

Partnerships and Participation of Community Residents in Health Promotion and Prevention: Experiences of the Highfield Community Enrichment Project (Better Beginnings, Better Futures)

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Abstract

We provide a description and analysis of the role of partnerships between community residents and service-providers in planning and implementing a health promotion/prevention programme for children and families. The context for this study is the Highfield Community Enrichment Project, a multi-component, community-based promotion/prevention project operating in Toronto, Ontario, Canada. The nature and amount of resident participation in this project are described, as well as barriers to resident participation and strategies to reduce those barriers. The findings are interpreted in terms of empowerment and partnership theory, and the implications of these findings for involving citizens from low-income communities in planning promotion/prevention programmes are discussed.

Keywords

citizen participation, community, partnerships, prevention

THE OVERALL focus of this article is on the participation of disadvantaged community members in promotion/prevention projects and how to enhance their participation. Using the concepts of partnership and empowerment as a theoretical perspective, we describe and analyse citizen participation in one specific promotion/prevention project in Toronto, Canada—the Highfield Community Enrichment Project (the real name of the project). This project is designed to enhance the health of children, families and the community and to prevent cognitive, social and health problems of children. It is part of a larger initiative, the ‘Better Beginnings, Better Futures Project’, a longitudinal, community-driven promotion/prevention project operating in eight communities throughout the province of Ontario (Peters, Arnold, Petrunka, Angus, Brophy, Burke, Cameron, Evers, Herry, Levesque, Pancer, Roberts-Fiati, Towson, & Warren, 2000). The Highfield project is an exemplar of community health psychology, which is the theme of this special issue. We begin by contrasting traditional health psychology with community health psychology. Next we introduce the concepts of partnership and empowerment and review relevant research on resident participation in promotion/prevention projects.

Reorienting health psychology

Health psychology emerged from clinical psychology and social psychology in the late 1970s. While health psychology pays lip service to a biopsychosocial approach, it has, for the most part, retained an individualistic emphasis, as can be seen in the dominance of stress and coping and social cognition models of psychological processes that are associated with various diseases (see Marks, Murray, Evans, & Willig, 2000). While health psychology has branched out from one-to-one clinical interventions into health promotion and disease prevention, the focus has remained on the health status of individuals, including both disease (e.g. cardiovascular disease) and lifestyle habits and psychological characteristics related to disease (e.g. eating habits, exercise, smoking, personality types, social cognitive processes). Thus, traditional health psychology

has tended to have a very individualistic or psycho-centric view of health.

In contrast, community health psychology takes a broader view of health and well-being, focusing on the transactions between individuals and their social environments. For example, the *Ottawa Charter for Health Promotion* (World Health Organization, 1986) and the Canadian federal report *Mental health for Canadians: Striking a balance* (Epp, 1988) advanced the notion that health is more than an individual attribute; health also includes community development, equality and social justice. Community health psychology goes beyond health status in defining health in terms of an ecological, strengths perspective as: (a) the development of competence and self-efficacy; (b) active participation in multiple settings; and (c) the acquisition of valued resources, such as education, housing and income (Nelson, Lord, & Ochocka, 2001; Prilleltensky, Nelson, & Peirson, 2001).

Community health psychology also differs from mainstream health psychology in several other ways (Murray, Nelson, Poland, Matycka-Tyndale, Ferris, Lavoie, Cameron, & Prkachin, 2001). First, community health psychology contextualizes health by taking power inequalities and multiple ecological levels of analysis (micro, meso, macro) into account (Febbraro, 1994). Mainstream health psychology may use an ecological analysis, but typically it ignores the macro level and power inequalities, which are major social determinants of health (see Prilleltensky & Nelson, 2002, ch. 8). Second, community health psychology emphasizes the strengths of disadvantaged people and encourages their active participation and control in research and action that focuses on their health issues (Tolman & Brydon-Miller, 2000). Whereas many health promotion interventions are directed by professional ‘experts’, community health psychology emphasizes community-driven promotion/prevention approaches that involve a partnership between professionals and disadvantaged people (Nelson, Prilleltensky, & Peters, 2003). Third, in contrast with mainstream health psychology, community health psychology interventions strive to change social conditions that affect the health of disadvantaged people (Febbraro, 1994; Prilleltensky & Nelson, 2002).

Often, prevention demonstration programmes are driven by researchers and professionals (Nelson et al., 2003). Moreover, professionally driven approaches to programme development tend to focus on developing a programme model that has a solid theoretical and empirical basis. When professionals adopt this 'expert' approach to prevention, they tend to take control away from the community, promote a power imbalance between residents and professionals, emphasize deficits rather than the strengths of community members and limit the opportunities of people to take charge and help themselves. Another problem with professionally driven programmes is that they are often supported for a time-limited period by research grants, only to end when the research is completed.

