

# Rural Social Inclusion: The Evidence

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# Introduction

Australia is prosperous, and faring well in comparison to other nations in the world. However, not all Australians have access to the same opportunities and levels of inequality are rising. The concept of social inclusion is increasingly being explored as a solution to alleviate social inequality.

There is a plethora of literature debating the theory and ideology of the concept and definition of social inclusion. There is also much debate about the validity of alternative concepts such as social connectedness, social cohesion and social citizenship. Although alternative concepts and terminology are acknowledged, this paper will focus on understanding social inclusion/exclusion. As the intended audience for this literature review are professionals implementing social inclusion principles in community health and social services, the focus of this paper will be more on professional practice in relation to health, social and cultural factors.

To this purpose, the literature review provides a summary of the key findings and themes within the literature. It looks at the overall research and literature on social inclusion, and the findings specific to the rural context. In defining social inclusion it considers the relationship between social inclusion and social exclusion, identifying vulnerable populations and significant risk factors. Concepts such as social isolation, social capital and social justice are explored, in relation to social inclusion. Strategies to increase social inclusion including effective community engagement, empowerment, collective action, freedom from discrimination and using a joined up approach are considered and key themes identified.

The objectives of the literature review are to provide an understanding of social inclusion/exclusion and the evidence base to implement and progress social inclusion, particularly in the rural context. The limited literature on social inclusion in the rural context, necessitated broadening the review to the general population. This does not diminish the content but allows the multidimensional, inter-sectoral nature of the topic to be explored.

The types of literature included were peer reviewed and grey written documents, with the aim of restricting the search within the last 15 year period, where possible. The following forms of literature were included in the search:

- Systematic reviews on defining social inclusion/exclusion and implementing strategies to progress the health and wellbeing needs of the disadvantaged populations across the breadth of the service system.
- Non-systematic reviews in the form of reports, guidelines, evaluations, editorials, conference papers and commentaries were also included due to the nature of the project and focus on service system development.
- Primary research studies evaluating effectiveness of implementation processes and strategies (interventions or methodologies) that addressed the health and wellbeing needs of the disadvantaged populations across the breadth of the service system. This included both quantitative and qualitative studies.

The review only included written material that was published in English, using the following sources:

- Systematic review clearing houses (free library access): The Cochrane Library; Effective Public Health Practice Project (Canada); Evidence for Policy and Practice Information and Coordinating Centre (United Kingdom); The Campbell Collaboration; Centre for Reviews and Dissemination, York (United Kingdom); National Institute for Health and Clinical Excellence (United Kingdom)
- Internet search engines such as Google and Google Scholar
- Key websites such as: Australian government department websites
- The review of references and citations within key literature or documents with project synergies (bibliography snowballing) was also used to ensure key elements, such as foundational theories, were included in the literature.



Social inclusion, social exclusion, social isolation and social connectedness as concepts are multi-dimensional, complex and the terms are often used interchangeably (ACT Council of Social Service, 2012). Defining these terms is problematic with no universally agreed definitions. Definitions also involve making assumptions that society is a desirable place to live and how people should live. Therefore it can be argued that these terms are not absolute concepts, but relative to the norms and expectations of society, at a particular point in time (Taket, 2009). However, without understanding the concept of social inclusion, there is a risk that the term will become an overused buzzword that has little meaning and no value.

## 3.1 SOCIAL INCLUSION

The ability to participate in society, and to be free from discrimination and disadvantage is not only an ideal, it is a basic human right. It is a right documented in the Universal Declaration of Human Rights, agreed by the international community in 1948. This document outlines the basic civil, political, economic, social and cultural rights to which all humans are entitled, and states that human rights are to be enjoyed by all people, no matter who they are or where they live (Triggs, 2013). The Copenhagen Declaration and Programme of Action, a key outcome of the 1995 World Summit for Social Development, contained a specific commitment to advance social integration through fostering inclusive societies (United Nations Educational Scientific and Cultural Organization, 2012).

The definition used by the UNESCO (2012) highlights the value of human rights in a socially inclusive society:

*'Inclusive society is defined as a society for all, in which every individual has an active role to play. Such a society is based on fundamental values of equity, equality, social justice, and human rights and freedoms, as well as on the principles of tolerance and embracing diversity.'*

This definition resonates with the concept of social citizenship. Although social citizenship shares characteristic with social inclusion, some would argue that social inclusion lacks the conviction and the crucial emphasis on participation as a right (Sweet, 2012). Social citizenship can be defined as participation in or membership of a community, as expressed through various rights, obligations and institutions (Buckmaster & Thomas, 2009). At the heart of social citizenship is that disadvantaged people are provided with the resources necessary for participation, as a right rather than as state benevolence (Sweet, 2012).

It is now globally recognised that a range of factors and characteristics (personal, social, economic and environmental determinants) influence the health and wellbeing outcomes of individuals, families and communities, above and beyond individual behaviours (World Health Organisation, 2005). In addition, social support and good social relations give people the emotional and practical resources they need for resilience and good health (R. Wilkinson & Marmot, 2003).

The Australian Social Inclusion Board recognised the role of the social determinates of health in social inclusion. Their report identified that the items hindering social inclusion in Australian communities are; poverty and low income; lack of access to the job market; limited social supports and networks; the effect of the local neighbourhood and; exclusion from education, childcare, health and transport services (Australian Social Inclusion Board, 2012).

The South Australian Social Inclusion Board has defined social inclusion as:

*'providing people with the fundamentals of a decent life: opportunities to engage in the economic and social life of the community with dignity; increasing their capabilities and functioning; connecting people to the networks of local community; supporting health, housing, education, skills training, employment and caring responsibilities' (Cappo, 2009).*

Adding to the above definition the Australian Social Inclusion Board also state that to be socially included people must be given the opportunity to access services, enjoy social capital, deal with personal crises, and importantly have their voices heard (Australian Social Inclusion Board, 2012).

Throughout the literature social inclusion and social exclusion concepts are examined together and are often referred to as 'twin' concepts. Thus, an understanding of social exclusion is essential in order to promote social inclusion (Labonte, 2004).

## 3.2 SOCIAL EXCLUSION

Social exclusion is more often the focus of research and comment than the concept of social inclusion. This is perhaps because it is a narrower concept, often focusing on a select group of people rather than the whole of society and it is easier to identify the elements people do not have, which result in them experiencing social exclusion (ACT Council of Social Service, 2012).

Although there is a long history linking the concepts of social exclusion, poverty and deprivation, the characteristics of social exclusion relate to people being unable to do what they seek to do due to lack of resources, which is not solely related to poverty. While income and resources have a significant influence on people's lives, poverty in life leading to social exclusion should be viewed in terms of 'poor living', rather than just a lack of or low income (Sen, 2000). This is reflected in more recent definitions of social exclusions which state:

*Social exclusion involves the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole (Levitas et al., 2007).*

Generally, social exclusion describes what occurs when individuals or communities experience multiple disadvantages simultaneously, making it difficult for them to participate in their community, for example in work, education or in joining a community group (Social Inclusion Unit, 2008).

Care must be taken in using the term social exclusion, outside the context of social inclusion. It has been argued that labelling people as socially excluded

insinuates that they 'don't fit' or are deficient, which is based on an idea of what is considered 'normal', and only reflects the dominant values of mainstream society (Buckmaster & Thomas, 2009). It also requires people to meet set criteria before they are entitled to support, rather than place the onus on services to adapt to meet individual needs. In contrast, social inclusion has an emphasis on prevention, where the capacity of all individuals to determine their own direction is supported. The focus is on inclusion and support, which leads to addressing the range of barriers which prevent individuals from achieving their goals (ACT Council of Social Service, 2011a).

