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Title:

Evaluating a Model For Engaging Multicultural Communities in Dialogue About Community Improvement

Author:

Vicky Totikidis
Centre for International Corporate Governance Research
Victoria University

Contact:

Ms Vicky Totikidis
Centre for International Corporate Governance Research
Faculty of Business and Law
Victoria University
PO Box 14428 Melbourne City MC
MELBOURNE 8001

Email: vicky.totikidis@vu.edu.au
Tel 613 9919 1334

Evaluating a Model For Engaging Multicultural Communities in Dialogue About Community Improvement

Abstract

In 2001, researchers from the Wellness Promotion Unit at Victoria University in partnership with the community welfare organization Good Shepherd Youth and Family Service received an Australian Research Council grant to explore community wellness in a disadvantaged multicultural suburb in the Western region of Melbourne (St Albans). As part of this broader project, the present author conducted qualitative research with culturally diverse community members. The research included interviews and focus groups with Maltese, Vietnamese, Italian and Anglo Australians and utilised a holistic model of well being designed to explore the personal, relational and collective aspects of well being/wellness. The purpose of the current paper is to present some of the main findings of the research and to evaluate the utility of the model for engaging multicultural communities in dialogue about community improvement. In summary, the research: 1.) Produced valuable information about the community's perceptions of personal, relational and collective well-being; 2.) Highlighted some of the positive strengths of the community; 3.) Helped us to identify community needs and barriers to wellness and 4.) Pointed to ways to improve well being in the community. The current paper focuses mainly on the first and fourth outcomes. The paper also presents quantitative data from the Australian Bureau of Statistics relating to the region as a contrast to the qualitative information gathered from the community members. The paper will be a resource to anyone wanting to embark on research and community development work in culturally diverse communities.

KEY WORDS: Engaging Multicultural Communities, Community Well being, Community Wellness.

Evaluating a Model For Engaging Multicultural Communities in Dialogue About Community Improvement

Introduction

University Community Engagement

The importance of community involvement, participation or engagement is becoming widely recognised in the public and university sectors. Engaging community members in the decisions that affect their lives, can contribute to a more relevant and responsive service or program, and may be seen as a democratic and human right.

The Democracy Collaborative within the University of Maryland (USA) sees university-community involvement as central to questions about democracy and community building and universities as strategic agents to advance global democracy. Affiliates of numerous "citizen engagement organizations" and universities have joined this Collaborative, including the Australia National University and University of Queensland from Australia. Another Australian university association known as the Australian Universities Community Engagement Alliance (AUCEA) is committed to university-community engagement in order to promote the social, environmental and economic and cultural development of communities. While AUCEA have recognised the difficulties in defining community engagement some of the definitions cited on the AUCEA website were:

- "The engaged campus is involved in community relationships, community development, community empowerment, community discourse, and educational change" (Delaforce, 2005).

- "The engaged university … is considerate and responsive to community identified needs and works in active partnership with its communities in order to help achieve those needs" (Temple, 2005).

- Another aspect of community engagement is that of "mutually beneficial exchange"… "These interactions enrich and expand the learning and discovery functions of the academic institution while also enhancing community capacity" (Holland, 2005).

The term community engagement overlaps with many similar concepts. Terms such as community/public participation, involvement, consultation, collaboration and partnerships may have subtle differences in meaning but all imply an inclusive attitude towards working with community stakeholders. According to Gahin and Paterson (2001) an emphasis on community participation emerged during the late 1980s and was related to the Healthy Community and Sustainable Community movements and a host of quality-of-life initiatives, which also shared an interest in developing and using community indicators to collect data on which to base discussion and decisions.

Social and health indicator efforts can be traced back even further to the social reform movements of the 1800s in Belgium, France, England, and the United

States with more recent efforts aimed at community well-being (Gahin and Paterson, 2001). Community engagement is also central to community building and community governance efforts.

Viewed within the context of these community movements, *University Community Engagement* may be seen as an attempt by universities to apply their knowledge and skills to real world concerns and issues. University academics are also suitably positioned to take advantage of research funding and to disseminate research findings for the betterment of society. While the desire to do the best for community may underlie community engagement many definitions and models of engagement are possible. Models and goals can vary, with community engagement serving as the means towards some ideal or objective. The community engagement strategy will undoubtedly be different depending on whether it was designed by an engineer, nurse or community development worker, for example. The model discussed in the remainder of this paper has its roots in the discipline of community psychology but may inform and guide the work of community development workers, social workers and other social scientists interested in improving community well being.