Conceptualizing resident participation in promotion/prevention projects: partnership and empowerment

In contrast to the professionally driven health promotion that is characteristic of mainstream health psychology, community health psychology utilizes a value-driven partnership approach that emphasizes the active participation of community residents, particularly low-income and disadvantaged citizens (Nelson, Amio, Prilleltensky, & Nickels, 2000). Elsewhere, we have defined the concept of value-based partnerships as: 'relationships between community psychologists, oppressed groups, and other stakeholders that strive to advance the values of caring, compassion, community, health, self-determination, participation, power-sharing, human diversity, and social justice for oppressed groups' (Nelson, Prilleltensky, & MacGillivray, 2001, p. 651). To develop value-based partnerships for prevention, Nelson et al. (2000) argued that there are three steps that should precede the delineation of programme goals, activities and evaluation (i.e. creation of the programme model): (a) forming the partnership; (b) deciding on the vision and values of the partnership; and (c) identifying and merging the strengths of the different partners.

With respect to the first step, it is essential to identify key stakeholders and to create a forum

for stakeholders to come together to form a partnership (Peirson & Prilleltensky, 1994). While researchers typically involve service-providers and teachers in planning community and school promotion/prevention programmes, there is little research literature that describes partnerships in which the intended beneficiaries of the programme, disadvantaged citizens, participate or have a say in the intervention process (for an exception, see Comer, 1980). According to Heller, Price, Reinhartz, Riger and Wandersman, citizen participation can be defined as 'a process in which individuals take part in decision making in the institutions, programs, and environments that affect them' (1984, p. 339). Arnstein (1969) has constructed a 'ladder' of citizen participation that differentiates the amount and depth of participation. According to Arnstein, citizen participation can range from minimal and token levels to meaningful citizen control and decision-making power. Moreover, fundamental questions, like 'Who will benefit?', and 'Who will control the process?' need to be addressed in frank discussions before proceeding with the partnership (Lord & Church, 1998). Professionals need to find out what community residents want and need in community-based projects.

A second important step in a partnership is to clarify the vision, values and working principles. Values and ground rules about how those values will be enacted form the foundation of the partnership and have been shown to be important for the implementation of promotion/prevention projects (Prilleltensky, Peirson, & Nelson, 1997). However, consideration of the values underlying the partnership is often neglected. Developing a shared vision and values is important both for getting the partners 'on the same page', but also as a guide for partnership activities. Partnership values, such as collaboration, democratic participation, power-sharing, solidarity, trust and reciprocity, may be quite important for promoting citizen participation in the creation of prevention programmes.

A third step is to identify and merge the strengths of the different partners. The importance of the collaborative nature of the partnership that builds on the strengths and assets of all stakeholders cannot be underestimated (Kretzmann & McKnight, 1993). Prevention

researchers and service-providers typically bring scientific and professional knowledge to partnerships, while disadvantaged people bring experiential knowledge, including an understanding of their local context. All of these types of knowledge are valuable and need to be pooled in an equal partnership (Kress, Cimring, & Elias, 1997).

Value-based partnerships are guided by a philosophy of empowerment. The Cornell Empowerment Group has defined empowerment as 'an intentional ongoing process centered in the local community, involving mutual respect, critical reflection, caring, and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources' (1989, p. 1). Like other conceptualizations of empowerment (Wandersman & Florin, 2000; Zimmerman, 2000), this definition suggests that empowerment consists of both process and outcomes that occur at multiple levels of analysis (individual, organizational, community). Empowering processes are those that provide people with opportunities for participation, while empowered outcomes refer to increased control and acquisition of resources on the part of disadvantaged community members (Wandersman & Florin, 2000; Zimmerman, 2000). Value-based partnerships are designed to promote empowering processes and empowered outcomes for disadvantaged citizens and their communities.

What does the literature tell us about the participation of disadvantaged citizens in the planning and implementation of community-based promotion/prevention projects? First, qualitative research with low-income parents participating in the creation of supportive services for their children and families has found that low-income parents can play active roles, including leadership roles, in such projects, and that there are many benefits of resident participation to the residents themselves, the programmes that are created and the community as a whole (Cameron & Cadell, 1999; Cameron, Peirson, & Pancer, 1994; Pancer & Cameron, 1994).

Second, literature from a variety of different types of partnerships has suggested a number of processes that inhibit or facilitate resident participation (Cameron & Cadell, 1999;

Cameron et al., 1994; MacGillivray & Nelson, 1998; Nelson, Prilleltensky, & MacGillivray, 2001; Peirson & Prilleltensky, 1994; Wandersman & Florin, 2000). Some of the barriers to resident participation that have been identified include professional power and control issues, inaccessible meetings and costs, residents' lack of training, knowledge and information, professionals' lack of skills for involving residents and ineffective communication patterns between professionals and citizens. Language and cultural differences have also been shown to be barriers to accessing mental health services for immigrants and refugees (Beiser, Gill, & Edwards, 1993). On the other hand, strategies that facilitate resident participation include developing shared values and norms, mandating minimum levels of participation (a quota for residents on committees), encouraging professionals to share power and resources, enhancing accessibility and providing concrete supports, providing many different avenues for participation, training and supporting residents for their roles, enhancing the interpersonal skills, sensitivities and openness to change of professionals and improving communication. The key to all of these strategies is that they break down the social distance and power differentials between professionals and residents and build relationships and trust between these two groups (Derksen & Nelson, 1995). Moreover, building relationships and trust takes time.