It is important to distinguish social exclusion from social isolation (Barry, 1998). Social isolation is generally understood to occur when a person has minimal levels of social participation and perceived inadequate social experiences (Greaves & Rogers-Clark, 2009). Barry (1998) opines that 'social exclusion' is a subset of cases in which social isolation occurs for reasons that are beyond the control of the individual, inferring that social isolation may be voluntary or involuntary.

## 3.3 SOCIAL CAPITAL

In an inclusive society individuals feel connected with their communities; resulting in strong and sustainable communities (Johnson, Headey, & Jensen, 2005; Marmot & Wilkinson, 2006). Social inclusion incorporates concepts of social capital, social networks, social connectedness, trust, reciprocity, civic cooperation, social cohesion, local democracy and group solidarity (Cappo, 2009; Jermyn, 2001).

Social capital generally means to describe the resources available to individuals and to society which are provided by social relationships (Kawachi et al., 2002). The key elements of social capital include:

- Social resources (e.g. informal arrangement between neighbours and members of clubs or churches)
- Collective resources (e.g. self-help groups, community banks)

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- Economic resources (e.g. levels of unemployment, access to green spaces, community gardens)
- Cultural resources (e.g. libraries, art centres, neighbourhood houses, local schools) (Dutta, 2008)

In this context of a cohesive society, social capital is a term used to describe the particular features of social relationships within a group or community that facilitate collective cooperative behaviour (Johnson et al., 2005; Stone, 2001). This includes such things as the extent of trust and respect between people; whether they have a shared understanding of how they should behave toward and care for one another (mutual obligation); and the extent of participation in civic organisations, such as sporting clubs and school councils (Kawachi & Berkman, 2000; VicHealth, 2005).

Social capital is seen as a meaningful measure of community strength and a means of reversing community decline. To understand, measure and increase social capital, it is necessary to recognize the multi-dimensional nature of its sources. The most common types of social capital have been identified:

- Bonding capital: refers to the relationships and bonds among close family members, friends and neighbours or social networks between homogeneous groups of people. Bonding social capital has strong but localised trust and is essential for a sense of personal identity and belonging (Leonard & Onyx, 2003). Personal networks of strong ties provide emotional and social support. However, the homogeneous nature of the network may create narrow, intolerant communities and can be oppressive even to those who otherwise benefit (Onyx, Edwards, & Bullen, 2007).
- Bridging capital: refers to the weaker ties that are formed among distant friends, acquaintances, colleagues and associates or social networks between socially heterogeneous groups (Kim, Subramanian, & Kawachi, 2006). Bridging capital can be used in at least three different ways; to cross demographic divides, to bridge structural holes between networks, and to access information and resources outside the community in question.

Bridging too can be empowering as it serves to expand the networks of skills, diversity and resources not otherwise accessible. (Onyx et al., 2007)

- Linking capital, which refers to the connections between institutions and members of a community, or between groups with different levels of power and social status (Kim et al., 2006; Woolcock, 2001)

These categorisations can guide the mapping of networks available or are needed to build a cohesive and healthier community. For example, a network that has a high bonding capital may have a high trusting relationship to influence health and social behaviours but a network with high bridging capital may provide more diversity and better sharing of information (Eriksson, 2011).

Trust is an essential component of social capital in facilitating cooperation (Scull, 2001). However, Molm (2007) shows that being linked to others through social networks is not enough to produce trust. The establishment of trust requires repeated acts of voluntary reciprocity and a demonstrated willingness to invest in the relationship. It is this reciprocal exchange in social relationships that tend to build trust and commitment that differentiate them from simple material transaction.

Reciprocity is the type of social capital embedded within personal relations and is often aligned with the giving of benefits to another in return for benefits received (Molm, Schaefer, & Collett, 2007). Putnam (2004) argues that it is reciprocity that is the highly productive component of social capital, and most likely to be associated with dense networks of social exchange (cited in Molm et al, 2007). Networks of civic engagement are an essential form of social capital. It is argued that the denser the networks of civic engagement the greater the likelihood of cooperation for mutual benefit as they instigate wider cooperation for mutual benefit (Scull, 2001).

Studies have shown that social capital is an important resource for supporting communities to take collective action on issues of concern to them,

contributing to social and economic growth. Putnam (2001) demonstrates that in the USA, high social capital is related to better educational performance, improved welfare of children (eg teen pregnancy, infant mortality), reduced crime at the state, community and neighbourhood level, better physical health and less economic and civic inequality.

A systematic literature review across countries found significant positive association between social capital and health at an individual level, in particular for self-rated health (Islam, Merlo, Kawachi, Lindstrom, & Gerdtham, 2006; Kim et al., 2006). A number of links between the social capital embedded in social networks and health include:

- social support that may function as a buffer to stress
- social influence on health behaviours such as smoking and diet (the benefit is dependent on the norm of the network group)
- social participation provides opportunities to learn new skills and a sense of belonging to the community
- group membership provides access to material resources eg job opportunities and health services (Eriksson, 2011; Merzel & D'Afflitti, 2003).

The Australian Government developed a national Social Inclusion Measurement and Reporting Framework to monitor progress being made in addressing social exclusion at a national level.

The indicators included in the framework cover three key concepts:

- Resources; which allow people to make choices about how they participate in society.
- Participation; such as in work, training or connecting with friends, helps build people's resources such as work experience, qualifications or support networks, which assists further participation.
- Multiple disadvantage which is measured by the proportion of people aged 18 to 64 years experiencing three or more of six disadvantages (Australian Social Inclusion Board, 2012).

The United Kingdom government use similar measures including resources and participation but have a point of difference measuring quality of life rather than multiple disadvantages (Levitas et al., 2007).

The report produced by the Australian Social Inclusion Board indicates statistically that Australia is prosperous, and faring well in comparison to other nations in the world. Yet despite this prosperity the levels of inequality remain high. Of particular concern is the overall increase in Australia's growth in income disparity in the past 15 years (Australian Social Inclusion Board, 2012).

Further, it is estimated around 5% of the working age population (640,000 people) experience multiple and entrenched disadvantage which may affect their ability to fully participate in the everyday activities of Australian society. Other areas that have been highlighted as areas requiring improvement include:

- 7% of people aged over 15 years have low economic resources and high financial stress (around 1.5 million people). The bulk of these are families with children.
- Only 54% of Aboriginal and Torres Strait Islanders aged 15-24 were fully engaged in education and/or work in 2008.

- Around 100,000 people were counted as homeless on Census night in 2006
- Attitudes towards people from different cultures worsened between 2007 and 2011
- The proportion of Australians who reported feeling safe walking alone in the city or area in which they live (64%) was lower than the OECD average (67%) (Australian Social Inclusion Board, 2012).

Vinson (2007) mapped levels of social disadvantage across Australia and found that despite Australia's recent strong economic growth, some communities remain caught in a spiral of low school attainment, high unemployment, poor health, high imprisonment rates and child abuse. Pockets of concentrated and severe social disadvantage have become entrenched across rural and remote as well as suburban Australia. The report estimates that in Victoria nearly one third of all communities suffer from 'low social cohesion' – where inadequate levels of community reciprocity, trust and resources make it more difficult for individuals and families to overcome the individual and family problems that lead to intergenerational poverty (Vinson, 2007).



Efforts to achieve social inclusion require commitment from all levels of government and the community. It is not just about fitting people into existing systems and structures, it is about transforming systems and structures to make them work for everyone (Australian Social Inclusion Board, 2012).

Understanding and utilising the term social inclusion can help build a strong policy framework that focuses on early intervention and prevention (ACT Council of Social Service, 2012).

Social inclusion which is broad and involves multiple domains, requires the government to see the importance of 'joined-up' services and implementing a whole-of-government approach. The government also needs to recognise the wide range of services that may not have been traditionally targeted, are required to address multiple areas of disadvantage (Kurzak, 2013; Smyth, 2010). Conversely, the same concept complexity means it is difficult to form policies where there is no clear responsibility and measurable outcomes (ACT Council of Social Service, 2011a).

