participation is neither easy nor linear. Critics of Arnstein refer to the snakes amongst the ladder rungs, but for rural communities, there is a need for fundamental awareness of the key challenges before even taking the first step.

Acknowledgements

No funding was received for this work, and the authors have no conflict of interest.

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Publication 3:

Hyett, N., Kenny, A., Dickson-Swift, V., Farmer, J., & Boxall, A-m. (2014). *How can rural health be improved through community participation?* Canberra Retrieved from https://ahha.asn.au/system/files/docs/publications/deeble_issue_brief_no_2_improving_rural_health_through_community_particpation_.pdf

Journal impact factor: N/A

deeble institute issues brief

no: 2

date: 26/03/2014

Title

How can rural health be improved through community participation?

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Executive summary

Rural Australians generally experience poorer health than their city counterparts. Rural Australia is a vast geographical region, with significant diversity, where there is good health and prosperity, as well as disadvantage. The purpose of this issue brief is to provide evidence on how the health of rural Australians can be improved through community participation initiatives, which are currently being funded and delivered by health services and networks.

Rural Australians need innovative health services that are tailored to the local context and meet increasing healthcare demands, without increases to expenditure. There are community participation approaches supported by research that can improve existing practice. Avoiding duplication, including the current work of Medicare Locals and Local Hospital Networks, is important for ensuring good outcomes from community participation initiatives.

The following recommendations are made to improve practice:

- New ways to contract and pay for health services are needed, which use ideas developed with communities, within current budgets
- State and federal government competitive grants and tenders should prioritise proposals that demonstrate effective community participation approaches
- Community-based services, such as community health centres, Medicare Locals and Local Health Networks, have an important role to play in facilitating community participation, including:
  - Building partnerships between existing services and leveraging existing participation strategies, rather than developing new services or standalone initiatives – to leverage available funds and maximise outcomes
  - Employment of a jointly-appointed, paid community leadership position across existing community-based health services, to avoid duplication and overcome barriers of over-consultation and volunteer fatigue
- Formal and robust evaluation of initiatives is necessary to guide future policy and research

A national innovative online knowledge sharing portal is required to share best practice in rural community participation, save time and money on ineffective approaches, and to support the rural health workforce.

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What is the policy issue?

Rural people, one-third of Australia's population, generally experience poorer health than their city counterparts [1]. Rural Australia is a vast geographical region, with significant diversity; where there is good health and prosperity as well as disadvantage. The purpose of this issue brief is to provide evidence on how we can improve the health of all rural Australians, but particularly for people experiencing disadvantage.

Overall, rural Australians are more likely to experience poor health, and their life expectancy is up to four years lower than urban counterparts [1]. Preventable health conditions, including obesity and accidental injuries, are more prevalent in rural compared with urban areas; and there are higher rates of unhealthy behaviours, mainly risky alcohol use and tobacco smoking [1]. Suicide prevalence is high, particularly for young men and men aged over 85 years old [1]; as are rates of chronic diseases, including mental illness.

The distribution of health services in rural versus urban areas contributes to poorer health outcomes. Rural health services are generally small with fewer resources and infrastructure, but at the same time are expected to provide a broad range of services over a large dispersed area [2]. There are high demands placed on them because of fewer alternative options, high population needs and persistent workforce shortages [2]. In 2011, fewer available health professionals and limited access to specialist services resulted in an estimated $3 billion shortfall in health service provision in rural Australia, primarily for dental, allied health and aged care services [3]. Access to timely and affordable health care for rural people is a national problem.

Commentators predict rural-urban inequities will worsen with new challenges to the health sector [4]. One reason for this is the increasing privatisation of health services, which makes it difficult for people on low incomes to access care. Health budgets are tightening, while ageing populations and the increasing burden of chronic disease are placing increasing demands on health systems and challenging current capacities [5, 6]. Recent national health reforms may go some way to improve the health of rural people. However, there is no evidence to date that they have made significant progress in addressing rural health priorities [2]. With ongoing rural health inequities and an uncertain fiscal future, it is becoming increasingly important that we find effective, affordable and sustainable ways of improving rural health.

What is the proposed solution?

One way of tackling disparities without large increases in expenditure is to engage rural communities in redesigning health services, so they better address local needs. Community

[1] We use the ABS (2011) definition of rural as "outside major cities" , a geographical grouping that includes regional and remote, noting that health varies across these regions

participation[2] is a process of collective action, which takes full advantage of local assets and capacities, mobilising citizens to take control of health at the local level. Communities participate in a partnership with services to deliver health programs and initiatives. There are already instances of this occurring across Australia [7-10].

National standards require health organisations to engage consumers and communities in service planning, design, evaluation and governance [11, 12], and the majority of hospital and primary care networks are releasing community participation plans. 'Standard 2: Partnering with Consumers', found within the National Safety and Quality Health Services Standards, notes that consumer participation will improve the "safety and quality of care" [11]. Primary care reform requires that Medicare Locals coordinate primary health care services "with a greater focus on the specific needs of local communities" [13]. The aim of policy initiatives is to have consumers and communities participate in the delivery of health services they consume, and to mobilise communities to take action on local issues that impact on their health and wellbeing.

One of the challenges for health services executives charged with meeting these standards is that there is little guidance on how to *do* community participation so that it improves health outcomes [14-16]; this lack of evidence extends to the rural context [8, 17]. Experts suggest that community participation will improve outcomes for communities and health services when it is facilitated effectively, and argue that people have a right to be involved in decisions about publicly funded services [18, 19]. Drawing from the best available research, this issue brief provides recommendations on how to facilitate rural community participation to improve the health of rural communities.

Community participation in the rural context is enabled and challenged by a range of factors. There are numerous examples of successful community participation in Australia, particularly in Indigenous health, which demonstrate that it can be effective (see for example westerndesertkidney.org.au). There are several reasons why, for instance, rural communities tend to have fewer services, therefore people have more incentives to participate in discussions about them [9]. Generally, rural communities have higher rates of community connectedness and volunteering [1]. There are longstanding traditions of community participation with small rural hospitals and health centres, particularly in times of threat and protest, or natural disasters [20, 21]. And, outside of mainstream health services, community participation has been integral to rural wellbeing through strong establishments such as the Country Fire Authority and the Country Women's Association.

Relying on strong rural community bonds alone, however, is not enough. Some rural citizens have no interest in contributing to discussions on how public healthcare services are delivered or run. Research has reported that ad hoc, informal or responsive involvement is enough in some communities; however, at the same time, some people have no desire to

[2] We use Schmidt and Rifkin's (1996) definition of community participation in healthcare, "social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decision and establish mechanisms to meet their needs"

take on public healthcare responsibilities [22]. Initiatives that burden volunteers with additional responsibility run the risk of exploiting rural 'goodwill' and destabilising existing good community work.

Rural communities with changing demographics might encounter difficulties in facilitating community participation using traditional strategies, for example, a 'town hall' style meeting might be insufficient to understand broad community concerns because of the growing diversity of views and agendas. For example, 'tree-changers' (people who move inland from metropolitan cities seeking new life styles and opportunities within regional Australia) might have different ideas about local hospital priorities than farming families with young children, or newly-settled refugees. And finally, because rural people have past experiences of services being withdrawn, it is understandable that participation approaches implemented by public institutions may be met with suspicion and resistance.

There is little guidance for health services on how to effectively facilitate community participation in meaningful ways that results in positive outcomes. Without evidence, there is a risk that tokenistic methods or a 'tick box' approach will be used to meet legislation and standards on community participation. The challenge policymakers face is finding best practice approaches to community participation that can be implemented across rural Australia, which improve the delivery of services and health outcomes for rural people.

Best practice approaches to community participation

The following strategies for effective community participation have been developed from research currently being conducted by the La Trobe University Rural Health School (refer to *Building Healthy Rural Communities Research* page 13 below for more details). A case study of community participation in Canadian food programs and initiatives, including a national food security network, a provincial-level food and farming alliance and several local community gardens and kitchens, reveal a number of effective participation strategies. The findings of this case study, together with preliminary findings from three rural Australian research initiatives, have been used to develop the strategies outlined in this issue brief. They are designed to improve community participation initiatives that are currently being implemented in rural health care services in Australia and to enhance outcomes for the organisation and the community.

1. Gather local knowledge with local people

A comprehensive understanding of local context is required to facilitate participation at a community level—a one-size-fits-all approach to community participation rarely works. Generic approaches underutilise local knowledge, social networks, assets and expertise, and fail to respect historical experiences, cultural context and local health conditions. The diversity of rural communities needs to be understood by examining the local context through a process of gathering experiential and tacit knowledge (lived experiences) as well as scientific knowledge.

The story of Warracknabeal, Victoria, demonstrates how national data can be an inaccurate depiction at the community level (see Box 1 below for more details). This example demonstrates that knowledge of the local context will contribute to more accurate health planning and prioritisation as well as increase awareness of local assets and attributes to support health initiatives, for instance, the availability of volunteers and neighbourhood safety.

Box 1. Warracknabeal, Victoria

Warracknabeal

Warracknabeal is situated in the Yarriambiack Local Government Area (LGA), about 330 kilometres north-west of Melbourne. Warracknabeal is an affordable place to live, and the LGA has the second lowest median house price in the state, with over 97% of rental housing classified as affordable. This community has a high sense of belonging, trust, and safety; 45% of residents volunteer; membership of groups and parental involvement in schools is above the state average, and crime is low.

Unique to this rural area, population projections indicate an increase in young adult residents, possibly due to affordable housing costs, and availability of public schools (see www.facebook.com/WarracknabealSecondaryCollege) and health services (see www.rnh.net.au). Unemployment (4.6% compared with 5%) and welfare dependence (8.8% compared to 9%) are below the state average, although, take home wages are low, and almost half of households live on less than $650 per week (6th lowest of Victorian LGAs).

There are high demands on health services because of an ageing population and high prevalence of disability. The rate of primary health occasions of services is more than five times the state average. Despite cancer incidence being lower in rural than urban areas on a national level [1], locally cancer incidence in males is double the state average, the highest incidence of all Victorian LGAs.

Digital stories, Warracknabeal, 2012:

Katie, nurse, challenges stereotypes to pursue her dream rural health career
http://www.patientvoices.org.uk/flv/0633pv384.htm
Peter, feeling powerless due to illness draws from community for wellbeing
http://www.patientvoices.org.uk/flv/0632pv384.htm
Norma, respecting elders and relationships in rural context
http://www.patientvoices.org.uk/flv/0630pv384.htm

Understanding the local context through local knowledge and lived experiences, statistical information and other relevant sources will support community participation that takes full advantage of local assets and capacity.

2. A dynamic, multidimensional approach is more effective than a single method

To effectively facilitate community participation, health services should use a range of strategies that are integrated to form a broad organisational approach. In the Canadian case study, for example, participation strategies were used at all levels of community activities, operations and governance. This included policymaking with community conversations, newsletters to provide community updates, and webinars to share examples of good

practice with a larger audience. Multiple dynamic approaches were used, which meant they could be adjusted to suit the local context, energy levels and available funding. The intensity or demands required of the strategy could be changed—for instance, time, resource investment, efforts, skills, responsibilities and expectations of citizens and staff. Using multiple strategies did not necessarily mean more funding or resources were needed. Engagement from volunteers, interns and students and use of social media were key factors to a successful approach.

Another key to success in community participation is determining the right balance of strategies with the community. In Rochester, Victoria, for example, seeking input from existing, established community groups on local health service priorities was found to be more successful than beginning a new community reference group specifically for this service.

Table 1 outlines how multiple strategies can be integrated to form a broad organisational approach, based on a Canadian case study. High and low demand strategies were integrated to form a comprehensive approach, without a requirement for extensive financial or human resources.

Table 1. Example of a multidimensional community participation approach integrating different strategies

Participation strategy	***Objective***	**Example**
Inform	*Provision of information to community*	- Newsletter, website, calendar, household canvassing
Consult	*Seeking information from community*	- Online, written or photographic submissions - Feedback through community leaders
Involve	*Intentional strategies to engage community*	- Twitter feed, Facebook page - Skills workshops and social events - Interactive webinar
Collaborate	*Participating with community, cooperative*	- Community food hub e.g. food market, garden, kitchen - Social enterprise e.g. bike shop, meals on wheels, café - Story-making or art workshops - Students placements or internships - Online learning portal, open access resources - School nutrition programs - Community working groups
Empower	*Full decision-making by community*	- Participatory policy making, priority setting and strategic planning
Note: Modified from the International Association for Public Participation (IAP2) Public Participation Spectrum (see http://www.iap2.org.au/resources/iap2s-public-participation-spectrum)		

3. Leveraging existing community assets and capacity

To encourage community participation with health services, it is important to leverage existing capacity rather than develop a new initiative in isolation. This approach recognises that good community participation may already be occurring and new initiatives are more likely to succeed and be cost effective if they build on what exists. For example, building a community garden on a health service site is a strategy that has been used in Canada and in Australia. It creates a social community space within existing health services, which provides new opportunities for health promotion and recreation while improving awareness and access to onsite primary health care programs [9, 23, 24]. This practical approach means that limited financial and human resources are used to capitalise on existing community activities or assets, energy and motivation. In this example, existing assets and capacity included the health service, spare public land, volunteer gardeners, and local community groups and business sponsors. Leveraging that aims to form new community partnerships between existing entities maximises value, capacity and outcomes for community participation initiatives. Examples of leveraging in Canada are provided in Boxes 2 and 3.

Box 2. Student-led Meals on Wheels by bike, Montreal

Student-led Meals on Wheels by bike, Montreal

In Montreal, Quebec, a youth-driven healthy food delivery program, a 'meals on wheels' by bike, makes use of local university partnerships for land use and for student volunteers who deliver healthy meals to elderly residents by bicycle - important for the city because of high rates of elderly residents living alone (see housing profile http://www.fgmtl.org/en/vitalsigns2010/housing.php). The outcomes are three-fold: improved access to healthy meals, youth vocational training in agriculture, hospitality and social care, and intergenerational social interaction through meal deliveries and events. The program is multidimensional and entrepreneurial, volunteers and members can choose what level and type of engagement they prefer, for example newsletter subscriber or board member, and volunteers schedule their own shifts in food preparation or deliveries. The organisation creates stronger neighbourhood connections; the building is a bustling hub for youth and an incubator for innovation, for example urban agriculture projects like bee-keeping, and a bicycle repair shop. See http://santropolroulant.org/

Box 3. Community agriculture, Halifax

Community agriculture, Halifax

Community participation in Halifax, Nova Scotia, utilises local connections with farmers, a community centre car park, and volunteer energy and labour for agriculture projects that have benefits for the broader community. See http://www.youtube.com/watch?v=u34-x26kCYQ

4. Paid community leaders are fundamental

Employing community leaders to generate effective community participation with health services is fundamental. Employing a local person with valuable contextual knowledge and local relationships will contribute to the success of community participation initiatives, as well as reduce volunteer over-reliance and burden. Community leaders, also known in the

literature as 'community animators' or 'community organisers', are resourceful people who are well connected with linkages within and across neighbourhoods, and with local business and industry leaders. They are keen organisers who bring people together and facilitate participation in community activities. Their responsibilities include organising social events, evaluating local issues, providing education and advocacy, and maintaining stakeholder partnerships with business, health and education. Community leaders are strong advocates with contagious enthusiasm, who are trusted and respected by their community [25].

In the Canadian case study, community food programs employed a local person who had a good understanding of the local context and existing relationships in the community, and who was able to organise and mobilise people. The majority of community leaders observed in the Canadian case study were paid staff, or volunteers paid an honorarium. Leaders were sought out and invested in through a leveraging and capacity building process. See Box 4 for an example of how community food animators were utilised for a national community participation initiative.

Box 4. Community food animators

Community food animators talk food security

Community food animators were responsible for holding 'kitchen table talks' during a national citizen consultation strategy implemented in Canada. This involved organising a meeting with citizens in their existing networks, and writing a submission on food security together. Online and written submissions were used to develop a robust policy platform for a national food strategy. See an advertisement from Ontario Health http://www.ohpe.ca/node/11623 and the final report at Food Secure Canada http://foodsecurecanada.org/policy-advocacy/resetting-table

Community food animators are currently employed by FoodShare Toronto. See a description of their role at http://www.foodshare.net/toronto-community-food-animators

5. Use specific strategies to include marginalised community subgroups

Communities need to develop specific strategies that will enable marginalised subgroups to participate in community activities. Traditional community participation methods can marginalise and exclude people because of age, illness, disability, transport, language or culture. Employees of health and welfare services may have existing trust and legitimacy, and are well placed to develop strategies that encourage marginalised groups to participate. This could involve storytelling rather than surveys, or submitting photos rather than written responses. Methods should be developed in collaboration with relevant community members.

One example of where this has been done well is in Heathcote and Warracknabeal, rural communities in Victoria. In these places digital storytelling was used with different groups to share community experiences. Similar approaches have been used in Canada. In the Canadian community food programs, for example, leaders supported participation with newly settled migrants and people living in social housing by building community gardens together (see Box 5). Social media and webpages can be used with accessibility options to

provide information and to seek comment from people who find it difficult to attend face to face consultations, or in languages other than English.

Box 5. Community gardening with new Canadians in Halifax

Community gardening with new Canadians in Halifax

See Herald Magazine, October 25, 2013; 'Rooted in the community'; gardening with new Canadians in Halifax had positive outcomes for community participants. The community garden is described by two Nepalese refugee women as a place to grow food to feed their families and to meet the local residents of Halifax.

http://thechronicleherald.ca/heraldmagazine/1162380-rooted-in-the-community

Box 6. Inclusive community participation in a Halifax community garden

Inclusive community participation in a Halifax community garden

This video provides a virtual, narrated tour of community gardens across the Halifax municipality, to demonstrate how food and gardening can be used as a vehicle for wide participation that has positive benefits for communities. In this example, food and gardening were used as strategies to include community subgroups that generally might find it difficult to participate. See video: http://www.youtube.com/watch?v=6OEhlMAq73Q

6. Shared decision-making improves outcomes and experience for the community

Involving the community in decision-making with health services staff is more effective than seeking isolated consultation feedback, as this may or may not provide relevant or practical ideas or outcomes. For example, involving community members in a budget and resource allocation meeting with finance officers and managers may result in more practical outcomes than seeking feedback through a survey. This is because community members are likely to find it difficult to provide practical solutions without appropriate information and explanations needed to make good decisions.

The value of the shared decision-making approach is supported by research on citizen juries and participatory budgeting [14 , 22]. A good example of where shared decision-making works in practice is in 'co-production models' in Australia and the United Kingdom. In these models, service provision responsibilities are shared between management, service providers and service users, and lines between these groups are intentionally blurred [9 , 26-29].

In our Warracknabeal study we observed the value of shared decision-making with rural communities. We found that having health staff attend community meetings led to quick decision-making and practical ideas that could be implemented within current budgets. Similarly, across southern Ontario, cooperative working groups including parents, teachers, community food workers and council officials, deliver successful healthy food programs in schools. There are many examples of community programs that have staff and community members working cooperatively and sharing decision-making and other responsibilities to

complete various activities; for example, writing newsletters and online blogs (see for example, Sustain Ontario website www.sustainontario.com and Box 7 for an example from the school nutrition programs delivered across southern Ontario).

Box 7. FoodShare Toronto Farm to Table school nutrition program

FoodShare Toronto Farm to Table school nutrition program
This program uses a cooperative model of governance and demonstrates how sharing decision-making and other responsibilities with staff and community members has positive outcomes. See website for program description and a video: http://www.foodshare.net/field-to-table-schools

What are the challenges of community participation in rural areas?

Our research points to two challenges associated with community participation with rural health services.

Over-consultation and volunteer fatigue

Over-consultation and volunteer fatigue often impact on community participation in rural places. We found that participation approaches that require a high level of community time and investment are challenging to implement over a prolonged period. This difficulty may increase with smaller populations, and has been confirmed in other rural studies [30, 31]. Participation strategies must be in the community's best interests over time [9]. Volunteer fatigue can be avoided by using a combination of high and low demand strategies; changing demand in terms of time, resource investment, efforts, skills, responsibilities and expectations of citizens and staff. For example, health services can use high demand options such as community priority setting meetings once a year, alongside low demand options such as ongoing social media information updates and online progress reports with feedback options.

Volunteer fatigue can also be counteracted by balancing paid staff and volunteer labour, and by offering incentives such as transport or food vouchers. In a Toronto-based community food initiative, volunteers at a food distribution centre were given a public transport pass and a box of fruit and vegetables to acknowledge their work. Health organisations are encouraged to regularly celebrate achievements by using social media and local news outlets to acknowledge awards, contributions and investments; food programs in the Canadian case study did this weekly via Twitter and Facebook.

Sustainability of approach

Our research shows that sustaining a consistent approach to community participation is more important than maintaining one particular strategy. High demand participation strategies, such as a community forum, might be more effective if they are used for short periods of time on a regular basis, rather than frequently. Strategies should not be prolonged if they are not in the community's best interests. For example, alternating community town hall-style meetings with an online webinar or a meeting in an aged care

home would maintain consistency of the participation approach, while also encouraging broader participation beyond the 'usual suspects' to different community subgroups. The challenge is to sustain a community participation approach that is dynamic and flexible in responding to local conditions, energy and motivations, and recognises that an extensive, long term participation strategy might not be the most effective or meaningful method of participation for communities[32]. Local conditions and objectives should determine indicators of success [9].

What happens when you do it well?

Our research demonstrates that community participation with rural health services can deliver social benefits to the community and improve health literacy.

Social benefits

Community participation is a social process that can lead to social benefits such as better relationships and community cohesion. Social benefits of community participation can be difficult to measure, but there are useful evaluation tools such as questionnaires designed to measure social capital [33].

Social benefits reported by key informants in the Canadian case study included improved social connections, trust, belonging, cohesion, safety, and reduced social isolation, which confirms what other studies have found [24 , 34-36]. It is too early to determine what the social benefits are from the rural community research initiatives underway as part of this study, however, the Warracknabeal study indicates new positive social connections as a result of attending community meetings. In other studies, researchers looking at rural communities and participation have reported improvements in infrastructure and access to funding to create social community spaces [17]. For example, Men's Sheds are a well-known social community space, created through participation, which support friendships and belonging in communities [37].

There is good evidence that a higher sense of community 'belonging' is associated with good mental health [33]. This indicates that community participation that results in social benefits is one strategy that might be effective for tackling rural health priorities including reducing high rates of mental illness and suicide.

Improved uptake of health information: health literacy

Being health literate means having the ability to understand and utilise health information, and apply it when accessing services [38]. Health literacy is a particular requirement for effective use of electronic personal health records and online technologies for managing, accessing and navigating health services [39]. By communicating with services, communities can learn about the health system, the various programs offered, and about appropriate service access for health complaints. In this way, community participation with health services may prevent inappropriate service use; for example, emergency presentations for health complaints that could be managed by a General Practitioner.

In an extensive literature review, researchers reported that improved health literacy was linked with positive health behaviour change [40]. In our study, Canadian community food leaders described the importance of health literacy related to food and nutrition, and linked this with increased healthy food consumption and choices in shopping and meal preparation.

Community participation initiatives that include peer discussions and skill sharing, education sessions and workshops, and information distributed via social media, may improve health literacy. Further research, some of which is under way, is needed to explore methods of measuring health literacy so we can determine which are most effective. Our initial findings suggest cooperative methods that utilise shared decision-making combined with social media are likely to be effective.

Key messages for policymakers

- New ways are needed to contract and pay for health services, using ideas developed with communities and within current budgets. Current funding models need to be more flexible to allow this. Solutions developed with communities do not necessarily need more funds, but the inflexibility in current funding arrangements means that they cannot be implemented easily [13].

- State and federal government competitive grants and tenders should prioritise proposals that demonstrate effective participation approaches as outlined in this issue paper.

- Community health services, Medicare Locals and Local Health Networks have an important role to play in facilitating community participation by gathering local knowledge, mapping existing assets, and leveraging capacity at regional and local levels. This should include:

    - Building partnerships between existing services, which have established trust and legitimacy, and leveraging existing participation strategies, rather than developing new services or standalone initiatives. This will result in focussed investment of currently available funds, maximising outcomes.
    - Employment of a joint-appointed paid community leadership position across community health services, Medicare Locals and Local Health Networks, in order to avoid duplication of community participation initiatives, improve efficiency, and overcome barriers of over-consultation and volunteer fatigue. This position, similar to the 'health animator' model used in Canada, and the research leader in our rural community research initiatives, would be responsible for the coordination of community participation approaches within communities, and develop and facilitate a dynamic, multidimensional approach for the local area. This would meet objectives of the National

Primary Health Strategic Framework [12] for integrated community participation. Local knowledge is key to success for this position, therefore in large catchment areas, for instance Tasmania, more than one employee might be required. This person would be responsible for volunteer support, communication and social media strategy, education, capacity building and evaluation.

- Evaluation of community participation in health services should use tools to measure social benefits and health literacy, in order to collect evidence of outcomes that are relevant to rural health reform priorities[2], see for example Community Capital Tool: http://www.sfu.ca/cscd/community-capital-tool-launched.html
- A national innovative online knowledge sharing portal is required, to share best practice in rural community participation, to support the rural health workforce, and save time and money on approaches that are not effective or efficient. This knowledge sharing website should be interactive and use social media including blogs, videos and webinars; with a particular emphasis on how to overcome challenges and barriers. A good example of an online knowledge portal is: http://foodsecurecanada.org/resources-news

Building Healthy Rural Communities research

This issue brief contains research findings from the Building Healthy Rural Communities research program, currently in progress on the regional campuses of La Trobe Rural Health School, La Trobe University, Bendigo; led by a team of university researchers, service managers and six doctoral students. The research is a three year project, commenced in December 2012, which is investigating community participation in health service improvement. Findings reported in the current paper were selected from a scoping review, an international case study, and three northern Victorian community research initiatives.

Scoping review

A scoping literature review by Kenny et al [17] located six studies (English, peer-reviewed) that describe effective participatory approaches to rural health service improvement; two were located in Australia; one in Tasmania [9], and one in Victoria [10]; and four others were from North America. Several challenges to implementing community participation are highlighted; additionally, we note there is a shortage of rural research in this field.

Case study

A case study of community participation in Canadian community food programs and initiatives was conducted in October 2013-January 2014. The purpose of this case study was to investigate an exemplary case of community participation, to examine best practices in community participation in Canada and identify 'what works'. Data were five key informant interviews with community food leaders in Toronto, Montreal and Halifax, 11 site visits

including guided tours of food programs and community gardens, and evaluation of documents, images, videos and social media. This is the first of three case studies in an ongoing doctoral research project on international community participation in democratic, high-income countries.

Community research initiatives

Three community research initiatives are being conducted in partnership with rural health services. Each initiative is led by a doctoral student and involves regular community meetings and other strategies, such as a health seminar or community expo. Community participants include hospital chief executive officers, local leaders, interested citizens, health service staff, and academics from the research program. The group's objectives are to enhance community participation with the health service, and to formalise an approach that supports effective community participation in health service planning, design, delivery and evaluation. The health services include:

- Heathcote Health http://www.heathcotehealth.org/
- Rural Northwest Health http://www.rnh.net.au/
- Rochester and Elmore District Health Service http://www.redhs.com.au/

Limitations

Research literature in this field is extensive and multidisciplinary, and difficult to synthesise; for example, community participation and consumer participation have different meanings[41]. Inconsistent terms used to describe rural (e.g. regional, remote), participation (e.g. engagement, consultation) and community (e.g. place, group of people) add to the complexity. In this issue brief, 'rural community participation' has been used as an umbrella term to aid communication of research findings for a broad audience. The quality of the research on rural community participation is limited by biomedical standards, consisting mainly of qualitative studies or small cohort studies which are relevant to the research topic, but do not easily lead to authoritative conclusions and recommendations for policymakers. The recommendations provided are based on the status quo of community participation policy in health services, and seek to improve current practices that are being implemented and funded across Australia.

The Canadian case study includes interviews with urban-based key informants, who were the best available experts in their field; selected for interview because they are known for developing best practice approaches to community participation in food programs and initiatives at national, provincial, and municipal levels. Two key informants were employed at a national level and coordinated community participation approaches across provinces and regions; three worked at a municipal level with some operations at a provincial level, for example policy advice or partnership development with regional food and farming industries.

Acknowledgements

The authors would like to acknowledge the researchers and communities involved in the research program, including health service CEOs Dan Douglass (Heathcote Health), Catherine Morley (Rural Northwest Health) and Matt Sharp (REDHS); researchers Peter O'Meara and Guin Threlkeld, and doctoral students, John Aikten (Northwest Health), Elena Wilson (Heathcote Health), Mary Magennis (Rochester and Elmore), Emma Pattern, and Diana Guzys.

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HESTA is proud to have sponsored this Deeble Scholar.

Publication 4:

Hyett, N., Kenny, A., & Dickson-Swift, V. (2014). Methodology or method? A critical review of qualitative case study reports. *International Journal of Qualitative Studies on Health and Well-being, 9*. doi:10.3402/qhw.v9.23606

Journal impact factor: 0.909 (retrieved 27/03/2016)

International Journal of
Qualitative Studies
on Health and Well-being

COACTION PUBLISHING

REVIEW ARTICLE

Methodology or method? A critical review of qualitative case study reports

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Abstract
Despite on-going debate about credibility, and reported limitations in comparison to other approaches, case study is an increasingly popular approach among qualitative researchers. We critically analysed the methodological descriptions of published case studies. Three high-impact qualitative methods journals were searched to locate case studies published in the past 5 years; 34 were selected for analysis. Articles were categorized as health and health services ($n = 12$), social sciences and anthropology ($n = 7$), or methods ($n = 15$) case studies. The articles were reviewed using an adapted version of established criteria to determine whether adequate methodological justification was present, and if study aims, methods, and reported findings were consistent with a qualitative case study approach. Findings were grouped into five themes outlining key methodological issues: case study methodology or method, case of something particular and case selection, contextually bound case study, researcher and case interactions and triangulation, and study design inconsistent with methodology reported. Improved reporting of case studies by qualitative researchers will advance the methodology for the benefit of researchers and practitioners.