Purpose and research questions

The purpose of this research is to examine the participation of citizens from a low-income community in a promotion/prevention project. The primary partners or stakeholders in this project include project staff, service-providers (including teachers) and community residents. The main research questions are as follows:

1. What is the nature and amount of resident participation in the partnership?
2. What factors inhibit and facilitate resident participation in the partnership?

The Highfield Community Enrichment Project: a case study

Context—Better Beginnings, Better Futures: a prevention policy research demonstration project

Better Beginnings, Better Futures is a community-based, promotion/prevention policy research demonstration project (Peters, 1994). The project is funded by the Ontario Ministries of Community and Social Services, Education and Training and Health and Long-term Care. Based in eight economically disadvantaged communities in Ontario, Canada, the project has three major goals: (a) the prevention of problems in young children; (b) the promotion of competence and health of young children; and (c) strengthening vulnerable families and communities. In strengthening the health of children, families and the community, it is presumed that health and social problems will be prevented. During the demonstration phase (from 1993 to 1998), the project provided four years of intervention for one of two groups of children: birth to age four (in five of the sites) or age four to age eight (in three of the sites). Since the end of the demonstration phase, the provincial government has continued to provide funding for the eight sites. Better Beginnings is a universal programme for all families with young children in the community. Specific individuals are not targeted for intervention based on risk factors.

The Highfield community The Highfield Community Enrichment Project is located on the grounds of Highfield Junior School (which serves children from Junior Kindergarten (JK) to grade 5) in the northwest end of Metro Toronto (Pancer, Nelson, Dearing, Dearing, Hayward, & Peters, 2003). Office space for project staff, meeting rooms, the research office and the Family Resource Centre are located in portables adjacent to the school. Most of the project's programmes are undertaken within the school, on school grounds, in project portables or in parents' homes. For the outsider, it is sometimes difficult to distinguish the project from the school.

The Highfield community is one with a great

deal of ethnoracial diversity and is the home to many new Canadian families. According to the Canadian census, 54 per cent of the area's population was born outside Canada in 1991, and this percentage had risen to 60 per cent by 1996. While people from all over the world live in this neighbourhood, the two largest ethnocultural groups are those people from India and the Caribbean. The number of students at Highfield Junior School increased substantially over the years from 518 in 1990 when the proposal was submitted to 888 students in 1995, which led to an addition being built onto the school.

This area is also socio-economically disadvantaged. Unemployment rates for men (14.1 per cent in 1991 and 13.3 per cent in 1996) and women (12.6 per cent in 1991 and 17.5 per cent in 1996) living in the community have been considerably higher than the provincial averages for men (8.6 per cent in 1991 and 8.7 per cent in 1996) and women (8.4 per cent in 1991 and 9.6 per cent in 1996). The mean family income in 1990 was \$43,841 compared to the provincial average of \$57,227. By 1995, family income had dropped by 18 per cent to \$36,054, while the provincial average increased by 4.5 per cent to \$59,830.

The Highfield Community Enrichment Project Partnerships began to develop in the Highfield community when there was a call for proposals for the Better Beginnings, Better Futures programme in 1990. The design of projects, as outlined in the guidelines for proposals, was to emphasize inter-sectoral partnerships among service-providers, a high degree of resident participation and a multi-component intervention with programmes for children, families and the community. To this end, a core group of seven service-providers and one community resident came together to plan and submit a proposal for the Highfield site. The key service-providers included representatives from the three sectors that were providing funding for the project: education (the Principal from Highfield Junior School); community and social services (representatives from two agencies); and health (a public health nurse).

Since there were only three to four months available to develop the basic elements of a programme model and to submit the proposal, a great deal of time was required of the core

group to complete all the necessary work. A needs survey was conducted with residents to determine the types of programmes that should be offered. The results of this survey led to an emphasis on three areas of programme development: (a) in-school programmes; (b) family support programmes; and (c) community development initiatives. Following the survey, parents were invited to the school to hear about and to discuss the results of the survey in small groups. With child care and translation provided at the meeting, about 70 to 80 parents attended this meeting and gave further input on what they wanted within their community.

Based on this input, the core group submitted a proposal in 1990, and in 1991, they learned that they were successful in the competition. Site researchers began working with Highfield residents in 1991, and in 1992 a Project Manager was hired. In 1992, the programme model was fine tuned and approved by government and staff were hired. Implementation of programmes began in 1993. Thus, more than two years was devoted to project planning and start-up.