## 5.1 INTERNATIONAL

The extent to which governments and organisations have considered social inclusion to inform social policy demonstrates a growing awareness of the global implications. Since the 1990s social inclusion strategies have been growing in popularity and there is now an international acknowledgement of social inclusion in health and social policy (Keleher & Armstrong, 2005).

Social inclusion became a priority in the UK government in 1997, with the establishment of the Social Exclusion Unit which reported directly to the Prime Minister. The aim of the unit was to develop coordinated policies to address social exclusion with the catch cry of "joined-up policies for joined-up problems". The Social Exclusion Unit was disbanded and transferred to a smaller taskforce in the Cabinet Office and shifted focus to the most severely excluded. The UK social inclusion policies that are directed at wide social exclusion have been reported as more successful, with a reduction in poverty among pensioners and children. However, poverty among working-age adults had not reduced and there as a problem of "in-work poverty" and the most disadvantaged families have not benefited and are still being left behind (Hayes, Gray, & Edwards, 2008).

During a meeting of the European Council in Lisbon, the Heads of State or Government launched a "Lisbon Strategy", aimed at making the European Union (EU) the most competitive economy in the world and achieving full employment by 2010. This was to be achieved in part by investing in human resources and combating social exclusion. The social inclusion approach evolved to tackle a wide range of social problems in Europe (Hayes et al., 2008).

Much of the social exclusion debate in the United States revolves around economic poverty and need for wealth generating interventions and strategies as the means to address the issue. More recently US commentary on social inclusion has alluded to the benefits and potential of adopting a policy which accepts that poverty is multidimensional and not limited to inadequate income (Boushey, Fremstad, Gragg, & Waller, 2007).

## 5.2 THE NATIONAL AGENDA IN AUSTRALIA

If social inclusion is about human rights, then there is a number of human rights legislation to guide the work of government departments and organisations (Government of South Australia, n.d.). The relevant legislation includes:

- the Equal Opportunity Act 1984, that seeks to prevent certain kinds of discrimination based on sex, chosen gender, sexuality, race, disability or age
- the Disability Services Act 1993, that provides for persons with disabilities to enjoy the same rights and responsibilities as other members of the Australian community including the same right to the assistance and support that will enable them to exercise their rights, discharge their responsibilities and attain a reasonable quality of life
- the Carers Recognition Act 2005, that seeks to recognise and support carers and their role in the community

# Policy context

- the Australian Government's Racial Discrimination Act 1975, Sex Discrimination Act 1984, and Disability Discrimination Act 1992 that prohibit discrimination on the basis of race, sex and disability respectively.
- United Nations Convention on the Rights of the Child. Specifically, Article 12 that relates to the right of children and young people to have an opinion and to be listened to, particularly in relation to the policies and programs that impact upon them.

From a policy perspective social inclusion strategies are gaining momentum as it is generally accepted that social inclusion can lead to significant economic savings through healthcare, justice and welfare (The Roeher Institute, 2003). The previous Australian Government (Australian Labour Party 2007 – 2013), demonstrated their commitment to social inclusion with the release of the Australian Government's national statement on social inclusion,

*"Social Inclusion means ensuring no Australian is left behind by giving all the opportunities, resources, capabilities and responsibilities to learn, work, connect with others and have a say in community life." (Gillard, 2010)*

The Australian National Social Inclusion Agenda included a ministerial portfolio and the establishment of the Social Inclusion Unit (Australian Government, 2009). The Social Inclusion Board, a part of this unit, was the main advisory board to the government on ways to engage the community to provide better outcomes for the most disadvantaged (Australian Ageing Agenda, 2013).

In 2014, the Coalition disbanded the Australian Social Inclusion Unit and abolished the social inclusion ministerial portfolio. The changes to the unit and other advisory boards indicate that responsibility now lies with social support providers (Australian Ageing Agenda, 2013). The Minister for Social Services media statements suggests the reforms in the welfare sector will see a move towards a civil society and a greater reliance on community involvement and participation (Andrews, 2014). This will see not-for-

profit organisations take on a greater role in finding innovative solutions to societal problems and creating a more inclusive society (Australian Ageing Agenda, 2013).

## 5.3 AUSTRALIAN STATES AND TERRITORIES

South Australia (SA) was the first to adopt a social inclusion strategy in 2002 and remain leaders in this area. The Government of South Australia, Department for Communities and Social Inclusion consists of Housing SA, Disability SA, Disability and Domiciliary Care Services and Youth Justice. The department brings together a range of services and policies designed to support vulnerable people and to help build resilient communities (Government of South Australia, 2014). In 2008 Tasmania established a Social Inclusion Unit as part of the Department of Premier and Cabinet, a Social Inclusion Strategy for the State was developed shortly thereafter (Tasmanian Government, 2008).

Victoria adopted a community development approach to address complex social issues for disadvantaged individuals and a neighbourhood renewal approach for disadvantaged locations. The government framework for addressing disadvantage and creating opportunity is entitled A Fairer Victoria, and cross-government work is being undertaken in relation to a number of priority issues including Indigenous people, those with mental health problems, refugees, vulnerable children and family violence (Hayes et al., 2008).

In Sept 2014, the Family and Community Development Committee tabled its report in Parliament for the Inquiry into Social Inclusion and Victorians with Disability. The report acknowledges that although there has been some progress in legislation and policy there is still a great deal of work to be done to operationalise disability action plans across local government. A Government response to this report has not yet been released, but it anticipated that this will further stimulate the social inclusion discussion (Family and Community Development Committee, 2014).

# The rural context

Nearly one in three people live outside Australian major cities - in rural, regional and remote areas across Australia (Australian Bureau of Statistics (ABS), 2008). They live in a variety of circumstances, from farms in remote areas to inner regional towns. They also live in a variety of social and economic conditions, with personal social and economic wellbeing often tied to the overall outcomes of their local area (Australian Council of Social Services, 2013).

The two main characteristics that differentiate between rural and urban communities are physical geographical isolation and smaller sized populations. Another critical difference is the level of disadvantage and poverty (Australian Council of Social Services, 2013). Rural areas are over presented among the disadvantaged according to indicators of disadvantage (ABS, 2000). As the level of inequality increases in Australia, the rural people are disproportionately impacted (Australian Social Inclusion Board, 2012).

People living in rural and remote areas tend to have higher levels of disease risk factors and illness than those in major cities and can have difficulty accessing services and staying connected with others (AIHW, 2010). This is reflected in the Accessibility/Remoteness Index of Australia that indicates people in outer regional areas are more likely than people in major cities to have a comparatively high proportion of people needing assistance (ABS, 2008).

People living in more isolated areas, even a few kilometres from a small country town, have to travel to access even basic services. Rural and remote communities have suffered over recent times from the reduction and loss of local services. Transport disadvantage is also common in specific geographical locations such as outer-urban (or "fringe") areas, rural and remote Australia. This is the result of a range of intersecting factors including poor public transport infrastructure, a higher proportion of low-income households and the need to travel further distances in order to get to places of employment, services and activities (Rosier & McDonald, 2011).

There are many differences in the social, economic, and cultural features of rural areas, as well as the physical difference in accessibility, that are likely to influence the process of social exclusion in rural areas (Shucksmith, 2003). Factors particularly affecting rural communities are multidimensional and include: agricultural and trade policy reforms; demographic

change and migration patterns; house prices; labour and skills shortages, restricted careers, access to information technologies; depletion of fossil fuels, climate change and reduced government involvement in service provision (Alston, 2005; Rawsthorne, 2009; Shucksmith & Arkleton 2000)

A number of Australian regional economic problems have developed over recent decades. The rising globalisation trend is changing patterns of regional trade and investments, reducing global trade barriers and increasing electronic information technology and communication. This has resulted in the increasing role of the multi-national corporations in controlling both the inputs and the marketing of agricultural commodities resulting in increased global competition and falling commodity prices. Many regional communities are confronting significant and rapid adjustment processes and difficult rural trading conditions accentuated by severe droughts (Collits, 2000; Rawsthorne, 2009).