Key words: *Case studies, health research, research design, interdisciplinary research, qualitative research, literature review*

(*Accepted: 7 April 2014; Published: 7 May 2014*)

Case study research is an increasingly popular approach among qualitative researchers (Thomas, 2011). Several prominent authors have contributed to methodological developments, which has increased the popularity of case study approaches across disciplines (Creswell, 2013b; Denzin & Lincoln, 2011b; Merriam, 2009; Ragin & Becker, 1992; Stake, 1995; Yin, 2009). Current qualitative case study approaches are shaped by paradigm, study design, and selection of methods, and, as a result, case studies in the published literature vary. Differences between published case studies can make it difficult for researchers to define and understand case study as a methodology.

Experienced qualitative researchers have identified case study research as a stand-alone qualitative approach (Denzin & Lincoln, 2011b). Case study research has a level of flexibility that is not readily offered by other qualitative approaches such as grounded theory or phenomenology. Case studies are designed to suit the case and research question and published case studies demonstrate wide diversity in study design. There are two popular case study approaches in qualitative research. The first, proposed by Stake (1995) and Merriam (2009), is situated in a social constructivist paradigm, whereas the second, by Yin (2012), Flyvbjerg (2011), and Eisenhardt (1989), approaches case study from a post-positivist viewpoint. Scholarship from both schools of inquiry has contributed to the popularity of case study and development of theoretical frameworks and principles that characterize the methodology.

The diversity of case studies reported in the published literature, and on-going debates about credibility and the use of case study in qualitative research practice, suggests that differences in perspectives on case study methodology may prevent researchers from developing a mutual understanding of practice and rigour. In addition, discussion about case study limitations has led some authors to query whether case study is indeed a methodology (Luck, Jackson, & Usher, 2006; Meyer, 2001; Thomas, 2010; Tight, 2010). Methodological discussion of

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Citation: Int J Qualitative Stud Health Well-being 2014, **9**: 23606 - http://dx.doi.org/10.3402/qhw.v9.23606

qualitative case study research is timely, and a review is required to analyse and understand how this methodology is applied in the qualitative research literature. The aims of this study were to review methodological descriptions of published qualitative case studies, to review how the case study methodological approach was applied, and to identify issues that need to be addressed by researchers, editors, and reviewers. An outline of the current definitions of case study and an overview of the issues proposed in the qualitative methodological literature are provided to set the scene for the review.

Definitions of qualitative case study research

Case study research is an investigation and analysis of a single or collective case, intended to capture the complexity of the object of study (Stake, 1995). Qualitative case study research, as described by Stake (1995), draws together "naturalistic, holistic, ethnographic, phenomenological, and biographic research methods" in a bricoleur design, or in his words, "a palette of methods" (Stake, 1995, pp. xi–xii). Case study methodology maintains deep connections to core values and intentions and is "particularistic, descriptive and heuristic" (Merriam, 2009, p. 46).

As a study design, case study is defined by interest in individual cases rather than the methods of inquiry used. The selection of methods is informed by researcher and case intuition and makes use of naturally occurring sources of knowledge, such as people or observations of interactions that occur in the physical space (Stake, 1998). Thomas (2011) suggested that "analytical eclecticism" is a defining factor (p. 512). Multiple data collection and analysis methods are adopted to further develop and understand the case, shaped by context and emergent data (Stake, 1995). This qualitative approach "explores a real-life, contemporary bounded system (a ***case***) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving ***multiple sources of information*** … and reports a ***case description*** **and** ***case themes***" (Creswell, 2013b, p. 97). Case study research has been defined by the unit of analysis, the process of study, and the outcome or end product, all essentially the case (Merriam, 2009).

The case is an object to be studied for an identified reason that is peculiar or particular. Classification of the case and case selection procedures informs development of the study design and clarifies the research question. Stake (1995) proposed three types of cases and study design frameworks. These include the intrinsic case, the instrumental case, and the collective instrumental case. The intrinsic case is used to understand the particulars of a single case, rather than what it represents. An instrumental case study provides insight on an issue or is used to refine theory. The case is selected to advance understanding of the object of interest. A collective refers to an instrumental case which is studied as multiple, nested cases, observed in unison, parallel, or sequential order. More than one case can be simultaneously studied; however, each case study is a concentrated, single inquiry, studied holistically in its own entirety (Stake, 1995, 1998).

Researchers who use case study are urged to seek out what is common and what is particular about the case. This involves careful and in-depth consideration of the nature of the case, historical background, physical setting, and other institutional and political contextual factors (Stake, 1998). An interpretive or social constructivist approach to qualitative case study research supports a transactional method of inquiry, where the researcher has a personal interaction with the case. The case is developed in a relationship between the researcher and informants, and presented to engage the reader, inviting them to join in this interaction and in case discovery (Stake, 1995). A postpositivist approach to case study involves developing a clear case study protocol with careful consideration of validity and potential bias, which might involve an exploratory or pilot phase, and ensures that all elements of the case are measured and adequately described (Yin, 2009, 2012).

Current methodological issues in qualitative case study research

The future of qualitative research will be influenced and constructed by the way research is conducted, and by what is reviewed and published in academic journals (Morse, 2011). If case study research is to further develop as a principal qualitative methodological approach, and make a valued contribution to the field of qualitative inquiry, issues related to methodological credibility must be considered. Researchers are required to demonstrate rigour through adequate descriptions of methodological foundations. Case studies published without sufficient detail for the reader to understand the study design, and without rationale for key methodological decisions, may lead to research being interpreted as lacking in quality or credibility (Hallberg, 2013; Morse, 2011).

There is a level of artistic license that is embraced by qualitative researchers and distinguishes practice, which nurtures creativity, innovation, and reflexivity (Denzin & Lincoln, 2011b; Morse, 2009). Qualitative research is "inherently multimethod" (Denzin &

Citation: Int J Qualitative Stud Health Well-being 2014, 9: 23606 - http://dx.doi.org/10.3402/qhw.v9.23606

Lincoln, 2011a, p. 5); however, with this creative freedom, it is important for researchers to provide adequate description for methodological justification (Meyer, 2001). This includes paradigm and theoretical perspectives that have influenced study design. Without adequate description, study design might not be understood by the reader, and can appear to be dishonest or inaccurate. Reviewers and readers might be confused by the inconsistent or inappropriate terms used to describe case study research approach and methods, and be distracted from important study findings (Sandelowski, 2000). This issue extends beyond case study research, and others have noted inconsistencies in reporting of methodology and method by qualitative researchers. Sandelowski (2000, 2010) argued for accurate identification of qualitative description as a research approach. She recommended that the selected methodology should be harmonious with the study design, and be reflected in methods and analysis techniques. Similarly, Webb and Kevern (2000) uncovered inconsistencies in qualitative nursing research with focus group methods, recommending that methodological procedures must cite seminal authors and be applied with respect to the selected theoretical framework. Incorrect labelling using case study might stem from the flexibility in case study design and non-directional character relative to other approaches (Rosenberg & Yates, 2007). Methodological integrity is required in design of qualitative studies, including case study, to ensure study rigour and to enhance credibility of the field (Morse, 2011).

Case study has been unnecessarily devalued by comparisons with statistical methods (Eisenhardt, 1989; Flyvbjerg, 2006, 2011; Jensen & Rodgers, 2001; Piekkari, Welch, & Paavilainen, 2009; Tight, 2010; Yin, 1999). It is reputed to be the "the weak sibling" in comparison to other, more rigorous, approaches (Yin, 2009, p. xiii). Case study is not an inherently comparative approach to research. The objective is not statistical research, and the aim is not to produce outcomes that are generalizable to all populations (Thomas, 2011). Comparisons between case study and statistical research do little to advance this qualitative approach, and fail to recognize its inherent value, which can be better understood from the interpretive or social constructionist viewpoint of other authors (Merriam, 2009; Stake, 1995). Building on discussions relating to "fuzzy" (Bassey, 2001), or naturalistic generalizations (Stake, 1978), or transference of concepts and theories (Ayres, Kavanaugh, & Knafl, 2003; Morse et al., 2011) would have more relevance.

Case study research has been used as a catch-all design to justify or add weight to fundamental qualitative descriptive studies that do not fit with other traditional frameworks (Merriam, 2009). A case study has been a "convenient label for our research—when we 'can't think of anything 'better"—in an attempt to give it [qualitative methodology] some added respectability" (Tight, 2010, p. 337). Qualitative case study research is a pliable approach (Merriam, 2009; Meyer, 2001; Stake, 1995), and has been likened to a "curious methodological limbo" (Gerring, 2004, p. 341) or "paradigmatic bridge" (Luck et al., 2006, p. 104), that is on the borderline between postpositivist and constructionist interpretations. This has resulted in inconsistency in application, which indicates that flexibility comes with limitations (Meyer, 2001), and the open nature of case study research might be off-putting to novice researchers (Thomas, 2011). The development of a well-(in)formed theoretical framework to guide a case study should improve consistency, rigour, and trust in studies published in qualitative research journals (Meyer, 2001).

Methods

Assessment of rigour

The purpose of this study was to analyse the methodological descriptions of case studies published in qualitative methods journals. To do this we needed to develop a suitable framework, which used existing, established criteria for appraising qualitative case study research rigour (Creswell, 2013b; Merriam, 2009; Stake, 1995). A number of qualitative authors have developed concepts and criteria that are used to determine whether a study is rigorous (Denzin & Lincoln, 2011b; Lincoln, 1995; Sandelowski & Barroso, 2002). The criteria proposed by Stake (1995) provide a framework for readers and reviewers to make judgements regarding case study quality, and identify key characteristics essential for good methodological rigour. Although each of the factors listed in Stake's criteria could enhance the quality of a qualitative research report, in Table I we present an adapted criteria used in this study, which integrates more recent work by Merriam (2009) and Creswell (2013b). Stake's (1995) original criteria were separated into two categories. The first list of general criteria is "relevant for all qualitative research." The second list, "high relevance to qualitative case study research," was the criteria that we decided had higher relevance to case study research. This second list was the main criteria used to assess the methodological descriptions of the case studies reviewed. The complete table has been preserved so that the reader can determine how the original criteria were adapted.

Table I. Framework for assessing quality in qualitative case study research.

Checklist for assessing the quality of a case study report
Relevant for all qualitative research
1. Is this report easy to read?
2. Does it fit together, each sentence contributing to the whole?
3. Does this report have a conceptual structure (i.e., themes or issues)?
4. Are its issues developed in a series and scholarly way?
5. Have quotations been used effectively?
6. Has the writer made sound assertions, neither over- or under-interpreting?
7. Are headings, figures, artefacts, appendices, indexes effectively used?
8. Was it edited well, then again with a last minute polish?
9. Were sufficient raw data presented?
10. Is the nature of the intended audience apparent?
11. Does it appear that individuals were put at risk?
High relevance to qualitative case study research
12. Is the case adequately defined?
13. Is there a sense of story to the presentation?
14. Is the reader provided some vicarious experience?
15. Has adequate attention been paid to various contexts?
16. Were data sources well-chosen and in sufficient number?
17. Do observations and interpretations appear to have been triangulated?
18. Is the role and point of view of the researcher nicely apparent?
19. Is empathy shown for all sides?
20. Are personal intentions examined?
Added from Merriam (2009)
21. Is the case study particular?
22. Is the case study descriptive?
23. Is the case study heuristic?
Added from Creswell (2013b)
24. Was study design appropriate to methodology?

Adapted from Stake (1995, p. 131).

Study design

The critical review method described by Grant and Booth (2009) was used, which is appropriate for the assessment of research quality, and is used for literature analysis to inform research and practice. This type of review goes beyond the mapping and description of scoping or rapid reviews, to include "analysis and conceptual innovation" (Grant & Booth, 2009, p. 93). A critical review is used to develop existing, or produce new, hypotheses or models. This is different to systematic reviews that answer clinical questions. It is used to evaluate existing research and competing ideas, to provide a "launch pad" for conceptual development and "subsequent testing" (Grant & Booth, 2009, p. 93).

Qualitative methods journals were located by a search of the 2011 ISI Journal Citation Reports in Social Science, via the database Web of Knowledge (see m.webofknowledge.com). No "qualitative research methods" category existed in the citation reports; therefore, a search of all categories was performed using the term "qualitative." In Table II, we present the qualitative methods journals located, ranked by impact factor. The highest ranked journals were selected for searching. We acknowledge that the impact factor ranking system might not be the best measure of journal quality (Cheek, Garnham, & Quan, 2006); however, this was the most appropriate and accessible method available.

Search strategy

In March 2013, searches of the journals, *Qualitative Health Research*, *Qualitative Research*, and *Qualitative Inquiry* were completed to retrieve studies with "case study" in the abstract field. The search was limited to the past 5 years (1 January 2008 to 1 March 2013). The objective was to locate published qualitative case studies suitable for assessment using the adapted criterion. Viewpoints, commentaries, and other article types were excluded from review. Title and abstracts of the 45 retrieved articles were read by the first author, who identified 34 empirical case studies for review. All authors reviewed the 34 studies to confirm selection and categorization. In Table III, we present the 34 case studies grouped by journal, and categorized by research topic, including health sciences, social sciences and anthropology, and methods research. There was a discrepancy in categorization of one article on pedagogy and a new teaching method published in *Qualitative Inquiry* (Jorrín-Abellán, Rubia-Avi, Anguita-Martínez,

Table II. International Journal of Qualitative Studies on Health and Well-being.

Journal title	2011 impact factor	5-year impact factor
Qualitative Health Research	2.188	2.432
Qualitative Research	1.426	N/A
Qualitative Inquiry	0.839	1.850
Qualitative Sociology	0.780	N/A
International Journal of Qualitative Studies on Health and Wellbeing	0.612	N/A

Citation: Int J Qualitative Stud Health Well-being 2014, 9: 23606 - http://dx.doi.org/10.3402/qhw.v9.23606

Gómez-Sánchez, & Martínez-Mones, 2008). Consensus was to allocate to the methods category.

In Table III, the number of studies located, and final numbers selected for review have been reported. *Qualitative Health Research* published the most empirical case studies ($n = 16$). In the health category, there were 12 case studies of health conditions, health services, and health policy issues, all published in *Qualitative Health Research*. Seven case studies were categorized as social sciences and anthropology research, which combined case study with biography and ethnography methodologies. All three journals published case studies on methods research to illustrate a data collection or analysis technique, methodological procedure, or related issue.

Findings

The methodological descriptions of 34 case studies were critically reviewed using the adapted criteria. All articles reviewed contained a description of study methods; however, the length, amount of detail, and position of the description in the article varied. Few studies provided an accurate description and rationale for using a qualitative case study approach. In the 34 case studies reviewed, three described a theoretical framework informed by Stake (1995), two by Yin (2009), and three provided a mixed framework informed by various authors, which might have included both Yin and Stake. Few studies described their case study design, or included a rationale that explained why they excluded or added further procedures, and whether this was to enhance the study design, or to better suit the research question. In 26 of the studies no reference was provided to principal case study authors. From reviewing the description of methods, few authors provided a description or justification of case study methodology that demonstrated how their study was informed by the methodological literature that exists on this approach.

The methodological descriptions of each study were reviewed using the adapted criteria, and the following issues were identified: case study methodology or method; case of something particular and

Table III. Outcomes of search of qualitative methods journals.

Journal title	Date of search	Number of studies located	Number of full text studies extracted	Health sciences	Social sciences and anthropology	Methods
Qualitative Health Research	4 Mar 2013	18	16	Barone (2010); Bronken et al. (2012); Colón-Emeric et al. (2010); Fourie and Theron (2012); Gallagher et al. (2013); Gillard et al. (2011); Hooghe et al. (2012); Jackson et al. (2012); Ledderer (2011); Mawn et al. (2010); Roscigno et al. (2012); Rytterström et al. (2013)	Nil	Austin, Park, and Goble (2008); Broyles, Rodriguez, Price, Bayliss, and Sevick (2011); De Haene et al. (2010); Fincham et al. (2008)
Qualitative Research	7 Mar 2013	11	7	Nil	Adamson and Holloway (2012); Coltart and Henwood (2012)	Buckley and Waring (2013); Cunsolo Willox et al. (2013); Edwards and Weller (2012); Gratton and O'Donnell (2011); Sumsion (2013)
Qualitative Inquiry	4 Mar 2013	16	11	Nil	Buzzanell and D'Enbeau (2009); D'Enbeau et al. (2010); Nagar-Ron and Motzafi-Haller (2011); Snyder-Young (2011); Yeh (2013)	Ajodhia-Andrews and Berman (2009); Alexander et al. (2012); Jorrín-Abellán et al. (2008); Nairn and Panelli (2009); Nespor (2012); Wimpenny and Savin-Baden (2012)
Total		45	34	12	7	15

case selection; contextually bound case study; researcher and case interactions and triangulation; and, study design inconsistent with methodology. An outline of how the issues were developed from the critical review is provided, followed by a discussion of how these relate to the current methodological literature.

Case study methodology or method

A third of the case studies reviewed appeared to use a case report method, not case study methodology as described by principal authors (Creswell, 2013b; Merriam, 2009; Stake, 1995; Yin, 2009). Case studies were identified as a case report because of missing methodological detail and by review of the study aims and purpose. These reports presented data for small samples of no more than three people, places or phenomenon. Four studies, or "case reports" were single cases selected retrospectively from larger studies (Bronken, Kirkevold, Martinsen, & Kvigne, 2012; Coltart & Henwood, 2012; Hooghe, Neimeyer, & Rober, 2012; Roscigno et al., 2012). Case reports were not a case *of* something, instead were a case demonstration or an example presented in a report. These reports presented outcomes, and reported on how the case could be generalized. Descriptions focussed on the phenomena, rather than the case itself, and did not appear to study the case in its entirety.

Case reports had minimal in-text references to case study methodology, and were informed by other qualitative traditions or secondary sources (Adamson & Holloway, 2012; Buzzanell & D'Enbeau, 2009; Nagar-Ron & Motzafi-Haller, 2011). This does not suggest that case study methodology cannot be multimethod, however, methodology should be consistent in design, be clearly described (Meyer, 2001; Stake, 1995), and maintain focus on the case (Creswell, 2013b).

To demonstrate how case reports were identified, three examples are provided. The first, Yeh (2013) described their study as, "the examination of the emergence of vegetarianism in Victorian England serves as a case study to reveal the relationships between boundaries and entities" (p. 306). The findings were a historical case report, which resulted from an ethnographic study of vegetarianism. Cunsolo Willox, Harper, Edge, 'My Word': Storytelling and Digital Media Lab, and Rigolet Inuit Community Government (2013) used "a case study that illustrates the usage of digital storytelling within an Inuit community" (p. 130). This case study reported how digital storytelling can be used with indigenous communities as a participatory method to illuminate the benefits of this method for other studies. This "case study was conducted in the Inuit community" but did not include the Inuit community in case analysis (Cunsolo Willox et al., 2013, p. 130). Bronken et al. (2012) provided a single case report to demonstrate issues observed in a larger clinical study of aphasia and stroke, without adequate case description or analysis.

Case study of something particular and case selection

Case selection is a precursor to case analysis, which needs to be presented as a convincing argument (Merriam, 2009). Descriptions of the case were often not adequate to ascertain why the case was selected, or whether it was a particular exemplar or outlier (Thomas, 2011). In a number of case studies in the health and social science categories, it was not explicit whether the case was of something particular, or peculiar to their discipline or field (Adamson & Holloway, 2012; Bronken et al., 2012; Colón-Emeric et al., 2010; Jackson, Botelho, Welch, Joseph, & Tennstedt, 2012; Mawn et al., 2010; Snyder-Young, 2011). There were exceptions in the methods category (Table III), where cases were selected by researchers to report on a new or innovative method. The cases emerged through heuristic study, and were reported to be particular, relative to the existing methods literature (Ajodhia-Andrews & Berman, 2009; Buckley & Waring, 2013; Cunsolo Willox et al., 2013; De Haene, Grietens, & Verschueren, 2010; Gratton & O'Donnell, 2011; Sumsion, 2013; Wimpenny & Savin-Baden, 2012).

Case selection processes were sometimes insufficient to understand why the case was selected from the global population of cases, or what study of this case would contribute to knowledge as compared with other possible cases (Adamson & Holloway, 2012; Bronken et al., 2012; Colón-Emeric et al., 2010; Jackson et al., 2012; Mawn et al., 2010). In two studies, local cases were selected (Barone, 2010; Fourie & Theron, 2012) because the researcher was familiar with and had access to the case. Possible limitations of a convenience sample were not acknowledged. Purposeful sampling was used to recruit participants *within* the case of one study, but not of the case itself (Gallagher et al., 2013). Random sampling was completed for case selection in two studies (Colón-Emeric et al., 2010; Jackson et al., 2012), which has limited meaning in interpretive qualitative research.

To demonstrate how researchers provided a good justification for the selection of case study approaches, four examples are provided. The first, cases of residential care homes, were selected because of reported occurrences of mistreatment, which included residents being locked in rooms at

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night (Rytterström, Unosson, & Arman, 2013). Roscigno et al. (2012) selected cases of parents who were admitted for early hospitalization in neonatal intensive care with a threatened preterm delivery before 26 weeks. Hooghe et al. (2012) used random sampling to select 20 couples that had experienced the death of a child; however, the case study was of one couple and a particular metaphor described only by them. The final example, Coltart and Henwood (2012), provided a detailed account of how they selected two cases from a sample of 46 fathers based on personal characteristics and beliefs. They described how the analysis of the two cases would contribute to their larger study on first time fathers and parenting.

Contextually bound case study

The limits or boundaries of the case are a defining factor of case study methodology (Merriam, 2009; Ragin & Becker, 1992; Stake, 1995; Yin, 2009). Adequate contextual description is required to understand the setting or context in which the case is revealed. In the health category, case studies were used to illustrate a clinical phenomenon or issue such as compliance and health behaviour (Colón-Emeric et al., 2010; D'Enbeau, Buzzanell, & Duckworth, 2010; Gallagher et al., 2013; Hooghe et al., 2012; Jackson et al., 2012; Roscigno et al., 2012). In these case studies, contextual boundaries, such as physical and institutional descriptions, were not sufficient to understand the case as a holistic system, for example, the general practitioner (GP) clinic in Gallagher et al. (2013), or the nursing home in Colón-Emeric et al. (2010). Similarly, in the social science and methods categories, attention was paid to some components of the case context, but not others, missing important information required to understand the case as a holistic system (Alexander, Moreira, & Kumar, 2012; Buzzanell & D'Enbeau, 2009; Nairn & Panelli, 2009; Wimpenny & Savin-Baden, 2012).

In two studies, vicarious experience or vignettes (Nairn & Panelli, 2009) and images (Jorrín-Abellán et al., 2008) were effective to support description of context, and might have been a useful addition for other case studies. Missing contextual boundaries suggests that the case might not be adequately defined. Additional information, such as the physical, institutional, political, and community context, would improve understanding of the case (Stake, 1998). In Boxes 1 and 2, we present brief synopses of two studies that were reviewed, which demonstrated a well bounded case. In Box 1, Ledderer (2011) used a qualitative case study design informed by Stake's tradition. In Box 2, Gillard, Witt, and Watts (2011) were informed by Yin's tradition. By providing a brief outline of the case studies in Boxes 1 and 2, we demonstrate how effective case boundaries can be constructed and reported, which may be of particular interest to prospective case study researchers.

Box 1. Article synopsis of case study research using Stake's tradition.

Ledderer (2011) used a qualitative case study research design, informed by modern ethnography. The study is bounded to 10 general practice clinics in Denmark, who had received federal funding to implement preventative care services based on a Motivational Interviewing intervention. The researcher question focussed on "why is it so difficult to create change in medical practice?" (Ledderer, 2011, p. 27). The study context was adequately described, providing detail on the general practitioner (GP) clinics and relevant political and economic influences. Methodological decisions are described in first person narrative, providing insight on researcher perspectives and interaction with the case. Forty-four interviews were conducted, which focussed on *how* GPs conducted consultations, and the form, nature and content, rather than asking their opinion or experience (Ledderer, 2011, p. 30). The duration and intensity of researcher immersion in the case enhanced depth of description and trustworthiness of study findings. Analysis was consistent with Stake's tradition, and the researcher provided examples of inquiry techniques used to challenge assumptions about emerging themes. Several other seminal qualitative works were cited. The themes and typology constructed are rich in narrative data and storytelling by clinic staff, demonstrating individual clinic experiences as well as shared meanings and understandings about changing from a biomedical to psychological approach to preventative health intervention. Conclusions make note of social and cultural meanings and lessons learned, which might not have been uncovered using a different methodology.

Researcher and case interactions and triangulation

Researcher and case interactions and transactions are a defining feature of case study methodology (Stake, 1995). Narrative stories, vignettes, and thick description are used to provoke vicarious experience and a sense of being there with the researcher in their interaction with the case. Few of the case studies reviewed provided details of the researcher's relationship with the case, researcher–case interactions, and how these influenced the development of the case study (Buzzanell & D'Enbeau, 2009; D'Enbeau et al., 2010; Gallagher et al., 2013; Gillard et al., 2011; Ledderer, 2011; Nagar-Ron & Motzafi-Haller, 2011). The role and position of the researcher needed to be self-examined and understood by readers, to understand how this influenced interactions

Box 2. Article synopsis of case study research using Yin's tradition.

Gillard et al. (2011) study of camps for adolescents living with HIV/AIDs provided a good example of Yin's interpretive case study approach. The context of the case is bounded by the three summer camps of which the researchers had prior professional involvement. A case study protocol was developed that used multiple methods to gather information at three data collection points coinciding with three youth camps (Teen Forum, Discover Camp, and Camp Strong). Gillard and colleagues followed Yin's (2009) principles, using a consistent data protocol that enhanced cross-case analysis. Data described the young people, the camp physical environment, camp schedule, objectives and outcomes, and the staff of three youth camps. The findings provided a detailed description of the context, with less detail of individual participants, including insight into researcher's interpretations and methodological decisions throughout the data collection and analysis process. Findings provided the reader with a sense of "being there," and are discovered through constant comparison of the case with the research issues; the case is the unit of analysis. There is evidence of researcher immersion in the case, and Gillard reports spending significant time in the field in a naturalistic and integrated youth mentor role.

This case study is not intended to have a significant impact on broader health policy, although does have implications for health professionals working with adolescents. Study conclusions will inform future camps for young people with chronic disease, and practitioners are able to compare similarities between this case and their own practice (for knowledge translation). No limitations of this article were reported. Limitations related to publication of this case study were that it was 20 pages long and used three tables to provide sufficient description of the camp and program components, and relationships with the research issue.

with participants, and to determine what triangulation is needed (Merriam, 2009; Stake, 1995).

Gillard et al. (2011) provided a good example of triangulation, comparing data sources in a table (p. 1513). Triangulation of sources was used to reveal as much depth as possible in the study by Nagar-Ron and Motzafi-Haller (2011), while also enhancing confirmation validity. There were several case studies that would have benefited from improved range and use of data sources, and descriptions of researcher–case interactions (Ajodhia-Andrews & Berman, 2009; Bronken et al., 2012; Fincham, Scourfield, & Langer, 2008; Fourie & Theron, 2012; Hooghe et al., 2012; Snyder-Young, 2011; Yeh, 2013).

Study design inconsistent with methodology

Good, rigorous case studies require a strong methodological justification (Meyer, 2001) and a logical and coherent argument that defines paradigm, methodological position, and selection of study methods (Denzin & Lincoln, 2011b). Methodological justification was insufficient in several of the studies reviewed (Barone, 2010; Bronken et al., 2012; Hooghe et al., 2012; Mawn et al., 2010; Roscigno et al., 2012; Yeh, 2013). This was judged by the absence, or inadequate or inconsistent reference to case study methodology in-text.

In six studies, the methodological justification provided did not relate to case study. There were common issues identified. Secondary sources were used as primary methodological references indicating that study design might not have been theoretically sound (Colón-Emeric et al., 2010; Coltart & Henwood, 2012; Roscigno et al., 2012; Snyder-Young, 2011). Authors and sources cited in methodological descriptions were inconsistent with the actual study design and practices used (Fourie & Theron, 2012; Hooghe et al., 2012; Jorrín-Abellán et al., 2008; Mawn et al., 2010; Rytterström et al., 2013; Wimpenny & Savin-Baden, 2012). This occurred when researchers cited Stake or Yin, or both (Mawn et al., 2010; Rytterström et al., 2013), although did not follow their paradigmatic or methodological approach. In 26 studies there were no citations for a case study methodological approach.

Discussion

The findings of this study have highlighted a number of issues for researchers. A considerable number of case studies reviewed were missing key elements that define qualitative case study methodology and the tradition cited. A significant number of studies did not provide a clear methodological description or justification relevant to case study. Case studies in health and social sciences did not provide sufficient information for the reader to understand case selection, and why this case was chosen above others. The context of the cases were not described in adequate detail to understand all relevant elements of the case context, which indicated that cases may have not been contextually bounded. There were inconsistencies between reported methodology, study design, and paradigmatic approach in case studies reviewed, which made it difficult to understand the study methodology and theoretical foundations. These issues have implications for methodological integrity and honesty when reporting study design, which are values of the qualitative research tradition and are ethical requirements (Wager & Kleinert, 2010a). Poorly described methodological descriptions may lead the reader to misinterpret or discredit study findings, which limits the impact of the study, and,

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as a collective, hinders advancements in the broader qualitative research field.

The issues highlighted in our review build on current debates in the case study literature, and queries about the value of this methodology. Case study research can be situated within different paradigms or designed with an array of methods. In order to maintain the creativity and flexibility that is valued in this methodology, clearer descriptions of paradigm and theoretical position and methods should be provided so that study findings are not undervalued or discredited. Case study research is an interdisciplinary practice, which means that clear methodological descriptions might be more important for this approach than other methodologies that are predominantly driven by fewer disciplines (Creswell, 2013b).

Authors frequently omit elements of methodologies and include others to strengthen study design, and we do not propose a rigid or purist ideology in this paper. On the contrary, we encourage new ideas about using case study, together with adequate reporting, which will advance the value and practice of case study. The implications of unclear methodological descriptions in the studies reviewed were that study design appeared to be inconsistent with reported methodology, and key elements required for making judgements of rigour were missing. It was not clear whether the deviations from methodological tradition were made by researchers to strengthen the study design, or because of misinterpretations. Morse (2011) recommended that innovations and deviations from practice are best made by experienced researchers, and that a novice might be unaware of the issues involved with making these changes. To perpetuate the tradition of case study research, applications in the published literature should have consistencies with traditional methodological constructions, and deviations should be described with a rationale that is inherent in study conduct and findings. Providing methodological descriptions that demonstrate a strong theoretical foundation and coherent study design will add credibility to the study, while ensuring the intrinsic meaning of case study is maintained.