Engaging for the Purpose of Community Wellness/ Well Being

In 2001, researchers (Professor Isaac Prilleltensky and Ms Heather Gridley) from the Wellness Promotion Unit at Victoria University in partnership with the community welfare organization Good Shepherd Youth and Family Service received an Australian Research Council grant to explore community wellness in the disadvantaged multicultural suburb of St Albans. St Albans lies within the Local Government Area of Brimbank in the Western region of Melbourne and is the locality of both institutional partners.

Three students with community interests were invited to undertake various parts of the project. Shown in the top left and right squares above the horizontal line in Figure 1, a first stage of research began in late 2001 and consisted of two qualitative research studies involving diverse community members (Totikidis, 2003) and health and community service professionals (Robertson, 2003) from the St Albans region (see also Totikidis & Robertson, 2005).

The first stage involved the development and use of a model for engaging multicultural communities in dialogue about community improvement known as the known as the Community Wellness Cycle of Praxis (Totikidis & Prilleltensky; in press). This model also served as a basis for the second stage which began in 2002 and involved longer term collaboration with youth under the name of Social Action with Youth (Morsillo, 2002). The present paper discusses only the research with community members.

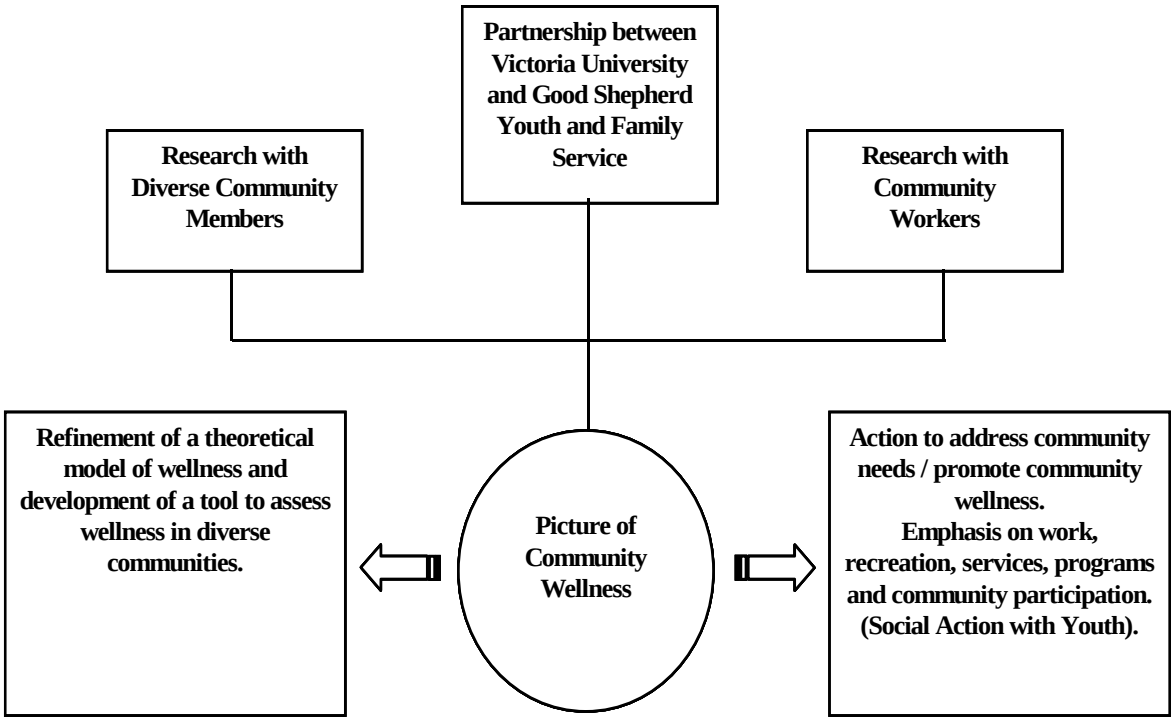


Figure 1. Map of the Community Wellness Project

The major aim of this paper is to discuss the way in which the model was utilised in qualitative research with culturally and linguistically diverse community members in the multicultural suburb of St Albans. Another aim is to evaluate the suitability and limitations of the model in light of a community profile and indicators relating to the broader Brimbank region and the results of the project. The profile and indicators are presented next to provide a background to the research and are followed by details of the research methods used in the study, the findings and the conclusion and evaluation.

Brimbank Community Profile

A brief profile of the Brimbank region consisting of information on country of birth, languages spoken, education and employment is presented below. The data were drawn from the Australian Bureau of Statistics (ABS) 2001 Census of Population and Housing 'Basic Community Profile' (BCP) Series (2002).

Country of Birth.