Research organization, methodology and process

The Research Co-ordination Unit (RCU) coordinates the research at Highfield and at the seven other project sites across the province. The RCU consists of an interdisciplinary team of researchers from several Ontario universities, support staff and site research teams (which include Site Researchers, RCU Site Liaisons, Research Assistants and Site Research Committees). There are two main components to the research: a quantitative outcome component and a qualitative component that focuses on how the programme developed in each of the project sites. The quantitative component is used to answer the questions of how effective and affordable the programmes are, while the qualitative component is used to examine the structures and processes associated with project results. The outcomes from the quantitative component of the research over the first five years of operation (the 'demonstration' phase) are reported elsewhere (Pancer et al., 2003; Peters, Petrunka, & Arnold, 2003; Peters et al., 2000).

In this article, we utilize primarily the

qualitative research data to generate a case study of the Highfield project (Yin, 1989). Through attendance at project meetings and activities, Site Researchers and the Site Liaison collected descriptive (semi-verbatim recordings of what people said) and analytic (impressions and reflections) field notes. These field notes were entered into a software package called Ethnograph (Seidel, Kjolseth, & Seymour, 1988) and were coded into major programme themes (e.g. resident participation) and sub-themes (e.g. barriers to participation). Researchers also examined programme documents, such as Project Managers' six-month reports to government, newsletters and minutes of meetings not attended. Finally, individual and group interviews were periodically conducted with residents, programme staff and service-providers on particular topics (e.g. programme model, project management). Like the field notes, the qualitative interview data were coded into major programme themes and sub-themes.

The qualitative data were collected beginning in 1991 and through 1998. Over the course of the qualitative research, the researchers wrote reports on: (a) the development of the proposal; (b) resident participation; (c) service-provider involvement; (d) the programme model; and (e) project management. In 1998, the researchers conducted additional interviews to provide current information on these issues and wrote updates of each of these reports, except for the proposal development report.

The research at Highfield was guided by a local Research Committee, which met roughly every other month from 1991 through 1999. The meetings were typically held over the lunch hour and included lunch for committee members. The committee consisted of the researchers, teachers, parents, the Project Manager and service-providers and was chaired for much of the time by a community resident. The role of the committee was to steer all aspects of the research. Members of the Research Committee and those who provided information for the different reports were provided with the opportunity to read and provide feedback on each report, and after review, the Research Committee and the Executive Team approved each report. One community resident read and gave us feedback on this article.

Findings regarding partnership processes

An overview of the findings is presented in Fig. 1. The nature and amount of resident participation was influenced by barriers and strategies employed by the project to overcome those barriers.

Nature and amount of resident participation in the partnership

As we noted earlier, only one parent was involved in the development of the proposal. However, after the project was funded, a core group of about 10 residents (nine women and one man), became very active in the planning and start-up phase of the project. They participated on the project's Steering Committee and on numerous sub-committees of the project; they went door-knocking in the neighbourhood to tell residents about the project and encourage them to get involved; they hired staff; and they played a leadership role in chairing meetings and speaking on behalf of the project in the community. There are three main findings regarding the first research question about the nature and amount of resident participation in the Highfield project: (a) resident participation increased over time; (b) residents participated in many different ways; and (c) some residents assumed leadership roles within the project (see Fig. 1).

First, there is evidence that as parents became more familiar and comfortable with the project, their level of participation increased. Residents moved from minimal levels of participation to substantial participation and decision making (Arnstein, 1969):

... a lot of the parents were hesitant in coming on board because it seemed so big and overwhelming ... and 'what are they talking about?' ... and they didn't really understand ... it had to be explained several times before parents really understood what the project was about and even then they were hesitant on coming on board because of all the agency people. There's a lot of distrust with the CAS [child protection agency] and people were very hesitant ... 'we don't know those big words', 'we're not government people', ... 'we can't talk with them' ... we were also feeling 'what if our personal lives are dug into?' ... so there was a lot of fear. (community resident)

The first time I sat on the [Steering Committee], I didn't say anything because I was scared if I said anything it might come out wrong ... so I just sat because I was so scared [that] if I said anything they would laugh at me. (community resident)

Just as the qualitative data show increased resident participation in project committees over time, quantitative data show that residents also participated more over time in programmes provided by the project. For instance, for the six-month period from April 1993 to September 1993, 651 parents and 904 children used the project's Family Resource Centre. This increased to 1247 parents and 1502 children for the six-month period from October 1994 to March 1995. We conducted interviews with 50 parents at two different time periods (when their children were in JK in 1993–1994 and Senior Kindergarten (SK) in 1994–1995) on a variety of different topics, including participation in Highfield programmes. During JK, parents and their children used the different family support programmes (home visitation, toy lending library, play groups, drop-in) less than five times (on average); while during SK, the average number of times that parents and children participated (on average) in these programmes increased substantially (home visitation—six times, toy lending library—13 times, play groups—18 times, drop-in—34 times).