The value of this review is that it contributes to discussion of whether case study is a methodology or method. We propose possible reasons why researchers might make this misinterpretation. Researchers may interchange the terms methods and methodology, and conduct research without adequate attention to epistemology and historical tradition (Carter & Little, 2007; Sandelowski, 2010). If the rich meaning that naming a qualitative methodology brings to the study is not recognized, a case study might appear to be inconsistent with the traditional approaches described by principal authors (Creswell, 2013a; Merriam, 2009; Stake, 1995; Yin, 2009). If case studies are not methodologically and theoretically situated, then they might appear to be a case report.

Case reports are promoted by university and medical journals as a method of reporting on medical or scientific cases; guidelines for case reports are publicly available on websites (http://www.hopkinsmedicine.org/institutional_review_board/guidelines_policies/guidelines/case_report.html). The various case report guidelines provide a general criteria for case reports, which describes that this form of report does not meet the criteria of research, is used for retrospective analysis of up to three clinical cases, and is primarily illustrative and for educational purposes. Case reports can be published in academic journals, but do not require approval from a human research ethics committee. Traditionally, case reports describe a single case, to explain how and what occurred in a selected setting, for example, to illustrate a new phenomenon that has emerged from a larger study. A case report is not necessarily particular or the study of a case in its entirety, and the larger study would usually be guided by a different research methodology.

This description of a case report is similar to what was provided in some studies reviewed. This form of report lacks methodological grounding and qualities of research rigour. The case report has publication value in demonstrating an example and for dissemination of knowledge (Flanagan, 1999). However, case reports have different meaning and purpose to case study, which needs to be distinguished. Findings of our review suggest that the medical understanding of a case report has been confused with qualitative case study approaches.

In this review, a number of case studies did not have methodological descriptions that included key characteristics of case study listed in the adapted criteria, and several issues have been discussed. There have been calls for improvements in publication quality of qualitative research (Morse, 2011), and for improvements in peer review of submitted manuscripts (Carter & Little, 2007; Jasper, Vaismoradi, Bondas, & Turunen, 2013). The challenging nature of editor and reviewers responsibilities are acknowledged in the literature (Hames, 2013; Wager & Kleinert, 2010b); however, review of case study methodology should be prioritized because of disputes on methodological value.

Authors using case study approaches are recommended to describe their theoretical framework and methods clearly, and to seek and follow specialist methodological advice when needed (Wager & Kleinert, 2010a). Adequate page space for case

study description would contribute to better publications (Gillard et al., 2011). Capitalizing on the ability to publish complementary resources should be considered.

Limitations of the review

There is a level of subjectivity involved in this type of review and this should be considered when interpreting study findings. Qualitative methods journals were selected because the aims and scope of these journals are to publish studies that contribute to methodological discussion and development of qualitative research. Generalist health and social science journals were excluded that might have contained good quality case studies. Journals in business or education were also excluded, although a review of case studies in international business journals has been published elsewhere (Piekkari et al., 2009).

The criteria used to assess the quality of the case studies were a set of qualitative indicators. A numerical or ranking system might have resulted in different results. Stake's (1995) criteria have been referenced elsewhere, and was deemed the best available (Creswell, 2013b; Crowe et al., 2011). Not all qualitative studies are reported in a consistent way and some authors choose to report findings in a narrative form in comparison to a typical biomedical report style (Sandelowski & Barroso, 2002), if misinterpretations were made this may have affected the review.

Conclusion

Case study research is an increasingly popular approach among qualitative researchers, which provides methodological flexibility through the incorporation of different paradigmatic positions, study designs, and methods. However, whereas flexibility can be an advantage, a myriad of different interpretations has resulted in critics questioning the use of case study as a methodology. Using an adaptation of established criteria, we aimed to identify and assess the methodological descriptions of case studies in high impact, qualitative methods journals. Few articles were identified that applied qualitative case study approaches as described by experts in case study design. There were inconsistencies in methodology and study design, which indicated that researchers were confused whether case study was a methodology or a method. Commonly, there appeared to be confusion between case studies and case reports. Without clear understanding and application of the principles and key elements of case study methodology, there is a risk that the flexibility of the approach will result in haphazard reporting, and will limit its global application as a valuable, theoretically supported methodology that can be rigorously applied across disciplines and fields.

Conflict of interest and funding

The authors have not received any funding or benefits from industry or elsewhere to conduct this study.

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Publication 5[8]:

Hyett, N., McKinstry, C., Kenny, A., & Dickson-Swift, V. (2016). Occupational therapists: improving the health and wellbeing of populations. *Australian Journal of Occupational Therapy, 63*(1), 5-8. doi:10.1111/1440-1630.12222

Journal impact factor: 0.827 (retrieved 27/03/2016)

[8] Due to copyright agreements, this publication will be removed after thesis examination

Australian Occupational Therapy Journal

Australian Occupational Therapy Journal (2016) **63**, 5–8 doi: 10.1111/1440-1630.12222

Viewpoint

Community-centred practice: Occupational therapists improving the health and wellbeing of populations

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KEY WORDS *centred practice, community, community participation, health reform, occupational therapy, population health.*

Introduction

The purpose of this viewpoint is to challenge occupational therapists to design and implement initiatives that improve community health and wellbeing. Wilcock (2006) and Scaffa and Reitz (2013), pioneers of 'community-based' practice, have been pivotal in shifting occupational therapy beyond mainstream healthcare services and into non-traditional, community settings. To further develop the scope of community-based practice, we explore the possibilities of a 'community-centred' approach.

For many occupational therapists, the idea of community-centred practice may not be fully understood. In community development research, community-centred practice is described as working *with*, rather than *for* communities, on goals that are identified by the communities themselves (Minkler, 2012). The key values underpinning community-centred approaches parallel client-centred practice, which is intrinsic to occupational therapy philosophy (Scaffa & Reitz, 2013; Townsend, Polatajko, Craik & Davis, 2007). The community is viewed as the client and an entity for collaboration, not simply the setting in which occupational therapy is undertaken (Scaffa & Reitz, 2013). Similar to client-centred approaches commonly adopted by occupational therapists, community-centred approaches involve centralising the community in all elements of practice. To expand the current scope of practice, occupational therapists must develop evidence and practical skills for working collaboratively with communities. The article outlines emerging evidence for adopting a community-centred approach, and explains how this is a multifaceted process that encompasses both opportunities and challenges.

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Accepted for publication 17 July 2015.

Defining 'community'

To develop a comprehensive understanding of communities, occupational therapists are encouraged to consider the multiple definitions and understandings of 'community' within health sociology and public health. There is agreement that community is more than a place of residence. Community can be defined as a *social group*, which encompasses historical events, cultural traditions and inter-connected social networks or layers, and can alternatively be defined by *place*, meaning a spatially defined geographical location (Jewkes & Murcott, 1996). Definitions of community adopted by health services usually combine social group and place perspectives. However, their understandings are often simplistic and fail to acknowledge the inherent diversity and power interplays that occur when communities are formed (Jewkes & Murcott; MacQueen *et al.*, 2001). MacQueen *et al.*'s definition of community was developed with community members as 'a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings' (MacQueen *et al.*, 2001, p. 1929). This definition is useful for practitioners because it incorporates social and geographical dimensions and highlights community heterogeneity (MacQueen *et al.*, 2001).

Within occupational therapy, communities are understood to have multiple dimensions that impact upon opportunities for occupation, participation and health (Scaffa & Reitz, 2013; Wilcock, 2006). Likewise, principal scholars in health sociology such as Jewkes and Murcott (1996) argue that practitioners must explore the unique

dynamics of communities they work within. The community's physical features, including the landscape, natural environment and climate, infrastructure and built environment, and geographic proximity to other places; and spiritual dimensions, such as personal or symbolic affiliations, or the presence or absence of a sense of belonging, can have wide ranging influence. In addition, the political context and the power dynamics of communities can create social divisions that prevent community participation and access to essential resources (Jewkes & Murcott; Minkler, 2012). Communities are unique socio-cultural-political spaces that comprise new options for addressing health issues, which are not generally accessible within traditional, clinical settings (Scaffa & Reitz, 2013).

Why should occupational therapists work with communities?

Occupational therapists traditionally provide services to individuals and groups who access health-care services. If occupational therapists were to work more broadly with communities, there is greater potential for a larger population impact. An individual's capacity to access occupational therapy services is influenced by their personal skills, geographical and cultural factors, and in some instances, ability to navigate complex service eligibility criteria and secure financial means (Rifkin, 2009). Adopting a community-centred practice approach would reduce barriers to service access by providing care with the community, promoting engagement of hard-to-reach groups (Minkler, 2012; Scaffa & Reitz, 2013).

In Australia and the United Kingdom, policy makers call for greater community participation to address increasing health-care demand and costs. Community participation is mandated in health-care quality and safety standards in Australia (Australian Commission on Safety and Quality in Healthcare, 2011) and in the United Kingdom, through the National Health Service, and the Scottish Government's 'participation standard' (Tritter, 2011). Methods used to increase service-community cooperation include consultation and deliberation techniques such as citizen juries, consumer boards, and service user co-design and co-production processes (Conklin, Morris & Nolte, 2012). Additionally, the World Health Organization leads global calls for health practitioners, health service staff and communities to work cooperatively (Rifkin, 2009). Occupational therapists should heed these policy directives and lead the design and implementation of innovative community-centred practices.

Lastly, occupational therapists are philosophically and theoretically well situated to work with communities. Values underpinning the profession of occupational therapy support a cooperative model of working with individuals, and this philosophy has potential to extend to communities (Townsend *et al.*, 2007).

How can occupational therapists utilise a community-centred practice approach?

Occupational therapy encompasses many skills and capabilities that can be incorporated in a community-centred practice approach. Scaffa and Reitz (2013) encourage a community-centred occupational therapist to take on the role of 'consultant, facilitator or mentor', rather than the professional (p. 6). Similarly, Townsend *et al.* (2007) recommend utilising enablement approaches with communities, which are outlined in their Canadian Model of Client-Centred Enablement model. Using this model, the community is conceptualised as the 'client' and enablement skills, including advocacy, teaching, collaboration, consultation, education and evaluation, are applied to achieve community health objectives. Use of enablement strategies aims to intentionally balance the power dynamics that exist between 'therapist' and 'client' within a therapeutic interaction, which is essential for community-centred work (Townsend *et al.*, 2007).

Taking an occupational perspective to community-centred practice would involve applying an occupational philosophy in the assessment, intervention and evaluation of community health issues (Moll, Gewurtz, Krupa & Law, 2013; Parnell & Wilding, 2010). Parnell and Wilding support this argument, and agree that the profession should 'broaden its view and apply an occupational perspective to many of the challenges that plague contemporary life' 2010, (p. 346). An occupational perspective could be valuable in assisting communities to identify and explore health issues, problem-solve, and propose and co-implement solutions (Scaffa & Reitz, 2013). In addition, an occupational lens could reveal solutions hidden by a narrower disciplinary focus. Emerging research in non-traditional areas of practice demonstrate how an occupational perspective can be valuable, such as work with natural disaster preparedness and post-disaster relief, and with asylum seekers and refugees (Kronenberg, Pollard & Sakellariou, 2011).

Integrating an occupational therapy perspective to planning and design of the built environment with community stakeholders can improve pedestrian safety and prevent falls, and increase mobility and access to resources (Parnell & Wilding, 2010). Moll *et al.* (2013) describe how occupational therapy input can be used to enhance public health initiatives, including, the design of 'age-friendly communities', and programs that improve access to extra-curricular activities for youth. However, few studies have examined the actual processes used for designing and implementing health programs collaboratively with communities from an occupational therapy perspective.

A philosophical framework to guide community-centred practice can be drawn from extant professional paradigmatic beliefs and trends. The occupational

science paradigm emphasises the intimate link between occupational participation, population survival and health, and core occupational science concepts highlight the importance of community and belonging (Wilcock, 2006). Paradigmatic shifts away from traditional 'mechanistic', bio-medical practices, towards a more balanced practice philosophy that encompasses science, art, culture and wellness (Gillen & Greber, 2014, p. 39), are more conducive to a community-centred practice philosophy. Core occupational therapy values of equity, social justice and human rights, and creative and context-specific interventions (Polatajko, 2001; Scaffa & Reitz, 2013), are critical for community-centred work. (Cunsolo Willox *et al.*, 2012; Kenny *et al.*, 2013; MacQueen *et al.*, 2001; Rifkin, 2009).

Challenges and barriers to community-centred practice

Challenges and barriers to community-centred practice are identified within health research. In developed affluent countries, policy centred on community-centred practice is largely driven by austerity measures and health-care budget cuts. This can influence the community's willingness to engage with initiatives that are driven by health-care institutions (Kenny *et al.*, 2013; Tritter, 2011). In addition, a history of unpopular service closures or sensationalised media reports about health-care problems might result in communities being suspicious or reluctant to engage. To address issues relating to community engagement, practitioners are recommended to assess community-institution dynamics and politics, historical experiences with collaboration, and levels of institutional trust (or mistrust) (Jewkes & Murcott, 1996; MacQueen *et al.*, 2001). Additionally, community needs, expectations, and objectives must be considered (Minkler, 2012).

Generally, community-centred practice approaches to health-care are recommended over generic one-size-fits-all models. However, evidence to guide practice is limited (Kenny *et al.*, 2013). Globally, the majority of evaluation has been conducted in developing countries with poor and under-served communities (Rifkin, 2009). Research involving developed nations is still in preliminary stages and it is not yet established if community-centred interventions are more effective than interventions developed without community input (Conklin *et al.*, 2012; Rifkin, 2009). Cross-disciplinary partnerships within population health are needed to overcome challenges in research and evaluation, and to address knowledge gaps (Wilcock, 2006).

More specifically to occupational therapy, barriers exist within the profession that may limit transitions to community-centred practice, such as levels of public awareness of occupational therapist capabilities, restrictive service delivery and payment models, as well as inadequate public funding for population health initiatives (Gillen & Greber, 2014; Scaffa & Reitz, 2013). Generally, education for occupational therapists on community-centred practice approaches is limited, and changes to include community practices in university curriculum, for example service-learning or project placements, are relatively new (Fortune & McKinstry, 2012; Scaffa & Reitz). To transition to any non-traditional practice area, occupational therapists require skills, confidence, knowledge and evidence, systemic and political support, and backing from professional associations.

Conclusion

Occupational therapists are well situated to design and implement initiatives that improve community health and wellbeing. A community-centred practice approach should be adopted, which expands 'community-based' roles to enable working with, not simply within, communities. Many occupational therapists work with individuals. However, we argue that occupational therapists are philosophically, theoretically, and practically well situated to work collaboratively with communities. Occupational therapists adopting a community-centred practice approach are encouraged to take on non-traditional roles of mentor and facilitator, and to utilise fundamental participation enablement skills, including advocacy, coaching, and education. A shift from 'mechanistic', or bio-medical dominant interventions and roles is needed, and occupational therapists must be willing and capable of adopting practices that emphasise creativity, culture, and wellness. Community-centred practice approaches should draw on the unique capabilities of a diverse community context, which requires an understanding of the dynamic nature of communities, and influences of myriad dimensions.

Barriers within the profession must be overcome if occupational therapists are to establish a position within the population health arena. Currently, as with any non-traditional practice area, limited evidence exists within occupational therapy to guide this practice transition. There is great potential for occupational therapists to develop and research community-centred approaches that draw on existing disciplinary values, models and skills, and utilise cross-disciplinary partnerships with practitioners who are already working in this space. With increasing political impetus for health practitioners to cooperate with communities, it is timely for occupational therapists to lead initiatives, and demonstrate the value of their unique perspective. As a profession, we must build evidence for an occupational perspective of community-centred practice, and champion robust research and evaluation.

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Chapter 5

How do people participate with community initiatives? Case study of community participation with a Canadian food security network

"It may only be 30 people that actually garden, but then 150 people participate in their photo competition, and then another 1000 come to their once a year party, but then the rest of them love looking down on the garden." Key Informant 3, Case Study 1 participant.

5.1 Introduction

This chapter includes Case Study 1, which is a qualitative case study of community participation with a Canadian food security network. In this chapter, I introduce the case study and outline background literature, which is important for understanding the case study context, and why this case was selected for study. The purpose of the doctoral research is to investigate community participation in Western, developed contexts, and to examine how and why people participate in community initiatives. In this Chapter, I argue that this case study provides new insights into how communities participate, and discuss emergent (emic) issues that relate to how community participation is sustained over time. My aim is to convert this chapter into a manuscript for publication after thesis submission, therefore the chapter is organised using conventional manuscript sections, including background sections, a concise summary of research methods, description of study findings include case background and key themes, and discussion and conclusion sections.

5.2 Introduction to the case study

In many Western countries, community participation with food and agriculture projects is evident in many neighbourhoods (Baker, 2004; Firth, Maye, & Pearson, 2011; Litt

et al., 2011; Starr, 2010). However, to address population health objectives (such as the United Nation's Sustainable Development Goals), community participation must be enacted with a long-term vision that encompasses sustainable actions targeting social and political change (Sachs, 2012). The myriad of challenges inherent in community participation are widely documented, which conclude that participation processes can be difficult to enact and sustain over the long term (Kenny et al., 2015; Morgan, 2001; Rifkin, 2014; Shediac-Rizkallah & Bone, 1998; Zakus & Lysack, 1998). The aim of this case study is to investigate how and why people participate in community initiatives, by exploring community participation in the context of a Canadian food security network.

5.2.1 Community participation in food security initiatives

The rising popularity of community-driven food security projects is linked with increasing public understanding of socio-economic and environmental challenges, which arise from how food is produced, purchased and consumed (Starr, 2010; Wekerle, 2004). Agriculture and food projects have been established within communities, which aim to increase access to healthy food, via sustainable food sources. This is achieved through localised fruit and vegetable distribution centers, markets or schemes, partnered with consumer-focussed campaigns, which aim to change purchasing habits and increase awareness of the benefits of buying food from local and ethically responsible sources (Johnston & Baker, 2005; Levkoe & Wakefield, 2011; Macias, 2008; Stroink & Nelson, 2013; Sumner, Mair, & Nelson, 2010). Similarly, community agriculture projects, such as urban farms, aim to shift public perceptions of land use, and promote creative thinking about how food can be produced in industrialized, built environments (Baker, 2004; Lyson, 2014).

Researchers call for wider use of participation-based approaches within food security policy development, research, and practice. It is argued that community participation can

contribute to more equitable, sustainable and innovative food systems (Blay-Palmer, Knezevic, et al., 2013). However, research is needed to develop effective methodologies, and to overcome challenges relating to enacting and sustaining participation (Gliessman, 2015; Pretty et al., 2010; H. Putnam et al., 2014).

5.2.2 Challenges of community participation

Researchers describe a range of challenges relating to community participation. There is often inadequate funding for community participation initiatives, and difficulties with maintaining community interest and involvement over the long term (Rifkin, 2003, 2009, 2014). Problems relating to volunteer burden or fatigue can emerge in long-term initiatives (Calderwood & Davies, 2013; Henderson & Kendall, 2014). It can be difficult to maintain consistent leadership and governance (Brownill & Carpenter, 2007; Kegler, Rigler, & Honeycutt, 2010; O'Meara et al., 2007), and community members can grow tired of repeated, participation processes, particularly if outcomes are not achieved (Attree et al., 2011; Cornwall, 2008; Kenny et al., 2015). These challenges must be addressed if community program leaders are to effectively utilise community participation as a platform for action on population health, and social and political change.

Despite wide interest in community participation methods (Conklin, Morris, & Nolte, 2012; Mitton et al., 2009), few studies have explored how participation processes can be sustained. Sustainability is commonly used within outcome measures to evaluate community participation processes, and is used to indicate program longevity (Draper et al., 2010; Morgan, 2001). Defined as "long term viability", sustainability is understood as the dynamic process of maintaining an initiative (Shediac-Rizkallah & Bone, 1998, p. 87). Early studies proposed that sustainable community participation involves maintaining an initiative with partial or complete community control, which could include integrating or institutionalising

participation methods within a larger system (Shediac-Rizkallah & Bone, 1998; Zakus & Lysack, 1998).

Community participation processes need to be sustained for a certain period, to ensure scarce resources are invested effectively and the full range of outcomes realised (Head, 2011; Rifkin, 2009; Shediac-Rizkallah & Bone, 1998). Employing participation methods that are not sustainable increases risk of early dissolution, which may reinforce community mistrust of institutions and prevent people from engaging in initiatives (Shediac-Rizkallah & Bone, 1998). However, sustaining participation for 'participations sake' is inappropriate (Draper et al., 2010; Morgan, 2001). Shediac-Rizkallah and Bone (1998) argued that not all community participation processes should be sustained indefinitely, and in some cases continuation is ineffective and potentially harmful.

5.2.3 Conceptualizing 'community' and 'community participation' in the Canadian food security context

The Canadian food security network that was selected for case study operates as part of a national social movement with global connections, known as food security, or 'local food' or 'agri-food' movements (Boicean et al., 2013; Starr, 2010). Internationally, a key objective of the food security movement is to campaign for healthy, safe and accessible food for all, which stems from poverty and food inequities in developed and developing countries, the increasing dominance of trans-national food corporations, and the impacts of mass food manufacturing on public health and environmental sustainability (Boicean et al., 2013; Starr, 2010). Brown and Zavestoski (2004) define social movements as collective action for the purpose of social change that uses formal and informal networks to challenge "political power, professional authority, and personal and collective identity" (p. 679). The classification of the Canadian food movement as a social movement is debated (Starr, 2010),

however, Brown and Zavestoski (2004) and others (Bauermeister, 2016; Levkoe, 2006; Lyson, 2014; Starr, 2010; Wekerle, 2004) have classified the Canadian food security movement as a social movement.

Participation in social movements is characterised by 'self-mobilized' participation, which is a bottom-up, community-driven approach that is commonly observed in autonomous initiatives (external of government) (Cornwall, 2008; Pretty, 1995). It is argued that participation grows from community capacity to self-mobilize and participate in action that challenges social and political systems (Cornwall, 2008; Pretty, 1995). Communities participate in an evolving process of "conflict, confrontation, and accommodation" that aims to "influence the political process or obtain political power" (Mansuri & Rao, 2013, p. 31).

Social movements rely on the recruitment and activation of participation within communities and their networks. The efficacy of food movements is determined by their ability to mobilize citizens, and to form a cohesive collective mission and identity (Bauermeister, 2016). Authors argue that participation is identifiable as a social movement as long as it is autonomous, and is observed to communicate protest and 'move itself' (Fuchs, 2006). In this context, community participation should occur in "spaces people create for themselves", and involve "people who come together because they have something in common, rather than because they represent different stakeholders or different points of view" (Cornwall, 2008, p. 275).

Community is central to food movement dialogue and collective identity. Within food security initiatives, community is described as the people, groups and stakeholders, who are connected via their social, cultural and/or economic interests in food security, and who participate in joint action to promote, celebrate and lobby for safe, accessible, sustainable and culturally-appropriate food (Bauermeister, 2016; Blay-Palmer, Knezevic, et al., 2013; Blay-

Palmer, Landman, Knezevic, & Hayhurst, 2013; Firth et al., 2011; Sumner et al., 2010). Food security initiatives promote community as the antithesis of modern society, a traditional and simpler way of living with food (through growing, purchasing and consuming), which is threatened by modernity (including large-scale development and urbanism). This dichotomous view of food systems distinguishes community-based, local food producers from powerful, multi-national food corporations, and community-based food purchasing is promoted as an ethical and responsible alternative (Bauermeister, 2016; Blay-Palmer, Knezevic, et al., 2013; Sumner et al., 2010).

In the context of food security initiatives, the benefits of being community-based are highly publicised, and sometimes conflated (Lyson, 2014). Community-based food security projects are reported to have various outcomes (including health/wellness, social, cultural, and/or political) (Obach & Tobin, 2013). Community kitchens and gardens, for example, are reported to create opportunities for improving social connections, and for improving knowledge of fruit and vegetable production, and increasing consumption of healthy food (Levkoe & Wakefield, 2011). Community food security projects are argued to foster political agency, and community participation is used to grow food justice networks and encourage activism (Levkoe, 2006).

Because of the myriad of challenges reported with community participation, including problems with sustaining participation over the long term, the reality of enacting and maintaining community participation with food security initiatives is likely to be less straightforward. The complexity inherent in community participation can be visualized using Tritter and McCallum's (2006) metaphor of a "messy mosaic" (p. 165), which describes how community participation involves a convoluted arrangement of horizontal and vertical partnerships, and multifaceted power dynamics. Ultimately, if the food movement is to

achieve its objectives, community participation must be enacted in ways that achieve a re-distribution of power and control (Arnstein, 1969; Rifkin, 2014), which requires sustained action towards changing social and political factors that underpin food insecurity and injustice. Using the Canadian food security network as a lens, the purpose of this research was to investigate the ways in which community participation is maintained with food security initiatives, and to critically examine the processes used.

5.2.4 Case study aims

The aim of this case study was to examine how and why people participate in community initiatives. The case study of a Canadian food security network was selected, which operates as part of a food security movement that originated in the 1970s. The case study is an exemplar of long-term, sustained community participation, which provides a lens for identifying and critically analysing processes used for community participation in a grassroots social movement, or self-mobilized form of community participation (Cornwall, 2008; Pretty, 1995).

5.3 Methods

5.3.1 Study design

A qualitative case study design was used that incorporated Stake's (1995) instrumental case study approach. The phenomenon of interest, community participation, was explored via case study of a Canadian food security network. This particular case was selected because it was located in a Western, developed, high-income context, and had been reported to contain several characteristics of exemplary community participation. Programs and organisations that were linked into the food security network have sustained community

participation for an extended length of time, some programs had expanded in size and scope, and participation was reported to contribute positive health and well-being outcomes for communities. Ethics approval from La Trobe University, College of Science, Health and Engineering, Human Research Ethics Committee was obtained for the study procedures (approval number FHEC13/170).

5.3.2 Data collection

A range of data sources were purposively sampled to provide an in-depth description of the case from multiple perspectives, and to enhance data triangulation (Hyett, Kenny, & Dickson-Swift, 2014; Merriam & Tisdell, 2016; Stake, 1995). The data sources included interviews, researcher reflections and field observations, public documents, webpages and social media.

Interviews

Internet searches were conducted to locate community leaders involved with Canadian food security programs that operated as part of a national network. Two interviewees were recruited by email invitation, who then recommended key people from their network. Further potential participants were approached by email and three agreed to participate. Five interviews were conducted in October 2013; including, three in Toronto, Ontario (pop 2,615,060), one in Montreal, Quebec (pop 1,649,519), and one in Halifax, Nova Scotia (pop 390,096) (Statistics Canada, 2012). Participants were all employed in paid positions, two in national level organisations, and three at a municipal level. Participants were selected as key informants, because of their leadership positions and capacity to describe methods and strategies employed within programs.

The interviews were conducted in-person at the informants' place of employment. They all provided informed written consent to have interviews audio-recorded and transcribed verbatim. Interviews were conducted by myself and my research supervisor (Professor Amanda Kenny) using a semi-structured question guide, and lasted approximately 60 minutes.

Field observations

Field observations were recorded over two weeks in October 2013, including a total of 11 site visits (seven field sites in Toronto, two in Montreal and two in Halifax). Field observations included researcher reflections, written notes to describe field sites and observations of community participation, and photographs (not of people). Observations were taken of food security program sites, and community gardens and markets, and included three guided tours of community food hubs led by program leaders (not interviewed).

Public documents

Public documents of seven organisations were collected during fieldwork in October 2013 and via online sources until December 2013. The thirty-four documents included in the data analysis were program annual reports, evaluation reports, policy submissions and reports, research papers written by interviewees, program manuals, and information handouts.

Social media

Online strategies were used to support community participation, and to explore this, social media data were collected and analysed. The social media data of seven organisations were collected. These data were publically available online. Online social media data sources (N=94) included Twitter (n=9), Facebook (n=9), YouTube and Vimeo (n=6), blog pages (n=22), and webpages (n=48). Data were collected between July and December 2013, which

involved extracting and storing social media data using the NVivo 10 application and NCapture plugin (QSR International, 2014).

5.3.3 Data analysis

The data coding process was assisted by the computer software application NVivo 10 (QSR International, 2014). All data sources were coded using techniques common to case study approaches, including descriptive, in vivo, and process coding methods (Saldaña, 2013). Codes were grouped into categories, which were analysed to develop themes (Saldaña, 2013). The themes describe strategies used by community leaders to enact and sustain community participation, and relate to how people participate with the community food security initiatives. The themes are: *use of multiple methods*, *good leaders are fundamental*, *online participation via social media*, and *leveraging outcomes: "Is there a way we can seed it or spark it"*.

5.4 Findings

5.4.1 Case background

The Canadian food security network operates as part of a civil society movement that began in the late 1970s. Over the past three decades, more than 5000 Canadians have participated in food security programs and initiatives (Peoples Food Commission, 1980; Peoples Food Policy Project, 2011), and there are an increasing number of food security initiatives in major cities (Baker, 2004; Blay-Palmer, Landman, et al., 2013; MacRae & Donahue, 2013; Stroink & Nelson, 2013). Food security, defined as "access to adequate amounts of safe, nutritious, culturally appropriate food produced in an environmentally sustainable way and provided in a manner that promotes human dignity" (Levkoe, 2006, p.

91), is the goal of the movement. Beginning in the 1970s with grassroots activism in rural communities, citizen-led groups were formed to take action on food insecurity issues affecting their livelihood (Peoples Food Commission, 1980). Citizen-led action is identified as a guiding philosophy, and key achievements include a national policy development project, which utilised a Kitchen Conversations method to consult with over 3000 Canadians. Community submissions were used to develop shared principles and discussion papers that underpin ongoing national food systems work.

The Canadian food security network was selected for case study because it had potential to address the doctoral research questions, which were how and why people participate with community initiatives. The selected food security network exemplifies *how* participation processes have been supported and sustained, and in ways that were reported to deliver positive health and social outcomes for communities (Engler-Stringer & Berenbaum, 2007; Johnston & Baker, 2005; Levkoe & Wakefield, 2011; Wakefield, Fleming, Klassen, & Skinner, 2013; Wakefield, Yeudall, Taron, Reynolds, & Skinner, 2007). Therefore, in the Findings section, the themes address how community participation was enacted. Further research was needed to explore the research question relating to why people participate with community initiatives. This research question is addressed in the subsequent case study. This case selection strategy is commonly used for inductive qualitative research, and is a key characteristic of instrumental, collective case study design (Stake, 1995).