Basic calculations of the census statistics showed that 82,831 (50.84%) of the people in Brimbank were born in Australia while 52,902 (32.47%) were born overseas in a 'Non-English Speaking' (NES) country. The Indigenous population for Brimbank was recorded as 490 persons, which constitutes .29% of the Brimbank population and 1.95% of the total Indigenous population in Victoria. The top ten NES countries of birth are shown in Figure 2 with the greatest number of people from Viet Nam, Malta, Italy, Macedonia and Philippines.

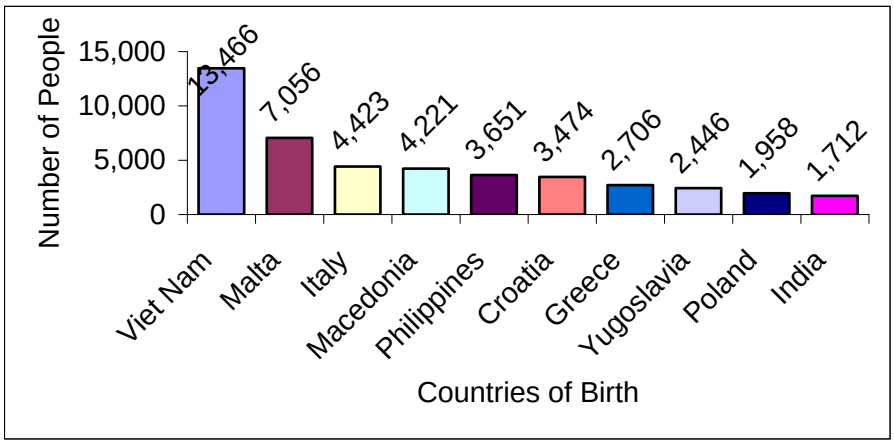


Figure 2. Top Ten Countries of Birth in Brimbank

Languages Spoken.

The BCP for Brimbank showed that 67,161 (41.22%) of the population speaks English only while 80,239 (49.25%) speaks a 'Language Other Than English' (LOTE) at home. As shown in Figure 3, the most widely spoken LOTE in Brimbank included Vietnamese, Maltese, Italian, Greek and Macedonian.

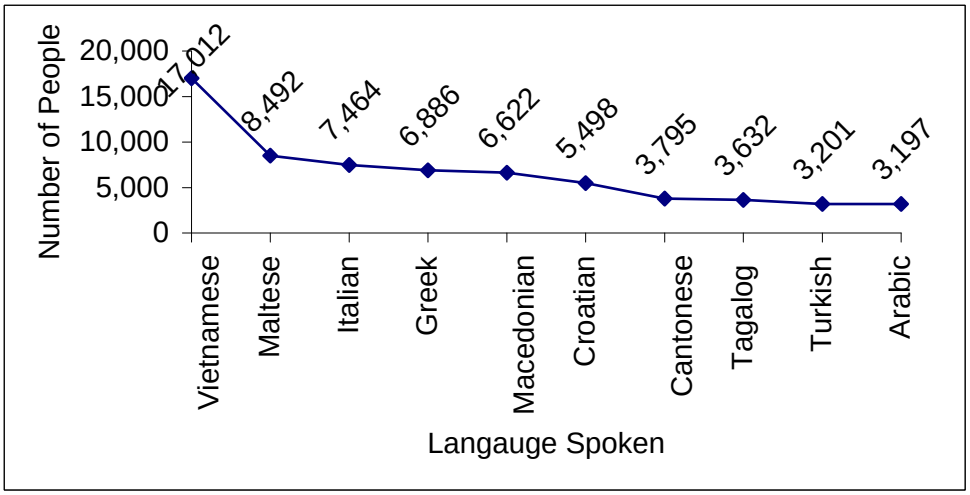
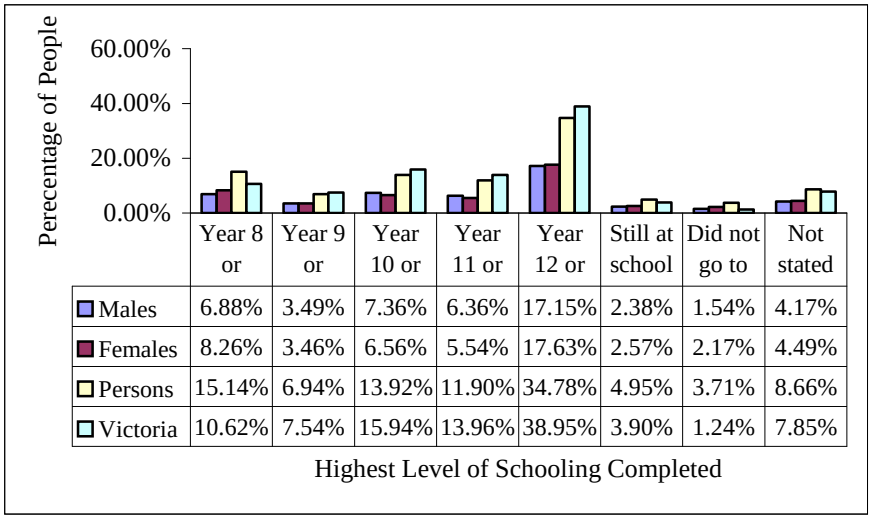


Figure 3. Top Ten LOTE in Brimbank

Education.