Second, residents participated in a variety of different ways within the project. Consistent with Arnstein's (1969) conceptualization of a ladder of citizen participation, the types of participation differed dramatically in the level of responsibility, leadership and decision-making power experienced by residents. The least demanding and most frequent type of participation involved participation in the programmes themselves. The programmes ranged from small English as a Second Language (ESL) classes for adults to hundreds of people attending a community breakfast or festival.

Another type of participation involved working as unpaid volunteers in the school or in project programmes on a regular basis. Volunteer participation increased over the course of the project:

We have an increased number of volunteers

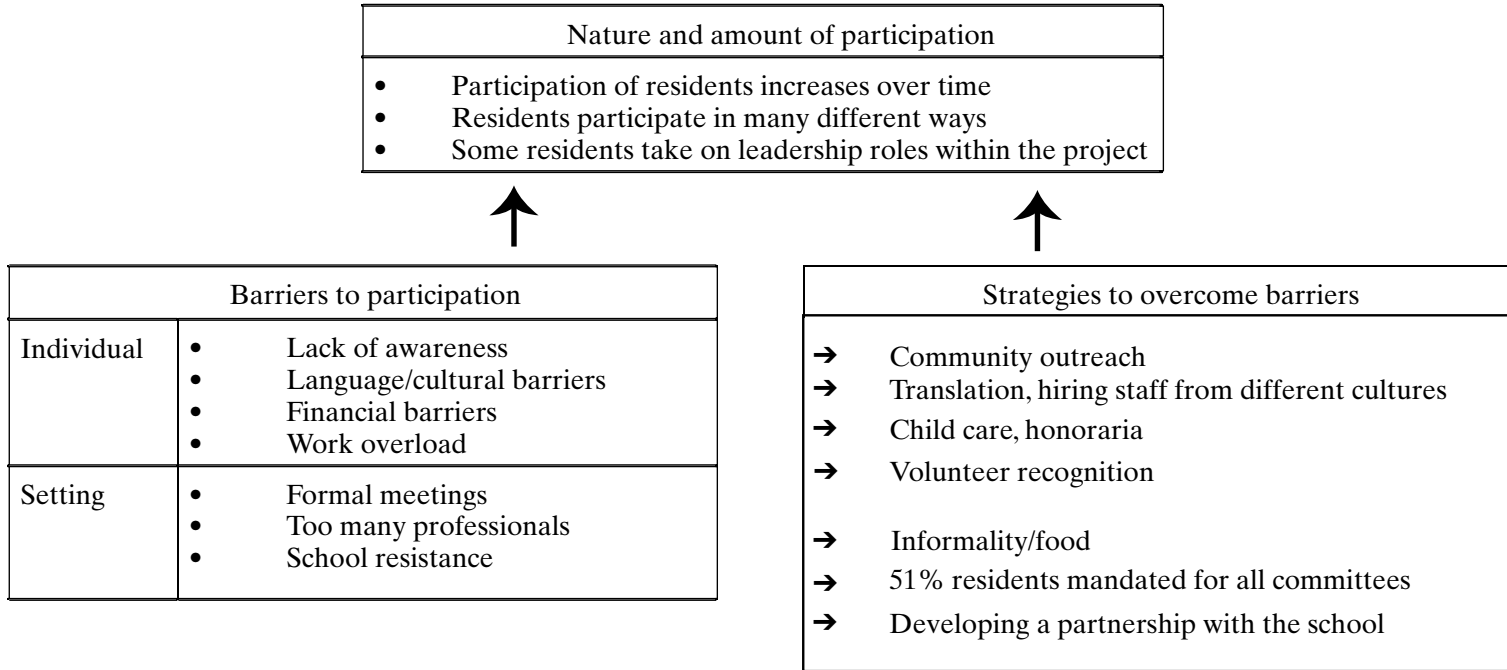


Figure 1. Nature and amount of participation, barriers and strategies to overcome barriers.

than years ago . . . I think that's been the major goal. (project staff member)

It's a bigger group. Lots of grandmas, especially in the snack [programme] in the kitchen. (project staff member)

Some community events were jointly planned by project staff and members of different ethnic groups. For example, the South Asian community collaborated with the project to organize events that celebrate South Asian holidays; the Black community worked with the project to plan activities for Black history month each February; and members of different ethnic groups assisted in the planning of a multicultural caravan held at the school. These events and the planning for them have been important vehicles for forging relationships between the project and the different ethnoracial groups that reside in the community.