Traditionally, rural communities have relied on the farm sector for their economic wellbeing but this is changing. Agriculture is increasingly accounting for less of Australia's economic output, farms are fewer, bigger and increasingly mechanised resulting in a fall in farm labour. In addition, farms are becoming less profitable and require to be supplemented by off-farm income. This has consequences for rural communities in the need for fewer farm workers, also the nature of the services provided to farms by the communities has changed and their level diminished, and the formerly close relationship between farms and rural communities has diminished (Collits, 2000).

This has resulted in the declining population in farming communities, with the fastest population declines in Australia experienced in rural areas (Barr, Karunaratne, & Wilkinson, 2005; Bureau of Rural Sciences, 2008; Kiem, Askew, Sherval, Verdon-Kidd, & Clifton, 2010). Population decline has a wide ranging effect on rural communities, including the most visible indicators

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such a decline in key industries and withdrawal of services such as banking and schools (Forth, 2001). Population decline has a negative impact on family incomes, educational attainment and opportunities and deteriorates quality of life and well-being, particularly in drought-affected rural communities (Bureau of Rural Sciences, 2008; Forth, 2001; Kiem et al., 2010).

An important regional trend is the ageing of rural areas compared to urban areas, with the majority of rural populations aged between 35 and 64 years (Bureau of Rural Sciences, 2008). In Australia the proportion of young people and families in rural areas has been declining, as young people move to urban areas for better education and employment opportunities (ABS, 2003). An aging population results in increasing demand for aged care services and raises concerns about the sustainability of the workforce in general, and the health and aged care workforce more specifically, in regional, rural and remote areas (Productivity Commission, 2011).

In the contexts of close-knit rural towns dominated by family farms, these shifting socio-demographic profiles can confront the identity, values and connections of communities. In some towns, this has inspired local response in the forms of economic and community development initiatives to stave off population decline, including tourism, with varying degrees of success (Kiem et al., 2010). In other rural locations, the decline of population continues with some respite due to inward migration of low-income families and new immigrants seeking affordable housing, a trend that has created its own social issues for rural areas in terms of service provision and support (Barr et al., 2005).

Seeking support services is negatively impacted by increased stigma and decreased anonymity. This particularly affects people who are disadvantaged in rural areas. The level of stigma rises and anonymity decreases as the size of the community decreases. In addition, the interconnected nature of rural community further reduces anonymity resulting in rural residence less likely to seek care than their urban counterparts. This is seen particularly in the case of mental illness (Smalley & Warren, 2014).

In rural communities, the smaller populations mean that there are fewer people to inform decision-making or initiate action. Although this prompts greater interactions between people in order to sustain the community, it is argued that heightened social involvement between rural members does not necessarily lead to better social equity. In fact, access to community influence and benefits is dependent on becoming a privileged or elite community member through family tenure or wealth and status (Alexander, 2005). Evidence suggests that upon securing an elite status, community members are able to use their status to maintain their standing and influence in community decisions. This results in the privileged community influencing decisions on the entitlement, allocation, and timing of community resources, leading to greater exclusion for those without power or influence (Onyx et al., 2007; Ostrom, 2000; Wilson, 2005).

Studies have shown that rural communities have less trust and tolerance of people outside the community and are resistant to social diversity. They attribute this to limited amount of bridging social capital (Onyx et al., 2007; Stone, 2001). They further state that an imbalance between poor bridging and high bonding social capital in rural communities restricts an incorporation of diverse thinking and material in future decision-making (Onyx et al., 2007; Stone, 2001). Marchant (2013) asserts that rural communities may fail unless they are able to renew existing social structures to more socially inclusive arrangements and that better social inclusion of individuals will supply novel solutions to innovate rural communities.

Due to the rapid development of digital media, access to this media has become crucial to participating in our modern society. In most developed countries computers and mobile phones have become indispensable to how people communicate, work and learn (Mayo, 2009 cited in Charleson, 2012). Increasingly, lack of access to information technology is creating a real social and cultural divide that is perhaps as potentially significant as the lack of ability to read and write. This is often referred to as the 'digital divide' (Charleson, 2012).

Much has been written about the 'digital divide' and



its impact on those affected. It refers to the perceived gap between those who have access to the latest information technologies and those who do not. Research tells us that there a range of factors that contribute to this digital divide along racial, economic, ethnic, and educational lines (Charleson, 2012). There is also geographical divide, where access to the internet is considerably lower in regional and remote areas compared to major cities. In addition, Regional and remote areas are at least 40% less likely to have Broadband access relative to major cities (ABS, 2007).

# Vulnerable population

The literature indicates that people most at risk of social exclusion are those who experience multiple and complex problems (financial, social, physical and psychosocial). Multiple disadvantages can have a compounding and persistent effect, reinforcing barriers to achieving wellbeing, accessing resources and utilising capabilities (UK Social Exclusion Task Force, 2007; Vale, Watts, & Franklin, 2009).

At a personal level, people experiencing multiple disadvantages often have increased mental health issues, higher levels of domestic violence and other criminal and antisocial behaviour, lower educational and employment, inadequate income that results in diminished access to affordable and appropriate housing and transport, and increased geographic and/or social isolation (Social Exclusion Task Force, 2007).

## 7.1 KEY TRANSITION PERIODS

The literature discusses the tendency of social exclusion to cluster at certain points across a lifecycle, for instance when people experience a change in their role or status, in expectations and responsibilities. The research shows that critical transitions include: early childhood and going to school for the first time; the transition to adulthood; leaving school or college (particularly early leavers); moving out of the family home; becoming a parent; becoming unemployed; retirement; losing a partner; leaving prison, hospitals or hostels, especially after a significant length of time or period of 'cycling in and out' of tertiary care (Bradshaw, Kemp, Baldwin, & Rowe, 2004; Chi-Wai Lui, Warburton, Winterton, & Bartlett 2011; The Roeher Institute, 2003).

At these times, people can be more vulnerable in their relationships as well as in their physical, mental and emotional resources. This weakens their capability to adapt to their changing needs (Vale, Watts, & Franklin, 2009).

## 7.2 INTERGENERATIONAL DISADVANTAGE

One of the most important aspects of any social inclusion agenda is that it aims to address intergenerational disadvantage. Inter-generational disadvantage refers to the disadvantage induced by the attitudes, social circumstances or economic limitations of a person's parents or guardians (Vinson, 2009b). A lack of education options, occupational status, poverty,

family violence, alcohol and/or other drug misuse and receipt of welfare all persist across the generations (d'Addio, 2007; Hayes, 2006; UNICEF & The Body Shop, 2006). Studies have also linked parental incarceration and young people who are engaged with the youth justice system (Australian Government Department of Family and Community Services, 2003).

## 7.3 DISADVANTAGED AREAS

A report that mapped levels of social disadvantage across Australia found pockets of localities with concentrated, severe and entrenched social disadvantage (Vinson, 2007). It has been found that when social disadvantage becomes entrenched within a limited number of localities a disabling social climate can develop that is more than the sum of individual and household disadvantages and the prospect is increased intergenerational disadvantage (Vinson, 2009a). Limited education, employment and the capacity for economic independence contribute to the making and sustaining of localised disadvantage in Australia (Vinson, 2007).

The indicators of disadvantage e.g. unemployment, limited education, high crime rates are interconnected, creating a web of disadvantage that traps people within highly disadvantaged communities. For example, progress in creating employment opportunities, can be inhibited by related factors like poor health, inadequate training or having a criminal record (Vinson, 2009a). Areas of high disadvantage frequently have limited or deteriorated social infrastructure and environments. However, research shows that focus on renewal and development of public spaces, housing, transport systems and business will not make a sustainable impact. Rather, the challenge is to build social capital and strengthen community capacity to self-manage, problem solve and 'pull together' to achieve common goals (Atkinson & Kintea, 2001, cited in Vinson, 2009a).