The level of schooling completed by males and females in Brimbank and total persons in Brimbank and Victoria may be seen in Figure 4. This shows a lower percentage of people in Brimbank who completed Year 9, 10, 11 and 12 compared with the state averages for these levels while the rate of people who completed only year 8, were still at school or did not go to school were higher than the state percentages.



Notes. Constructed from B12 of the BCP for Brimbank. Data refer to persons aged 15 years and over (excluding overseas visitors) (ABS, 2002).

Figure 4. Highest Level of Schooling Completed in Brimbank and Victoria

Employment.

Table 1 shows the employment status of males and females in Brimbank. Basic calculations of the ABS employment data showed that 43.36% of the total Brimbank population are in the labour force (73,635/169,839). Of these, only 25.80% are employed in full-time positions and 11.11% in part-time positions, with an unemployment rate of 11.00%. Unemployment is greater for people in Brimbank (10.99%) compared to the Victorian rates (6.8%).

Table 1. Employment and Unemployment Rates in Brimbank

Employed	Males	Females	Persons	LGA Labour Force	Victorian Labour Force
Full-time	28,970	14,854	43,824	59.52%	60.64%
Part-time	6,775	12,101	18,876	25.63%	29.69%
Not stated	1,707	1,139	2,846	3.87%	2.88%
Total	37,452	28,094	65,546	89.01%	93.20%
Unemployed	4,644	3,445	8,089	10.99%	6.80%
Total labour force	42,096	31,539	73,635	100.00%	100.00%
Not in the labour force	18,116	29,891	48,007	65.20%	57.20%

Notes. Constructed from B22 of the BCP for Brimbank. Data refer to persons aged 15 years and over. Full-time is defined as having worked 35 hours or more in all jobs in the week prior to Census night (ABS, 2002).

Brimbank Indicators

Out of 78 LGAs in Victoria, Brimbank ranks within the top ten or so on a range of indicators related to disadvantage/special community needs. The indicators together with the ranking, rate and average LGA rate are shown in Table 2.

Table 2. Indicators Related to Community Needs

Indicator	Rank	Brimbank Rate	Average LGA Rate
Population (2001)	3rd	169,839	61,827.74
Rate age 15-24	6th	147.98	120.11
Number on Low Income	2nd	103,137	34,330.03
Rate of women as one parent families	11th	69.57	53.14
Rate still at school	4th	37.02	29.82
Rate did not go to school	2nd	27.76	6.53
Rate low English proficiency	3rd	100.25	18.36
Total household rate	4th (lowest)	307.80	421.48
Gender disparity in income	9th	0.62	0.48
Rate born in non-Engl spkg country	2nd	380.55	100.90

Notes. Source of data: ABS 2001 Census of Population and Housing 'Basic Community Profile' Series (2002). Calculations by Totikidis: Rates were calculated per 1000 of the population. Gender Disparity in Income was calculated as the difference between the percentage of males on high income and the percentage of females on high income. Low English Proficiency consisted of two summed categories (Speaks other language and speaks English: Not well or Not at all).

In summary, the profile shows that Brimbank is a culturally and linguistically diverse region with lower rates of education, higher rates of unemployment and various unmet needs related to disadvantage. This information complements the research presented following.

Research Methods

The research with community members, involved four focus groups with a total of 29 Vietnamese, Maltese, Italian and Anglo-Australians (15 women and 14 men) and two pilot individual interviews with a Maltese and Serbian woman. The general aim of the study was to ground the Community Wellness Cycle of Praxis in qualitative research with diverse community members from the St Albans region in order to gain a theoretical and practical understanding of well-being from a multicultural perspective. Specific research questions were:

1. What are the community wellness ideals (a); needs (b); and strengths (c); of St Albans community members?

2. What actions can be undertaken to improve well-being in this community?

The Community Wellness Cycle of Praxis may be described as a model of community engagement that seeks to understand the ideals, needs and strengths of the community in order to improve well being (see Figure 5). The model was an integration and adaptation of earlier wellness and praxis models and also pays attention to needs theory as proposed by Roth (1990).