Residents were also hired by the project. In 1996, 11 of the 17 full-time and part-time paid project staff were community residents. Some of these staff began their involvement with the project in a volunteer capacity. Also, some residents did occasional work for the project on a fee-for-service basis. Part of the motivation for hiring residents as staff was to reflect the ethnoracial diversity of the community:

The original vision was to have the community have this 51 per cent ownership . . . and that is [happening] in the staff [as well] . . . It creates that circle [between the project and the community] and it could not have been done any other way. (service-provider)

What we try to do is hire people that reflect the community. So, for example, the family visitors, there was a West Indian, someone from the black community, the South Asian community, and there's someone from the Spanish community . . . So we have a number of different people from different backgrounds working within the project and that was what we set out to do. (project staff member)

Finally, residents participated on committees or on the project's Executive Team (formerly the Steering Committee). This type of participation requires decision-making responsibility on the

part of residents, which ties in with the third main finding regarding the nature and amount of resident participation; some residents grew into leadership roles with the project. As residents become more comfortable, they are better able to participate in project decision making, and this participation further reinforces and sustains their participation:

I think the parents have taken on a lot more leadership roles. With chairing and co-chairing and taking responsibility—especially when you have Principals and teachers at the meetings, in trying to keep them on time and keep them on topic, and that's kind of hard. It can be intimidating. (project staff member)

Several residents who participated at this level became involved in advocacy and lobbying politicians and others:

[One parent] did the Policy Forum with four children's ministries. Quite incredible. [This parent and a parent from another Better Beginnings site] had a room of 80 senior officials in tears. Reality of what's life like. Really good presentation . . . This parent also did a Poverty conference. The approach [this parent] took was to talk about her riches, even though she doesn't have any money. She did that on her own. (project staff member)

While some residents took on leadership roles, there was difficulty recruiting new residents into committee work and leadership roles. Comments about this issue became a familiar refrain in the story of the project:

[We] need more parent representation on [the Executive Team] . . . It's a challenge. (community resident)

I guess the challenge is . . . that we're not good at growing leaders, and I guess the question becomes 'How do you do that?' (project staff member)

It's easier for us to get people to come in and help in the kitchen or help on a trip or help with skating than it is to get people to come and work on committees and do those sorts of things. (project staff member)

Barriers and strategies to facilitate participation Regarding the second research question

about factors that inhibited and facilitated resident participation in the project, we identified several barriers to resident participation. These barriers can be conceptualized as characteristics of individuals or the setting (the Highfield project). The project developed strategies to overcome each of these barriers. Beginning with individual barriers, lack of awareness of the project was a barrier to participation. The project initially tried to overcome this barrier through advertising and outreach efforts, such as volunteers and staff going door-to-door in the neighbourhood, holding 'get to know you' events, making presentations on cable television and holding a volunteer recruitment forum in a local mall. Over time, as the project offered a number of different programmes, residents became more aware of and active in the project through their participation in programmes.

Language and cultural differences in the community were identified as barriers: 'Language is a barrier, a major, major barrier. I remember trying to get them involved in the parents' group and it was a major problem' (community resident). The project sought to overcome these barriers by providing information in several different languages, using interpreters at different events (e.g. parent-teacher interviews), offering some programmes in different languages (e.g. parent group in Punjabi), having ESL classes and hiring staff from the different ethnic backgrounds, who could speak to people in their native language and who understood the different cultures: 'What we've done is worked with another agency to get 25 people trained as cultural interpreters . . . so a number of those people are on our staff' (project staff member).

Tangible, financial barriers inhibited resident participation in committee work. Providing child care, covering residents' travel costs and providing lunch or snacks were ways that the project used to overcome these barriers. As well, financial honoraria were sometimes used to support volunteer participation.

Once residents became actively involved in the project, they became vulnerable to being overused and to burning out. In this regard, the project used a variety of ways to support volunteers. One way the project attempted to maintain resident involvement was to provide training and mentoring for residents in chairing

meetings, leading group discussions and public speaking, all of which were used to overcome the problem of lack of skill or confidence in these areas. Another important part of the culture of the project was the annual volunteer recognition dinner. Each year, project participants gathered for a dinner, dance and recognition. Certificates of appreciation, coffee mugs, tote bags and sweatshirts were used as tangible reminders of the importance of volunteers' contributions to the project. As the number of community residents volunteering in the project grew over time, the project took steps to have one staff member co-ordinate the orientation, training and placement of volunteers in different activities.