## 7.4 POPULATION GROUPS

Many organisations and local government councils in particular, identify vulnerable populations using demographic definitions (Brackertz, 2007). The most commonly identified population groups most at risk of social exclusion include:

- those with limited employment opportunities, particularly women,
- Cultural and linguistically diverse,
- refugees,
- gay, lesbian, bisexual, transgender and intersex community
- female and male sex workers,
- people living with disabilities,
- people living with drug addiction,
- people living with chronic illness (including mental ill-health),
- the long term unemployed/underemployed,
- people who are homeless,
- young people (especially early school leavers) and
- older people (especially those living on pensions). (ACT Council of Social Service, 2011a; Australian Social Inclusion Board, 2012; Government of South Australia, n.d.; Levitas et al, 2007)

The Australian Social Inclusion Board (2012) identifies particular population groups that are currently experiencing multiple disadvantage. These include low income, unemployed, homeless, children, Aboriginal people, CALD and people with disability. In Victoria there is also a focus on the older population in relation to social exclusion and social isolation.

Internationally there is a large body of evidence, and increasing policy attention being turned to issues of social exclusion in relation to the ageing population (Chi-Wai Lui et al., 2011). Social exclusion can be

particularly acute in later life for three primary reasons: people who are socially isolated in mid-life will usually experience further exclusion when they grow old; key life events or transition in later life like losing a partner can lead to social exclusion and isolation; and age discrimination inherent in social attitudes as well as institutional arrangement can intensify the marginalisation of older people (Barnes, Blom, Cox, & Lessof, 2006; Social Exclusion Unit, 2005).

The factors of cumulative social disadvantages, age-related characteristics, and age-based discrimination, coupled with the prevalence of non age-friendly community or neighbourhood characteristics, are the major causes of exclusion of older people (Chi-Wai Lui et al., 2011). Evidence from the English Longitudinal Study of Ageing suggests that social conditions such as depression, living alone or having no living children, having few transport options, living in rented accommodation, or having low income or low welfare benefits have the strongest statistical association with exclusion in later life (Barnes et al., 2006).

Carers are at high risk of becoming socially excluded and isolated. Caring often leaves little opportunity or time to maintain participation, inclusion and connection in other realms of life. As a result, carers can become disconnected from education, employment, family, friends and recreational pursuits (Department for Communities and Social Inclusion, 2013).

In Australia around 33% of those in the lowest income group experience fair or poor health compared to 6.5% of those in the highest income group. They are less likely than those in the highest income group to be able to get support in a time of crisis, have a lower life satisfaction rate and have access to the internet (Australian Social Inclusion Board, 2012). There has also been a sharp increase in the proportion of those with multiple disadvantages living in private rental housing and increased disadvantage faced by single people and lone parent families (Australian Social Inclusion Board, 2012).

Like other indicators of social exclusion, homelessness shows considerable continuity over life cycles and across generations. A major factor in homelessness is

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domestic violence, Mental illness and unemployment. It can have serious negative impacts, especially on the development, health, wellbeing and educational participation of young people (Hayes et al., 2008). A social Inclusion pilot program confirms that given the right level of support, people who have experienced long term homelessness can improve emotional and physical health, lower levels of stress, anxiety and depression and maintain their housing. However, the study also found that having a home does not necessarily lead to social acceptance and social inclusion. The extent to which the participants felt connected to and supported by the community did not change. With limited employment options, few social networks outside of the homeless population, and few alternative social activities, opportunities for social inclusion are limited (Johnson, Kuehnle, Parkinson, Sesa, & Tseng, 2014).

One group who experiences disadvantage across a whole range of factors, including but not limited to, employment, housing, education, health care, incarceration, homelessness, discrimination and alcohol and/or other drug misuse are Aboriginal and Torres Strait Islander peoples (Aboriginal people) (Silburn, Zubrick, Lawrence, & Mitrou, 2006). The Australian Social Inclusion Board (2012) reported that Aboriginal people, compared to the general Australian population have more substantiations of child protection notifications, been a victim of physical or threatened violence, are receiving welfare, live in a jobless household, not fully engaged in work or education, have not completed Year 12 and experienced discrimination. The high levels of intergenerational disadvantage continue to reinforce the cycle of social exclusion (ACT Council of Social Service, 2011b; Silburn et al., 2006).

Research in the United Kingdom has identified that social capital may be formed differently in culturally and linguistically diverse communities. This means that the concept of social inclusion and how people perceive themselves may vary significantly between different communities and can be influenced by experiences of migration, and economic, social, political and cultural factors (Zetter et al., 2006).

The research work undertaken through the Scanlon Foundation highlighted that one in two people from Non English Speaking Backgrounds are likely to be subject to discrimination during their lifetime (Markus & Dharmalingam, 2007). It is also recognised that there is a correlation between discrimination and social exclusion (Kabeer, 2000). Many exclusions stem from discrimination of individuals or groups on the grounds of their attributes, social, economic or physical disadvantages. Discrimination can impact a person's employment and income, their access to health care, education and other services. It can also make it very difficult to participate in their community, such as joining a community group (Triggs, 2013).

In 2010, the Australian Human Rights Commission conducted a review of human rights and social inclusion within African Australian communities. The research found that a lack of housing, limited employment opportunities and access to education were barriers to successful settlement and social inclusion, with an overlay of negative stereotypes, prejudice and racism (Triggs, 2013).

One in four Australians is directly touched by disability, either having a disability themselves or caring for someone with a disability (SCOPE, 2013). People with disability are more than twice as likely to live in poverty than other people in Australia (Australian Council of Social Services, 2012). New research reveals that Australians living with a disability are still feeling excluded from society, with community attitude still one of the biggest problems they face. Research conducted by disability service provider Scope in partnership with Deakin University found that 94% of the respondents said they do not have enough meaningful participation in their community. Almost 90% of people with a disability who completed the survey said their needs were not met for social contact with others and did not feel respected or valued by other people (SCOPE, 2013).

In 2009, over two million Australians of working age have a disability. The labour force participation rate for people with a disability (54%) was lower than for people with no disability (81%) (ABS, 2012). Although employment is an important factor in addressing



poverty and disadvantage, and builds self-esteem and social connectedness, there still appears to be a the lack of flexible job opportunities for people with disability, in particular mental illness (Cowling, 2005).

There is evidence that Australian children's development, health and wellbeing are increasingly being compromised, with signs of growing disadvantage, social exclusion and vulnerability in some communities. The interplay of child, family and community factors is seen in the areas of abuse and neglect, school failure and criminality, among others (A. Hayes et al., 2008). Child abuse rates provide one indicator of the extent of the problem, with the number of notifications of child abuse has increased by over 50% in the last five years, 2002–07 (Australian Institute of Health and Welfare, 2008).

Later childhood and youth is a key transition point that can determine a young person's future life chances. Young people who are at risk of a lifetime of social exclusion often have common characteristics which can be seen as risk factors, for example growing up in poverty or with poor parenting. Evidence shows that people who fall into certain groups at this life stage experience poor outcomes and are at risk of facing a lifetime of social exclusion, for example teenage parents, young offenders and problem drug users (UK Social Exclusion Task Force, 2007).

## 7.5 RISK FACTORS

Using the demographic grouping to identify and engage target groups becomes more complex in different contexts or locations and compounded when people fall into multiple groups (Brackertz, 2007). An alternative approach is to identify risk factors associated with social exclusion, which are prominent in creating and maintaining adverse life paths. This enables a focus on the needs of the socially excluded to identify a range of early intervention and prevention initiatives (Health and Safety Executive, 1994). Homel et al (1998) has divided the risk factors into Child, family, community and cultural factors and life events (see appendix 1).