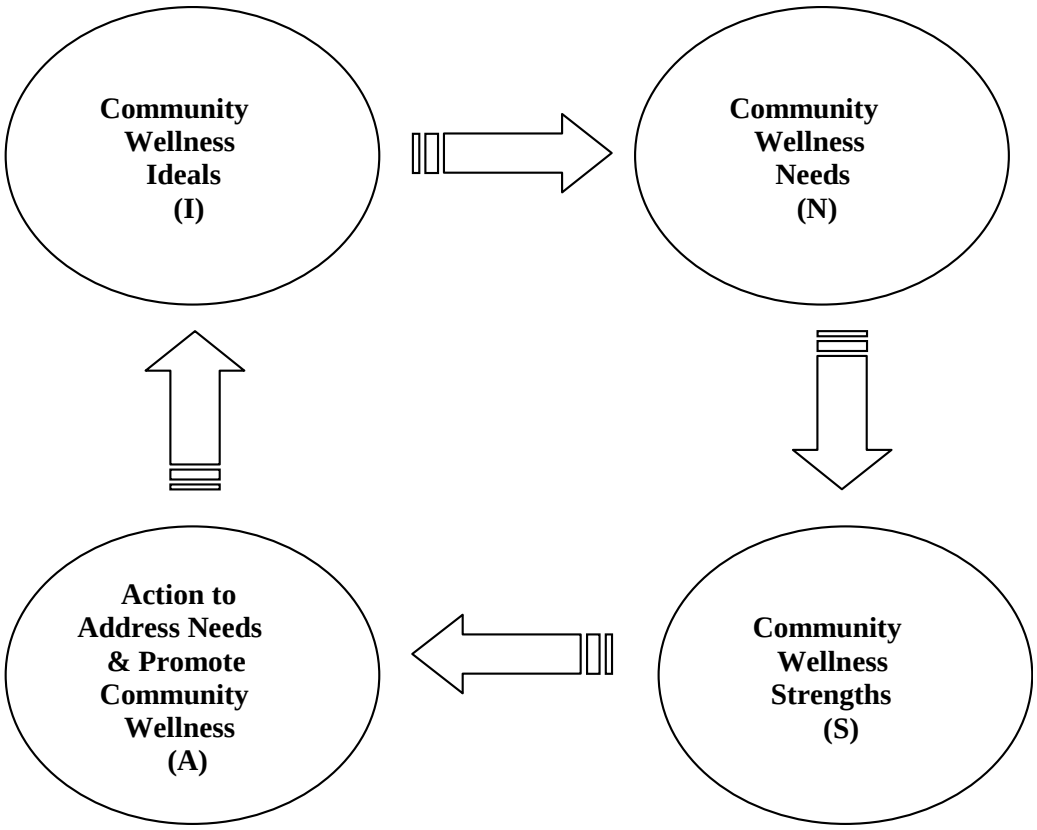


Figure 5. The Community Wellness Cycle of Praxis (Adapted from Prilleltensky, 2001a, b & c)

Wellness as denoted by this model is a holistic state of affairs, brought about by the simultaneous and balanced satisfaction of personal, relational, and collective needs of individuals and communities alike (Totikidis & Prilleltensky, in press). Needs may be viewed as the negative or missing aspects of well-being while strengths are positive and existing aspects of well-being (e.g., low crime, adequate educational facilities, good health). The model proposes that positive action (A) that aims to maintain and further develop community strengths (S) and address community needs (N), leads to an ideal state of community wellness (I).

A semi-structured questionnaire/interview schedule consisting of four sections or themes (A-D) and ten questions was developed from the model above. The 10 questions are shown in Table 3 with the corresponding parts of the praxis model (ideals, needs, strengths and actions) and research questions in column two. The participants were recruited from local community centers, ethnic clubs and the St Albans shopping precinct following communication between the researcher and a key person from each cultural group or by referral from GSYFS staff.

Each focus group session began with informal conversation and introductions over morning tea to facilitate discussion between participants. Name-labels were distributed, and the format of the session together with matters of confidentiality, privacy and other rights were explained when participants were seated. The questions were presented to participants both verbally and visually

using transparencies and an overhead projector to assist understanding. All the discussions were tape-recorded and verbatim transcriptions were produced.