5.4.2 Key themes

Use of multiple methods

Multiple methods are employed simultaneously to enable and sustain community participation. Methods, listed in Table 12, include social events, such as movie nights and themed dinners, and public green spaces and urban agriculture projects, including car park

and roof top gardens. By utilising several methods simultaneously, programs maximise participation opportunities for various age and cultural subgroups. Key informants explained that community participation is sustained as a result of the combination of multiple methods employed.

Table 12. ***List of Methods Used for Community Participation***

List of community participation methods
Newsletter
List serve
Website
Wall calendar
Household canvassing/door knocking
Postal survey
Online written or photographic submissions
Twitter feed
Facebook page
Food skills workshop
Social events, e.g. volunteer night
Community food hub e.g. food market, garden, kitchen, distribution centre
Urban agriculture projects e.g. bee-keeping, composting
Social enterprise e.g. bike shop, meals on wheels, café
Story-making workshops
Students placements or internships
Online learning portal, open access resources
School-based food education and healthy food access programs
Citizen blogs
Community meetings for policy making, priority setting and strategic planning e.g. Kitchen Conversations
Community working groups for food, environment and farming issues
Peer advocacy service

Methods used to promote participation of specific community subgroups include school-based healthy eating and gardening projects in Toronto and Halifax. These involve

children, teachers and parents, and include breakfast programs, edible gardens, food education and cultural activities, and cafeteria healthy meals programs. In a Montreal community food hub, social events are held for young adults and elderly people to encourage intergenerational interaction. Informants provided several other examples of participation initiatives that were used to increase community participation of specific socio-cultural groups, such as vocational training programs with adolescents, cooking skills workshops with families, and multicultural community gardens and urban farms with new migrant populations. Using multiple methods sustained community participation by improving attendance numbers, and reducing over-reliance on one particular community sub-group.

The multiple method strategy for community participation was described by informants as dynamic and changeable to suit the local context. Methods used have multiple purposes, described by a key informant (KI3) in Toronto:

> It may only be 30 people that actually garden, but then 150 people participate in their photo competition, and then another 1000 come to their once a year party, but then the rest of them love looking down on the garden.

The methods used are frequently adapted in response to current policy problems, media interest, and the availability and source of funding. Citizens with innovative ideas are involved in creating new methods, for example a bee-keeping collective within a Montreal program, and a composting demonstration project in Toronto. Key informant (KI3) described the dynamic nature of community participation:

> Often food is used as a way to, you know you start a garden and all of a sudden you can do energy efficiency projects, you know people are sort of together, working, and know each other, and working on these other initiatives, as residents.

The informants described a multiple method strategy that supported community participation in all organisation activities, operations, and governance. This strategy is embedded in the local context and aligned with the national food security movement vision and agenda.

Good leaders are fundamental

Food leaders, known as "commissioners", "animators" or "champions", have a fundamental role in the coordination and implementation of food security initiatives. There were several characteristics used by informants that describe how food leaders are used strategically for enabling and sustaining community participation. An informant (KI1) described food leaders as "people who worked at organisations like *The Stop*, and *Santropol Roulant*, and community health centres, who were really anchored in a community, and a place, and already had legitimacy and leadership and all that stuff established…" Food leaders were characterised as "visionary people with big ideas", who were "dedicated" and "instrumental" (KI1). Key people who are able to (KI1) "popularise the notion of food sovereignty" and support community participation in food security initiatives.

Food leaders are employed or volunteer in community food programs, and are people that have respected food, health and farming leadership roles in their communities (K14). Another key informant (KI3) described the "food animator" role in a current food and garden initiative that is run in partnership with a social housing organisation:

> This work does need to be animated right? In Toronto Community Housing we have a resident, we call them animators, you know resident leaders as well as staff whose job it is to do some of that hard work, convening meetings, putting up posters, providing resources and navigating. Frankly, the system, you know it's not easy to start a community garden.

The role and responsibilities of food leaders have evolved to support community participation over time. In addition to original responsibilities of creating awareness, building interest and momentum, and organising community events (KI1), current community food animator roles described include community capacity building and sourcing food production resources and infrastructure (KI2 and KI3). One informant (KI5) noted that food leaders need to be

politically savvy, and all key informants identified that grant writing and policy submission skills, and skills to liaise with philanthropic funders, are valued.

Food leaders are selected for their public profile and personal skills. Described by an informant (KI2), food leaders in Halifax programs are people who are good "networkers", "connectors and resourcers", "people who are working on the ground, in community food programs, that know what the needs of the community are to some degree". A key informant (KI1) indicated that leaders are thought to "represent the diversity in the food movement". She described effective leaders as "facilitators and staff who are sensitive and skilled at drawing people into the process", who are able to support "other people to see their work as contributing to this food systems perspective" (KI1). Situated in community food programs, effective leaders are able to make horizontal and vertical linkages between local people and the national identity of the food movement.

Informants argued that food leaders support community participation initiatives with their local knowledge and influence. Food leaders are people who already have leadership roles in their respective communities, are 'insiders', and this is used to maximize participation and outcomes. One key informant (KI3) explained how this approach "values the work that is happening on the ground – that is already happening in communities by existing leaders". Food leaders are selected to support linkages across neighbourhoods, communities and regions, which provides a strong foundation for their national network.

Online participation via social media

The social media pages of organisations linked with the Canadian food security network illustrate how people participate with communities via online mediums. Community leaders use social media to engage with the public, and at a national level, to communicate across Canada's vast regions and provinces. The importance of a dynamic web platform and

social media presence was argued by three key informants (KI1, KI4, KI5), and social media data analyses revealed how online methods are used.

Social media are primarily used to provide information to community members. Online mediums including webpages, blogs, Facebook and Twitter, are used to increase organisational membership, attract sponsors, advertise employment or internships, and to promote community food security activities. Social media are used to provide a real time mechanism of celebrating achievements and awards, and acknowledging efforts of volunteers. Community leaders use social media to promote organisational ideas and values, and sometimes were used to indicate policy endorsements or alliances. Current participation opportunities are advertised online, including a Google map of community gardens in Halifax, and tweets about an upcoming cooking workshop in Montreal.

Analysis of Twitter feeds and Facebook wall posts revealed how community leaders involved with the national network use micro-blogging to share short messages about healthy food, food security, and related policy issues. Twitter and Facebook are used pre, post and during community activities to increase participation, and appeared to provide links between online and in-person participation methods. Community food hubs in Toronto, for example, use Twitter and Facebook posts to encourage people to share photos of what they purchased at the healthy food market, and what they cooked with their good-food-box delivery.

There are various mechanisms for community participation via online mediums. Community members participate by reading information, clicking hyperlinks or observing photos and videos, and interact with the information by adding comments. This allows community members to share information with their own wider social networks via Facebook 'like' or Twitter 'retweet' functions. The number of Twitter followers for each program ranged from 562 to 10,691, with a mean average of 4472 followers across nine Twitter

accounts. Facebook users ‘like’ a program’s page to be a member, and can ‘rate’ the organisation by using a five-star system and provide written feedback. For example, on one organisation’s Facebook page a user had rated them five stars and commented “What is it but one of a handful of great organisations paying it forward to future generations”, and three other Facebook users ‘liked’ this comment. Facebook pages have less members than Twitter, with page ‘likes’ ranging from 351 to 5018, with a mean average of 2279 across nine Facebook accounts.

The images provided in Figure 13 and 14 demonstrate how Facebook is used to stimulate conversations about food. Facebook posts with the most amount of ‘likes’ were photos; examples of two photos with a high number of ‘likes’ are provided. The picture in Figure 13, received 1,207 ‘likes’ and was ‘shared’ by 1,999 Facebook users. Users wrote comments such as “We need A LOT more "Farmacists"!” and “Terrific. Best advice. You are what you eat and absorb. Eat veggies”. Most comments were made in good humour, and commented on the satire of healthy food, medication and health. Other users stated their personal opinion or made comments in direct response to other users. The picture in Figure 14, was of fruit and vegetables from a terrace garden linked to a food organisation, the picture was liked by 70 users and was shared in 18 instances. One user commented “It's amazing how wonderful the food you grow right in your own backyard/frontyard looks. Keep growing more and more”.

Figure 13. ***Example of Facebook "Farmacy" Comic Wall Post***

Note. Comic posted on Facebook by a food security organisation that depicts a 'Farmacy' Images posted on Facebook and are transferrable under Intellectual Property law (see https://www.facebook.com/legal/terms). The owner of Figure 13 has given permission for this comic to be used 'responsibly' (see http://www.bizarrocomics.com), and this comic has been posted on several other websites by different Internet users.

Figure 14. ***Example of Facebook Fruit and Vegetable Image Wall Post***

Note. Image of fruits and vegetables purchased by a Facebook user from a food security organisation. Images posted on Facebook and are transferrable under Intellectual Property law (see https://www.facebook.com/legal/terms).

Social media is used to create a positive public profile. This profile includes the organisation name, location, vision, values, objectives, current activities and intra-organisational links. The content displayed on the organisations website and social media profiles demonstrates what food-related polices they endorse, and some have clear links to members of parliament or political parties who advocate for food system policies.

Leveraging outcomes: "Is there a way we can seed it or spark it"

Leveraging is a method reported by key informants (K2, K3, K4, K5), which is used to expand community capacity and support program sustainability. Key informants explained, in the current fiscal context, funding for food security programs and initiatives is inconsistent, and often comes from philanthropic donors or short term government grants. They argued there is a need for programs to utilise existing resources and maximise outcomes. This involves leveraging existing resources to support community participation, rather than building new initiatives. One key informant (KI3) explained "we [municipal food council initiative] don't have the capacity to start fresh, but to add something to the work that is happening".

In an annual report of a Toronto-based food organisation, leveraging is described as "transformational", and "[leveraging] ensures that each dollar we invest in our programs multiplies, impacting the greatest number of people". Three key informants described how leveraging is used to increase the scale of food security initiatives, which increased the number of community members who could participate (K2, K3 and K5). There were similarities identified in the analyses in how community leaders utilise leveraging as a strategy for supporting community participation, which are grouped into a four stage process outlined in Table 13.

Table 13. ***Four Step Leveraging Approach***

Stage	Description
1. Assessing community readiness	• Food security needs to be a community-owned priority • Involves "feeling out" (KI5) community readiness and interest, capacity and resources • KI2: [we] went around the province and did a tour, to see where there is need and where we could infuse those resources, so we have hired somebody in [regional place] because there was a real readiness there and people were already working on food issues • Locating a community, "a place where there is already energy that we can build on" (KI2) • Access to local partners, funding and resources
2. Partnership development	• Finding suitable partners and forming effective partnerships • KI2: "we work through neighbourhood organisations, with people who understand those neighbours" • KI3: "we always work with community partners and also engage local community leaders to make sure that those projects are a success" • Partnerships include non-food related programs including community health centres, social housing commissions, and schools and educational facilities
3. Resource investment	• Strategic investment of human, material and financial resources in skill and infrastructure development projects • Securing existing community resources minimises expenditures, e.g. vacant land or buildings, and human resources, including business owners, volunteers, students and interns, and community leaders • Resource investment at a local level is important, to "increase local capacity" (KI5), and support "local communities so that they can organise themselves, and you know, hire coordinators to do this work, and it builds capacity at that local level" (KI3) • Skill sharing is an integral investment in human resources, via "mentoring communities" and "sharing resources freely in an open source approach" (annual report)

4. Support for participation sustainability	• Food leaders maintained a level of support for leveraged community projects • High staff turnover in partner organisations influenced their ability to sustain an autonomous project (KI2) • Sustainability is supported through funding, human resources and skills (KI2 and KI5). • KI2: "[our main challenge is] supporting the program staff at one of the organisations that we work at, to increase their capacity, so that they can be the ones that keep supporting that, not always us, one of our biggest challenges, is all of the organisations we work with have a lot of turnover, they are really high intensity community development jobs and I think people burn out, people move on"

5.5 Discussion

The findings of this case study provides new insights into how people participate in community initiatives, and processes and strategies used to enact and sustain their participation. The key themes describe four strategies that were identified as central to the network's objective of sustaining community participation in the Canadian food security movement. The findings of this case study, similar to other studies of social movements, can be used to increase understanding of the different ways in which 'self-mobilised' forms of community participation are enacted and sustained over the long term (Barnes & Coelho, 2009; Passy & Giugni, 2001; Starr, 2010; Wallerstein, Mendes, Minkler, & Akerman, 2011). One particular issue highlighted by this research, is how methods and strategies used to support community participation were changed over time, which was needed to sustain community interest and involvement with food security initiatives.

To critically examine the community participation processes used by the food security network, theories drawn from the social movement literature are useful. In this

discussion section, principal theory from the social movement literature is used to discuss the case study findings.

In this case study, people participated in food security initiatives in similar ways to what has been observed in other social movements in affluent, Western societies (McCarthy & Zald, 2001). The informants (study participants) described how community participation was facilitated using organised practices that were guided by well-formed objectives. Like other modern social movements, historically, the informants described how deprivation and protest were key elements of community activation. However, in order to sustain long-term community participation, they argued that rather than working in opposition to government, there is increasing need to partner with governments and decision-makers, and leverage outcomes for social and political change. The views of the informants are comparable to existing research, which highlights that organisational capacity building, resource acquisition, and partnership development are important elements of sustaining participation in social movements (B. Edwards & Gillham, 2013; Jenkins, 1983; McCarthy & Zald, 2001).

Sociological theories developed from research on social movements, primarily Resource Mobilisation Theory (RMT), can be used to understand why the strategies described in the case study could have enabled and sustained community participation within the food movement (McCarthy & Zald, 2001). Resource Mobilisation Theory was developed within the context of large-scale social movements with centralised participation strategies (McCarthy & Zald, 2001), which closely aligns with descriptions of the Canadian food movement within the case study. Using a resource mobilisation theoretical lens, we argue that community participation within the food movement was sustained because strategies used were effective for activating communities, and for mobilising and deploying the required resources (B. Edwards & Gillham, 2013; Jenkins, 1983; McCarthy & Zald, 2001).

Community participation within the food movement was observed to be influenced by the presence or absence of resources (Jenkins, 1983). The community leaders in the case study recommended that several types of resources are needed to sustain participation (B. Edwards & Gillham, 2013; B. Edwards & McCarthy, 2004). These include human resources, such as moral, social or cultural capital, and physical objects that include organisational assets or monetary resources (B. Edwards & Gillham, 2013). Within the case study, the informants argued that resource acquisition was key to sustaining community participation. They identified good leadership and online social media platforms as valuable resources, and described how the absence of resources, for example stable funding, was overcome by utilising volunteers, local assets, and by building capacity through leveraging strategies.

Authors contend that participation within modern social movements is largely determined by rational choice and perceived costs and benefits of participating (Canel, 1997; B. Edwards & McCarthy, 2004; McCarthy & Zald, 2001). Elements of strategies described in the case study can be used to support this argument. The informants described how strategies were used to increase community participation by incentivising participation and removing potential barriers, for example by offering travel reimbursements and honorariums for volunteers. The informants developed the multiple methods strategy to provide a range of choices and options to suit a variety of participation preferences. Online participation options were provided via social media to increase community accessibility. Resource mobilisation theorists argue that incentives must be sufficient to influence individual and collective decision-making, and to overcome personal barriers or competing commitments (B. Edwards & McCarthy, 2004; Jenkins, 1983). This provides one possible explanation for why the strategies described in the case study may have been effective for supporting people to participate with community food security initiatives.

Within the case study, the informants described how historical experiences with food insecurity were important for initiating the food movement and defining their vision and objectives. However, resource accessibility, such as through community leaders, online platforms and leveraging strategies, were identified as key to sustaining current programs. Bosco (2001) argues that one drawback of participation strategies informed by resource mobilization theory, is that historical and cultural dimensions are not considered. McCarthy and Zald (2001) agree, and emphasise the importance of understanding the real life context of participation when forming strategies, including competing life commitments and the availability of social support (McCarthy & Zald, 2001, p. 536). Authors claim that even when participation is the rational answer, actions are not automatic and participation does not always occur (McCarthy & Zald, 2001).

Generally, the purpose of many Western social movements is to empower disenfranchised populations, however, affluent community members are often required for sustainability (B. Edwards & Gillham, 2013; B. Edwards & McCarthy, 2004). This was evident in Canada, where recruitment of affluent community members was observed in participation methods such as farmers markets, and through philanthropic partnerships developed through leveraging strategies. Social media were used to promote a positive public profile and to co-opt additional supporters, and skilled and well-connected leaders were identified as important for increasing movement membership. Resource mobilisation theorists agree that personal grievances and experiences of disadvantage are important for initiating participation, however, a wide range of monetary and social resources are needed for large-scale participation initiatives to be sustained (Canel, 1997; B. Edwards & Gillham, 2013; Jenkins, 1983).

There are potential limitations to the strategies described in the case study. Researchers have advised that strategies that require harnessing collective control over

resources are not always easy to implement (B. Edwards & McCarthy, 2004; Jenkins, 1983). For example, employing leaders who are skilled in resource mobilisation might have enhanced food movement sustainability, but participation could have been perceived as less legitimate by the Canadian communities (B. Edwards & McCarthy, 2004; Jenkins, 1983). B. Edwards and McCarthy (2004) suggest resource mobilisation is simpler for privileged groups, and consequently, if the food leaders focussed solely on resource mobilisation, unintended negative consequences such as social exclusion might result (B. Edwards & McCarthy, 2004; Jenkins, 1983). However, communities may benefit from food movement outcomes, specifically food security policy outcomes, which might be sufficient justification for utilising participation methods that focus on resource acquisition (McCarthy & Zald, 2001). Researchers recommend that social exclusion might be avoided if entrepreneurial and political leadership qualities are balanced with community social and cultural interests, and if a democratic methodology is maintained (Bosco, 2001; Canel, 1997). These are factors that should be integrated with the four strategies described in the study findings.

5.5.1 Limitations of the study

This is a small case study that contributes preliminary conceptual findings, which will provide a foundation for further empirical research. The data were collected from a small number of informants, and their views might be influenced by the nature of their employment positions. Some interview questions required participants to recall historical events. To increase trustworthiness of the subjective and retrospective nature of the interviews, an historical document analysis was used to triangulate responses. Generalisations drawn from qualitative case study findings are limited and contextual factors need to be considered for knowledge translation (Stake, 1995). During fieldwork, data collected were from best available and accessible sources at the time of travel, and repetition of interview responses indicated data saturation (Merriam & Tisdell, 2016). However, inclusion of informants from

other provinces and programs that were connected to the national network, but inaccessible at time of travel, might have provided different perspectives.

This case study was effective for addressing the research question relating to how people participate with community initiatives. Some reasons why people participate were identified including a need or desire to contribute resources, skills and time, a need to address a perceived injustice, to address a skill shortage or service gap, or to improve access to a desired community resource (for example, green space, gardens and healthy food) (see Chapter 5). However, the key themes from case analyses of Case Study 1 primarily related to how people participated with food security programs, and the methods and strategies used by community leaders. It is common practice when using an instrumental, collective case study design, to analyse each case study in its entirety before selecting further cases. Each case study informs the next, and a collection of case studies (more than 1) is used to answer the research questions (by increasing understanding of the phenomena of interest) (Stake, 1995, 2006). The gaps lefts in answering the research questions, primarily, further data on why people participate with community initiatives, will be the focus of the second case study, and will inform case selection.

5.6 Conclusion

Methods and strategies used to sustain community participation over the long term might maximise outcomes from scarce resources and increase longevity of initiatives. In this case study, community participation was enacted and sustained by using a dynamic combination of multiple methods, which utilises local leaders, leverages outcomes from strategic partnerships, and uses social media to complement in-person methods.

The participation strategies described in the case study highlight how some of the issues and challenges relating to enacting and sustaining participation processes, could be overcome by focussing on resource acquisition and mobilisation. However, it is likely that no single participation method can be sustained indefinitely, and multiple strategies are needed, which require human and financial resources. The case study findings illustrate how strategies used to support community participation that draw on resources acquisition and mobilisation approaches can be useful. However, processes that build resources, might be less attuned to historical and cultural contextual factors, lack legitimacy with communities, and conflict with efforts to promote social inclusion.

To achieve population health objectives, including food security for all, strategies are needed that support a broad range of people to participate with community initiatives. Lessons learned about how people participate with community initiatives in the Canadian context contribute a deeper understanding of strategies used to support participation, and issues and challenges of sustaining community participation over the long-term.

Chapter 6

Why do people participate with community initiatives? Case study of community participation with a rural Australian community banking initiative

"I think in any community, there are 10% of people that make things happen, 40% who watch things happen, and 50% of people say 'what's happened?'." John, Case Study 2 participant.

6.1 Introduction

This chapter includes Case Study 2, which is a qualitative case study of community participation with a rural Australian community banking initiative. In this chapter, I introduce the case study and outline background literature, which is important for understanding the case study context, and why this case was selected as part of this doctoral research. The purpose of the research was to investigate community participation in Western, developed contexts, and to examine how and why people participate in community initiatives. In this Chapter, I describe a case study that provides new insights into the reasons why people participate with community initiatives. The case study illustrates reasons why people participate with a rural community banking initiative in the context of a small rural town in Victoria, Australia, and emergent (emic) issues relating to personal motivations and contextual drivers are described and discussed.

My aim is to convert this chapter into a manuscript for publication after thesis submission, therefore the chapter is organised using conventional manuscript sections, including background sections, a concise summary of research methods, description of study findings include case background and key themes, and discussion and conclusion sections.

6.2 Introduction to the case study

Internationally, health policy emphasises the importance of working collaboratively with communities when implementing health improvement programs and initiatives (Draper et al., 2010; Morgan, 2001; Rifkin, 2014; Tritter, 2011). The Ottawa Charter (World Health Organization, 1986) and the World Health Organization primary healthcare reform agenda (World Health Organization, 1985; World Health Organization and UNICEF, 1978), underpins much of this policy, where community action is promoted as a lever for improving population health and well-being.

In many Western countries, policy is enacted through governments requiring health organisations to develop and utilise various community participation strategies (Rifkin, 2009; Tritter, 2011). Whilst these requirements are in theory directed at improving health outcomes, researchers argue there are major knowledge gaps concerning community participation that limits the translation of policy to the community or health service level (Baum & Sanders, 2011; Draper et al., 2010; Morgan, 2001). Practitioners and community leaders report difficulties with mobilizing communities to take action on health issues (Kegler et al., 2010; Minkler, 2012; Motley, Holmes, Hill, Plumb, & Zoellner, 2013). Engaging a wide range of community members can be challenging, and it is difficult to sustain community motivation and interest for the duration of initiatives (Minkler, 2012).

Rural places have fewer services and higher need for community participation, which is often used to fill service gaps and leverage outcomes from rural community assets (Hanlon & Halseth, 2005). Across rural Australia, the Bendigo Bank community banking initiative uses a model of community participation that is unlike approaches used in the health service sector. Rural community participation is used to leverage local assets and resources to establish a community-owned retail banking business (Cutcher, 2010). The community-

owned business operates as a conduit between the private Australian company, Bendigo Bank, and the community. Australian rural community banks operate in the 'Third Sector' as a type of co-operative, hybrid social enterprise (dual purpose business, 50 per cent of profits are reinvested for social, environmental and community good (Kerlin, 2006; Munoz, Steiner, & Farmer, 2015)).

Internationally, the community banking initiative is identified as an exemplary model of rural community participation (Cutcher, 2010; Stubbs & Cocklin, 2007). In Australia, over 100 rural communities participate in the national initiative (Bendigo Bank, 2014a). Compared to existing retail services, community banking is argued to be user-centred, which offers a greater voice to consumers and personalised services tailored to grassroots community needs (Cutcher, 2010; Martin, 2011). Despite the availability of alternative, competitive banking products and services available online, the appeal of community banking is reported to be unwavering (Cutcher, 2014).

In this doctoral study, our interest in this community banking initiative focuses on the success of these initiatives in mobilising communities to participate. Through exploration of community participation with a rural community bank, the purpose of this research was to explore reasons why people participate with community initiatives in a rural context, including personal motivations and contextual drivers. It is expected that case study findings will provide useful learnings on community participation, which contribute theoretical and conceptual knowledge of this complex phenomenon of interest. Increased knowledge is needed that will improve practitioners and community leaders abilities to enact and sustain community participation initiatives in a variety of multidisciplinary contexts (including population health and occupational therapy) (Baum & Sanders, 2011; Draper et al., 2010; Hyett et al., 2016; Morgan, 2001).

6.2.1 Defining community participation

There are numerous definitions and understandings of community participation within the health literature. Community participation can be defined as a process, and as an objective or outcome (Morgan, 2001). When used as a process, community participation is understood as the joint action residents take, within their shared locality, to pursue common interests and needs (Taylor et al., 2006). Authors describe community participation as an evolving process (Rifkin, 2014) that emerges as a vague mosaic (Tritter & McCallum, 2006), occurring differently across contexts as a "reflection of the context in which it takes place over time" (Rifkin, 2014, p. ii103). Generally, key features of community participation processes include leadership, capacity building, resource mobilisation, and governance (Rifkin, 2014). Outcomes of community participation are usually concerned with issues of power and control, which have proved difficult to quantify and measure (Draper et al., 2010; Morgan, 2001; Rifkin, 2014).

6.2.2 Community participation in the rural context

In the rural context, researchers describe significant practical challenges with community participation (Kenny et al., 2015). Small communities, with a history of health service closures, can be difficult to mobilise for health service participation because of entrenched institutional mistrust (Abelson, 2001; Herbert-Cheshire & Higgins, 2004). Bureaucracies and power differentials can create divisions between institutions and community members, which prevents meaningful co-operation required for long term planning and development projects (Head, 2011). Conflicting interests between participants and groups are more pronounced in small rural populations (Kenny et al., 2015). Few rural places have economies of scale, and many essential community services are reliant on volunteers (Pick, Holmes, & Brueckner, 2011), which might increase participation burden or

fatigue (Attree et al., 2011). Geographical characteristics of rural places can be obstacles, including population size and distribution, relative distance to health amenities, and the physical landscape (Farmer & Nimegeer, 2014; Kilpatrick, 2009; Rifkin, 2014; Wright, 2009).

Research in rural settings is crucial to develop a comprehensive understanding of their unique contextual challenges (Farmer & Nimegeer, 2014; Kenny et al., 2015; Kenny et al., 2013). While increasing numbers of researchers attempt to measure outcomes of rural community participation (Bath & Wakerman, 2013; Preston, Waugh, Larkins, & Taylor, 2010), fewer studies explore the critical step of why rural people participate and what factors influence their participation decisions. For example, it is unclear why rural people participate with particular initiatives, but choose not to participate with others (Farmer & Nimegeer, 2014; Kenny et al., 2015), and a number of challenges are unresolved (Kenny et al., 2015; Morgan, 2001). Further conceptual exploration is required to critically examine why rural people participate, and to build theoretical knowledge to inform research and practice.

6.2.3 Study aim

The aim of this case study was to explore *why* people participate with a rural community banking initiative in Victoria, Australia.

6.3 Methods

6.3.1 Situating the researchers

As practitioners and researchers in the health sector, we are acutely aware of the challenges encountered by health professionals trying to enact and sustain community participation initiatives in rural contexts. While none of the researchers participate with

community banking, where we live, in rural Victoria, Australia, community banking is a popular form of participation. In selecting an existing, successful case of community banking, the aim was to understand why people and communities become involved, through investigating the context of community participation and the experiences of community banking volunteers. Selecting a local case study provided us with unique insight into the case study context (Stake, 1995), including lived experience of the natural disasters and major economic challenges that have impacted our region.

6.3.2 Study design

The qualitative case study design incorporated Stake's (1995) instrumental case study approach, which was used to investigate the phenomenon of interest, community participation. This type of case study design is effective for gathering rich descriptive data, and allows for selection of data sources and analysis methods that are most suited for understanding the case (Creswell, 2013a; Hyett, Kenny, & Dickson-Swift, 2014; Merriam & Tisdell, 2016). Drawing from naturalistic case study principles, this particular case was studied with minimum intervention, by gathering perspectives on the case from existing sources of data that were available in the bounded context (place and time) (Abma & Stake, 2014). Ethics approval from the La Trobe University, Human Research Ethics Committee was obtained for the procedures described (approval number FHEC13/170).

6.3.3 Case selection

In using Stake's (1995) qualitative case study methodological approach, a case was selected that exemplified community participation in a rural context. An established community bank was purposively selected in consultation with the Bendigo Bank national office that oversees the initiative. The Eylestown community bank is located in a small rural town of Victoria, Australia, with a population of approximately 1,000 people. This particular

community bank was identified as an exemplary initiative because it has been sustained for ten years, has increased its scale of operations, and scope of community grants and sponsorships (over $1 million raised and distributed).

6.3.4 Data collection

Multiple data sources were sampled, to collect sufficient contextual data, to develop a holistic case study and to enhance data triangulation (Merriam & Tisdell, 2016; Stake, 1995). Sources included in-person, semi-structured interviews with key informants, researcher reflections and field observations, and data from documents and webpages.

Interviews and field observations

The community bank chairperson identified potential participants associated with the community bank, who were invited to participate in the doctoral study via email. Six people provided written consent and participated in an interview during July 2014. Interviews were semi-structured and included open-ended questions regarding their motivations and aspirations, and experiences with, and perspectives on community participation, for example 'why do you participate with the community bank?' and 'what do you hope to achieve?' Interviews were held at the participant's home or at the community bank site, ranged from 45-90 minutes, were audio-recorded and transcribed verbatim. Table 14 describes the sample of participants, which is provided to increase understanding of the actors in the case study (Stake, 1995). Field observations and researcher reflections were recorded with written notes immediately after each interview, to support researcher immersion in the case and understanding of case context (Abma & Stake, 2014).

Table 14. ***Description of Participants***

Pseudonym	Gender	Age	Employment status	Involvement	Time served
Geoff	Male	>50	Retired	Past	>5 years
Michael	Male	>50	Semi-retired	Current	>5 years
John	Male	>50	Retired	Past	>5 years
Steve	Male	<50	Employed full time	Current	<5 years
Jack	Male	>50	Employed part time	Current	>5 years
Bob	Male	<50	Employed full time	Current	>5 years

Note. To protect anonymity, 'Age' is defined as <50 or >50, 'Time served' is defined as >5 years or <5 years, and 'Involvement' is defined as past or current.