# Protective factors

Risk factors point to where intervention may be needed. Protective factors suggest the form the intervention needs to take.

There is no predictable linear path from one kind of social exclusion outcome to another. Rather there is a set of mutually interacting circumstances, reinforcing a cycle of social exclusion (Bynner, 2000). There are also key turning points in a person's life, particularly in early childhood, when exclusion processes are most easily reversed onto the path of inclusion and vice versa (Bynner, 2000).

Belonging to a social network of communication and mutual obligation makes people feel cared for, loved, esteemed and valued. This has a powerful protective effect on health .behaviour patterns (R. Wilkinson & Marmot, 2003). High social capital may protect individuals from social isolation, create social safety, lower crime levels, improve schooling and education, enhance community life and improve work outcomes (Whiteford, Cullen & Bangana (in press) cited in Vic Health 2005).

Prevention and early intervention efforts are not only focused on vulnerability and risk. They also aim to enhance strengths, amplify protective factors and promote pathways to wellbeing (Hayes, 2006). Much of the focus of prevention and early intervention is in a child's early years. Many studies have demonstrated short to medium term positive effects but to break the cycle of social exclusion the benefits need to be sustainable (Hayes, 2006). Longitudinal studies show that participation in interventions that include improved school quality and parent participation are powerful determinants of longer term outcomes, with the benefits evident into early adulthood (Bynner, 2000; Currie & Thomas, 1995; Reynolds, Ou, & Topitzes, 2004).

The investment in human capital (skills, knowledge) has been shown to be protective against intergenerational effects within families and is also beneficial to the a state's economy (Bartholomae, Fox, & McKenry, 2004). Countries that do more to upgrade education and skills have faster economic growth, likewise in countries where fewer workers have relatively low basic skills, fewer households have relatively low incomes (Hirsch & Darton, 2003).

As social inclusion increasingly informs social policy, there is a strong level of demand for community workers to implement the ideals of community engagement, community capacity building, embracing diversity, facilitating collective action and empowerment on the ground (Alexander, 2005).

There is a growing body of practitioners working in these areas who are working to build networks in disadvantaged communities to mobilise collective social capital and break the cycle of intergenerational disadvantage. The multidimensional nature of social inclusion requires a joined up approach not only at government level but at a local level to promote the inclusion of individuals and communities in genuine participation.

Consistently evaluation of health and social initiatives highlight the importance of a systematic approach using project management processes. In the Victorian Government social inclusion Count Me In! Evaluation, the projects that reported high levels of success also reported having very structured action plans with documented tasks, timeframes, roles and responsibilities and supported by senior management. Project plans also built in sustainability factors at the outset (Victorian State Government, 2011).

Any strategies to address social inclusion require recognition of the complexity and multilayered nature of the local issues, taking into consideration the national policy and economic impacts, within a geographical context. Effective engagement is undertaken with an understanding of the historical, cultural and social complexity of specific local or regional contexts and with a genuine attempt to share power in relationships that foster mutual trust (Hunt, 2013). This enables a shared understanding of the issues resulting in better decisions for the solution, as is often coined 'understanding the problem is half the solution' (Holmes, 2011).

## 9.1 COMMUNITY ENGAGEMENT AND PARTICIPATION

Community engagement is not a new concept; it is about involving everybody in making decisions that affect them. A community engagement approach aims to improve services by being responsive to the needs of communities and helping people to find their own

solutions to local problems (Tasmanian Government, 2013). Yet, in 2010, nearly half of Australians aged 18 years and over reported to have difficulty in having a say in community issues (Australian Social Inclusion Board, 2012).

Successful and sustainable community participation requires community consultation and engagement. Effective consumer consultation creates transparency and a sense of trust, ownership and facilitates commitment (Department of the Environment Heritage and Local Government, 2005). Determining who is representative of the community is a complex and sometimes contentious issue, particularly where a small group is taken to represent a larger population (Brackertz, 2007). It is important to include the voices of the disadvantaged but it is also important to ensure equity and incorporate diverse people, voices, ideas, and information to ensure democratic legitimacy (Foot, 2009). Engaging the community may require creative thinking, a network of local contacts and the development of local understandings (S. Wilkinson, Stockl, Taggart, & Franks, 2009).

The development of community participation has also been a means to address health and social problems through social policy, legislation and engagement of the public in health planning. At a national and state level, a variety of models for community participation have been developed in Australia ranging from incorporating individuals into existing organisational committees to public partnerships, advisory committees, community health councils and citizen juries (Centre for Clinical Research in Health, 2006).

Research into community participation in social inclusion partnerships identified several key principles to encourage active community participation. These are: trust; equality; clarity of roles and responsibilities; agreement to listen; power sharing; accessible and transparent decision-making structures; empowerment; training, skills development and education for all partners (Chapman, Kirk, Carley, & Brown, 2001). The study found that community participation in multi-

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agency and local authority partnerships promotes comprehensive, holistic and innovative approaches to regeneration and social inclusion. It is now widely recognised that more should be done to ensure that communities are treated as true equal partners and that communities can influence the decisions that directly impact on their day-to-day lives (Chapman et al., 2001).

There is a long tradition of Australian rural community participation, in contributing to the development of services and programs. It is often premised on the assumption that the health of the community, its vitality and sustainability is threatened if services and programs are unavailable or inappropriate (Preston, Waugh, Larkins, & Taylor, 2010). A research synthesis of empirical studies linking rural community participation and health outcomes demonstrated that community participation can result in better access to services, more relevant and culturally appropriate services and the ability to maintain a service in the face of a threat to remove it (Preston et al., 2010). Further to this, Preston et al (2010) found evidence that community participation can result in beneficial health outcomes and increased uptake of services. One study that had a profound effect on health outcomes used an empowerment and developmental approach to community participation resulting in significant improvement in birth outcomes in a poor rural population. Through a cluster randomised trial they demonstrated a significant reduction in infant and maternal mortality rates (Manandharet al, 2004).

Revitalizing rural areas must include the participation of communities in search of positive change, whereby local people are encouraged to think more about their futures and to put into practice their ideas for securing those futures (Keller, 2000). This requires community capacity building, which aims to 'increase the self-sustaining ability of people to recognize, analyse and solve their problems by more effectively controlling and using their own and external resources' (De Graaf, 1986). This approach has been described as the empowerment approach to community capacity building. (Preston et al., 2010). Such an effort requires passion for the issues, expertise in planning and program development, and an appreciation for existing

community networks, leadership skills, and, most of all, time. (Goodman et al., 1993 cited in Crisp et al., 2000).

## 9.2 EMPOWERMENT

Empowerment is a key theme throughout the literature on social inclusion, in some instances referred to as self-determination. Most importantly it refers to the capacity of individuals and communities to get what they want or need; and to influence others effectively to further their own interests (Baum et al., 2000).

In an attempt to move from top-down frameworks of imposed development models, empowerment places the emphasis on local people, local contexts, and local forms of power and change. This is not to say that there is no element of top-down facilitation and pressure involved, indeed top-down stimulus can facilitate bottom-up rural development (Sobels, Curtis, & Lockie, 2001).

At the very core of empowerment is the concept of power. How the balance of power works is heavily debated. Understanding power as zero-sum means that one person's power gain is equivalent to another's loss of power and remains in the hands of the powerful unless they give it up. This gives a perspective on the power struggles and conflict that underpin the work of community developers in whichever arena they work (Labonté & Laverack, 2008). An opposing argument is that aspects of power are not zero-sum, but are shared, one that is characterized by collaboration, sharing and mutuality. Conceptualizing power in this way mean that gaining power actually strengthens the power of others rather than diminishing it such as occurs with domination (Kreisberg, 1992 cited in Page & Czuba, 1999). It is this concept of power, as a process that occurs in relationships, that gives us the possibility of empowerment (Page & Czuba, 1999).