Table 3. Questions Employed in the Interviews and Focus Groups, Parts of the Praxis Model and Research Questions

Interview and Focus Group Questions	Praxis Components & Research Questions
Section A: The meaning of well-being and the lack of/or opposite of well-being 1). What does well-being mean for you? 2). What does the lack of/or the opposite of well-being mean for you?	IDEALS 1.a. What are the community wellness ideals of St Albans community members?
Section B: Positive things about your present state of well-being 3). What is good about your present state of personal well-being? 4). What is good about your present relationships with other people? 5). What is good about the present conditions in your life and community?	STRENGTHS 1.b. What are the community wellness strengths of St Albans community members?
Section C: Negative things about your present state of well-being 6). What is not so good or missing for your personal well-being at present? 7). What is not so good or missing in your present relationships with other people? 8). What is not so good or missing in terms of the present conditions of your life and community?	NEEDS 1.c. What are the community wellness needs of St Albans community members?
Section D: Actions or changes that could improve well-being in St Albans 9). What are some of the things that you and other people who live in St Albans could do to improve well-being in the community? 10). What could other people (health and community service workers, governments, researchers) do to help us improve well-being in this community?	ACTIONS 2. What actions can be undertaken to improve well-being in this community?

Following the first two questions, a simple diagram illustrating the personal, relational and collective levels was shown and explained to participants (Figure 6). The model was explained simply to allow participants to apply their own definitions and to avoid biasing the research. Personal, relational and collective well being were described as well being relating to one self; to self and other people; and to one's surroundings or environment.

Figure 6. Diagram Illustrating The Personal, Relational And Collective Levels

Findings

The research with community members 1.) produced information about the community's perceptions of personal, relational and collective well-being; 2.) highlighted some of the positive strengths of the community; 3.) helped us to identify community needs and barriers to wellness and 4.) pointed to ways to improve well being in the community. The present paper focuses mainly on the first and fourth outcome with the others discussed in detail elsewhere (Totikidis, 2003; Totikidis & Prilleltensky, in press; Totikidis & Robertson, 2005).

Multicultural Perceptions of Personal, Relational and Collective Well-Being

Three tables illustrating participants perceptions of personal, relational and collective well-being are shown following. These tables show the *combined* responses from the individual interviews and the Vietnamese, Italian, Maltese and Anglo-Australian focus groups and are for this reason referred to as a 'multicultural perspective' of well being.

The term multicultural is not intended to imply that all participants necessarily identified as such or shared a multicultural perspective. Indeed when one participant stated that she was multicultural during one of the focus group sessions, another participant replied that she was not multicultural but Italian. In another focus group, a couple of participants made comments that seemed to express racist or 'anti' multicultural attitudes. In contrast to the multicultural tables presented following, separate tables for each of the cultural groups can be also be seen in the previous works mentioned.

Table 4 shows the participants' perceptions of *personal* well being. Due to the wealth of information generated, the responses from column 2 were further analysed and summarised into common themes as may be seen in column 1. In summary, the community members responses point to three common themes for personal well being: Physical and Psychological Health; Positive Thoughts and Feelings (towards oneself and others); and Spirituality.

Table 4. A Multicultural Perspective of Personal Well Being

Issues discussed on the topic of Personal Well Being	Summary of Emergent Themes/Ideals
Authentic self. Balance between home/external activities. Caring. Confidence. Contentment. Control. Coping ability. Coping with death of loved ones. Cultural integration (mental). Education. Emotional strength (ability to cope with stresses and problems). Feeling complete. Feeling relaxed, not nervous, not stressed, comfortable. Happiness. Not worried. Peaceful. Physical and emotional health. Physical health and absence of pain. Self care. Spirituality. Transcendence. Well organised. Emotional well-being. Empathy. Faith, religion and spirituality. Feeling good. Feeling safe. Free will. Fun. Good health. Good life. Health: physical, psychological, mental, spiritual and social. Healthy mind, body and soul. Hope, faith and motivation. Inner peace (vs inner conflict) Learning Opportunities. Love. Loving yourself and self-acceptance. Maintaining activity levels through physical work and recreation. Not being greedy. Not being isolated. Not having fear. Not having pain. Pleasant distractions from boredom and pain. Positive adjustment. Positive sense of identity. Positive thinking. Realistic expectations. Realistic expectations regarding pain/ageing. Relationship with God. Resilience. Satisfaction of basic needs (food, rest, shelter, procreation). Satisfaction with life. Secure (supportive) family. Self-acceptance. Self-esteem. Success. True happiness. Trust.	1. Physical and Psychological Health 2. Positive Thoughts and Feelings (towards oneself and others) 3. Spirituality

Table 5 shows a multicultural perspective of *relational* well being. As with the previous table, a summary of participants' responses are shown in column 2 with common themes in column 1. Community members' responses point to five common themes for relational well being: Family; Friendship and Social Support; Intra Cultural Harmony; Inter Cultural Harmony; Community Cohesion and Participation.

The terms intra and inter cultural harmony were developed to reflect a distinction between two types of cultural harmony identified in the research (Totikidis, 2003). Intra-cultural harmony was broadly defined, as harmony in relation to ones own culture and can include positive cultural identity, adjustment and self-acceptance. Inter-cultural harmony was defined as harmony between cultures and is related to tolerance and respect for cultural diversity (Totikidis, 2003). The term community cohesion and participation is used in a general way in the present context to refer to participants' comments relating to concepts such as sense of community, neighbourliness, community belonging and involvement.