Documents and webpages

Consistent with case study approaches, data in the form of documents and webpages (N=30) were obtained in addition to interviews, to gain an in-depth understanding of the case study context (Merriam & Tisdell, 2016). Media releases and newspaper articles were collected that detailed the community bank launch (n=6) and the first public meeting (n=2). The webpages of the community bank and the local Shire were reviewed and pages that contained information on community participation and that described the community context (social, political, physical aspects) (n=10) were included using the NVivo 10 NCapture application (QSR International, 2014). The community bank steering committee plan and business establishment plan (n=2), and ten years of annual chairpersons reports (n=10) were included, which provided additional information on why the community established the bank, and how people came to be involved with the initiative.

6.3.5 Data analysis

Data coding was completed using NVivo 10 qualitative data management software (QSR International, 2014). All data were thematically analysed using coding techniques common to qualitative case study approaches, including descriptive, in vivo, emotion and value coding methods (Saldaña, 2013). Codes were grouped into categories, which were analysed to develop themes (Saldaña, 2013). The themes that describe people's reasons for participating with the community banking initiative were: *the ten per centers, benefit to community,* and *taking control*. A case description is provided, to provide an overview of case study context, which is important for understanding influential historical and cultural factors. A description of each theme is supported by verbatim narrative for readers to compare the participants' experiences of participation with their own. This style of presenting case study findings aims to promote naturalistic generalization, which assists the reader to be an active participant in the construction of new knowledge (Stake, 1995).

6.4 Findings

6.4.1 Case background

A group of local residents established the Eylestown community bank during 2002-2003, local residents own the bank, and it is operated by a board of directors. Since establishment, the community banking business has grown to include three additional bank outlets, which serve a district of approximately 6,000 people. All profits are shared equally between the Bendigo Bank Corporation and Eylestown, a strategy aimed at boosting small rural town survival and sustainability (Mayne, 2005).

During the establishment phase, community participation included consultation meetings, completion of a business feasibility study, marketing through local media, and promotional activities. The Eylestown community banking business has endured many difficult periods, including drought, floods and the global financial crisis. Overall, Eylestown residents have operated the community bank for approximately ten years and distributed $1million in profits into the community through various sponsorships and grants. The scope of sponsorship has increased to include a major infrastructure project to support sport and leisure participation, and tourism. A wide range of community groups, including schools and sports clubs, have received small grants to purchase essential equipment or to upgrade their facilities.

The study participants were past and current board directors and one staff member, who volunteer their time to the bank, and four participants have been involved for its entire duration (ten years). All participants were male, mainly semi-retired or retired business owners, farmers and school teachers, and commented that it was difficult to engage female board members, and none had been appointed long term. A future strategy to increase female and youth participation was identified, for increasing the range of community views, and for ensuring board succession.

6.4.2 Key themes

The ten per centers

The ten per centers was the name given to the highly committed people involved with the Eylestown community bank. Descriptions of this group were provided by all interview participants, and were identified in the chairperson's reports and media releases. The ten per centers were described as community-minded people with an extensive history of participation. For example, the participants were involved beyond the community bank, with

farmer organisations, football club management, country fire brigades, and hospital and sports club fundraising. This group were identified as people who are known to participate with various initiatives, and who are frequently approached for their leadership, support, and for access to their networks.

Participation with Eylestown community bank was described as enjoyable, interesting, and rewarding. Steve states that he enjoys being on the board, "I quite enjoy the work… I don't feel it's onerous or anything like that, I don't mind doing that, it's enjoyable". The participants' described their hopes for making an impact through their participation, and the enjoyment that they received from the company of the people involved. They appreciate the opportunity to learn from others and to share their own knowledge and skills. Geoff explained how a diverse range of perspectives were valued within the leadership group at the community bank, and that this helped to define board member roles and ensure representation of a variety of community views.

John believed that the percentage of people who participate, the "ten per cent", is fairly static, and he relates this to over 50 years of experience with a range of community initiatives. He stated, "I think in any community, there are 10% of people that make things happen, 40% who watch things happen, and 50% of people say 'what's happened?'" John reflected on his experiences as bank chairperson,

> You are always trying to get more people involved, but I think that little formula is pretty right. You've got a certain number of people that will lead, and you've got a certain number who will join in and support you, and you've got a certain number who don't want to be involved.

John described feeling unsure of whether advertising and marketing strategies actually changed the percentage of people who participate. To support his claim, he explained the differences between the people who chose to participate with the bank, and those who opted out or opposed it:

> Well when you think about it, it's only a small community, go back to our committee of ten, there is a small hard core group that are quite determined to promote it, and below that a section of the community that will support it in name, and they are our shareholders and account holders, and beyond that are the group that are either too lazy to change or don't even entertain the thought, and the far end are the radicals that are totally opposed.

All participants agreed that despite their ongoing efforts to involve the broader community over the past ten years, they do not expect everyone to participate. However, initially, this confused and disappointed them. John explained:

> Oh I tended to ignore them after a while, you never get 100 per cent. Some of my board members in those days, they'd get a bad comment from somebody, because you're asking people for money, eventually, and I'd say well look we've never get a 100 per cent and some people won't like you, they won't like me, I don't know why, so you'll never get a 100 per cent of people supporting you. But no, I just tried to ignore them.

Participants described the ten per centers as people who are not deterred by hard work or responsibility, describing their participation with the community bank as self-sacrifice and selflessness. Michael described his position on the board as a "labour of love", and stated that he was prepared to accept personal responsibility if the community bank failed. The participants provided several anecdotes of key people who were involved in establishing the community bank, which demonstrate the value of the ten per centers with this rural community initiative. For example, the participants provided stories of farmers who moved their business to the community bank, despite tough financial times caused by drought, transfer fees, and less competitive products. A participant recalled how a local businessman owned a local bank agency outlet, and sold this agency to the bank at a low price, which provided essential start-up capital and improved bank feasibility. Another recalled how a local servicemen's group provided the land to a local builder to build the bank, which is leased on a long term agreement at less than market price. Although they were only a small

percentage of the community overall, the participants identified the ten per centers as instrumental to the community bank establishment and long term success.

Benefit to community

Participants agreed that their central motivation to participate is their belief that the bank benefits the community. John explained, "It's a method of pouring money back in the community that the big banks don't do." Their motivations draw from success stories shared by other rural community banks, and Bob explains that this is especially important in a rural context, "small country towns are the real success stories". Success stories and possibilities are prominent in promotional materials produced by the Bendigo Bank, rural word-of-mouth, and the media. Participants described the success of community banks by the number of franchises that have been purchased and established in nearby rural towns, the amount of money raised, and number of grants and sponsorships distributed. John explained: "Once you get involved, and once you start finding out what can be achieved, well then you get enthusiastic and you want to push it along and make it happen". It is accepted that not all rural community banks are immediately successful, but the ones that have been successful inspire hope and belief in the concept and its potential.

The goal shared by the participants was to create a community-controlled revenue stream to invest in community groups and assets. It is their opinion that investment in community assets would attract newcomers and retain residents, and enhance community sustainability. Michael said community bank sponsorships are used to run various social events and community activities, which provide opportunities for new residents to integrate and mix with existing residents. Bank sponsorship of infrastructure projects is expected to attract young people to return home after completing university studies (Michael and Steve). Additionally, grants provided to leisure and sporting groups enable elderly residents to

remain active and well (Bob and John). Participants strongly believed that investment in their community would slow the population decline and enhance town liveability.

Participants argued that community members who banked with them shared their belief in the concept. Jack explained: “Oh, I think people can see that the benefits that have accrued in the last ten years, the amount of money that's come into the community, is probably up to about 1.2 million now, in ten years, which is amazing.” Jack described how community bank grants and sponsorships are channelled into programs that target community needs, “…there's been particular focus to some of the major sponsorships towards the youth, so it's trying to support the clubs in continuing to promote their sports to young people, so that's certainly getting young kids healthy, [which] has a health aspect to it.” Additionally, sponsorships are provided to arts projects. Bob explained that the bank provides support for a range of community groups, which “…might still exist anyway, but are able to function better”. They believed distributing sponsorships and grants strengthened the community’s belief in the concept and reinforced motivations to support their community banking business. The participants described how their belief in the benefit to community outweighed any fears, risks and challenges, including their fear of failure, risk of harm to local reputation, and the challenge of building a viable business in a small rural town. Reflecting on his ability to maintain his motivation, Bob stated “you’d never do it unless you really believed in it”.

Taking control

The participants described how the events of drought, bank and business closures, and population decline, prompted rural residents to come together and find a solution to their concerns. Geoff described how bank closures spurred him to take action:

> Basically what happened was the banks went through a period of closing down country branches, and at one stage we had four, we had four major banks represented

> in town and one by one they gradually closed down. The last one to go was the Big[9] Bank. The others had put in agencies or else had shifted their account holders to a different town. The Big Bank was the last one to close down and so happens, my daughter was working at the Big Bank … the town was quite upset, not only are you losing population, you are losing workers.

The bank closures caused an emotional response in the community, and action to establish the community bank was fuelled by "anti-big bank sentiment" (Jack) and concerns about the future of their town. John explained:

> The two other banks closed, and everyone got a bit depressed, you know 'the town is finished' 'what's going to happen to [*the town*]?' And then we started to promote the idea of bringing in a community bank. So that created a bit of interest in people's eye, people were saying well that something's that might happen.

Establishing a community bank was seen as an opportunity to create a new future for their town, which capitalised on the community's antagonism towards the big banks (Michael). Participants recalled that during the period of bank closures, residents were vocal about their concerns regarding Eylestown's future. Michael explained how the bank closures affected him personally:

> We banked with Australia[10] Bank, my grandfather and father, we had banked with Australia Bank for years and years and years. And we got this letter in the mail, directing our account to [*nearby town located approximately 60 kilometres away*]. And it was really, we had like a hundred years of banking with them and we got a letter telling us, you know, that our banking would be located in [*other town*]. No thank you very much, no courtesy phone call to ask where we would like to do our banking, and yeah I was pretty insulted by that. I just thought that was astonishing.

The participants' shared concerns about the sustainability of their small community, which held a tradition of being a prosperous and proud town. Michael explained, "Well I'm born and bred here, never been anywhere else", and two participants have lived on family

[9] Bank name removed to protect anonymity
[10] Bank name removed to protect anonymity

farms locally for three generations (Michael and Steve). Building a successful community bank was hoped to rejuvenate town pride and community spirit. John explained:

> Ohh well it's just another pride I suppose, you need to do something, and we've got a nice facility, and it's just like anything in the town, you want to see your town improving, you want something significant, and you don't want to see your little town disintegrating.

In telling the story of how the community bank was built, the participants described how the physical presence of the community bank emerged as a symbol of hope. They described how the community were surprised by the rare sight of building construction on a heritage main street, and were excited by the opening of a new business during a 10-year drought. The local newspaper associated the community bank opening with new life and growth. The headlines read "Cutting the cord", with a picture of the local doctor cutting the ceremonial ribbon at the bank opening. The doctor stated "Today we celebrate a birth in Eylestown. It has been over 12 months since a baby was delivered at the Eylestown Hospital, but today we are celebrating the birth of a new business in the town". John described:

> Yeah nothing much happens in these sort of towns, but this was a vacant block, we had to go and negotiate with the Servicemen's Club to buy the land, and negotiate with the builder to build it … We had a bit of fun, because it was a tin fence that was there before, and we kid ourselves our bit, and said to the builder, we will just cut a hole in the fence, an inspection hole, [*indicates this is for people to peek through, laughing*] it was like we were building a skyscraper in a big city.

The "presence of a viable community bank" (Bob) was important to renew faith in community well-being and sustainability. Michael contends the bank closures were "more than just losing a bank", but were visible evidence of their town decline, which impacted on community spirit. The participants agreed that building the community bank was a timely, community-driven solution that was effective in taking control of their collective problem.

6.5 Discussion

6.5.1 Rural community participation

The findings provide unique insights into why people might participate with community initiatives in a rural context. In the context of community banking, participants included volunteer board directors, shareholders and account holders, who Cutcher (2010) describes as 'co-producers', meaning they are active participants in the consumption and production of products and services. The leadership group, defined as the ten per centers, were described as 'local champions' (Kenny et al., 2015), who are capable and confident operating a not-for-profit company within a legal business franchise agreement. The participants described how their participation with community banking was driven by their emotional attachments to their community, including people, groups and places. This attachment to community was key to community bank establishment, which motivated them to activate and mobilise social networks that were integral to bank establishment and sustainability (Fairbrother et al., 2013).

Health policy-makers and executives have expressed interest in co-operative or co-production models in the healthcare sector (Bovaird, 2007; Munoz, 2013), which are similar to community banking. However, there are risks in employing co-operative models in rural communities (Sellick, 2013). Volunteer labour may be exploited for commercial gain; for example, Bendigo Bank is entitled to 50 per cent of profits from the community banking business. In addition, a high burden of responsibility is placed on a small percentage of the community that are capable and interested in taking on leadership roles, who in the current study were identified as the ten per centers.

The participants in this doctoral study were all male, and mainly middle-aged, retired or semi-retired, business owners, farmers and school teachers. This sample reflects the

demographic profile of community bank board directors at a national level. Nationally, the majority of board members are male and middle aged, and 32% identify themselves as small business owners (Cutcher, 2010). Cutcher (2010) argues that small business owners are the population group with the most to lose from dissolution of rural banking services, which might motivate their participation.

The focus of the discussion will be on examining the key themes to build theory on why rural people participate in community initiatives. Improved understanding of the motivators and drivers for community participation is needed to overcome the myriad of challenges involved with enacting community participation within a rural health context (Farmer, Currie, Kenny, & Munoz, 2015; Farmer & Nimegeer, 2014; Head, 2007; Herbert-Cheshire & Higgins, 2004; Morgan, 2001).

6.5.2 Place attachment and community participation

In this Australian study, rural people participated in community banking because of the value they placed in community sustainability and well-being. The rural community was important to the participants, and the findings illustrate how emotional connections and attachments to place underpinned their community participation.

Manzo and Perkins (2006) explore the relationship between place attachment and community participation, and argue that cross-disciplinary health and place research is needed to understand complex issues with community participation. Adopting this novel analytic lens of place and community attachment theories, we explored why place attachment has an influence, which will increase understanding of the reasons why people participate with community initiatives, and provide new insights to researchers. Whilst this case study is of community banking, the findings illuminate the participants' rural community

participation experience, which has broader implications for health and social science research.

Universally, people are known to form emotional attachments to geographical locations they perceive as meaningful or significant, through their everyday experiences with places (Seamon, 2014). In this doctoral study, the participants' emotional connections with Eylestown, was formed and developed through their experiences with family and friends, community work and local employment. It is argued that place attachment strengthens over time (Seamon, 2014), which was evident in the participants' long standing community participation, across a number of groups, which for some, was fostered over many generations. The participants described how their emotional connections to Eylestown strongly influenced their participation with community banking, and they expressed desires to protect and preserve the community for themselves and for their family and friends.

In the case study, the connection between participation with community banking and place attachment was illustrated by the participants' reflections on place identity and place dependence. Williams, Patterson, Roggenbuck, and Watson (1992) contend that places become intertwined with peoples' identities, and over time, people become dependent on places to sustain their livelihood and well-being. The study participants, who worked on farms and in local schools and businesses, were cognizant of several threats to Eylestown. Population decline, loss of business and local employment, and relocation of families and elderly residents away from Eylestown, directly impacted on the participants and their capacity to sustain employment and be financially secure. Threats to Eylestown were perceived as having a major impact on participants' sense of current and future well-being (Williams et al., 1992). Because of the value they placed on being an Eylestown community member, and their dependence on Eylestown for employment and social connections, they

were willing to take action on threats to preserve their community (which is intertwined with place, livelihood and identity (Manzo & Perkins, 2006)).

The interrelationships between people, place and community, and community participation can be explored through the lens of community attachment theory. In previous studies, authors have identified that high community attachment can increase participation on behalf of the community. For example, community members participated in pro-environmental action on unwanted industrial and residential developments to protect the natural landscape and valued place features that they believed distinguished their place and/or community from others (Devine-Wright, 2009; Manzo & Perkins, 2006; Mihaylov & Perkins, 2014). In this doctoral study, participation in community banking was driven by a similar desire to protect place and community, and to maintain valued place characteristics and resources, such as sporting and leisure facilities and heritage buildings.

Within the Eylestown community, the participants' feelings of belonging and sense of community demonstrates their strong community attachment (Mihaylov & Perkins, 2014). Feelings of belonging arise through the development of social bonds, and in the case study, this was evident through participants' neighbourhood relations, shared history, culture and traditions, mutual concerns and interests, and perceptions of trust and cohesion (Manzo & Perkins, 2006; Scannell & Gifford, 2010). In a rural context, strong feelings of belonging are known to increase community participation and are associated with community resilience (McManus et al., 2012). The participants expressed positive perceptions of community, which were influenced by their individual and collective understandings of community identity, community capacity, and potential for empowerment (Clarke, 2008; Lewicka, 2005). Ponzetti (2003) argued that sense of community has a major influence on why people value and choose to live in rural places, despite challenging environmental conditions. This was

evident in the case study, where the participants' decided to stay and protect Eylestown, despite severe drought and floods.

Place and community attachments are thought to serve several functions. In Eylestown, the participants' community attachments were useful in creating social networks, which other authors have argued are important for community safety (Mihaylov & Perkins, 2014). In the case study, the decline of the community and threats to banking services and financial security disrupted community attachment and prompted varied responses, including grief and loss, apathy or ambivalence (Manzo, 2005; Scannell & Gifford, 2010). While participants appeared to have positive community attachments that were conducive to community participation in times of threat, other community members did not participate with the banking initiative. This might be because some people can feel oppressed or restricted by their attachment to places, which can result in non-participation or opposition (Manzo, 2005).

Disruptions to place and community attachments can reveal previously hidden or sub-conscious place meanings and values, which might be what inspired the participants to commit to, and participate in, community planning and development (Manzo & Perkins, 2006; Mihaylov & Perkins, 2014). Mihaylov and Perkins's (2014, p. 147) Model of Community Place Attachment Leading to Collective Action, Adaptation, or Acceptance in Response to Environmental Disruption, can be used to understand why some community members participated with the Eylestown community bank, and others chose not to. By applying Mihaylov and Perkins's (2014, p. 147) model to the case study, participants' responses to threat can be understood as fear for community safety, and the actions of the ten per centers as protective and adaptive.

In Eylestown, only a small percentage of community members volunteered to join the community bank leadership group, and protect their community from threat. Manzo and Perkins (2006) state that "Certainly, there are cases where people do not identify with their neighborhood, where they do not feel attached or have a sense of community, and where they do not participate in community improvement or planning efforts" (p. 344). For the 90 per cent of community members who were not highly involved with the community bank, their participation avoidance could reflect an acceptance of how things are, a lower desire or need to protect the community, or a high level of confidence in the community leaders (the ten per centers) (Mihaylov & Perkins, 2014). A low level of place attachment could result from the increasingly transient nature of rural communities in Western countries (Hunter & Biddle, 2011; Ministerial Advisory Council on Rural Health, 2002). Place attachment in rural populations is likely to be influenced by seasonal and contractual nature of major industries, commonly agriculture and mining, and the influx of retirees to inland rural areas (known as 'tree-changers') and second home owners, and the new arrival of low-income families who move to rural areas to secure affordable housing (Anton & Lawrence, 2014; Hanlon, Skinner, Joseph, Ryser, & Halseth, 2014; Williams & Patterson, 2008).

Overall, it could be theorised that designing community participation initiatives that prompt people to reflect on their attachments to place and community might effectively motivate participation in rural places. However, as a consequence, community members with no or lower attachments might be excluded, or might decide not to participate (Manzo, 2005). In establishing the Eylestown community bank, strategies that called on place attachment to mobilise community participation divided the community. This supports Manzo's (2005) contention that place attachment is not always inclusive or functional. However, using place attachment and drawing upon community vision and values was effective in activating ten

per cent of the community, which was sufficient to meet and exceed the community banks financial objectives.

6.5.3 Problems with 'community'

There are several limitations of current conceptualisations of community, which influence interpretation of the case study findings, and the potential usefulness of community attachment theory for building knowledge of community participation. Definitional problems associated with community make it difficult to ascertain whether community attachment theories are relevant across contexts (Mihaylov & Perkins, 2014). In the broader health sociology literature, the concept of community has been heavily criticised, and practitioners are yet to reach a common understanding (Barrett, 2014; Jewkes & Murcott, 1996, 1998; Mihaylov & Perkins, 2014). It is generally agreed that community is not a simple notion, being both spatiality and socially constructed, and the meaning of community varies across contexts (Rifkin, 2009), and for members and non-members (Jewkes & Murcott, 1996). The only consensus reached across studies is that communities involve people (Jewkes & Murcott, 1996), are more than a shared locality, and are inseparable from context or place (Jewkes & Murcott, 1996; Rifkin, 2009, 2014; Shaw, 2008), which are characteristics that were reflected in the participants' views.

The German philosopher Ferdinand Tonnies (1957) defined community, *Gemeinshaft*, as dichotomous with modern society (*Gesellschaft*). In communities, he proposed, people live traditional and harmonious, communal ways, and bond over shared social mores, seeking help from each other, independent of the State (Tonnies, 1957). Tonnies (1957) suggested that in rural places, like Eylestown, this characterisation of community is more pronounced, stating "all praise of rural life has pointed out that the Gemeinshaft among people is stronger there and more alive; it is the lasting and genuine form of living together" (p. 35). Critics

have deconstructed this romanticised characterisation of community (Kenny et al., 2015; Shaw, 2008), which reveals that modern understandings of rural communities in Western countries may be better aligned with Tonnies (1957) definition of Gesellschaft. Tonnies (1957) contends societies are places where people are driven by rationalised individualism and self-interest, where individuals act inter-dependently, governed by a capitalist market and State law. In the case study, the participants' experiences of rural community banking illustrates that Gemeinshaft is important for motivating community participation, however, Gesellschaft is required for meeting the communities financial objectives and for ensuring initiative sustainability (Cutcher, 2014). It can, therefore, be argued that definitions of community that align with Tonnies (1957) traditional views might no longer be relevant.

The commodification of Gemeinshaft within community banking initiatives was examined by Cutcher (2010), who suggests romanticised views of community have been cleverly integrated into marketing and branding. She proposes that the perceived demise of Gemeinshaft in rural places has increased participation with community banking initiatives, and contributed to the brands appeal (Cutcher, 2010). The use of nostalgia and the past, as a lens for critiquing the present, is highlighted as a key emotional driver Cutcher (2008). The case study findings support Cutcher's extensive work (2008, 2010, 2014), which concluded that participation with community banking is driven by nostalgia for the traditional sense of community, which is underpinned by a sense of loss and fear of modernisation, and desire for moral certainty and traditional simplicity. Within Eylestown, the community bank appeared to benefit from this juncture, drawing motivations to participate from both backward-looking romanticism of traditional customer service and loyalty, and progressive forward thinking of producing a sustainable revenue stream to circumvent rural town decline (Cutcher, 2014).

Within the health context, exploitation of Gemeinshaft for organisational and political purposes is not a new phenomenon (Shaw, 2008). A community is often narrowly defined as

an entity or object, a 'thing' that is controlled or harnessed, or a target group identified for a specific purpose or problem (Jewkes & Murcott, 1996). Criticised as politically persuasive, community is used as a label or brand, which never seems to be used unfavourably, and is employed to conjure nice images of imagined people and places (Jewkes & Murcott, 1996; Shaw, 2008).

In the absence or inaccuracy of a conceptualisation of community (Shaw, 2008), the development of a *place-based participation* framework, drawn from place theories, offers an alternate theoretical framework for community participation, which is well supported by evidence (Lewicka, 2011; Manzo & Devine-Wright, 2014). A theory of place-based participation may provide a more accurate conceptualisation of participation to guide policy and practice, which avoids misleading people, or using idealistic visions of community to co-opt or exploit residents' time and energy. However, Eylestown residents may have been less willing or motivated to participate if community ideology was not used. Health policy makers are encouraged to consider the potential harmful consequences of using an unrealistic or unattainable community vision to motivate participation and build initiatives, which could include institutional mistrust, exclusion and social divisions (Kenny et al., 2015; Minkler, 2012). In this case study, the vision of Gemeinshaft was at the crux of why people participated with community banking, which was sufficient to motivate the ten per cent and achieve objectives relating to town sustainability. However, not all Eylestown residents were motivated by traditional community ideals, nostalgia or romanticised visions of social togetherness, and non-participation did not deter the ten per centers from achieving community objectives for the benefit of others.

The theoretical knowledge gained from this qualitative study can be used to improve understanding of community participation in small rural contexts, and the reasons why rural people choose to participate in community-based initiatives. A wide range of health and

social programs, such as rural community health services and councils, have community participation mandates, and implement strategies to increase community participation with service planning, decision-making, and evaluation, sometimes with disappointing results (Kenny, Farmer, Dickson-Swift, & Hyett, 2015). The research findings should be used to tailor health services or councils' participation strategies to community interests, and to stimulate further enquiry into why people do or do not participate, and factors that might improve social inclusion.

6.5.4 Limitations of the study

This is a small case study that has contributed preliminary theoretical and conceptual findings that will provide a foundation for further empirical research. This could include a longitudinal study design and place attachment measurement tools, to study the interrelationships between community participation and place and/or community attachment over time. The current case study was effective for addressing the overall doctoral study aims and research questions, and contributed research findings that fill knowledge gaps that had not been fully addressed by Case Study 1, particularly the research question, why do people participate in community initiatives.

This case study had a small number of interview participants, however, repetition of interview responses across participants indicated data saturation (Merriam & Tisdell, 2016), and data triangulation was used to confer interview content and to understand study context (Stake, 1995). The themes relate personal accounts of motives and drivers recalled by the study participants, who were a sample of highly involved, community-minded males who regularly participate with local development initiatives.

Using qualitative case study methodology, the findings cannot be generalized to other populations (Merriam & Tisdell, 2016; Stake, 1995). It was not our intention to represent the

breadth or diversity inherent in rural community participation, which has been reported by several authors (Farmer et al., 2015; Munoz, 2013; Torgerson & Edwards, 2012; Winterton, Warburton, Clune, & Martin, 2014). The gender profile, for example, of participation in community banking initiatives differs to rural participation more broadly, which is generally even (Torgerson & Edwards, 2012), or has slightly higher rates of female participation (Winterton & Warburton, 2014). The middle-age dominance of participants in community banking, however, does exemplify the greying nature of rural communities, and the ageing profile of rural places in Western countries (Hanlon & Halseth, 2005; Winterton et al., 2014).

The themes do not account for the experiences of community members who were less involved, or did not participate, and further study is recommended to explore instances of non-participation and community exclusion, to fully conceptualise rural community participation in its entirety.

6.6 Conclusions

In a rural context, motivations for participating with a community banking initiative were related to desires for community sustainability and well-being, and were driven by emotional connections to place and community. The case study exemplified the perspectives of a group of community-minded rural men, who were highly involved with community groups and initiatives, and found participation to be enjoyable and rewarding. Their community participation stemmed from a shared vision of community and community values, and was motivated by threat to place identity, livelihood, and well-being. Community and place attachment theories were used to conceptualise the person-place-community relationship, which provides a new perspective on why rural people participate with community initiatives. The case study findings emphasise that while a small percentage of community members choose to become highly involved in community planning and

development efforts (the ten per centers), others who demonstrate lower or no attachment to places might avoid participating, or be excluded.

Further exploration of the links between community participation and place could be achieved through further research that utilises a longitudinal study design and place attachment measurement tools. Research findings would be valuable for designing community programs that are better suited to residents' placed and/or community-based motivations and needs. However, limitations of current theories must be considered, and the problems that emerge when defining community, or when community is commodified or exploited for political or commercial gain. Ongoing challenges with conceptualizing community participation indicate that a new place-based participation framework could be explored. Overall, further understanding of the connections between people, places and communities is needed.

Chapter 7

Discussion

"No social study that does not come back to the problems of biography, of history and of their intersections within a society has completed its intellectual journey." (Mills & Gitlin, 2000, p. 6)

7.1 Introduction

In this chapter, I discuss key findings from the research. My aim is to compare and contrast findings, and expand on the theoretical discussions presented in Chapters 5 and 6. The first section of this discussion relates to the multiple meanings of community that were apparent in this research. I contend that there are a myriad of definitions of community, and discuss how inaccurate assumptions or misunderstandings can impede community participation. In this discussion, my aim is to support a re-imagining of the traditional occupational therapy client, to a conceptualisation of client as community, which is informed by a sociological lens.

In the following sections, I discuss the research findings that relate to the primary research questions; how and why communities participate in initiatives in Western, developed contexts. In this discussion, I critique assumptions that are commonly made about community participation, and examine purported outcomes of empowerment, inclusion, and sustainability. My aim is to contribute to the development of critical perspectives on community participation within occupational therapy, which are needed at a macro-level to inform organisational and government health policy, practice standards and guidelines. Additionally, at the micro, practice level, the aim is to increase understandings of community

participation for occupational therapists, who might be working in roles that require them to enact participation.

7.2 Understanding 'community'

If occupational therapists are to work with communities, a shared understanding of community is required. Within the chapters and published articles in this thesis, definitions of community from the health sociology literature were used to illustrate how interpretations of community are influenced by socio-political, and cultural contexts. By adopting a sociological perspective to interpret the research findings, my aim was to explore the intersectionality of the research, with the social structures, history, and politics that defined the research context (Brewer, 2013; Mills & Gitlin, 2000). My intention was to compare the research findings with theory, because, "neither the life of an individual nor the history of a society can be understood without understanding both" (Mills & Gitlin, 2000, p. 3).

7.2.1 Understanding 'community' in occupational therapy

In examining definitions of community within occupational therapy research literature, theoretical models, and texts, I became aware of several limitations with commonly used definitions. This is argued in the viewpoint [Publication 5], and I recommend that a sociological-grounded understanding would be beneficial for practitioners (Hyett et al., 2016).

One of my concerns is that the inherent diversity within communities is not well described. In key texts, for example, community is defined as a "unified body of individuals" (Radomski & Trombly Latham, 2014, p. 841), or as a "collective of people who share common values and demonstrate mutual concern for the development and well-being of the group; [that] may share interests, interactions, and sense of identity" (Schell et al., 2013, p.