Turning now to setting-level barriers, formal meetings with service-providers inhibited resident participation. Residents reported feeling intimidated by the power difference between themselves and professional service-providers at the beginning of their involvement. Professional jargon and residents' lack of familiarity with the issues added to this intimidation:

I remember one of the first ones [Steering Committee meetings], two parents came, I won't mention names, and they sat through the Steering Committee and they never said one word and as soon as it was over, they said 'Don't ever ask me to go to that again'. They were really bowled over by how formal it was. (community resident)

Project members found that making the meetings more informal, avoiding professional jargon and professional sensitivity to residents were important in overcoming this barrier. It became a part of the Highfield project culture to provide food at most project meetings. This sharing of food and friendships helped to create a family-like atmosphere in the project. Also, service-providers, researchers and staff tried to make residents as comfortable as possible by presenting themselves as people, rather than as professionals, not dressing in expensive clothing and being friendly and welcoming. Providing information and encouragement is very important for nurturing resident participation:

The individuals who worked with us were incredible. They [the professionals] were amazing . . . They treated us like people; we

mattered; our input was important. They encouraged us, boosted us. They sometimes pushed us to where we thought was beyond [our capabilities] . . . 'I can't do this'; 'I'm not adequate'; 'I haven't the right education'; 'I don't know how'; and yet they pushed until 'Hey, you're right, I can do this'. (community resident)

I am asked for my opinion and feedback . . . I found the service-providers went out of their way to make you feel comfortable . . . They didn't treat you as if they're above you. (community resident)

Even with these efforts to reduce the social distance between professional and residents, having too many professionals in a meeting was found to inhibit resident participation. Striving to have 51 per cent resident participation on all committees was one concrete way that the project dealt with this problem. When the Steering Committee was restructured into a smaller Executive Team in 1993 (with four residents, the Principal of the school and two service-providers), there was a noticeable change in residents' level of participation in the meetings. While other committees strived to have 51 per cent resident participation, this was not always achieved.

A final barrier to resident participation arose from the discomfort that the school staff initially experienced having a community project operating in their school. It took some time for teachers and school administrators to accept project staff and parent volunteers as partners in the operations of their school. With a concerted effort, relationships between the project and the school improved over time, and this resulted in a changed attitude towards parent volunteers. Residents and staff spoke of the teachers and school becoming more welcoming and supportive of parent volunteers: 'I think there's less mystification around people in the school and their roles. So they're seen as real people which can have a good side and a down side to it' (project staff member).

Some other barriers to resident participation were more difficult to overcome. Lack of time and interest on the part of residents, turnover in parents and the transient nature of the community all inhibited participation. One 'problem' related to turnover of parent

volunteers was that several parents who had leadership skills (as volunteers) became project staff. While this was a positive development for these residents, it also created a challenge for the project because other parents needed to be recruited to replace them. A gender-related problem was and continues to be the relative absence of men participating in the project. Only one man played a major volunteer role in the 10-year history of the project. The lack of male role models in the project was a barrier along with the larger socio-cultural expectation that caring for children is the responsibility of women: 'What I keep saying, "Where are the men?" And the answer back is "They're working", when in fact not everybody is working' (community resident).

Discussion and lessons learned

In this article, we examined resident participation in a community-driven promotion/prevention initiative for children and families. With regard to the first research question about the nature and amount of resident participation, we found that resident participation in the project grew over time. An increasing number of residents participated in committee work or used the programmes provided by the projects; the number of volunteers increased; and some residents became involved in leadership roles in the project. At the same time, however, the project experienced difficulty in recruiting new residents who were willing to assume leadership roles. New parents did become involved in leadership roles, but overall the number of people participating at this level remained small (no more than 10 people at any one time).

It is important to recognize that people have different needs and motivations for volunteering (Clary, Snyder, & Ridge, 1992; Omoto, Snyder, & Berghuis, 1993; Pancer & Cameron, 1994; Wandersman & Florin, 2000). Reasons for participation included the opportunity to meet new people and to reduce isolation, the desire to improve their community and develop programmes for their children and wanting to learn new skills, obtain employment and further their personal growth. Since volunteers participate for different reasons, many different opportunities for participation need to be provided. Having multiple opportunities and levels for resident participation is consistent

with a successful school-based prevention project developed by James Comer (1980) in New Haven, Connecticut. The focus of the New Haven project was on developing a healthy school climate through partnerships between parents and teachers in a low-income African-American community. Parent involvement not only increases the person power to provide programmes and support for children, but it brings in a different perspective, which combined with teacher involvement can have a synergistic effect on the school and community.

It is also important to recognize that resident volunteers may not be able immediately to take on leadership roles in a partnership with human service professionals. Omoto et al. (1993) and Pancer and Pratt (1999) suggested that volunteering is a process, and that volunteers move through a series of stages in their involvement with a project or programme. Initially, individuals are often motivated to volunteer in order to gain personal benefits, such as the opportunity to meet others, gain employment or learn new skills. It is only after they have had an opportunity to experience some of the benefits of volunteering that they begin to identify with the project, and see it as an important part of their lives. At this point, they may be willing to take on more responsible levels of partnering. However, in order to carry through this willingness to take on higher-order functions, community volunteers must also feel confident that they have the skills and the support necessary to function at this level. Research on the process of personal empowerment (Lord & Hutchison, 1993; Nelson, Lord, & Ochocka, 2001) is consistent with this conceptualization of volunteering as a process that changes over time.