Table 5. A Multicultural Perspective of Relational Well Being

Issues discussed on the topic of Relational Well Being	Summary of Emergent Themes/Ideals
Caring for others. Caring/helping others. Celebrations with family. Children behaving well. Collectivism (community). Communication with neighbours. Community acceptance of cultural diversity. Community cohesion (vs. individualism). Community participation and protest. Community spirit. Compromising. Connectedness. Cross-cultural communication. Cultural integration. Cultural maintenance and contact with own culture. Cultural maintenance or connection to roots. Cultural reconciliation. Democratic participation. Family health and well-being. Feeling accepted in the community. Feeling connected. Friendship. Golden rule. Good communications – family and others. Good friendships. Good relationships with immediate and extended family. Good relationships with neighbours. Good relationships with partner, family and extended family. Intercultural cohesion and mingling. Intercultural interactions/integration (vs. cultural segregation). Joy in watching children grow. Kindness to others. Loving parents and family. Loving partner. Many friends. Multiculturalism. No discrimination. No racism or racial conflict among youth. No racism/stereotyping. Not blaming others. Not having fear of others. Part of community. Political participation by community. Positive peer relationships. Reciprocal relationships. Reciprocal relationships with adult children (not being taken for granted). Relationship with God. Respect for diversity (of culture and personality). Respect for elders' needs. Respect for everyone. Respectful relationships. Responsibility. Safety. Sense of belonging (community). Social activities. Strong (extended) family connections. Strong identification with friends. Supportive social group. Tolerance. Tolerance and friendliness with others. Trust. Trust with partners. Understanding. Understanding partner.	4. Family 5. Friendship and Social Support 6. Intra Cultural Harmony 7. Inter Cultural Harmony 8. Community Cohesion and Participation

Table 6 shows the participants' perceptions of *collective* well being. The responses are shown in column 2 with the common themes again in column 1. The issues of importance for collective well being raised by community members were categorised into seven common themes: Human Rights; Safety; Employment; Education; Community Services, Resources and Information; Community Development; and Good Government.

Table 6. A Multicultural Perspective of Collective Well Being

Issues discussed on the topic of Collective Well Being	Summary of Emergent Themes/Ideals
Access to free legal services. Access to support services: welfare, housing, transport. Adequate education and hospitals. Adequate income. Adequate infrastructure: education, hospitals, shops, higher education, employment, transportation, ethnic clubs & services for elders. Adequate meeting places. Adequate opportunities (e.g., career, education). Adequate parent, family and mental health support services. Adequate parks, gardens and public meeting places. Adequate policing – crime and safety. Adequate recreational facilities. Adequate response to community issues: drugs, gambling, smoking, violence, graffiti, dental health care, education, GST (goods and services) burden, poverty trap, rich/poor gap, cost of living, employment. Adequate response to vandalism. Adequate shopping facilities – variety and 'quality' shops. Adequate support for migrants Availability of specialist services (eg, optometrist). Awareness of global issues/ecology. Basic necessities (roof over head). Being informed about the community. Clean environment (no rubbish and beautification). Community festivals and cultural events. Community information and education. Drug free kids. Education for responsible adolescence (eg, respect, morals, graffiti, vandalism). Egalitarian government funding to community. Employment opportunities. Employment: basic human right. Equality. Fair system. Financial security: (money, property, car). Free health care. Free youth facilities (recreation and places to go). Funding to local community groups. Good government - responsible, effective, honest, democratic. Home ownership. Information regarding services to non-English speaking people. Low crime rate – safety. Multicultural church. No GST. Peace (no war). Policing of drug risks to residents and crimes against elders. Policy response to gambling. Quality teaching/mentoring. Responsive local government. Responsive/representative government. Safety. Safety in community. Safety on transport. Services to accommodate elders and diversity. Social well-being: being able to walk out on the street freely. Staying alive in St Albans (no racial or turf wars). Support/funding for ethnic elderly clubs, churches. Temples and churches.	9. Human Rights 10. Safety 11. Employment 12. Education 13. Community Services, Resources and Information 14. Community Development 15. Good Government

Actions or Changes that Could Improve Well-Being

Table 7 shows a summary of issues in response to the two questions on what community members felt they could do and on what they thought others (health and community service workers, governments, researchers) could do to improve well being in the community. The table shows considerable wisdom and good will by the community as well as intimate knowledge about community issues and community improvement. As with the previous tables only the combined multicultural perspective is shown.