1231). These definitions explain how community can be formed for a shared purpose or mutual concern (for example, reducing food insecurity), which was supported by the doctoral research findings. What is not reflected in these definitions, however, is an understanding of community heterogeneity (or diversity). I argue that communities comprise a range of diverse interests, cultures and values, and expectations of community membership, and preferences for participation, which should be recognised in a mutual disciplinary understanding.

Commonly used definitions of community within occupational therapy texts can appear one-dimensional and fragmented. Principal occupational science authors argue that "occupational therapists and other health professionals have not always appreciated the deeper complexities of working in community settings, and, in particular, whether they work **in** the community, **for** the community or **with** the community" (Pollard, Sakellariou, & Kronenberg, 2010, p. 269).

Community, for example, is often described as a type of occupational environment (defined by districts and area boundaries), or as a therapy setting (Polatajko & Townsend, 2007), or as an environment that contains resources, objects, and assets that can be manipulated by practitioners (Kielhofner, 2008). Defining community only by location or certain physical characteristics may lead to over-simplifying the term (Laverack & Keshavarz Mohammadi, 2011). Occupational therapists may overlook the meaning or significance of community (as it is understood by community members), if they simply define community by what it provides, or by what it means for some people (for instance, health professionals) (Jewkes & Murcott, 1996). Assumptions that community is simply defined, or easily engaged in therapy, limits occupational therapists' abilities to conceptualise community as client. Key characteristics of communities that were valued by participants in Case Study 2, such as place, belonging and safety, are not visible in common occupational therapy definitions.

I am intrigued that communities are identified as a key client of occupational therapy services (World Federation of Occupational Therapists, 2010), but there seems to be a propensity to use the term 'client' interchangeably with community without consideration of extant definitions. Scaffa and Reitz (2013), in their key occupational therapy text, acknowledge that a range of definitions are available, and that researchers are yet to reach consensus. However, this provides little guidance for occupational therapists, which are interested, or currently working in, community practice roles.

A shared understanding is needed to guide occupational therapists to extend their practice to community clients, and enable participation at the community-level. This will support occupational therapists currently working with community groups (Kronenberg et al., 2011; Scaffa & Reitz, 2013), and with communities that are socially and culturally identifiable, including Indigenous communities (Gerlach, 2015; Thibeault, 2002). I maintain that the arguments in the viewpoint are relevant (Hyett et al., 2016), and that a shared understanding of community will support occupational therapists to work collaboratively with community groups, which is a policy requirement in many Western countries (Farmer et al., 2015; Ham & Murray, 2015; Kenny et al., 2015; National Health Service, 2013; O'Mara-Eves et al., 2013).

As a profession, to re-imagine client as community, occupational therapists must move beyond textbook, fragmented definitions, to develop a sociological-grounded understanding that integrates an occupational lens. The following discussion of sociologically informed definitions of community is driven by this objective.

7.2.2 Definitions of community in the health literature

In reviewing the health sociology literature, I found that definitions of community are highly variable across studies and disciplines (Jewkes & Murcott, 1996; Scaffa & Reitz,

2013), and in a healthcare research context, community is often not well defined (for example, see Attree et al., 2011; O'Mara-Eves et al., 2013). Researchers have argued that 'community' is used "loosely and ambiguously" (Taylor et al., 2006, p. 38), and have identified several problems with the use of the term (Barrett, 2014; Jewkes & Murcott, 1996; Taylor et al., 2006). Rifkin (2014) concludes that there is no standard definition of community, which limits practitioners' ability to develop shared meaning.

Extant definitions provide conflicting meanings that might confuse practitioners. In the viewpoint [Publication 5] (Hyett et al., 2016), it is argued that a community is commonly defined as a place and social group. The definition proposed by MacQueen et al. (2001) is used, which describes community as "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" (p. 1929). Definitions of community used by health researchers include key characteristics of mutuality of interests, collective participation, and shared locality or setting (Jewkes & Murcott, 1996; Kilpatrick, 2009). Reflecting on the communities involved with the doctoral research, I pondered whether all communities align with this definition. In considering the views of Jewkes and Murcott (1996), I queried whether common understandings of community describe "what 'community' *should* mean rather than what it *does*" (p. 556).

Researchers argue that communities are characterised by "social ties", which indicates social cohesion and a network of relationships, and that community members have shared perspectives, culture, and a collective purpose or goal (MacQueen et al., 2001). Theories proposed by key sociological authors, describe community as a 'social field' or 'social unit', which supports this view (Kaufman, 1959; Taylor et al., 2006; Wilkinson, 1970). However, social cohesion is not always reflected at the community-level (Kilpatrick, 2009). I argue that

idealistic or romanticised notions of a harmonious community, which are common in policy and practice initiatives (Cutcher, 2008; Shaw, 2008), do not always reflect practice realities.

In many definitions of community, capacity for 'joint action' is emphasised, and some authors claim that participation is embedded within community, and is explicit in community membership (Taylor et al., 2006). Wilkinson (1991) highlights the value of the social interactions that occur within communities, and suggests that internal community dynamics are important to support joint action (or participation). However, defining community by joint action may lead to inaccurate presumptions about community capacity, or individual expectations of, or motivations for community membership. Definitions that include joint action are likely to be context specific, not universal (Rifkin, 2014).

In doing this research, I found that communities are often formed for a particular purpose (or because of a shared problem), for example, to gain social or economic advantages or resources [Publication 1] (Kenny et al., 2013). In the Canadian case study [Case Study 1], communities were formed to mobilise resources needed for political influence. Similarly, in the Australian case study [Case Study 2], rural residents of Eylestown formed a community to establish a community bank that would generate revenue for local groups or projects.

However, within communities, the existence of a shared purpose did not necessarily mean community members share interests (or motivations). In the community banking case study [Case Study 2], for instance, while some community members chose to be active participants or leaders, others preferred to be bystanders, or members in name only. These research findings illustrate how some community members may respond with apathy, ambivalence or avoidance. I contend that community membership extends beyond people who are typically involved in invited forms of 'joint action', and it should not be assumed that community participation is overt, or is always harmonious or functional.

In the research [Publication 1, 2 and 3], contextual factors, such as rural population decline, and demographic changes caused by migration, were found to influence community membership, dynamics and cohesion (Hyett, Kenny, Dickson-Swift, et al., 2014; Kenny et al., 2015; Kenny et al., 2013). The importance of community geographic location was diminished in online or virtual communities. This demonstrates how with the advent of social media, a community no longer needs to be confined to a particular geographic locality (Barrett, 2014). Community membership can include a multitude of stakeholders, and in the Canadian food security case study [Case Study 1] communities combined online and personal interactions, which enabled community membership to extend beyond spatial boundaries. This aligns with the conceptualisation of community described by Barrett (2014), which he concludes extends beyond individuals, and "embodies structures, institutions and social processes" (p. 2).

7.3 Critical perspectives of 'community'

In examining critical perspectives of community, I have developed an appreciation of its inherent complexity, and identified some of the implications of the use of the term. Comparing the research findings to existing literature and theory, I have realised two key perspectives that can be used to question the ways in which community is commonly conceptualised. Firstly, the perspective that community is *responsible*, and secondly, the perspective that community is a *homogenous group*. In this section, I discuss how these two perspectives might lead practitioners to inaccurate interpretations or assumptions.

7.3.1 Community as responsible

In this thesis, a common research finding was that communities were formed in response to a shared problem, to be 'responsible', and to take on responsibility. In mobilising communities for participation, sometimes practitioners assume that communities will

responsibilise, and participate in ways that contribute to a shared goal or purpose (Herbert-Cheshire, 2000). This is particularly relevant in rural communities, where participation is described as conducive with cultures of rural stoicism, resilience and self-help (Herbert-Cheshire, 2000). One focus of this doctoral study was to explore reasons *why* communities participate, and I was interested in understanding drivers and motivations. In this process of research, I found that I needed to reverse this question, and instead of asking why do communities participate, I wondered *why should they?* In the following section, I consider the reasons why communities studied in this doctoral research might have been expected to participate and responsibilise (through their respective programs) by societal forces, including social and political factors (Rose, O'Malley, & Valverde, 2006).

Political theories of community "responsibilization" can be used to explain how government uses community to encourage people (as autonomous citizens) to act rationally and in ways that benefit the State (Burchell, 1996, p. 29). It is argued that governments, guided by this viewpoint, use communities as a tool or apparatus, that allows them to retreat 'to an arm's length', and to govern citizens through communities (Rose, 1996b). Utilising Foucault's understanding of government (being "the conduct of conduct"[11] (Dean, 2010, p. 17)), community can be understood as a vehicle for authorised organisational and governmental actors (including occupational therapists and other community workers), to exercise power over citizens and promote responsible conduct (Herbert-Cheshire, 2000; Rose et al., 2006). This governmentality (action and rationale of government), involves a myriad of political techniques, technologies and procedures to maintain community, which is believed to reward government by strengthening State and power (Rose et al., 2006).

[11] Dean (2010) and Burchell (1996) both utilise Foucault's general definition of government, 'the conduct of conduct'. They argue that Foucault presented government as a methodical and rational "way of doing things", or "art", for acting on the actions of people, which aims to shape, guide, correct and modify the ways in which individuals and collectives conduct themselves (Foucault 1988a, in Dean, 2010, pp. 19).

Building responsible communities requires varying degrees of what Jacques Donzelot (1991b, in Burchell, 1996) described as "contractual implication" (p. 29), in which communities are offered the opportunity to become involved in action to resolve issues, which were "previously the responsibility of authorised governmental agencies" (Burchell, 1996, p. 29). Examples of contractual implication are reported in this doctoral research. In the Australian case study [Case Study 2], a group of citizens formed a community group to adopt responsibility for banking services that were needed by the town (previously the responsibility of large corporations) and to secure a stable funding source for community clubs and groups (previously responsibility of local council and the Australian State Government). In the Canadian case study [Case Study 1], clusters of people, groups and organisations identified themselves as communities responsible for alleviating food insecurity, by developing and implementing food programs and initiatives (that were previously the responsibility of governments and charitable food agencies).

Further examples of community responsibilisation and contractual implication can be identified in health policy, which requires people to participate in healthcare planning and delivery in Australia (Australian Commission on Safety and Quality in Healthcare, 2011), Canada (Montesanti, Abelson, Lavis, & Dunn, 2015), Scotland (Farmer & Nimegeer, 2014; Farmer et al., 2010) and England (National Health Service, 2013). Likewise, studies reviewed in the scoping article [Publication 1] illustrate how rural communities were defined by their responsibility for addressing health issues and delivering programs that filled public service gaps (for example, see Broussard et al., 2003; Johns et al., 2007; O'Meara et al., 2007).

It is argued that policy that promotes community responsibilisation is underpinned by neoliberal political rationality, which encourages social and economic regression of the State, and promotes entrepreneurialism, community self-determination, and private marketization of the public sector. This has resulted in public policy that aims to increase community-level

responsibility for public issues, and reduce welfare and State dependence (Argent, 2005; McKenzie, 2003; Rose, 1996a). Herbert-Cheshire (2000), utilising the substantial work of Rose (1996a), argues that governments guided by this rationality intend to use community as an arm of government, to be used for indirect political intervention, which "encourages individuals to take responsibility for their own fate and that of their families and communities" (Herbert-Cheshire, 2000, p. 206). In adopting a neoliberal political view, community is understood as something that "is to be promoted, celebrated, nurtured, shared and instrumentalised" (Rose, 1996a, p. 335). This ensures that "individuals are made aware of their allegiance to a particular community and are prompted to participate in projects of mobilisation, reform or regulation on its behalf" (Herbert-Cheshire, 2000, p. 206).

Governments argue that increasing community responsibility will result in better State-community partnerships, which will allow them to work more closely with their constituents (Australian Commission on Safety and Quality in Healthcare, 2011; National Health Service, 2013). However, this responsibility might be a heavy burden for some communities, and policy that requires communities to plan, design, deliver, evaluate, and champion health service reform (Australian Commission on Safety and Quality in Healthcare, 2011, 2013; Ham & Murray, 2015; National Health Service, 2013) is highly demanding and has limited evidence of success (Attree et al., 2011; O'Mara-Eves et al., 2013; Rifkin, 2014; Taylor et al., 2006).

The unintended consequences of defining and forming communities in response to 'responsible community' political ideals are largely unknown. Minkler and Wallerstein (2008) suggest that communities that defined themselves using negative stereotypes in response to policy initiatives, such as poverty or social disadvantage, reinforce feelings of powerlessness and negatively influenced personal identity and perceptions of collective capacity.

Few studies have explored the potential longer term social and health impacts that policy initiatives might have on communities. Farmer et al. (2015) reported that some community members are reluctant to take on responsibility from the public sector, and perceptions of responsibility can divide communities. In their study in rural Scotland, community members were concerned that they would miss out on funding or services if they demonstrated their competence when publically funded services were removed (Farmer et al., 2015).

7.3.2 Community as a homogenous group

In exploring the research question of *how* communities participate, I was intrigued that within health policy, definitions of community, commonly liken it to homogeneity; and describe an easily harnessed social group (National Health and Hospitals Reform Commission, 2009; National Health Service, 2013; World Health Organization, 1985, 1986). However, as argued in the critical review [Publication 2], this over-simplified understanding of community contributes to a policy/practice translation gap, which makes it difficult for practitioners (including occupational therapists) to develop an understanding of community diversity and to develop ways of working with them (Kenny et al., 2015).

Historically, community development approaches have supported understandings of community as a homogenous object or entity, which assumes that communities can be (and should be) mobilised into a group that will find consensus and participate on identified health issues, with support and guidance from health professionals (Rifkin, 2003). This view perpetuates the false understanding that communities are easily identified and controlled (or harnessed), and that organisational and governmental actions should be taken to build and maintain community (which is believed to be threatened by urbanism and other factors) (Jewkes & Murcott, 1996; Rifkin, 2003).

In adopting views of community homogeneity, practitioners may ignore the continuous, interactional and changing nature of socio-cultural phenomena and human experience (Kaufman, 1959; Quick & Feldman, 2011). This perspective of community, promotes a static social identity. In my doctoral research this was observed in the romanticised views of 'rural community' promoted in marketing materials and the vision of the Australian community banking initiative [Case Study 2]. Within occupational therapy literature, it is common for homogenous community identities to be uncritically assigned to population groups, for example people with mental illness or refugees, which might conflict with the identity persons or groups assign for themselves (Gerlach, 2015). This illustrates how the construction of community identity might negatively influence the ability of occupational therapists to work collaboratively with communities. Critically, assumptions of homogeneity might lead to presumptions about how communities *should* participate, and the use of methods or approaches that privilege some community members over others (Mills & Gitlin, 2000).

Understandings of community as homogenous might stem from the German philosopher Tonnies (1957) research of pre-modern community values and ideals (*Gemeinshaft*), which promote community as united and harmonious. In Case Study 2, it was proposed that Tonnies (1957) Gemeinshaft conflicts with modern societal realities (in Western, developed countries), including capitalism and free market economies, globilisation and migration, and increasing population diversity. However, rather than agreeing with Tonnies, and conceding the demise of Gemeinshaft to modernity (and the development of modern and impersonal, large-scale, capitalist societies) (Giddens, 1986; Tonnies, 1957), it was argued that community needs to be understood differently, by reflecting on historical conceptualisations, and building new ideas informed by social theory and critical thought.

Critical perspectives of community illustrate increasing complexity and cultural diversity (Liepins, 2000), and community spatial and social boundaries are considered fluid and less defined (Barrett, 2014). This suggests that instead of viewing community as a homogenous group, community might be better understood as a social field (Kaufman, 1959; Taylor et al., 2006; Wilkinson, 1970). In conceptualising community as a social field, individuals may simultaneously belong to multiple (and over-lapping) groups (Clark, 1973; Laverack & Keshavarz Mohammadi, 2011; MacQueen et al., 2001; Rose, 1996a). A community's social field is expected to have socially negotiated, highly-contextualised inter- and intra-group boundaries, which is supported by research findings in Publications 1 (Kenny et al., 2013), and Case Study 1 and 2. In adopting this alternate view of community, as a fluid and evolving social mosaic, it can be understood how communities are defined differently across contexts (Rifkin, 2014), and are perceived differently by members and non-members (Jewkes & Murcott, 1996).

This view is supported by the research findings, which illustrate how the profile of people who are identified within a community group, and participate in community activities, might not represent, or give an accurate indication of broader community heterogeneity [Case Study 1 and 2]. In the community food case study [Case Study 1], for example, leaders of the Canadian food movement were not observed to be socio-demographically representative of the broader food communities, which included diverse individuals and stakeholders (including farmers and food producers, low income groups and homeless and jobless persons, school children and university students, and middle class 'foodies'). In the Australian community bank case study [Case Study 2], the people who participated were a homogenous group (white, middle aged males), however, the broader community was known to have a diverse membership, influenced by a number of contextual factors, such as floods, drought, the global financial crisis, and population ageing. In both studies, communities included

transient population groups, such as agricultural workers and new migrants, and people from a range of backgrounds, who have different interests and priorities, which were not necessarily represented by the community leaders who formed the easily identifiable community leadership sub-group.

Understandings of community are limited when community is defined only by members who are observed to participate in "socialised" ways, which are within the confines of social norms (Mills & Gitlin, 2000, p. 91). The doctoral research findings appear to align with views of Rifkin (2014) and other health sociology authors (Barrett, 2014; Draper et al., 2010; Jewkes & Murcott, 1996; Laverack & Keshavarz Mohammadi, 2011; Montesanti et al., 2015). These authors propose that communities are increasingly diverse and contain a wide range of dissimilar and sometimes conflicting cultures, interests and views. One view is that misrepresentations of community may be intentionally promoted to be politically persuasive. It is suggested that community is a term that never seems to be used unfavourably, which is used to cast an irrefutable positive light on policy or programs (Jewkes & Murcott, 1996; Shaw, 2008), and to promote a nostalgic desire for tradition and belonging (Cutcher, 2008, 2014).

Occupational therapists are encouraged to consider the possible consequences of using fragmented or incomplete understandings of community in research and practice. A lack of understanding can result in communities being burdened with unwanted responsibilities (Burchell, 1996; Herbert-Cheshire, 2000), or use of inaccurate definitions can create divisions between members and non-members, and reinforces marginalization of disadvantaged groups (Barrett, 2014; Jewkes & Murcott, 1996). The doctoral research findings support the need for a conceptualisation of community, which views community as a continuous and changeable social field or mosaic that is highly influenced by social forces,

and includes a diverse social and cultural membership, as compared to a definitive, homogenous group (Kaufman, 1959; Quick & Feldman, 2011).

The following section builds on this discussion of community by discussing several practice challenges. Specifically, practices and approaches that are used to enact community participation in spaces created and moderated by powers holders (that is, community participation in "invited spaces"), which was the focus of doctoral research that underpins this thesis.

7.4 Community participation in 'invited spaces'

In this research, community participation was identified as an internationally-recognised exemplar of community practice, which is used in a myriad of programs and initiatives to improve community-level health and well-being. A central argument of this thesis is that occupational therapists, and similarly other health professionals and community leaders, must understand the issues and challenges inherent in community participation, if they are to practice with communities. In this section, I argue that examining the doctoral research findings using a sociological lens can develop this understanding.

In completing the literature reviews [Publication 1, 2 and 3], several key challenges that might impede the capacity of practitioners to enact community participation within healthcare settings were identified (Hyett, Kenny, Dickson-Swift, et al., 2014; Kenny et al., 2015; Kenny et al., 2013), and in the case studies, key issues relating to sustainability, inclusion and empowerment were discussed. This discussion is of findings from across the research, relating to how and why communities participate. Several issues are discussed relating to community participation that occurs in invited spaces, which are spaces that are

created for participation by power holders (Cornwall, 2008), including occupational therapists.

7.4.1 Why participate?

A primary research question was *why* do communities participate? In the community banking case study [Case Study 2], which was central to answering this question, research findings illustrate how individuals and communities have different motivations and reasons for participating, and that this varies across contexts. It was proposed that attachments to place and community are influential, which was central to the participants' motivations for community banking. Although this research question was not the primary focus of the remaining published articles, other possible reasons for participating were identified, including a need or desire to contribute resources, skills and time, a need to address a perceived injustice, to address a skill shortage or service gap, or to improve access to a desired community resource [Publication 1 and Case Study 1] (Kenny et al., 2013). What I was surprised to identify, was the issue of non-participation, which has led me to question why people and communities choose not to participate, and to critically examine presumptions that are made about individual or community preferences, desires or capabilities for participation. The central ideas discussed in this section, is that participation is driven by people, community and place relationships, and that not everyone wants to participate, and people and communities will participate in different ways.

Participation is influenced by the interrelationships between people, place and community

In the community bank case study [Case Study 2], motivators and drivers of community participation were explored, and it was suggested that emotional connections to rural place influence why people participate with community initiatives. The research findings were used to explain how emotional connections to place are formed through a

myriad of processes and experiences, including place identity and dependence, and sense of community and belonging (Manzo & Devine-Wright, 2014). These findings support Manzo and Perkins (2006), who argue that place attachment is an important driver of community participation in planning and development initiatives. To conclude Case Study 2, it was proposed that building knowledge of people, place and community connections will improve understanding of the reasons why people participate with community initiatives.

In comparing the research findings to the existing literature, I have come to understand that there are multiple dimensions of place and community that have potential to influence participation choices. In the community banking case study [Case Study 2], social and cultural aspects of community were influential, which Abelson (2001) argues shape the style of participation preferred by the community, and the roles adopted by different actors. Political dimensions of community are linked with motivations for participation and are thought to underpin participation choices (Abelson, 2001; Head, 2007, 2011). This was illustrated in the food security case study [Case Study 1], where many community members had political reasons for participating with food and gardening programs. Overall, I argue that community participation is being influenced by multiple dimensions of place, which leads me to question the value of broad health policies that require participation, without consideration of people, community and place interrelationships (Abelson, 2001; Manzo & Perkins, 2006).

Expectations that people and communities should participate, without consideration of influential place factors, might reinforce indiscriminate community homogeneity ideals (which were discussed in the previous section). Place characteristics and contextual factors thought to influence community participation include length of residence, industry and the availability of employment, economic and lifestyle migration, housing affordability, and access to essential amenities (Hanlon et al., 2014; Patten et al., 2015). It is expected that globilisation and forced migration (Cunsolo Willox et al., 2012; Lewicka, 2011), and climate

and natural disasters (Anton & Lawrence, 2014; Cunsolo Willox et al., 2012) will have increasing influence on place attachment, and sense of community and belonging.

I contend that improved knowledge of place and context, and the connections between people, place and community [as outlined in Case Study 2] might improve occupational therapists understanding of community participation, and improve their capacity to practice with communities. However, this idea of place, people and community interrelationships conflicts with dominant occupational therapy models, which emphasise an individual or person-centric approach to practice, where the person is at the centre of practice, and central driver of change (Iwama et al., 2009; Whalley Hammell, 2013). The study findings support research that examines people-place-community attachments, and how this interrelationship might influence participation in community occupations (Iwama et al., 2009).

People participate in different ways

A major flaw of current policy is that it requires communities to be willing and capable of participating in ways that effectively improve community health and well-being (Rifkin, 2003, 2014). This assumption fails to acknowledge that within communities, people have varying expectations of participation, and levels of motivation, capability, knowledge and experience. The research findings illustrate how community members participate in different ways, and with different motivations. This argument is supported by findings that have been discussed earlier in this chapter. For example, I discussed how communities vary across contexts, for example, because of social dynamics, place characteristics and contextual factors. I argued that some people or communities might not want to or have the capacity to take on responsibility for a shared problem. Earlier, I discussed some of the political rationalities that are thought to unpin governments' community participation expectations, which can conflict with communities' expectations.

This finding, that people participate in different ways, is supported by existing research. Authors suggest that while some people enjoy participating in community initiatives, others can have negative participation experiences and can feel burdened by their participation responsibilities (Attree et al., 2011; Henderson & Kendall, 2014; Herbert-Cheshire, 2000; Minkler, 2012). I argue there is a need to critically examine why communities should be expected to participate in certain ways, and why some forms of participation are discredited.

In conducting the research, I was specifically interested in why communities participate in initiatives that were deliberatively created by community members, leaders and stakeholders for a specific purpose (Cornwall, 2008; Kenny et al., 2013; Taylor et al., 2006). The implementation and success of these types of community participation initiatives usually rely on wide participation by community members within "invited spaces", created by initiative leaders (who are typically power holders) (Cornwall, 2008, p. 275). I have used Pretty's (1995) typology to conceptualise the multiple forms of community participation that were observed in the research [specifically, in Publication 1, and Case Study 1 and 2]. Examples from the research are provided in Table 15 to illustrate how people participate differently, and how community participation was multidimensional (with multiple elements of the different types of participation listed). This illustrates how it can be difficult to categorise and differentiate forms of community participation using existing typologies, and within a single initiative, multiple forms of participation exist (Cornwall, 2008).

Table 15. ***Typology of Participation, Adapted from Pretty (1995)***

Type of participation	Examples from the research publications
1. Manipulative participation	Community members are selected as lay or token representatives, for example, to serve on an official

	health service board, however, are unelected, and have no power over decision-making [Publication 1]
2. Passive participation	Community members are kept informed of decisions made by organisational representatives or professionals through newspaper articles and online newsletters [Case Study 1 and 2]
3. Participation by consultation	Participation is planned and delivered by leaders, to consult with community members, to define problems and to gather information, for example, via a community meeting. There is no obligation for power holders to utilise their input [Case Study 1 and 2]
4. Participation for material incentives	Community members participate by contributing resources, for example, time and labour to deliver community projects, or cash through fundraising or membership fees [Publications 1, Case Study 1 and 2]
5. Functional participation	Community members are co-opted into projects to serve external goals, which increase efficiency of community services, for example health programs or charitable foodbanks [Publications 1, Case Study 1 and 2]
6. Interactive participation	Community groups participate in joint analysis, planning, decision-making, and action, which strengthens community processes, structures, and institutions. Participation processes integrate multiple perspectives and support social learning processes, for example community coalitions and advocacy groups [Publication 1 and Case Study 1]
7. Self-mobilisation	Self-initiated participation, within initiatives that are external to institutions, which aims to challenge and change unjust systems, for example large-scale food manufacturing or corporate banking. Authoritative agencies may provide supporting frameworks/policies [Case Study 1 and 2]

There is a need to recognise and understand the different ways in which people and communities participate and the diversity in peoples' participation interests, values, cultures, and choices, which is supported by the research findings. The idea that people participate in different ways is well situated within occupational therapy understandings of participation.

Occupational therapy is underpinned by theories of human occupation, which explain how people's participation choices are autonomous, driven by volition and self-efficacy, habituation (roles, habits and routines), performance capacity, and environmental opportunities and barriers (Kielhofner, 2008). While this understanding of participation provides insight into an individual's participation choices and behaviour, broader societal influences warrant further investigation, including conditions that influence collective social behaviour (Mills & Gitlin, 2000). For instance, how participation is influenced by community socialisation and cultural expectations of community membership (Mills & Gitlin, 2000; Taylor et al., 2006).

Not everyone wants to participate

Findings from the community banking case study [Case Study 2], illustrate that not everyone will participate within communities. Even in initiatives that are regarded as highly successful (or *exemplary*), such as the Australian community banking initiative and Canadian food security programs, people will choose not to participate.

Participants in the community banking case study [Case Study 2], estimated that up to 50 per cent of community members avoided participating with activities that leaders used to establish and sustain the initiative. In this case study, only a small percentage of the community actively participated in identifying goals, developing plans and taking action to overcome identified problems (the ten per centers), and the larger majority were bystanders who might have participated by reading newspapers articles or attending community events, but chose not to become involved in decision-making processes.

As an occupational therapist, the research findings relating to non-participation were especially intriguing. Occupational scientists have reported on non-participation that occurs as a result of social and occupational exclusion or alienation (Nilsson & Townsend, 2010;

Whiteford & Townsend, 2011). However, the idea of non-participation, participation avoidance, or active self-exclusion, has had relatively less attention. Similarly, in the literature reviews, few health researchers addressed this issue [Publications 1 and 2] (Kenny et al., 2015; Kenny et al., 2013).

There are reasons why issues of non-participation may have been overlooked within occupational therapy. A core assumption of occupational therapy is that participation in occupation is central to health and well-being (Wilcock & Hocking, 2015), and similar to other health and development researchers, it is often assumed that people will want to participate if they are able to (Cornwall, 2008). The aim of occupational therapy is to create opportunities and remove barriers for participation, therefore the idea of active self-exclusion conflicts with mainstream disciplinary views.

In completing this research, several possible reasons why people might not participate have been explored. It was suggested that non-participation might be indicative of attachment to place and community, which can be influenced by transient populations groups and forced relocation (Manzo & Perkins, 2006). Another suggestion was that lower perceptions of community capacity or collective empowerment might result in non-participation (Mihaylov & Perkins, 2014). Similarly, in the Canadian food security case study [Case Study 1], barriers to participation were identified, including insufficient time, money, or transport, which correspond with literature review findings [Publication 1, 2 and 3] (Hyett, Kenny, Dickson-Swift, et al., 2014; Kenny et al., 2015; Kenny et al., 2013).

Authors argue, that within invited spaces for community participation, self-exclusion can occur because of timing and household priorities, the location and cultural relevance of spaces in which people are expected to meet, or a lack of confidence or fear of reprisal (Cornwall, 2008). People may feel "they have nothing to contribute, that their knowledge and ideas are more likely to be laughed at than taken seriously" (Cornwall, 2008, p. 279).

Researchers explain how participants make decisions and choices about participating through a process of negotiation, or a 'weighing up' of the potential benefits, versus costs and potential risks to well-being (Attree et al., 2011; Cornwall, 2008). In the rural context, participation choices might be influenced by large travel distances and isolation (Farmer et al., 2015; Farmer & Nimegeer, 2014). Community expectations are likely to influence willingness to participate (Conklin et al., 2012; Robyn Eversole, 2012), and historical experiences of service closures or waves of unsuccessful participation initiatives, might influence community participation decisions (Attree et al., 2011; Cornwall, 2008; Farmer et al., 2015).