Governments and organisations cannot 'give' empowerment to people. Organisations can facilitate, support and encourage empowerment but empowerment must come from within to actually be empowering. Specific actions do not lead to empowerment; rather it is the context in which these actions and decisions are taken which facilitate and



promote empowerment (Laverack & Wallerstein, 2001; Oxaal & Baden, 1997).

Empowerment can be facilitated by making the space, creating the conditions and removing the barriers. Social capital can be enhanced through a process of building capacity and self esteem that can come from skills attainment and learning (Bourdieu & Passeron, 1990). Building the capacity of community members is an investment for the future as it focuses on building the skills base of people that are going to be active in that community for a long time to come. This in turn, becomes a key strategy for building ownership in communities (King & Cruickshank, 2010).

Increasingly, community workers/developers are working to build networks in disadvantaged communities to gather their collective resources and utilise their social capital (Alexander, 2005). The power within bonding social capital is closely related to the notion of empowerment within horizontal networks of equals. Bridging social capital can also be empowering as it serves to expand the networks of skills and resources not otherwise accessible (Onyx et al., 2007).

A case study of the Landcare networks in rural areas attributed their success to the available and developed social capital (Sobels et al., 2001). They found the process to empowerment was based on trust, norms, expectations of reciprocity and linkages within the networks. From this base, social capital, government stimulus, financial capital, physical resources and information combined to solve collective action problems. These networks attracted substantial funding, created opportunities for participation and shared learning and carried out extensive on-ground works (Sobels et al., 2001).

Evidence based on multi-level research designs have demonstrated that empowering initiatives can lead to better health outcomes and is a viable public health strategy (Wallerstein, 2006). One of the most striking example of the strength of empowerment is the feminist movement (Oxaal & Baden, 1997). Women's empowering interventions, integrated with the economic, educational, and political sectors, have shown the greatest impact on women's quality of life,

autonomy, policy changes, and improved child and family health (Wallerstein, 2006).

Making community empowerment operational requires a process to implement and measure the progress of the initiative (Laverack & Wallerstein, 2001). A set of nine empowerment domains have been identified to provide a guide to planning, implementation and evaluation of health promotion programmes, at the local or community level (see table 1). The operational domains represent those aspects of community empowerment that allow individuals and groups to organize and mobilize themselves towards commonly defined goals of social and political change (Laverack & Wallerstein, 2001).

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**Table 1. The empowerment domains**

Empowerment domains	Domain descriptions
Participation	Only by participating in small groups or larger organisations can individual community members act on issues of general concern to the broader community.
Leadership	Participation and leadership are closely connected. Leadership requires a strong participant base just as participation requires the direction and structure of strong leadership.
Organisational structures	Organisational structures in a community represent the ways in which people come together in order to socialise and to address their concerns and problems.
Problem assessment	Empowerment presumes that the identification of problems, solutions to the problems and actions to resolve the problems are carried out by the community.
Resource mobilisation	The ability of the community to mobilise resources both from mobilisation within and the ability to negotiate resources from beyond itself is an important factor in its ability to achieve successes in its efforts.
Links to others	Links with people and organisations, including partnerships, others coalitions and voluntary alliances between the community and others, can assist the community in addressing its issues.
Asking why	The ability of the community to critically assess the causes of its own inequalities.
Program management	Programme management that empowers the community includes the control by the primary stakeholders over decisions on planning, implementation, evaluation, finances, reporting and conflict resolution.
Role of outside agents	The outside agent increasingly transforms power relationships outside agents such that the community assumes increasing programme authority.

Source: (Laverack, 2001)

### 9.3 JOINED UP APPROACH

It is generally agreed that given the complexity and multi-dimensional nature of social inclusion, multi-faceted, 'joined-up' responses are required to make a difference (Victorian State Government, 2007). Numerous phrases are used in the literature to describe 'joined up' approaches. These include 'multi-agency', 'service coordination', 'working in partnership', 'holistic approach', 'whole of government', 'Open Method of Co-ordination' and 'integrated services' (Tasmanian Government, 2009; Victorian State Government, 2007; Zeitlin, 2005). Governments are recognizing that traditional silo based government structures cannot address the complexities of social inclusion in isolation (Tasmanian Government, 2009).

Governments, in particular UK, EU, Canada and Australia are pursuing joined up government, with a focus on improving integrating and coordinating government policy and service delivery to achieve common goals and respond to an identified high priority issue, including social inclusion/exclusion (Victorian State Government, 2007; Zeitlin, 2005). Joined up government approaches require collaborative relationships where common goals, recognised interdependencies, high levels of commitment, and shared responsibilities and rewards are established (Victorian State Government, 2007).

Another important area that a joined up approach can address is the duplication and lack of coordination between agencies and services (Victorian Department of Health, 2010). This is further driven by the rising community expectations for government to provide accessible coordinated and integrated services that meet their needs rather than reflecting departmental structures and boundaries (Commonwealth of Australia, 2004).

The modern social and health care system is complex with a mixture of government, non-government and private service providers with different service, business and funding models. One of the critical factors leading to better access and coordination of services, reducing duplication and improving efficiencies' is the extent to which services are integrated (Victorian

Department of Health, 2010). The Victorian Department of Health (2012) defines service integration/coordination as;

*'Service coordination places consumers at the centre of service delivery to maximise their opportunities for accessing the services they need. Service coordination enables organisations to remain independent of each other, while working in a cohesive and coordinated way to give consumers a seamless and integrated response' (Victorian Primary Care Partnerships, 2012).*

Evidence from North America and Europe shows that integrated health and social care systems for older people and disease management for patients with long-term conditions can deliver positive health and social benefits (Curry & Ham, 2010).

Strong partnerships between local services provide opportunities to share information and resources to provide integrated care for the community and in particular those with complex and multiple disadvantages. However, continuous changes in political priorities and funding models make sustaining effective partnerships difficult. Rigid governance structures delay decision making and may not support the flexibility and responsiveness required for partnership work (Robertson & Wilkinson, 2010).

Partnerships and collaboration models are strongly integrated into Australian government policy and guidelines. However, logistically partnership work requires commitment, trust and at times extra resources, especially in rural areas that may need to sustain networks and partnerships over long distances (Chapman et al., 2001). To facilitate and support partnerships and service integration, the Commonwealth Government funded not-for-profit companies to improve coordination and integration of primary health care in local communities and address service gaps (Australian Government, 2014). In Victoria, the state government currently funds Primary Care Partnerships to facilitate local organisations to work together to provide their community with accessible and integrated health and social services and

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prevention opportunities. The Primary Care Partnership is particularly focused on a multi-sectoral approach, within a local context, to meet the needs of people with complex and multiple disadvantages (Victorian Department of Health, 2010).

Collective impact is gaining global attention as a vehicle to affect education, poverty, community development, social inequalities and environmental change. Collective impact has been defined as the commitment of a group of people from different sectors to a common agenda for solving a complex social problem (Kania & Kramer, 2013). Collective impact is different to a collaborative or a network in that it involves a centralised infrastructure, known as a backbone organization, with dedicated staff and structured processes that lead to common agenda, shared measures, continuous communication and mutually reinforcing activities between all participants (Kania & Kramer, 2013).

The Go Goldfields Alliance is an example of local organisations coming together as equal partners to address some of the major, complex social problems that are impacting on a rural shire. These organisations have formed an alliance, supported by the Primary Care Partnership, with a common agenda and shared measures, to develop a place-based approach to address issues that are barriers to an inclusive and equitable community. The interim evaluation highlighted the necessity of embedding processes to strengthen the ability to partner effectively and continuously work towards developing shared vision, language and frameworks across services and between service sectors (Shannon, 2013).

## 9.4 COLLECTIVE ACTION

The community is more powerful when they work together rather than in isolation, to improve the quality of their lives. Their shared beliefs in their collective efficacy to accomplish social change play a key role in the policy and public health approaches to improve wellbeing. Collective action involves a group of people that voluntarily engage in a common action to pursue a shared interest (Meinzen-Dick, Di Gregorio, &

McCarthy, 2004). Collective action can take many forms including resource mobilisation, activity coordination, information sharing or the development of institutions (Poteete & Ostrom, 2003).