Table 7. Multicultural Perceptions on Actions or Changes that Could Improve Well-Being

Community Action	Action by Others to Help Improve Well-being
Address transport issues. Be more collective, work on collective basis. Build relationships with neighbours. Children need to be taught about respect. Communication with neighbours. Community is apolitical – more people should be interested in politics. Community needs to communicate more. Community needs to have a special day (e.g., festival) to bring people together. Extend kindness and generosity to others. Contribute to improvement of education and hospitals. Need to keep religion going. Not judging others. Participation in protests. Safety needs to be improved. Security. Smile. Social support for elderly. Support family members and community – help one another. Talk to neighbours. Visiting an elderly person. Volunteer (“put back in the community”; “do something for people”; “planting trees”; “helping at schools”). Welcome newcomers.	Address cultural integration issues. Address traffic problems in St Albans. Awareness of services. Better monitoring by council and council services (e.g., hard rubbish collection) needs improving. Better representation of community in local government. Broken glass on bus stops. Cease fire in St Albans (conflicts among youth). Cleaning of public areas. Community education on environmental issues. Cost of living for low income should be addressed. Different religions are an issue. Discount for pensioners at shopping places. Education. Effort from migrant groups to mix. Employment. Free dental services. Funding for beautification of region. Gambling issues need to be addressed to protect peoples’ livelihood. Giving services back to certain areas. Government revenue (from penalties & fines) back into the community. Graffiti needs to be stopped. Improve medical services. Improve services and recreation to youth (14-18 years). Information about services needs to be disseminated to community. Local community groups need funding. More discipline in schools and education on respect and morals needed. More mental health services needed. No more tokenism from government. People have to have courage to speak out against bad policies. Policing, reduce crime and promoting safety. Preventative community education (health). Robberies need to be stopped. Safety of community needs to be addressed. Safety on transport. Security in trains. Sense of community. Shopping services need improving – more quality shops and bring it closer to the people. Social support groups. Staffing of stations. Support and help for families. Support for families with mental illness and more activities for people with mental illness. Teaching techniques need to change. Trust and friendship between agencies and community needs to be built up and language issues need to be addressed. Unemployment issues need to be addressed in this area. Work needed to guard peoples dignity and pride.

Recommendations

Another outcome of the research was the development of a list of recommendations for community improvement. These were developed following analysis and summary of the responses in Table 7, transcripts and issues of concern that were raised in the research with community members. The twelve recommendations were that:

1. Culturally appropriate family services and support to migrants be set up in the community.
2. Information regarding existing community services, resources and benefits reach migrant communities.
3. Mental health and other services in the area be strengthened and made more accessible.
4. Strategies to curb negative inter-cultural attitudes are implemented by government and services.
5. Local government, policy makers and community workers engage in ongoing consultations with the community to resolve community problems.
6. Policing of certain areas should be increased and crime prevention measures developed.
7. Strategies to enhance business and employment opportunities should be a priority.
8. Community events, celebrations and festivals be valued and encouraged.
9. Elderly clubs receive adequate support and funding.
10. Youth services, recreational activities and opportunities be improved and extended.
11. Affordable education and learning opportunities be provided to everyone in the community.
12. An ongoing community wellness group be set up and run by community members to identify emergent areas of need, initiate projects and monitor progress.

Conclusion and Evaluation

Overall, the praxis model was successful in that it stimulated interest and rich discussion about wellness from community members. The model was a useful way of determining community needs from various perspectives and was easy enough to use with people with low English fluency. The community wellness model and results of this research may be of use in various areas including university-community engagement, local government, community development, social work and applied community psychology work. The 15 common ideals generated may be used to guide the assessment of individual and community well-being as well as a model for action. For example, in assessment we can ask questions such as: Is this individual or community physically and psychologically healthy? Does this individual or community have cultural harmony, safety and adequate education, employment, community services, resources and information? In action, we can design programs, services and structures that address the needs of the community and build on their strengths.

One limitation of the research was that it was not sustained. The model was applied as a research instrument rather than as a model for ongoing community engagement and so had a definite start and finishing time. Although the second

stage of the research went on to develop social action strategies with youth, the first stage involving diverse community members ended. The action stage was not formally implemented. However, as suggested by recommendation 5 and 12, strategies should be ‘ongoing’. A community wellness group could be set up and run by community members (in collaboration with university and local community organisations) to identify emergent areas of need, initiate projects and monitor progress.

Engaging with the community in this way could also be complemented by ongoing development and analysis of community profiles and indicators to encompass issues in the community that are not recognised or known by community members. Such a design would have the benefit of being practical, sustainable and comprehensive and would contribute sincerely towards improving personal, relational and collective well-being for communities.

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