There is a risk that if people participate in ways that are outside the scope of what is invited, then their participation might not be valued, or may be considered less important, credible or functional. In the Canadian food security case study [Case Study 1], a wide range of participation options are reported, including newsletters, farmers markets, and social media, which demonstrates how some people prefer lower intensity or less time-consuming methods. It was argued that within community participation initiatives, meanings of, and preferences for participation are likely to vary between actors (Cornwall, 2008). For community leaders and practitioners, some methods might be valued over others because of the type of initiative they have planned and underpinning participation frameworks. For example, if using Arnstein's (1969) ladder, community leaders may prefer participation processes that enable degrees of citizen control in decision-making, while other, more passive or uni-directional forms might be undervalued (Cornwall, 2008; Tritter & McCallum, 2006).

Regardless of methods used, development of invited spaces for participation, without consideration of individual and community participation preferences is likely to be restrictive and have limited meaning for participants (Tritter & McCallum, 2006). Occupational therapists (and other community leaders) need to be aware that when they create spaces or

opportunities for community participation, they inadvertently define a set of participation objectives to which people and communities are evaluated against. Consequently, this creates categories of norm and deviant participation behaviours, which can potentially feed social divisions or lead to exclusionary "dividing practices" (Danaher, Schirato, & Webb, 2000, p. 60). Foucauldian theorists describe how dividing practices are used to qualify or disqualify people as fit and proper members of the social order, and can be used to distinguish good citizens from delinquent others (Danaher et al., 2000, pp. 60-61). Within community health and well-being initiatives, non-participation could be regarded as socially deviant behaviour, because it goes against government objectives to keep people "healthy, strong, active, hard working and safe", and makes it more difficult for health practitioners and government agencies to watch, regulate and control community and population health (Danaher et al., 2000, p. 64).

In Western, developed nations, societal ideas of what it means to be a 'good' citizen in an established democracy, inform value judgments regarding community participation. Mills and Gitlin's (2000) "ideal man" is one sociological perspective that can be used to understand societal expectations of a 'good' active community participant:

> The ideal man… is 'socialized'…he is the ethical opposite of 'selfish'. Being socialized, he thinks of others and is kindly toward them; he does not brood or mope' on the contrary, he is somewhat extrovert, eagerly 'participating' in the routines of his community, helping this community 'to progress' at a neatly adjustable rate. He is in and of and for quite a few community organizations. If not an outright 'joiner', he certainly does get around a lot. Happily, he conforms to the conventional morality and motives; happily, he participates in the gradual progress of respectable institutions. (p. 91)

Mills and Gitlin's (2000) impression of society's ideal man reflects characteristics of the doctoral study participants, for example the "food animators" [Case Study 1] and the "ten per centers" [Case Study 2]. Similarly, this characterisation is inferred in other studies of community participation. For instance, the 'usual suspects' persona, which is used to identify

people who regularly participate, and sometimes monopolise community initiatives (Kenny et al., 2015; Needham, 2002), or the local champions, who are typical community leaders, that are highly capable of participating with professionals, and have established networks across different community groups (Johns et al., 2007; Kenny et al., 2015; Laverack & Keshavarz Mohammadi, 2011). While this subset of community members are important and valuable participants, this persona should not be expected to be representative of broader community heterogeneity, and should not be used to judge peoples' participation preferences and ideas. Consequently, if occupational therapists design invited spaces for participation around societal values of the ideal community participant, which expects people to participate in similar ways and for similar reasons, there is a risk that a significant proportion of the community will be excluded, or their participation will be undervalued.

At the end of my studies, I have come to the conclusion that an understanding of the reasons why people and communities participate differently would be beneficial for occupational therapists. This includes why, from a sociological perspective, occupational therapists (and community leaders) might inadvertently expect people and communities to participate in a similar way, or discredit participation that is outside the scope of what is invited. Keeping with occupational therapy's core values, diversity in peoples and communities' participation preferences and choices should be celebrated and encouraged, which might involve challenging mainstream ideas, which suggest that people and communities should participate if they are capable.

7.4.2 How do communities participate?

The second research question that was addressed was *how* do communities participate in programs or initiatives that aim to improve community-level health and well-being? The Canadian food security case study [Case Study 1], was primarily conducted to address this

question. In this section, I discuss the research findings relating to how communities participate, using a sociological lens.

In researching this question, I expected to find several innovative methods that could be adapted and applied by occupational therapists within health service programs, and that could be integrated in organisational community participation plans.[12] However, upon further examination, and consideration of relevant sociological theory, I realised the need to challenge common ideas relating to *how* community participation is enacted.

Firstly, I challenge the assumption that community participation in invited spaces empowers marginalised people and groups. This was supported by the research findings, which described how commonly used participation methods appear to favour community members who are already empowered, people who are qualified and skilled, and are known within their community to participate, and who had access to resources. In the Canadian case study [Case Study 1], participation strategies used to promote sustainability might compromise social inclusion objectives, however, we concluded that people with less resources, or less capacity to participate might be excluded.

In this section, I discuss how these findings might contradict common assumptions that are inherent in health and development policy, which imply that community participation in invited spaces is empowering, inclusive and sustainable (Draper et al., 2010; Morgan, 2001; Rifkin, 2003).

Community participation and empowerment

There is an inherent assumption in occupational therapy that enabling participation in occupation will contribute to client empowerment (Polatajko & Townsend, 2007). When the

[12] I had been responsible for developing a community participation plan in my previous employment role, and these types of plans are increasingly required by governments for health services accreditation (Australian Commission on Safety and Quality in Healthcare, 2011; National Health Service, 2013).

term client is used to mean community, and the occupation is in a community context, this suggests that enabling or creating participation opportunities at the community-level might result in collective empowerment. Core occupational therapy models reinforce this relationship between participation and power. In the viewpoint [Publication 5] (Hyett et al., 2016), for example, the Canadian Model of Client-Centred Enablement (CMCCE; Townsend, Polatajko, Craik, & Davis, 2007) is identified as a model that can be used to guide occupational therapists to use a range of strategies to facilitate participation. Use of this model aims to support client (community) empowerment, including advocacy, coaching, consulting, or teaching. Authors argue the CMCCE model should be used to create a reciprocal relationship between occupational therapist and client (Townsend, Polatajko, et al., 2007), however, the space for participation is created by the occupational therapist (the power holder), and the emphasis remains on what therapists contribute, and how they serve the relationship (Whalley Hammell, 2013). Alternatively, occupational therapists are guided to use environmental interventions, which anticipates that by changing community spaces, individuals and communities will participate and empower themselves (Finlayson & Edwards, 1995; Tucker et al., 2014).

An adaptation of the CMCCE is provided in Figure 15 that incorporates the participation strategies identified in Case Study 2. This is to illustrate the potential for occupational therapists to adopt enabling roles with community participation. It is envisioned that the enabling strategies would be used *with* community clients (people, groups, networks, businesses and/or organisations) to support their participation in occupations. Community occupations would likely include activities that are meaningful to community members, which are driven by community volition and habituation, capacities, strengths and weaknesses, and the community's environmental context (Kielhofner, 2008).

Figure 15. ***Model of Community-centred Participation Enablement. Adapted from Townsend, Polatajko, Craik, & Davis, (2007)***

During the course of this research, I observed a myriad of participation strategies that were used to support people and communities to become involved in defined activities within invited spaces for participation. In the Canadian food security case study [Case Study 1], four key strategies were described including multiple methods, leadership, social media, and leveraging through partnership development. Similar to strategies used by occupational therapists, community leaders utilised participation strategies to increase community participation in social, educational and cultural activities, which aimed to empower people to make choices and act in ways that would benefit themselves and the broader community.

Participation is an important element of a community empowerment process or outcome (Laverack & Wallerstein, 2001). However, empowerment does not occur as a direct

result of communities participating, and the purpose, process and context of participation will influence empowerment goals or experiences (Laverack & Wallerstein, 2001; Rifkin, 2003). It is misleading to refer to community participation and empowerment synonymously. Empowerment is distinguished from participation by its explicit activism agenda, which aims to instigate social and political changes through protest, struggle, and liberation (Laverack & Wallerstein, 2001; Rifkin, 2003). This requires an incremental process, to gain power and control over decisions that have a detrimental and marginalising influence on the community's livelihood (Laverack & Wallerstein, 2001).

Reflecting on the research findings, I suggest, that even in community participation initiatives that are highly regarded, communities might not succeed in gaining power they need to exercise control over decisions, and influence social and political change. This is best illustrated by the Canadian case study [Case Study 1], where in the 1970s, large-scale grassroots activism was ultimately unsuccessful in changing federal government policy. Community leaders had to change their participation strategy to focus on human and financial resource mobilisation. This resource-focussed approach is effective for sustaining community interest and lobbying politicians, but is less inclusive of poor and marginalised groups (Bauermeister, 2016). Additionally, in this research, it was observed that the use of participation strategies within communities does not guarantee the participation of, or transfer of power to, marginalised people and groups. In the community bank case study [Case Study 2], for example, the national office (Bendigo Bank) retained control of decision-making for the community bank franchisee (Eylestown).

Barriers that limit the transformative potential of participation in invited spaces

Sociological perspectives, including key works of philosopher Michel Foucault, can be used to examine how communities participate (in processes that are essentially about

power redistribution), and the social and political factors that limit the transformative potential of participation in invited spaces.

Health and development policies require occupational therapists (and other health practitioners) to develop and implement participation strategies as a means of achieving community empowerment. A major flaw of this policy is that it is assumed that community participation in initiatives created by, and with practitioners, will "enable local people to have a greater say in transforming the fortunes of their communities" (Herbert-Cheshire & Higgins, 2004, p. 289). However, there are several reasons why, in the current socio-political context that the transformative potential of community participation is limited.

I argue that community participation in invited spaces requires *trading off between inclusion and sustainability*. Social inclusion is key to community empowerment, and is a common objective of community participation. However, inclusion can be difficult to achieve using conventional participation methods, and in the context of mainstream health (clinical) service settings (Minkler & Wallerstein, 2008; Quick & Feldman, 2011). A number of possible reasons for this have been outlined earlier in this chapter, including that people and communities have different reasons for, and interests in participating, have different participation capacities and cultural needs, and people who are marginalised, or are less connected to place and community might be excluded.

Social inclusion is a particular issue for practitioners who identify sustainability as a primary objective of community participation. Sustainable approaches that focus on resource acquisition and mobilisation, are highly reliant on resources and are likely to favor participants, who are highly skilled, have extensive networks, and who have power and resources to contribute (Canel, 1997; B. Edwards & Gillham, 2013; McCarthy & Zald, 2001). As a consequence, community participation approaches that focus on sustainability might be less inclusive and appear less legitimate to community members (Canel, 1997).

When enacting community participation with health services, occupational therapists may be confronted by *conflicting agendas*. Systemic barriers can prevent transformative community participation, including a lack of understanding and unclear definitions, which prevent research and utilisation of evidence-based methodologies (Laverack & Wallerstein, 2001; Morgan, 2001). Initiatives need to be adequately resourced and funded. However, biomedical perspectives continue to dominate healthcare budget decision-making, and "resource allocation and policy concerns remain rooted in a model of health that sees health as the absence of disease" (Rifkin, 2003, p. 168). Consequently, practitioners find it challenging to convince policymakers and the public of the value of community initiatives that are oriented towards health promotion and prevention (Morgan, 2001; Rifkin, 2003).

Occupational therapists might find it difficult to implement policy into practice, in ways that are aligned with their professional values and disciplinary teachings [Publication 5] (Hyett et al., 2016). While policymakers have called on health practitioners to create participation strategies that empower communities, this is fuelled by (and is at odds with) current dominant political rationalities of efficiency-focussed health reform and economic rationalisation, which essentially limits community capacity to direct their own participation agenda [as discussed in Publication 2] (Kenny et al., 2015). Morgan (2001) argues that there is potential for intersectionality between competing ideologies, including utilitarian-focussed participation approaches aimed at service efficiency, which ultimately retain power within services, and empowerment models, which involve a redistribution of power. However, to find this intersection, occupational therapists must question political rationalities that underpin health policy, including why community empowerment should be necessary for effective government (Dean, 2010).

Occupational therapists may be frustrated by their organisations *limited capacity for change*. Authors claim that government uses community empowerment agendas to populate

an illusion of freedom and citizen control (or "self-government"), in a social and political context where it is increasingly difficult to change the status quo (Ayo, 2011; Dean, 2010, p. 85). This agenda is implicit in health policy, which requires practitioners to create supportive environments to empower people and communities to take control of their own lives, which prevents them from "attacking the structures that kept them impoverished" (Rifkin, 2003, p. 170). Occupational therapists may inadvertently enable this government agenda, by focussing their practice on personal adaptation and coping, rather than taking critical or radical perspectives to challenge unjust social and political structures (Gerlach, 2015; Whiteford & Townsend, 2011).

Government and governmental agencies have encouraged practitioners to take an 'empower not serve' approach to *empower the powerless*, which relies on the agency of citizens and communities to lead change (Danaher et al., 2000). Policy built on this position implies that power can be summoned and harnessed by practitioners and community leaders, and intentionally transferred to people and communities deemed 'powerless'. However, Foucauldian theorists suggest, "power isn't a thing that is either held by, or belongs to, anybody" (Danaher et al., 2000, p. 70). It is argued, "Power moves around and through different groups, events, institutions, and individuals, but nobody owns it" (Danaher et al., 2000, p. 73). Likewise, power cannot be contrived within communities, and existing power must be shared or given up in order to benefit others (Laverack & Labonté, 2008). Occupational therapists must examine positions of power (including their own) and patterns of oppression within communities, and investigate opportunities for people and groups to influence "how forces of power are played out" (Danaher et al., 2000, p. 73).

Theorising from the research findings, I have suggested that conventional participation methods might bias participation towards people who are already empowered, which could be caused by the strong relations built between specific positions and interests

groups (Simons, 1995) [as described in Case Study 1 and 2]. Within communities, social and cultural identities can empower or oppress capacity to act, or to resist power, and this is changeable depending on time and context (Danaher et al., 2000; Simons, 1995). I propose that elements of participation approaches observed in the doctoral research (refer to Table 15 in this chapter) may unintentionally exclude or disempower some people. Consequently, communities that are disadvantaged and have little ability to act or influence power, might be less likely to participate in invited spaces where participation opportunities are only offered in ways that are preferred by practitioners and community leaders.

7.5 Chapter summary

In this chapter, the key research findings were discussed. The findings relating to meanings of community provide new insights into the myriad of meanings and definitions, which can be used to improve practitioners' understanding of community interventions and practice frameworks. Two key issues were identified and discussed, including that community can be perceived as responsible, and community can be perceived as a homogenous group. Possible implications of these perspectives were examined in the context of occupational therapy. In the second major section of this chapter, findings relating to community participation in invited spaces were discussed, and sociological perspectives were used to build knowledge of community participation for occupational therapy (who are identified as power holders). Key findings illustrate how integrating and adapting existing occupational concepts and models can strengthen community practices.

Chapter 8

Recommendations and Conclusions

"The potential to transform ourselves and society, to overcome barriers and to pursue aims such as health and happiness as well as wealth, lies in occupation."(Townsend, 1997, p. 18)

8.1 Introduction

In concluding this thesis, I outline several recommendations that are informed by the research. In proposing the following recommendations, my aim is to ensure the research findings are disseminated in ways that stimulate policy and practice debate. The recommendations provided address practice, education, research and policy issues, which primarily relate to my discipline of occupational therapy, including current or future occupational therapists, and leaders of occupational therapy professional associations, and pre-registration tertiary education programs. The policy recommendations are designed to address the issues, needs and gaps in policy frameworks more broadly, including state and federal health policies of Western developed countries (in which this research is situated). In utilising qualitative case study methodology, the aim of the research was not to provide research findings that can be generalised. Therefore, the recommendations relate to how the theoretical and conceptual research findings on community participation that were discussed in this thesis, can be used to guide further empirical work.

I strongly believe that these research findings on community participation can improve practice, by creating dialogue and debate about strengthening and expanding occupational therapist's adoption of community-centred practice roles. I conclude the recommendations by outlining a potential position statement on community-centred practice that should be reviewed by the World Federation of Occupational Therapists (WFOT), and

member organisations. My intention is to use this position statement to lobby for the validation of occupational therapists' roles with community-centred practice, and to formalise the profession's view on working with community clients.

I encourage the WFOT and member organisations to formally recognise the need to develop a shared understanding of community and community-centred practice, and to lead research and development in this area. I believe the recommended position statement (outlined in this chapter, Figure 16, page 227) will improve awareness of occupational therapist's potential to adopt and champion community-centred roles, and increase adoption of community practice curricula and placements in pre-registration tertiary education programs. This is needed to create and sustain practice change. Additionally, an agreed statement on community-centred practice will position occupational therapists as key players in international research partnerships in community and population health.

To conclude the thesis, I provide a summary of study limitations, and finish with my concluding remarks (or final, parting words).

8.2 Recommendations

Recommendation 1: The profession of occupational therapy must expand current definitions of community in practice, policy, research and education

In this thesis, I present a conceptualisation of community that could be used by occupational therapists to guide community practice. As a profession, occupational therapy should expand current definitions of community, to consider the interrelationships between people, groups and places, interdependences between community and society, and how communities encompass diverse social networks, cultures, norms, values and interests

(Barrett, 2014). This conceptualisation, which is different to typical occupational therapy person-centred models (Iwama et al., 2009), must conceptualise community as embedded in context. This includes a historical context, with a past, present and future, and social, political, physical and cultural contexts (Jewkes & Murcott, 1996). This conceptualisation will guide practice that is directed at identifying and acting on community level occupational goals, which are broader than (but often influence) individual problems or needs.

1.1 As a profession, occupational therapy must ensure that policy and practice guidelines refer to a conceptualisation of community that is theoretically-grounded and informed by health sociology

The conceptualisation of community that is presented in this thesis is theoretically-grounded and informed by health sociology. Perspectives from health sociology were used because they are essential for understanding how societal forces impact on participation and inclusion and health (Gerlach, 2015; Pereira & Whiteford, 2013; Whiteford & Hocking, 2012).

1.2 Occupational therapists should utilise a shared conceptualisation of community, to inform their understanding of client as community, and practice in community-centred roles

Occupational therapists are recommended to utilise the conceptualisation of community presented in this thesis to guide practice. This will influence how community clients are identified and approached, or received, and the types of interventions or services offered. For example, enablement strategies versus biomedical interventions (Polatajko, 2001; Townsend, Polatajko, et al., 2007), and practices used, including assessment and evaluation.

1.3 A shared conceptualisation of community should be incorporated into pre-registration tertiary education curricula to deepen understandings of client as community, and prepare graduates to practice in community-centred roles

Pre-registration tertiary education programs provide ample learning opportunities for students to build knowledge of how occupational therapists work with individuals, families, and groups. However, fewer programs offer comparable levels of training and preparation for working with community clients (Fortune, Farnworth, & McKinstry, 2006). Incorporating the conceptualisation of community presented in this research into education programs will likely improve graduates' knowledge, confidence, and practice competence.

1.4 Occupational therapy must define community in their research and consider the implications of the use of the term (or if another term is more suitable, e.g. population group)

The research findings illustrated the myriad definitions of community that exist in healthcare research. Occupational therapists must define the term community in their research, and depending on definition, they might consider if another term would be more suitable (Jewkes & Murcott, 1996; Shaw, 2008).

1.5 Further research is needed to develop a 'community' conceptual model using an occupational lens

In this thesis, I have presented a conceptualisation of community for occupational therapy that is based on the research, and relevant sociological perspectives. Further research is recommended to design a conceptual model and to collect feedback from community practice experts from within and outside of the occupational therapy profession (for example, occupational scientists, and authors who have published on community practices in the

Occupational Therapy Without Borders series (Kronenberg et al., 2005; Kronenberg et al., 2011).

Recommendation 2: The profession of occupational therapy should formally demonstrate a commitment to community-centred practice

Currently, community-centred practice is relatively new in the discipline of occupational therapy, and there are no occupational therapy models that explicitly guide community-centred practice. Professional associations, including the WFOT, need to demonstrate their commitment to community-centred practice in occupational therapy, and provide support and raise awareness on the need for research and development. There are many ways this could be done, for example, by including community-centred practice as a recurrent conference theme or stream, or by identifying community-centred practice as a graduate competency.

2.1 Occupational therapists are encouraged to trial and evaluate community-centred practice approaches

Community-centred practice approaches are relatively new within the occupational therapy profession. A period of trialing and evaluating approaches is needed, with timely and effective dissemination through research publication, professional networking, and conferences (Rifkin, 2014).

2.2 Occupational therapists should evaluate the potential to expand their scope of practice to include community-centred practice roles (role expansion)

Rather than referring to community-centred practice as a 'non-traditional' or 'role-merging' area (Thew et al., 2011), occupational therapists are encouraged to evaluate the

potential to include community-centred practice roles, by expanding on or re-negotiating their current employment position.

2.3 Community-centred practice approaches should be introduced to occupational therapy students during pre-registration practice placements

Occupational therapy students should be introduced to community-centred practice during pre-registration practice placements. This could be in addition to mainstream individual-focussed work, or be the focus of the entire placement, for example with service learning, project placements, or in community-controlled health settings, such as Aboriginal Community Controlled Health Services (see http://www.naccho.org.au/) (Fortune et al., 2006; Gerlach, 2015).

2.4 Occupational therapists are encouraged to form an international leadership group to champion community-centred practice in occupational therapy

Occupational therapists are qualified to take on leadership roles with community practice development (Rodger, 2012). There are a number of barriers to community-centred practice for occupational therapists, which could be addressed through the development of an international leadership group. This group could advocate for professional recognition, build confidence and awareness within the profession, provide education of theory, models and approaches, educate health executives and policy makers, and lobby governments for appropriate funding models that challenge the dominant biomedical, individualistic treatment paradigm (Rifkin, 2003).

Recommendation 3: Community-centred practice should be accompanied by critical reflection and action

Critical reflection is key to effective practice and professional development (Gerlach, 2015). Given the political nature of issues raised in this thesis, regarding practitioners' use of invited spaces for community participation, occupational therapists are encouraged to engage in critical reflection on their practice with communities. In comparison with traditional occupational therapy approaches that promote adaptation and coping, occupational therapists are recommended to reflect on ways they can engage in critical or radical action that challenges unjust power structures, systems and relations (Gerlach, 2015; Townsend, Polatajko, Craik, & von Zweck, 2011; Whalley Hammell & Iwama, 2012; Whiteford & Townsend, 2011).

3.1 Occupational therapists should examine power structures and relations that influence community capacities to participate in ways that create social and political change

Occupational therapists are encouraged to utilise their ability to advocate and influence power structures and relations, to examine and remove barriers to participation, and promote opportunities for communities to create and sustain social and political change (Pereira & Whiteford, 2013; Pollard et al., 2008; Townsend et al., 2011; Whiteford & Townsend, 2011). This will enhance the transformative potential of participation enacted by and within communities (Cornwall, 2008).

3.2 In creating invited spaces for community participation, governance structures must be examined to increase the likelihood that power and responsibility is distributed fairly, which will ensure that communities are able to decide their own level of involvement

In this thesis, the research findings illustrate several challenges occupational therapists might encounter in their attempts to enact community participation. When occupational therapists adopt leadership roles that require enactment of community participation, they are encouraged to advocate for the development of governance structures are democratic (genuine, trustworthy, and transparent) and inclusive (beyond the immediately observably leadership group) (Bovaird, 2007; Farmer et al., 2015). Governance should achieve an optimal distribution of power, so that communities are able to decide their own level of involvement, for example marginal participation, or higher levels of citizen control (Arnstein, 1969; Baum, 2008b; Pretty, 1995; Rifkin, 2014).

3.3 Occupational therapists are encouraged to critically reflect on their own position of power and privilege, and how this influences their facilitation of community participation

There is a risk that participation practices can exclude people and groups within communities. As leaders, occupational therapists have a responsibility to ensure their position of power and influence is used in ways that promote participation, occupation and health (Pollard et al., 2008; Rodger, 2012; Townsend et al., 2011). Critical reflection should be used as a tool to self-examine values, beliefs, and actions, to reduce potential bias or discrimination (Gerlach, 2015).

Recommendation 4: Future research should build on theoretical and conceptual research findings relating to community participation

In using qualitative case study methodology, the objective was to build new theoretical and conceptual understandings of community participation for the discipline of

occupational therapy, which would be a catalyst for future (larger, well-funded) studies (Stake, 1995).

4.1 Future research might use place attachment tools to explore interrelationships between people, place, community, and community participation

Future research on community participation could include place attachment measures to determine how interrelationships between people, places and communities, might influence community participation, particularly in the rural context. There is a range of tools available to measure place attachment and related constructs (Lewicka, 2011), including sense of community (Jason, Stevens, & Ram, 2015; Talò, Mannarini, & Rochira, 2014). Potential research questions could include: How does place and community attachment influence rural community participation? Can different levels of place and community attachment predict community participation in rural places?

4.2 The key issue of non-participation could be explored in future studies using new research methods, such as mapping technologies and social network analysis. This would be useful to further examine power relations and social networks within place-based communities, which was beyond the scope of the current study.

Researchers are recommended to utilise new research methods including mapping technologies (Lewicka, 2011) and social network analysis (Ackland, 2013; Ackland & Zhu, 2015; Bauermeister, 2016) in future studies of community participation. Data collection using these methods would enable examination of power relations and social networks within place-based communities, which was beyond the scope of this research. Mapping occurrences of participation (and non-participation or active self-exclusion) within communities could be useful for predicting and measuring outcomes. Future research that examines where

community participation does (and does not) occur might increase awareness and understanding of policy to practice translation failures.

4.3 Future research should examine what (or 'if') governance models or approaches to community participation are able to balance inclusion, empowerment and sustainability objectives

In the discussion, I queried assumptions made about community participation relating to inclusion, empowerment and sustainability. In future research, researchers are recommended to examine the interrelationships between inclusion and sustainability. There is a need to understand whether community practices can be designed that balance inclusion and sustainability, and promote community empowerment (Draper et al., 2010; Morgan, 2001).

4.4 Future research or program evaluation relating to community participation should include methods to evaluate why people do not participate, or if people participate in ways that might not have been defined or measured by initiative leaders

I have suggested several possible theories that explain why people might not participate in community initiatives, relating to participation preferences and interests, place attachment, social exclusion and disempowerment (Cornwall, 2008; Manzo, 2005; Minkler, 2012; Rifkin, 2003). Further research is needed to evaluate these theoretical findings. This will provide a greater understanding of the reasons why people do not participate in community initiatives, or are excluded from participating. Additionally, this would generate greater insight into the ways people participate that might not yet be defined.

4.5 I encourage occupational therapists to advocate for the inclusion of occupational perspectives in team-based, community participation research

The doctoral research involved team-based inquiry that utilised multidisciplinary collaboration and industry partnerships, to increase understanding of community participation in a range of health and well-being contexts. Occupational therapists are encouraged to advocate for a position in team-based research programs relating to community participation, and to utilise this doctoral study as an example of how we can contribute in this field.

Recommendation 5: Governments must provide policy frameworks and funding arrangements that support occupational therapists to practice with communities

In completing this research, I recommend that learnings about community participation should be used to inform health policies, which might improve policy translation at the community-level, and reduce the potential for negative policy impacts. The research findings provide support for the following policy recommendations.

5.1 Blanket policies that require community participation may have harmful consequences and should be avoided

Over-arching policies that require community participation across all contexts and places are not recommended (Rifkin, 2009, 2014). This perpetuates the idea that communities are responsible for State failings, and that they want to, and are capable, of participating in any given context (Dean, 2010; Rose, 1996a). Policy that mandates community participation as a regulatory requirement fails to acknowledge the challenges involved in enacting community participation, and how enacting participation without consideration of historical and cultural context is likely to have harmful consequences (Rifkin, 2009, 2014).

5.2 Policy initiatives that include community participation need to be adequately funded and resourced, and be supported by long-term vision

Community participation initiatives can end pre-maturely and fail to achieve expected outcomes because of a lack of funding and resources (Morgan, 2001; Shediac-Rizkallah & Bone, 1998). Policy makers have a responsibility to ensure that initiatives have sufficient funding if they need to be sustained over the longer term (Farmer et al., 2015; Rifkin, 2009).

5.3 When community participation is included as a process and/or outcome of health policy initiatives, participation objectives and methods need to be negotiated and agreed upon by a range of stakeholders (not just government or the leadership sub-group)

Policy makers are recommended to thoroughly scrutinise the possible harmful consequences of enacting community participation in invited spaces (Cornwall, 2008; Robyn Eversole, 2012; Kenny et al., 2015). Community participation objectives and methods need to be negotiated and agreed upon by stakeholders, including less visible people and groups if a diverse range of views are needed.

5.4 A position statement on community-centred practice is needed to educate policy makers and healthcare executives, and raise public awareness of occupational therapist's capabilities for community-centred practice roles

The position statement outlined in Figure 16 could be released for consultation, debate and discussion, and ultimately submitted to WFOT for consideration and adoption by member organisations. This position statement will improve occupational therapist's ability to conceptualise community-centred practice and how to work with community clients. This will support occupational therapists to strengthen and create new practices and partnerships that extend beyond the traditional, biomedical, individualistic (illness/treatment) paradigm, and will provide a platform to communicate how an occupational perspective can be used to

improve community and population health (Gerlach, 2015; Pereira & Whiteford, 2013; Polatajko, 2001; Whiteford & Hocking, 2012).

Figure 16. ***Proposed Position Statement on Community-centred Practice in Occupational Therapy***

POSITION STATEMENT

COMMUNITY-CENTRED PRACTICE IN OCCUPATIONAL THERAPY

Introductory statement of the purpose of this paper

Occupational therapy is a "client-centred health profession concerned with promoting health and well being through occupation" (World Federation of Occupational Therapists, 2010, p. 1). Occupation is defined differently across cultures, but generally refers to meaningful activities of daily living, which are observed in what people need to do, want to do, and are expected to do (WFOT, 2010).

The goal of occupational therapy is to improve participation in occupation, which is achieved by working with clients (people, groups, organisations, communities and populations) to enhance their abilities and to increase opportunities for and quality of engagement in their selected occupation/s. Occupational therapists enhance participation in occupation by using interventions and enabling actions, which address issues, restrictions or barriers encountered by the client, which result from limited capacities or opportunities, and contextual factors (i.e. social, institutional, cultural, political, physical) (WFOT, 2010).