With regard to the second research question, we identified a number of individual and setting-level barriers to resident participation and strategies that projects can use to overcome these barriers. While some of these barriers to resident participation have been identified in previous research (e.g. Cameron et al., 1994), this study demonstrated that empowering organizational processes can be set in place to reduce barriers and encourage resident participation. The environment in which individuals participate is all-important in giving them a sense of identity with the project, encouraging

them to stay on with the project and to take on higher-level functions (Pancer & Pratt, 1999). This kind of supportive social milieu was achieved at Highfield in many ways: reaching out and advertising the project; providing translation and child care; volunteer recognition; operating in a friendly and informal manner; mandating a high degree of resident participation; and establishing positive relationships with teachers and the school.

These findings about barriers and strategies to overcome barriers contribute to a growing body of research on empowerment processes. Across several settings, Maton and Salem (1995) found the following characteristics of empowering organizations: a belief system that inspires growth and focuses on strengths; opportunities for member participation and contribution; social support; shared leadership; and organizational power to effect community change. Similarly, in a study of change in community mental health organizations, Nelson, Lord and Ochocka (2001) found that settings that were committed to the value of mental health consumer participation were able to create a variety of ways to enhance consumer participation at all levels of the organizations. While each of the strategies used by the Highfield project was designed to reduce a specific barrier to resident participation, what is important is the overall responsiveness of the project to residents and its desire to create a welcoming atmosphere. From the perspective of empowerment theory (Wandersman & Florin, 2000; Zimmerman, 2000), it is not one particular strategy that is important, but rather a cumulative process of creating an empowering organizational climate that is intentionally designed to maximize resident participation. A major part of creating such a climate is the willingness of professionals to share power and control with residents (Derksen & Nelson, 1995).

While this study was not explicitly focused on the characteristics of volunteers, it is noteworthy that the great majority of volunteers with the Highfield project are low-income women. While women volunteer at a higher rate than men in Canada (Parmegiani, 2002), our experience is that women vastly outnumber men in these types of community-based projects. From one perspective, the project offers them an opportunity to gain skills, experience support

and satisfaction and improve their lives. In other words, women experience personal empowerment in the context of the Highfield project (Lord & Hutchison, 1993; Pancer & Cameron, 1994; Sheilds, 1995). From another perspective, however, low-income women who volunteer in the Highfield project can be seen as working for 'free' to provide needed human services in a society that is not willing to pay for these services. From this perspective, a more 'emancipatory', systems-level intervention, such as providing policies that increase income and employment opportunities for low-income women and families, would be a more appropriate way to help than a project which is designed primarily to provide services to individuals (Febbraro, 1994).

The findings from this research also support the steps in the partnership approach to prevention programme planning developed by Nelson et al. (2000). First of all, as others have found (Cameron & Cadell, 1999; Cameron et al., 1994; Comer, 1980), residents from low-income communities are interested in participating in the planning of such programmes and can be brought into the partnership alongside researchers, teachers, project staff and other service-providers. However, as the findings of this research indicate, the climate of the partnership has to be one that is informal and welcoming to community residents, who come with a great deal of fear and insecurity to meetings with professionals.

Establishing a positive climate for resident participation stems from the second step of the planning process, which involves clarifying the vision and values of the partnership and developing working principles (Nelson, Prilleltensky, & MacGillivray, 2001). In this particular project, the value of resident participation and self-determination was a major influencing factor on the success of the partnership. From the beginning, the government policy was that this initiative would be driven by residents, and the mandate of 51 per cent resident participation on the project Steering Committee became a norm throughout the life of the project. This value of resident participation along with the value of social justice (fair access to resources for disadvantaged people) also led to hiring the majority of staff from the community. Having the majority of staff from

the host community helped to establish a positive climate for resident participation. Fellow residents can see their neighbours as staff and active volunteers in the programme, which can create momentum for them to become involved.

The third step in the planning process is to identify and merge the strengths of the different stakeholders in the partnership. Residents bring different strengths and interests to these types of programmes. One lesson that can be learned from the Highfield project is that providing many different ways for residents to participate allows people to use their strengths where they fit best and feel most comfortable. Those who find volunteering in the classroom rewarding can do so, while those who want to become more active leaders and spokespersons can become involved in leadership roles with support and mentoring.

In this article, we have described many different aspects of resident participation in partnerships at the Highfield Community Enrichment Project. As the following quotation illustrates, the ultimate purpose of these partnerships is to meet better the needs of disadvantaged children: 'The project is about making a difference for kids and communities that are disadvantaged'. While this is a noble goal for partnerships, researchers and professionals are just beginning to learn about how to work with and create equitable, empowering partnerships with citizens from low-income communities in the planning and implementation of prevention programmes. This research takes a step in documenting that in spite of many barriers, resident participation is possible and can be enhanced through a number of different strategies.

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