The three subjective variables that could affect and motivate collective action that have received most academic attention are perceived injustice (unjust disadvantage), perceived efficacy (people believe this will make it more likely that relevant goals are achieved.), and a sense of social identity (Van Zomeren, Postmes, & Spears, 2008). Social identity theory proposes that people generally strive for and benefit from positive social identities associated with their membership groups.

When group membership is believed to be based on individual performance, members of disadvantaged groups will engage in individual behaviours designed to improve their personal position. However, if their attempts at upward mobility are continually being blocked, their perception of social stratification will be based instead on external characteristics such as race, sex or being born within a particular socio-economic class. This results in intergroup comparisons leading to dissatisfaction with their disadvantaged position and interest in collective action as a means of creating a more open system (Ellemers, Kortekaas, & Ouwerkerk, 1999; (Van Zomeren et al., 2008; Wright et al, 2001).

Case studies demonstrate that social networks are an important component of collective action and a more robust connection of relationships occur if collective action builds upon existing social networks (Adger, 2003; Ireland & Thomalla, 2011). Collective action is facilitated through the inhibition of short-term self-interested behaviour via a self-reinforcing cycle of trust, reciprocity and reputation (Rudd, 2000).

Belief in meritocracy is powerful in the United States, and there is very little serious discussion of structural impediments to individual achievement (Kluegel & Smith, 1986). This contributes to keeping collective action low through limiting system blame or the perpetuated sense of 'personal responsibility for not having X' (Duncan, 2012). Therefore, when members of low-status groups are relatively powerless, they

mostly believe it is their own fault and that if they exerted enough effort they would succeed. One major purpose of social movement organisations is to provide individuals with alternative, systemic explanations for their lack of power and influence, and to encourage and model collective action as a strategy for redressing power imbalances. Research has shown that education about systemic causes of powerlessness in a particular group increases group consciousness and collective action (Duncan, 2012).

Research highlights the importance of formal governance structures and processes in supporting or hampering collective action (Ireland & Thomalla, 2011; Rudd, 2000). Having competent and committed individuals in local governance processes that have access to adequate human and financial resources is a strong enabler of effective action at the community level. Equally important are the role and influence of certain interest groups, and the existing barriers due to limited resources and capacities, different priorities and approaches, distrust and tensions, and a lack of coordination of local government, NGO and private sector (Ireland & Thomalla, 2011). Political stability can also increase the odds of successful collective action by allowing increased levels of predictability about the social environment within which individuals engage in (Rudd, 2000).

## 9.5 CULTURAL DIVERSITY AND COMPETENCY

Australia has a rich and culturally diverse population. In 2009, about a quarter of the estimated resident population comprised of those born overseas (Australian Government, 2012). Within the framework of Australia's laws, all Australians have the right to express their culture and beliefs and to participate freely in Australia's national life (Australian Government, 2012). However, research tells us that one in two people from non English speaking backgrounds are likely to be subject to discrimination during their lifetime (Markus & Dharmalingam, 2007). In addition, studies have demonstrated a correlation between discrimination and social exclusion (Kabeer, 2000).

Cultural competence is a key consideration to ensuring cultural diversity is integrated into social inclusion agendas and initiatives (Hayter, 2009). This may require attention particularly in rural communities where there is less trust and tolerance of people outside the community and resistant to social diversity (Onyx et al., 2007; Stone, 2001). Cross et al (1989) define cultural competence:

*'as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross cultural situations'.*

Cultural competence requires organisations and their personnel to have the capacity to: value diversity; conduct self-assessment; manage the dynamics of difference; acquire and institutionalise cultural knowledge; and adapt to the diversity and cultural contexts of the all individuals and communities. Cultural competence means working effectively with individuals while discovering, recognising and understanding the influence of culture on practice (Cross, Bazron, Dennis, & Isaacs, 1989).

In the United Kingdom there has been some development work in understanding the nature of community cohesion within the context of cultural and linguistic diversity. What they have found is that a cohesive community is where:

- there is a common vision and sense of belonging for all communities
- the diversity of people's different backgrounds and circumstances is appreciated, respected and positively valued
- those from different backgrounds have similar life opportunities
- strong and positive relationships are being developed between people from different backgrounds in the workplace, in schools and within neighbourhoods (Cantle, 2004).



Although Australia is prosperous and faring well in comparison to other nations in the world, there still remains a widening inequality in which rural people are disproportionately impacted.

The literature argues that the ability to participate in society, and to be free from discrimination and disadvantage is a basic human right, providing a mandate for action. It is in the national interest to address social inclusion as there are links to productivity, economic development and participation in the workforce. However, the complexity and multi-dimensional nature of social inclusion challenges policy makers and practitioners to make an impact on the most disadvantaged populations in the community.

There is evidence that effectively engaging the community, building community capacity, mobilising collective social capital, embracing diversity and facilitating community empowerment may break the cycle of intergenerational disadvantage. Joined-up responses recognise the multi-dimensional nature of social inclusion whilst affording a significant focus on prevention and early intervention strategies.

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# Appendix 1

**Table 1. Risk factors for poor development, health and wellbeing outcomes**

Child factors	Family factors	School context, School failure	Community and culture
Prematurity	<b>Parental characteristics:</b>	Normative beliefs about aggression	Socioeconomic disadvantage
Low birth weight	Teenage mothers	Deviant peer group	Population density and housing conditions
Disability	Single parents	Bullying	Urban area
Prenatal brain damage	Psychiatric disorder, especially depression	Peer rejection	Neighbourhood violence and crime
Birth injury	Substance abuse	Poor attachment to school	Cultural norms concerning violence as acceptable
Low intelligence	Criminality	Inadequate behaviour management	Response to frustration
Difficult temperament	Antisocial models	<b>Life events</b>	Media portrayal of violence
Chronic illness	<b>Environment:</b>	Divorce and family break-up	Lack of support services
Insecure attachment	Family violence and disharmony	War or natural disasters	Social or cultural discrimination
Poor problem solving	Marital discord	Death of a family member	
Aggressive, acting out behaviour	Disorganised		
Beliefs about aggression	Negative interaction		
Poor social skills	Social isolation		
Low self-esteem	Large family size		
Lack of empathy	Father absent		
Alienation	Long-term parental unemployment		
Hyperactivity/ disruptive behaviour	Low family SES		
Impulsivity	<b>Parenting style:</b>		
	Poor supervision and monitoring of child		
	Discipline style (harsh or inconsistent)		
	Rejection of child		
	Abuse/neglect		
	Lack of warmth and affection		
	Low involvement in child's activities		

Source: (Hamel et al., 1999)

# Appendix 2

## Protective factors for development, health and wellbeing outcomes

Child factors	Family factors	School context	Community and cultural factors
Social competence	Supportive, caring parents	Positive school climate	Access to support services
Social skills	Family harmony	Pro-social peer group	Community networking
Above average intelligence	More than two years between siblings	Responsibility and required helpfulness	Attachment to the community
Attachment to family	Responsibility for chores or required helpfulness	Sense of belonging/ bonding	Participation in church or other community group
Empathy	Secure and stable family	Opportunities for some success at school and recognition of achievement	Community/ cultural norms against violence
Problem-solving	Supportive relationship with other adult	School norms re violence	A strong cultural identity and ethnic pride
Optimism	Small family size	Avoidance of deviant peer involvement	Participation in adult organised peer group activities
School achievement	Strong family norms and morality		
Easy temperament	Parental supervision/ monitoring		
Internal focus of control			
Moral beliefs			
Values			
Self-related cognitions			
Self-control or self-regulation			
Good coping style			

Source: (Homel et al., 1999)



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