A 'community' is identified as a potential client of occupational therapy. For the purposes of providing occupational therapy services for communities, a community can be defined as "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" (MacQueen et al., 2001, p. 1929)

Definitions of community are known to vary across disciplines, although occupational therapists agree that communities are characterised by:

- An environment or setting, distinguishable by space and/or place
- Fluid and changeable social networks and groups
- Shared culture, history, norms and values
- Mutual goals or purpose
- A diverse range of interests, socio-demographics, and historical and cultural knowledge and experience (Hyett, 2016)

Occupational therapy use a 'community-centred' practice approach to providing services with communities. Community-centred occupational therapy is underpinned by professional values of 'client-centredness', which centralises the community in all aspects of service delivery (Scaffa & Reitz, 2013). Community-centred practice approaches are informed by occupational therapist's education and expertise in 'occupational science', which recognises occupation as a determinant of health, well-being and survival (Wilcock & Hocking, 2015), and 'occupational justice', which promotes critical analysis of the interrelationships between people, communities and society, and actions that address social and political factors that influence occupational participation at the community-level (Whiteford & Townsend, 2011).

Statement of the position taken

Occupational therapists provide services with communities underpinned by community-centred practice principles, which promote partnership and collaboration, trust and respect.

In providing services with communities, occupational therapists will utilise community-centred approaches, including interventions and social and political actions. In working with a community client, occupational therapists will ensure that communities have opportunities to assess and identify occupational problems and needs, and partake in actions that enhance their occupational participation, and improves the health and well-being of community members.

Occupational therapists use community-centred practice approaches that promote accessibility and inclusion, and prevent or minimize exclusion or marginalisation, including advocacy and decision-making techniques, environmental design, and interventions that promote collective expression and meaningful occupational participation. Occupational therapists will work collaboratively with communities to plan and evaluate services to maximize community level health outcomes, and minimize potential risk or harms, for example issues with funding or sustainability.

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8.3 Study limitations

"I suppose we've all had the experience of working very hard to explain something to someone but coming away with the feeling that we had not communicated all that we might have" (Guba, 2013, p. 30). This doctoral study involved researching community participation in different contexts, and this thesis is my construction of the research. Another investigator, using a different research methodology or paradigm, would likely make different observations and come to their own unique (relative) conclusions (Appleton & King, 2002; Lincoln & Guba, 2013). Nevertheless, this was the reality that was created with the study participants, and the data sources that were available at the time of study.

Qualitative case study methodology was suited to the research questions, in that it allowed for theoretical and conceptual exploration of community participation in different (bounded) contexts. This provided rich, descriptive data on community participation, which had not previously been examined from the combined perspectives of health sociology and occupational therapy. This methodology was suitable for the limited timeframe (3 years, full time) and research budget provided for the doctoral research. The few financial resources secured through postgraduate students grants were spent on fieldwork in Canada, conference attendances for oral papers (Halifax 2013, Yokohama 2014, Melbourne 2015), and professional transcription of three interviews in Case Study 2.

There are limitations of qualitative case study methodology, which must be considered in the interpretation of the research findings. This method of case study was naturalistic, in that data were collected from naturally occurring sources, and with minimum intrusion. Therefore interviews were organised with people who were available and able to voluntarily participate at the time of fieldwork. People who were not available at that time, or who were unable to be accessed during the specified time period, were not able to be included. This meant that participants were people who were highly involved in their respective program, and I did not capture the perspectives of people who were less involved. This would have required a more time consuming, multifaceted recruitment strategy that is common practice for accessing hard-to-reach populations (Liamputtong, 2007). It is possible that the informants' research participation was influenced by their role in their respective programs, and their perceptions of community participation (either consciously or unconsciously) (Merriam & Tisdell, 2016). Because the purpose of this research was to investigate how and why communities participate, the data sample was appropriate for answering the research questions, however, further research is recommended to explore the perspectives of people who choose not to participate in community initiatives, or who participate outside the scope of what is invited by leadership sub-groups (whose perspectives dominated this study data).

I collected additional data from other sources that were relevant to the case study. This eclectic use of data sources is a key characteristic and strength of qualitative case study methodology (Hyett, Kenny, & Dickson-Swift, 2014). In the Canadian case study [Case Study 1], this included data on social media participation, and in the Australian case study [Case Study 2], this included a historical document analysis (including ten years of annual reports and media clippings). This additional data provided different perspectives on community participation within the case study context, which added necessary depth to the

interview data. I do not necessarily recommend that future case studies should have larger sample sizes, however, as discussed in the methodology paper [Publication 4] (Hyett, Kenny, & Dickson-Swift, 2014), it is difficult to demonstrate the value of qualitative case studies with small study samples to journal editors and reviewers. I have encountered challenges with peer review and publishing the research findings (in Chapter 5 and 6), and this has taken longer than first anticipated. It would appear that further advocacy work is needed to justify the value of qualitative case studies as a method of exploring and understanding complex phenomena in a particular setting, which is needed to precede further (larger, well-funded) empirical work, despite typically having small, non-representative study samples.

8.4 Concluding remarks

Overall, the aim of this doctoral research was to explore how and why communities participate in initiatives that address community-level health and well-being. In the beginning, I found that I had stumbled upon uncharted territory, which was the limited understanding of community participation within my own discipline of occupational therapy. I expected that this knowledge gap could be addressed by examining community participation using health sociology perspectives. My research journey involved challenging what was known about community participation in healthcare and occupational therapy, by conducting research in different, contrasting contexts (outside of mainstream healthcare settings). In conducting the research, I was able to collect and analyse rich descriptive data that explained why communities participate, and motivations and drivers of community participation. I uncovered a plethora of methods used to enact and sustain community participation, including use of social media, leadership networks, capacity building and leveraging.

In this thesis, I have raised important issues about the purpose and political rationales for community participation, and I have questioned the value of community participation in invited spaces led by power holders. This critical enquiry was conducted with the spirit of occupational therapy practice in-mind, and professional development needs. I hope that this doctoral research provides new, thought-provoking learnings for my colleagues, and stimulates global discussions of the ways in which occupational therapists practice with communities, and of the potential for new community practice roles.

In completing the research, I decided that I could maximise my intellectual contribution to the occupational therapy profession by discussing how the findings could be directly applicable to practice. I did this by using the research findings to argue how occupational therapists could adopt community-centred practice roles. Occupational therapists are advised to build new knowledge on community-centred practice through robust research and development, which is underpinned by a critical practice stance. Previous studies have considered how occupational therapists could adopt community practice models from other disciplines, for example community development or public health. However, I encourage occupational therapists to look within the discipline and profession, to design, trial, and evaluate an occupation-focussed conceptualisation of community-centred practice. This will ensure that developments in community-centred practice will maintain an occupation-focus, which is what differentiates occupational therapy from other health professions.

Additionally, given the increasing policy impetus for community participation, I believe that building and strengthening occupation-focussed, community-centred practice approaches will situate us in an enviable position within the healthcare sector. In consolidating and publicising capacities for community-centred practice, and our unique occupational perspectives on community participation, occupational therapists will be

identifiable as key players in community and population health practice, education, policy making, and research. However, further research is needed to build on this thesis, which continues to clarify occupational therapy's contribution, and why we should be invited into policy and leadership discussions.

With my final, parting words, I urge occupational therapists to critically reflect on the purpose and processes used for community participation, and to use the research findings to guide their questioning of how and why communities participate in health and well-being initiatives. I hope that further research will build on this thesis to develop a shared conceptualisation of community for occupational therapy, which draws on the wealth of knowledge available within and outside of the discipline. I hope to witness the translation of the study findings into community-centred practice approaches, in both mainstream and non-traditional settings. Finally, because of the methodology used, I hope to see this research used as a catalyst for further (larger, and well-funded) studies, which builds on this preliminary theoretical and conceptual work.

I strongly believe this thesis will stimulate debate about occupational therapists' roles in community health, and how community participation is enacted. I finish this thesis knowing that I have provided a plethora of new knowledge and ideas that can be used to advocate for the development of the profession. In this thesis, I have demonstrated occupational therapy's enormous potential for innovation in community practice, and to participate in, and lead international discussions of how practice change can circumvent complex challenges in community and population health.

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Appendix

List of Appendices

Appendix A: Ethics approval memo

FACULTY OF HEALTH SCIENCES

MEMORANDUM

To: **Amanda Kenny, Department of Rural Nursing & Midwifery, LRHS**

Student: **Nerida Hyett**

From: **Chair, Faculty Human Ethics Committee**

Subject: **Review of Faculty Human Ethics Committee Application No. FHEC13/170**

Title: **Exploration of international case studies on community participation and health**

Date: **11 October, 2013**

Thank you for your recent correspondence in relation to the research project referred to above. The project has been assessed as complying with the *National Statement on Ethical Conduct in Human Research*. I am pleased to advise that your project has been granted ethics approval and you may commence the study now.

The project has been approved from the date of this letter until 1 June 2015.

Please note that your application has been reviewed by a sub-committee of the University Human Ethics Committee (UHEC) to facilitate a decision before the next Committee meeting. This decision will require ratification by the UHEC and it reserves the right to alter conditions of approval or withdraw approval at that time. You will be notified if the approval status of your project changes. The UHEC is a fully constituted Ethics Committee in accordance with the National Statement under Section 5.1.29.

The following standard conditions apply to your project:

- **Limit of Approval.** Approval is limited strictly to the research proposal as submitted in your application while taking into account any additional conditions advised by the Faculty Human Ethics Committee (FHEC) .

- **Variation to Project.** Any subsequent variations or modifications you wish to make to your project must be formally notified to the FHEC for approval in advance of these modifications being introduced into the project. This can be done using the appropriate form: *Ethics - Application for Modification to Project* which is available on the Research Services website at http://www.latrobe.edu.au/researchers/starting-your-research/human-ethics. If the FHEC considers that the proposed changes are significant, you may be required to submit a new application form for approval of the revised

project.

- **Adverse Events.** If any unforeseen or adverse events occur, including adverse effects on participants, during the course of the project which may affect the ethical acceptability of the project, the Chief Investigator must immediately notify the FHEC Secretary on telephone (03) 9479 3570 or at fhechealth@latrobe.edu.au.Any complaints about the project received by the researchers must also be referred immediately to the FHEC Secretary.

- **Withdrawal of Project.** If you decide to discontinue your research before its planned completion, you must advise the FHEC and clarify the circumstances.

- **Monitoring.** All projects are subject to monitoring at any time by the Faculty Human Ethics Committee.

- **Annual Progress Reports.** If your project continues for more than 12 months, you are required to submit an *Ethics - Progress/Final Report Form* annually, **on or just prior to 12 February**. The form is available on the Research Services website (see above address). Failure to submit a Progress Report will mean approval for this project will lapse.

- **Auditing**. An audit of the project may be conducted by members of the FHEC.

- **Final Report.** A Final Report (see above address) is required within six months of the completion of the project**.**

If you have any queries on the information above or require further clarification please contact me at fhechealth@latrobe.edu.au.

On behalf of the Faculty of Health Sciences Faculty Human Ethics Committee, best wishes with your research!

Owen M Evans, PhD
Chair
Faculty Human Ethics Committee
Faculty of Health Sciences

Appendix B: Participant information and consent forms

Participant Information and Consent Forms developed for individual staff and volunteers

LA TROBE UNIVERSITY

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Bendigo
Albury-Wodonga
Mildura
Shepparton

Exploration of international case studies on community participation and health

PARTICIPANT INFORMATION STATEMENT

Individual staff and volunteers

Chief Investigator:

Dr Amanda Kenny, Associate Professor, Faculty of Health Sciences, La Trobe Rural Health School, PO Box 199, Bendigo, Victoria, 3552. Email: a.kenny@latrobe.edu.au

Co-Researcher:

Ms. Nerida Hyett, PhD Candidate, Faculty of Health Sciences, La Trobe Rural Health School, PO Box 199, Bendigo, Victoria, 3552. Phone: +61 3 54447432. Email: n.hyett@latrobe.edu.au

Co-Researcher:

Dr Virginia Dickson-Swift, Senior Lecturer and Research Fellow, Faculty of Health Sciences, La Trobe Rural Health School, PO Box 199, Bendigo, Victoria, 3552. Email: v.dickson-swift@latrobe.edu.au

Study overview

The aim of this study is to explore international case studies of community participation in health-related programs and services.

You have been invited to participate in this study because you are a staff member or volunteer within the selected organisation, and are able to share a useful perspective on the operations of the health program, and community participation processes used by this program.

If you choose to participate in this study you would be asked to:

- Participate in a semi-structured interview for approximately 60 minutes, which will be audio-recorded and transcribed verbatim

You might also be asked to:

ABN 64 804 735 113
CRICOS Provider 00115M

- Be accompanied by the researcher during your normal work day for a selected activity
- Have work site observations recorded in writing by the researcher on your program activities and operations
- Participate in an informal roundtable discussion about the program with other staff members or volunteers
- Provide copies of relevant public or non-confidential program reports to the researcher
- Provide written information by email
- Assist the researcher to identify other staff or volunteers who may be able to voluntarily participate in an interview that has additional consent procedures

The aim of these activities is to collect information on the following topics:

1. How the organisation facilitates community participation
2. How community participation contributes to program operations
3. What challenges were encountered in establishing effective community participation processes
4. What current challenges are encountered in sustaining effective community participation
5. What outcomes are achieved from effective community participation

Possible risks or benefits from participating in the study

It is unlikely that you will experience any distress by taking part in this study. However, should this occur, an appropriate confidential, online or in-person counselling service will be recommended that is accessible to you in your country/area.

You may chose not to answer any questions that cause you concern or distress.

Participation in the study is voluntary and unpaid, and we cannot guarantee that you will receive any benefits from taking part in the study.

There are no disadvantages, penalties, or adverse consequences for not participating or for withdrawing from the study. Importantly, your choice to not participate or to withdraw from the

study will have no impact on your relationship with your manager or organisation.

A summary of project findings will be sent to you for your feedback within three months of participation.

Distribution of research findings

Results will be presented at conferences and published in academic journals, reports may be published online through social media to disseminate research findings to the broader community.

No information will be included in any publication or presentation that could identify you personally, you will be assigned a pseudonym name and title so you can not be identified.

The name of your organisation will be identified, which will showcase your program internationally and may benefit your organisation profile. Alternatively, you can elect to have your organisation concealed by changing the name and address, although given the range of program information that is needed to be reported in the research to describe the program context and history, confidentiality of the organisation cannot be ensured.

No information will be reported that is defamatory, and copies of publications can be presented for review by your agency one month prior to publication by request.

Storage of confidential information

All information provided by you will remain confidential and will be disclosed only with your written permission, or as required by law. All electronic files and data will be stored in secure password protected files on a computer accessible only by the chief investigator and the co-researchers involved in this study. Upon completion of the study, any written data will be securely stored at La Trobe University for a period of five years. After this time, all information will be security shredded.

Right to withdraw consent

You have the right to withdraw from active participation in this project at any time and, further, to demand that data arising from your participation are not used in the research project provided that this right is exercised within two weeks of the completion of your participation in the project. You are asked to complete the “Withdrawal of Consent Form” or to notify the chief investigator by email or telephone that you wish to withdraw your consent for your data to be used in this research project.

LA TROBE RURAL HEALTH SCHOOL
Faculty of Health Sciences

If you are interested in participating in this study and/or have any questions regarding the study please contact Ms. Nerida Hyett, La Trobe Rural Health School, on telephone number +61 3 54447432, or email n.hyett@latrobe.edu.au.

If you have any complaints or concerns that the researcher has not been able to answer to your satisfaction, you may contact the Secretary, Faculty of Health Sciences Human Ethics Committee, Research Services, La Trobe University, Victoria, 3086, (phone +61 3 9479 3583, email fhechealth@latrobe.edu.au). Please quote FHEC application references number FHEC13/170.

Participant Information and Consent Forms developed for organisations and key spokespersons

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Exploration of international case studies on community participation and health

PARTICIPANT INFORMATION STATEMENT

Organisation and Key Spokesperson

Chief Investigator:

Dr Amanda Kenny, Associate Professor, Faculty of Health Sciences, La Trobe Rural Health School, PO Box 199, Bendigo, Victoria, 3552. Email: a.kenny@latrobe.edu.au

Co-Researcher:

Ms. Nerida Hyett, PhD Candidate, Faculty of Health Sciences, La Trobe Rural Health School, PO Box 199, Bendigo, Victoria, 3552. Phone: +61 3 54447432. Email: n.hyett@latrobe.edu.au

Co-Researcher:

Dr Virginia Dickson-Swift, Senior Lecturer and Research Fellow, Faculty of Health Sciences, La Trobe Rural Health School, PO Box 199, Bendigo, Victoria, 3552. Email: v.dickson-swift@latrobe.edu.au

Study overview

The aim of this study is to explore international case studies of community participation in health-related programs and services.

You are invited to participate in this study because you are a representative or key spokesperson of an organisation with an excellent health-related program, which utilises effective methods of community participation and engagement.

As a key spokesperson of the organisation, if you choose to participate in this study you would be asked to:

- Be accompanied by the researcher during your normal work day
- Permit researcher access to the organisation work site to observe usual program activities, or to attend meetings or interviews

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CRICOS Provider 00115M

- Have work site observations recorded in writing by the researcher on your program activities and operations
- Participate in a semi-structured interview for approximately 60 minutes, which will be audio-recorded and transcribed verbatim
- Provide copies of relevant public or non-confidential program reports to the researcher
- Respond to questions about program operations via email
- Have public social media and internet pages recorded, for example Twitter feeds, blogs or other webpages
- Have photographs and videos taken of the physical setting, not of people
- Assist the researcher to identify other staff or volunteers who may be able to voluntarily participate in an interview that has additional consent procedures

The aim of these activities is to collect information on the following topics:

1. How the organisation facilitates community participation
2. How community participation contributes to program operations
3. What challenges were encountered in establishing effective community participation processes
4. What current challenges are encountered in sustaining effective community participation
5. What outcomes are achieved from effective community participation

Possible risks or benefits from participating in the study

It is unlikely that you will experience any distress by taking part in this study. However, should this occur, an appropriate, confidential counselling service will be recommended that is accessible to you in your country/area.

You may chose not to answer any questions that cause you concern or distress.

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There are no disadvantages, penalties, or adverse consequences for not participating or for withdrawing from the study.

A summary of project findings will be sent to you for feedback within three months of participating.

Distribution of research findings

Results will be presented at conferences and published in academic journals. Additionally, reports may be published online through social media to disseminate research findings to broader audiences

No information will be included in any publication or presentation that could identify you personally. You will be assigned a pseudonym name and title so you can not be identified.

The name of your organisation will be identified, which will showcase your program internationally and may benefit your organisation profile. Alternatively, you can elect to have your organisation concealed by changing the name and address, although given the range of program information that is needed to be reported in the research to describe the program context and history, confidentiality of the organisation cannot be ensured.

No information will be reported that is defamatory, and copies of publications can be presented for review by your agency one month prior to publication at your request.

Storage of confidential information

All information provided by you will remain confidential and will be disclosed only with your written permission, or as required by law. All electronic files and data will be stored in secure password protected files on a computer accessible only by the chief investigator and the co-researchers involved in this study. Upon completion of the study, any written data will be securely stored at La Trobe University for a period of five years. After this time, all information will be security shredded.

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If you are interested in participating in this study and/or have any questions regarding the study please contact Ms. Nerida Hyett, PhD Student, La Trobe Rural Health School, on telephone number +61 3 54447432, or email n.hyett@latrobe.edu.au.

If you have any complaints or concerns that the researcher has not been able to answer to your satisfaction, you may contact the Secretary, Faculty of Health Sciences Human Ethics Committee, Research Services, La Trobe University, Victoria, 3086, (phone +61 3 9479 3583, email fhechealth@latrobe.edu.au). Please quote FHEC application references number FHEC13/170.

Appendix C: Example interview questions

Global question	Probe questions
What are the key components of effective and meaningful participation?	What would you identify as the key components of participation? How is your participation effective? How is it meaningful to people involved? Is it both at all times? Has it been ineffective at times? Or not meaningful?
Who initiates community participation, and does this influence process and outcomes? (community versus power holders initiation) Why is community participation initiative/enacted?	How was this program initiated? Did this or does this influence processes? Who was/in control? What motivates community members to participate, why do they choose to become involved? What are your reasons for participating?
How does community participation happen?	What are the processes for facilitating community participation? What are the barriers? What are the outcomes? How is this measured? How are different people involved? What structures are in place to enable participation? Policies, procedures, safety/risk guidelines? Does coproduction changes outcomes? What do you see as empowering about your program? How would you describe this?
How are key issues such as power, leadership and ownership negotiated?	How are decisions made? How has final say? Has this changed over time? Who are community leaders? How were these identified?
How is participation maintained? Is this cost-effective? (sustainability)	How is this program maintained? Funding? Cost-effective? Loss? What other factors contribute to sustainability of this program? Do you anticipate that the program will sustain itself into the future?
What are the outcomes for community (health literacy, other personal	What are the outcomes? Social, health, wellness, community, environmental, political,

development, civic responsibility and social capital)?	for children, families, adults, older people, migrants, special groups
Who is included in participatory approaches? Who is excluded?	Who is included, who isn't, what efforts have you made to include people, what extra efforts have you made to include special groups?
How is organisational and community readiness determined? (What happens when they are not ready?)	How did you know that the community was ready? What assessments did you make? How were citizens mobilised? What were motivating/mitigating factors?

Appendix D: Example of field observations and researcher reflections

Field Notes

[name removed] tour of facilities

[name removed]
Executive Director

[name removed]
Community Food Hub, Canada

Mission

[name removed] uses food as a vehicle to break social and economic isolation between generations and cultures. They use creativity and community collaboration to build capacity and health, using novel approaches to active youth engagement, urban food systems, food security and community care.

History

[name removed] was started in 1995 by two young people working in hospitality. The non-profit organisation was initiated because of increasing community concerns about health problems and lack of support from public sector and governments. The two young people were successful in obtaining a government grant, and since have obtained other funds from grants and fundraising, and utilise a large bank of volunteers. Success was in the context of high youth unemployment and public concerns about health, economy, and community wellbeing.

Relevant documents/social media: newsletters, Facebook page, principles of engagement report, annual reports, financial statements, and 2012 report on community engagement model

Programs and activities

Holistic meals on wheels

Student training

Intergenerational social activities

Edible campus garden at nearby University

Meal program for students

Urban agriculture

One off initiatives aimed at increasing food security of vulnerable groups (Question: which groups, success? Challenges?)

Supporting local growers (100 mile radius dinners)

Student volunteer program, linked with vocational training/tertiary studies

Social events (Question: who attends? Funding? Burden/burn out?)

Fundraising

Food donations to people and groups

Bicycle repair shop (social enterprise model)

Questions asked during program site tour

How are priorities identified? (refer to engagement strategy document)

Who contributes? (university students, TAFE students, older people, middle class foodies)

Who doesn't participate? (they are unable to support people to volunteer who have severe illness/disabilities)

How are efforts maintained? Funding? Partnerships? (fundraising, philanthropic, government funding for MoW program, private funded, income from enterprises)

How are volunteers recruited (newsletter, university partnership)? (and word of mouth)

What have been the major challenges? (sustainability, income)

What are the minor daily challenges? (working with volunteers, providing a good service)

[name removed] is a community organisation based in central Montreal. It is located in an affluent neighbourhood, and has been in this location since they purchased the building of three years ago. [name removed] meets with us for the tour, he vaguely remembered what we were visiting about and seemed a little apprehensive about investing too much of his time.

The building is on a corner block, it is a block shaped building, neighboured by beautiful terrace houses is a gentrified area of the city, buzzing with students from the nearby universities. The building has a notice board outside that explains the social features of the building and about the greenhouse and rooftop urban agriculture project. [name removed] commented that Montreal roofs were made for snow, they are flat roofed buildings, which are also suited to roof top gardens.

[name removed] is quietly busy, volunteers and staff sit at computers in an open office setting. Shortly after we arrive a group of young people are getting comfortable in the sofa

area, eating chocolate cake and greatly each other warmly. [name removed] explains they are the evening shift at [name removed], here to meet before their delivery shift.

Volunteers nominate themselves for a shift using the communal notice board, marking in pencil when they are able to work, and selecting what type of duty they would like to do for that day. The calendar is full and it seems that they have no shortage of volunteers. This is a social space and it feels comfortable, and as if people are enjoying themselves here, and like the work that they do.

There are three types of shifts people can volunteer for related to food, including phone service, cooking and preparation, delivery. Volunteers also run the bike shop, man phones, and engage in other innovative projects using this space. There are some staff around, but most others are interns who are doing an internship in agriculture, sponsored by the city, aiming to improve youth pathways into agriculture.

The building is on 4 levels. In the basement there is a food storage facility, where food is stored for distribution or used in cooking. There is a long workshop bench and a walk in refrigerator. This is a reasonably large room and is not over cluttered. The back entrance to the building on the lower floor is the bike shop. Here there are bike parts and equipment here so that volunteers can help people fix their bikes, aiming to encourage cycling, and to use for revenue. Community members can pay for a one off visit, or a year membership fee. Bike parts and second hand parts are also for sale. The philosophy here is that, people will help you to fix your bike, rather than do it for you. On a nice, busy day the back terrace can fill with 20-30 people waiting for help to have their bike fixed. This initially had potential to cause conflict with local bikes shops, which is not what [name removed] want to do, and they are mindful of making sure they're not inferring with local shops as much possible.

On the ground floor level there is a large commercial kitchen, kitted out with stoves, steel benches, and trays of fruit salad and packaged fresh food. The meals are distributed at $4.50 each which includes 2 sides, but cost $10-11 to make. Today's meal is Sheppard’s pie. [name removed] distributes an annual calendar which details what meal will be served that day, and this is planned for the year. Clients can call ahead and make a special consideration before 10am that morning if they wish, and this might mean asking for a vegetarian option, or paying extra to choose a dessert. This process adds another mechanism for engaging with their client group and building relationships between the clients, the organisation and the staff.

The core principles of [name removed] developed through the people involved with the work that they do, and are influenced by past and current political climate and issues such as high youth unemployment, and high loneliness among urban elderly city residents. In this way the organisation developed out of community need, youth entrepreneurship, and early success with grants and interest from philanthropic organisations. Most young people here are well educated and come from educated, middle class families, and [name removed] mentions they can only manage so much here and there are limitations to what they can do, who they can include, and who they have to exclude (e.g. people with more complex needs). He also mentions that currently their building is not accessible beyond the ground floor by people with gait issues/in wheelchairs, which he is unhappy with and would like to change with future funding.

Achievements of [name removed] have grown from champions and innovation, the values embedded in the work they do, and from social relationships and a good reputation. Essentially they are a non-government meals on wheels service for elderly people, and people qualify for the service through hospital assessment programs, and this might be a short term arrangement for people with injuries, or a long term arrangement for elderly people who are finding it difficult to cope alone. Some of the feedback he has had so far has suggested that clients enjoy the quality of the food, and I would imagine that having choice in the food (equal) is empowering those who might otherwise be 'given' food they have no choice over and do not like, by an unnamed person from an unnamed agency. [name removed] talks about how the meal delivery turns into something else, people can then come along to events, or participate in other projects with volunteers and staff, so the business is a vehicle for larger participatory activities.

This agency provides service all over the city on 8 different routes, they are not capped and do not have a waiting list, but earlier this year were up 19% on usual client numbers. Volunteers delivery staff use bikes or public transport to deliver food across the city, bikes and bus tickets are provided if the person does not have them. A van is used to get food to the greater city area on the over side of the mountain.

The shift system has been successful for a long time, and only occasionally do people not show up to shifts, which might demonstrate high ownership and respect for the agency by the youth community. By marking, 'new' on the roster, young people can sign up to shifts and learn new skills from the variety of work that is available. [name removed] explains variety and fun are key components of this model, and is a way of keeping people interested and engaged in volunteering.

This is also a space for young people to present their own ideas eg. A new Bee keeping collective has recently started, and an Urban fruit recovery project - people call to volunteer fruit from their garden, this is picked by volunteers, distributed 1/3 to each of the owner, volunteers and to the organisation

They state that the key to engagement is in day to day operations and in long term vision and commitment to social change.

Program acts as a safety check for elderly people who live alone, day to day check for safety, risk e.g. Heating in home appropriate, phone call on time, appearance/behaviour as usual... Then able to contact workers they know if needed (on an informal level, this is not formalised, nor is there a partnership agreement or funds for service). This is done between delivery shift volunteer and stay back manager in an informal way.

Funding for current programs
1/3 government
1/3 philanthropic
1/3 SR revenue

Garden space is provided by nearby university, and in exchange for greening their space they provide this for use.

Who participates

Young people, students, new graduates, educated, middle class, might be worried about employment, creative and has an idea, altruistic

Learn about urban agriculture, cooking, nutrition, social issues, enterprise, food security, social relationships, communicating with older people, needs of older people, being an employee (shift work), bikes and bike repairs, health organisation, risk and safety related to working with people

Participation
Phone calls relating to food and meals delivery, and to invite people to AGMs and board meetings or events (warm welcome committee) Social events Informal contact Shift workers Farming Markets Bike shop Social media Average age of client is 77

Who doesn't
People with high needs, people in wheelchairs or have physical mobility difficulties

What challenges?
Some things don't work, and we have learn by experimenting and we won't do these again, either not sustainable, or not in line with core values/practices E.g. Fundraising by second hand clothing sales, or running a bazaar

Outgrew old building, and also sustainability of service was threatened by a new building owner who didn't align with philanthropic principles and operations. Bought a new building with money raised and from funding, 1m plus 1.8m for infrastructure. Much more infrastructure now than what they had before. Also now have increased visibility and space.

Revenue raising is an ongoing consideration and they have several streams including room hire to community groups. This was neutral in past 3 years and is only starting to turn profit now, this has been difficult and has used staff time/wages to get it to work. In future, should be a useful source of revenue but currently reliable.

Outcomes?
Meals, market, school education, distribution of subsidised healthy food in low income neighbourhood through market, distribution of healthy food through kitchen and garden to volunteers at cost or reduced cost value, education of volunteers on agriculture, improved pathways into agriculture?

Question: Does this improve food literacy. (People learn about urban agriculture)

Funding?
Initial funding from Philanthropic foundation - can you scale up what you do? Created key principles based on what they were doing to share model of how it works.

Notes for follow up:
Has anyone else replicated this work? Program model?
Check evaluation report to code outcomes from this program